Record of Determinations –
Medical Practitioners Tribunal

PRIVATE RECORD

Dates: 29/01/2018 – 06/03/2018
Medical Practitioner's name: Mr David Patrick SELLU

GMC reference number: 1623518

Primary medical qualification: MB ChB 1973 University of Manchester

Type of case
New - Misconduct

Outcome on impairment
Not impaired

Summary of outcome
Case concluded

Tribunal:

Lay Tribunal Member (Chair)	Ms Gill Mullen
Medical Tribunal Member:	Mr Mike Hayward
Medical Tribunal Member:	Dr John Moriarty

Legal Assessor:	Mrs Nessa Sharkett
Tribunal Clerk:	Dr Joshua Kirby

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Ian Stern, QC, instructed by Weightmans LLP
GMC Representative:	Mr Paul Williams, Counsel

Record of Determinations –
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Allegation and Findings of Fact

That being registered under the Medical Act 1983 (as amended):

1. On 11 February 2010, you failed to provide good clinical care to Patient A, in that you did not:

    a. arrange for the requested CT scan to be carried out on 11 February 2010; **Found not proved**

    b. perform surgery on Patient A, despite being aware of Patient A's perforated viscus; **Found not proved**

    c. initiate resuscitative measures, in that you did not:

        i. prescribe antibiotics; **Found not proved**

        ii. ensure antibiotics were administered to Patient A; **Found not proved**

        ~~iii. review the results of Patient A's arterial blood gas measurements.~~ **Withdrawn by the GMC**

2. On 12 February 2010, you failed to provide good clinical care to Patient A, in that you did not:

    a. review Patient A; **Found not proved**

    b. make immediate arrangements to perform urgent surgery on Patient A; **Found not proved**

    c. give clinical priority to Patient A in that you did not:

        i. arrange to perform laparotomy surgery before you completed your clinic; **Found not proved**

        ii. return to Patient A until you had completed your afternoon list. **Found not proved**

    d. source an Anaesthetist for Patient A's surgery, in that you did not:

        i. break into a colleagues list; **Found not proved**

        ~~ii. ask for help to try and find an Anaesthetist.~~ **Withdrawn by the GMC**

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.

Attendance of Press / Public
The hearing was all heard in public.

Determination on Facts - 01/03/2018

Mr Sellu:

Application under Rule 34(13)

1. On day five of this hearing, Tuesday 6 February 2018, Mr Williams, Counsel, made an application on behalf of the General Medical Council ('GMC'), under Rule 34(13) of the GMC (Fitness to Practise) Rules 2004, as amended ('the Rules'), for Ms Ann Williams to give oral evidence by means of a video link. Mr Williams made the application on the basis that Ms Williams was unable to travel to Manchester for medical reasons. Mr Williams told the tribunal that Ms Williams had originally understood that the hearing would be taking place in London and that she had only raised the issue of travel with the GMC latterly, once it became clear to her that the hearing would take place in Manchester. Given that Ms Williams was unable to physically attend the hearing, Mr Williams submitted that it would be fair and proper for her to give evidence by means of a video link.

2. Mr Stern, QC, did not oppose the application on your behalf. However, referring the tribunal to the quality of the video link when Mr Nuno Rodrigues gave evidence by that means, Mr Stern told the tribunal that, were the quality of Ms Williams' video link also poor, he would seek her attendance in person.

3. The tribunal agreed to the application because it considered that it was in the interests of justice to do so, in accordance with Rule 34(14).

Application under Rule 35(5)

4. On day six of this hearing, following Dr Vishwanatha's evidence, Mr Stern made an application under Rule 35(5) for Ms B, one of Patient A's daughters, to be invited by the tribunal to give evidence by means of a telephone link.

5. Rule 35(5) states:

> The Committee or Tribunal may, on the application of a party or of its own motion, require a witness to attend a hearing and the relevant party shall exercise its power to compel attendance under paragraph 2 of Schedule 4 to the Act accordingly.

6. Mr Stern told the tribunal that in 2010 Ms B prepared a statement for the Coroner's Inquest into the death of her father, Patient A, and that she gave evidence during that inquest. Mr Stern submitted that there was no dispute that what Ms B said in her statement to the Coroner was pertinent to Dr Vishwanatha's evidence. Mr Stern submitted that given the nature of the case, it would not be the most sensitive course for Ms B to be called to give evidence by your legal representatives. He therefore invited the tribunal to consider whether it ought to call Ms B to give evidence. Mr Stern submitted that were the tribunal to agree to the application in principle, then Ms B could be contacted by the GMC and if she agreed to give evidence by telephone, then her availability could be accommodated and, if required, her evidence could be interposed with that of other witnesses.

7. Mr Williams did not oppose the application but reminded the tribunal that Ms B was not a witness relied upon by the GMC. Accepting the sensitivity of the situation, Mr Williams submitted that it might be more appropriate for the tribunal to call Ms B as a witness rather than your legal representatives, if the tribunal deemed her evidence to be sufficiently relevant to the issues under consideration.

8. The tribunal determined to grant the application under Rule 35(5) in principle, and it considered that it was in the interests of justice to invite Ms B to give evidence by means of a telephone link under Rule 34(13). In making its decision, the tribunal determined that Ms B's factual evidence was relevant to the issues it was required to determine at this hearing. Having agreed to the application in principle, efforts were made to contact Ms B, who agreed to give evidence to the tribunal by telephone on Tuesday 13 February 2018.

Application under Rule 17(6)

9. During the course of Mr Faiz's evidence on day twelve of this hearing, 19 February 2018, Mr Williams made an application under Rule 17(6) to amend the particulars of the allegation and to withdraw sub-paragraphs 1(c)(iii) and 2(d)(ii). Mr Williams submitted that the GMC no longer intended to pursue those sub-paragraphs of the allegation. Mr Stern did not oppose the application on your behalf.

10. The tribunal granted the application because it considered that the amendment to the allegation could be made without injustice. Sub-paragraphs 1(c)(iii) and 2(d)(ii) were therefore withdrawn from the allegation.

Background

11. You are a Consultant General and Colorectal Surgeon. You predominantly practise in the NHS, but you also undertake work in the private sector. You graduated with an MB ChB from the University of Manchester in 1973 and you then went on to train as a surgeon in hospitals in Manchester, London, and Birmingham. You were appointed as a Consultant Surgeon at a hospital in Oman in 1987, where you worked until 1993. That

year, you returned to the UK and took up a position as a Consultant General Surgeon specialising in colorectal surgery at Ealing Hospital in London, part of London North West Healthcare NHS Trust, where you continue to work. In 1997 you were granted practising privileges at the Clementine Churchill Hospital ('the Clementine') in Harrow, Middlesex; a private healthcare facility which is owned and operated by BMI Healthcare Limited.

12. It is alleged by the GMC that your fitness to practise is impaired by reason of your misconduct. The allegation you face relates to the standard of the clinical care you provided over the 11 February 2010 and 12 February 2010 to Patient A, a patient at the Clementine.

13. Patient A was admitted to the Clementine on 5 February 2010 for an elective procedure to replace his left knee, under the care of Consultant Orthopaedic Surgeon Mr Hollingdale. Having undergone the knee replacement procedure on 5 February 2010, Patient A was recovering well post-operatively apart from a suspected urinary tract infection (UTI) for which he had received intravenous antibiotics. However, on Thursday 11 February 2010 Patient A woke to abdominal pain which he continued to experience throughout the day. Having been approached directly by Patient A, through a telephone call to his secretary about the pain Patient A was experiencing, Mr Hollingdale attended personally upon Patient A and carried out an abdominal examination. Although Mr Hollingdale then proceeded to request x-rays and blood tests be carried out, he acknowledged that this was outside of his area of expertise and asked you to examine Patient A, which you did that evening. The following day, Friday 12 February 2010, a perforated bowel was identified on a CT scan and you operated on him that evening and into the morning of Saturday 13 February 2010. On 14 February 2010 Patient A died. His cause of death was recorded as: a) multiple organ failure; b) faecal peritonitis; and c) perforated diverticulum. Following Patient A's death a Coroner's Inquest took place, followed in turn by an investigation by the Police. You were subsequently prosecuted for and convicted of gross negligence manslaughter. You appealed your conviction, and your conviction was quashed when your appeal was allowed.

14. This case is not about causation. It is not alleged by the GMC that your actions or inactions were a cause of, or hastened the death of Patient A. The GMC accepts that your diagnosis was correct, and that the surgery you performed was of a good standard. What this tribunal is required to determine, is whether or not you failed to provide good clinical care to Patient A on Thursday 11 February 2010 and Friday 12 February 2010.

15. In respect of 11 February 2010, it is alleged by the GMC that you failed to provide good clinical care to Patient A in that you did not: arrange for the requested CT scan to be carried out that day; perform surgery on Patient A, despite being aware of his perforated viscus; and initiate resuscitative measures, in that you did not prescribe antibiotics to Patient A and ensure that antibiotics were administered

to him. In respect of 12 February 2010, it is alleged by the GMC that you failed to provide good clinical care to Patient A in that you did not: review him; make immediate arrangements to perform urgent surgery on him; give clinical priority to him in that you did not arrange to perform laparotomy surgery before you completed your clinic and return to him until you had completed your afternoon list; and source an anaesthetist for Patient A's surgery in that you did not break into a colleague's list.

Factual Witnesses and Evidence

16. In reaching its determination on the facts, the tribunal has taken into account signed witness statements from the following factual witnesses:

- Mr John Hollingdale: a Consultant Orthopaedic Surgeon at the London North West Healthcare NHS Trust, who also carries out private work at the Clementine;
- Dr Leena Ali: a Consultant Anaesthetist who holds practising privileges at the Clementine;
- Dr Sanjay Bajaj: a Consultant Anaesthetist who carried out private locum work at the Clementine in February 2010;
- Mr Brian Burgess (deceased): RIS/PACS Manager in 2010 at the General Healthcare Group, which owns and operates a number of acute care hospitals under the trading name BMI Healthcare;
- Ms Maxine Chandler: a Theatre Scrub Nurse and bank Advanced Scrub Practitioner at the Clementine in February 2010;
- Ms Mary Curran: a Clinical Lead – Cardiac Project at the Clementine in February 2010;
- Mrs Jane Hollingdale: Mr Hollingdale's Medical Secretary;
- Dr Robin Kantor: a Consultant Radiologist at the Hillingdon Hospital NHS Foundation Trust in 2010, who also carried out work at the Clementine;
- Ms Muhaddisa Kassam: a Diagnostic Radiographer at the Clementine in February 2010;
- Ms Geraldine Lenihan: Nursing Director at the Clementine in February 2010;

- Mr Tariq Mahmood: a part-time Radiographer at the Clementine in February 2010;
- Mr Julius Podaan: a Senior Staff Nurse at the Clementine in February 2010;
- Mr Nuno Rodrigues: a Theatre Scrub Nurse at the Clementine in February 2010;
- Ms Rita Rulach: a Nurse at the Clementine in February 2010;
- Ms Jean Salmorin: Clinical Nurse Specialist in Gynaecology and Urology at the Clementine in February 2010;
- Ms Hansa Sumaria: a Staff Nurse at the Clementine in February 2010;
- Dr Tan Tran: a Consultant Radiologist at the Clementine in February 2010;
- Dr Kashi Vishwanatha: a Consultant Anaesthetist at Central Middlesex Hospital in 2010 who also worked at the Clementine;
- Dr Elizabeth Whitehead: a Consultant Anaesthetist at the London North West Healthcare NHS Trust who worked with you at Ealing Hospital as well as the Clementine;
- Ms Ann Williams: Acting Theatre Manager at the Clementine in February 2010;
- Ms Yvonne Wilkins: Nurse Manager of the Blenheim Ward at the Clementine in February 2010;
- Dr Mark Wrigley: a Consultant Anaesthetist at Central Middlesex Hospital, part of the London North West Healthcare NHS Trust, who also worked at the Clementine in 2010;
- Ms Jacqueline Amodio: a Health Care Assistant at the Clementine in February 2010;
- Ms Kulvinder Sahota: a Staff Nurse at the Clementine in February 2010;
- Dr Bharti Shah: a Consultant Radiologist at the London North West Healthcare NHS Trust who also worked at the Clementine in 2010;

- Dr Gary Wares: Lead Consultant for Critical Care at the London North West Healthcare NHS Trust in 2010, with practising privileges at the Clementine;

- Mr Neil Garner: a Staff Nurse at the Clementine in February 2010;

- Ms Janice Hale: Executive Director at the Clementine in February 2010; and

- Ms B: one of Patient A's daughters.

17. A number of the aforementioned written statements were agreed between the parties, and the tribunal had no need to hear further evidence from them. Where evidence was not agreed, or the tribunal required further clarification, these witnesses gave oral evidence to the tribunal in addition to their witness statements. The tribunal has also had regard to the statements made to the police by a number of these individuals and, in respect of some of them, their statements made to the Coroner. In addition, the tribunal has also taken into account all the other documentary evidence, which included parts of Patient A's medical records.

18. The tribunal has taken into account two statements you made to the Coroner, dated 7 March 2010 and 21 July 2010, and extracts from the transcripts of some of your police interviews. It has also taken into account your signed witness statement prepared for these proceedings, dated 1 February 2018, as well as your oral evidence.

Expert Evidence

19. In addition to the evidence of the factual witnesses, the tribunal received reports from four expert witnesses. Two of the reports were prepared by Consultant Haematologists centring on a discrete issue. On behalf of the GMC it received a report dated 6 February 2018 from Dr Vanessa Martlew, a Consultant Haematologist at the Royal Liverpool and Broadgreen University Hospitals NHS Trust. On your behalf, the tribunal received a report dated 31 December 2017 from Dr Raj Patel, a Consultant Haematologist at King's Thrombosis Centre, King's College Hospital in London. The tribunal also received two reports, dated 12 January 2017 and 1 November 2017, from the GMC's expert witness, Mr Michael Zeiderman, a Consultant Surgeon and Clinical Lecturer at the Southport & Ormskirk Hospital NHS Trust. It also received a report on your behalf, dated 21 January 2018, from Mr Omar Faiz, a Consultant Colorectal Surgeon and Clinical Director of St. Mark's Hospital, London.

The Tribunal's Approach

20. In making its findings, the tribunal carefully considered all the evidence adduced, both oral and documentary, as well as the submissions made by

Mr Williams on behalf of the GMC and those made by Mr Stern on your behalf. It also accepted the advice of the legal assessor and reminded itself that hindsight should play no part when making its findings of fact.

21. The legal assessor reminded the tribunal that in these proceedings the burden of proof rests on the GMC and that it is for the GMC to prove the facts; you do not have to prove anything. She also reminded the tribunal that the standard of proof is that applicable to civil proceedings, which is on the balance of probabilities. In other words, the tribunal is required to decide which, if any, of the facts are more likely than not to have occurred. In addition, the legal assessor reminded the tribunal that it has heard that you are a person of good character, in that you have not had any previous findings before your regulator and there has been a range of positive good character evidence about you from more than one witness. She went on to advise the tribunal that while good character cannot provide a defence in itself, it does mean that: a) a person of good character is less likely to have committed an alleged wrong; and b) that they are more capable of belief when it comes to issues of credit.

22. In respect of your alleged failures to provide good clinical care to Patient A, the legal assessor reminded the tribunal that before determining whether or not there was a failing on your part, it must first be satisfied that you had a duty to carry out any of the alleged failures. She went on to remind the tribunal that in respect of a failure to act, it must adopt the appropriate test, which is that: a doctor who acts in accordance with a practice accepted at the time as proper, by a responsible body of medical opinion, would not be deemed to have failed to carry out an obligation or duty placed upon them. In other words, to find that you failed to provide good clinical care to Patient A, the tribunal must be satisfied, on the balance of probabilities, that at the time you acted as you did, no reasonable practitioner would have acted or not acted as the case may be, in the particular circumstances that the tribunal is considering relating to a specific charge.

The Tribunal's Analysis of the Evidence and Findings

Providing Good Clinical Care

23. It is alleged by the GMC that you failed to provide good clinical care to Patient A on 11 February 2010 and 12 February 2010. Before considering the paragraphs of the allegation separately, the tribunal had regard to the 2006 edition of Good Medical Practice ('GMP'), the edition in effect when you provided clinical care to Patient A in February 2010. The tribunal noted that GMP states that all practitioners have an overriding duty to provide good clinical care to their patients. What constitutes the provision of good clinical care is explained clearly in the paragraphs set out below:

Providing good clinical care

2 Good clinical care must include:

(a) adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient

(b) providing or arranging advice, investigations or treatment where necessary

(c) referring a patient to another practitioner, when this is in the patient's best interests.

3 In providing care you must:

(a) recognise and work within the limits of your competence

(b) prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the patient's needs

(c) provide effective treatments based on the best available evidence

(d) take steps to alleviate pain and distress whether or not a cure may be possible

(e) respect the patient's right to seek a second opinion

(f) keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment

(g) make records at the same time as the events you are recording or as soon as possible afterwards

(h) be readily accessible when you are on duty

(i) consult and take advice from colleagues, when appropriate

(j) make good use of the resources available to you.

<u>The Tribunal's Analysis of the Expert Evidence</u>

24. The tribunal was assisted by both expert witnesses and it was satisfied that both experts had suitable qualifications to fulfil their role. For the reasons given in paragraphs below, where there was dispute in the evidence of the expert witnesses, the tribunal preferred the opinion of Mr Faiz to that of Mr Zeiderman.

Thursday 11 February 2010

Paragraph 1

On 11 February 2010, you failed to provide good clinical care to Patient A, in that you did not:

a. arrange for the requested CT scan to be carried out on 11 February 2010; **Found not proved**

25. On 5 February 2010 Patient A was admitted to the Clementine to undergo an elective total replacement of his left knee under the care of Consultant Orthopaedic Surgeon Mr Hollingdale. The agreed evidence was that Mr Hollingdale's procedure was uneventful, as was Patient A's post-operative recovery over the following days apart from the aforementioned suspected UTI. The agreed evidence was that on Thursday 11 February 2010 Patient A complained to ward staff of abdominal pain, something supported by the nursing records from throughout that day. While the exact timing is unknown, it was not disputed that at some time around 16:30-17:00 on 11 February 2010 Patient A contacted Mrs Hollingdale by telephone with the same complaint of abdominal pain, and Mrs Hollingdale in turn informed Mr Hollingdale of Patient A's complaints. It was also agreed evidence that Mr Hollingdale then went to see Patient A on the Blenheim Ward at the Clementine, where he examined him at around 18:00 that evening.

26. In his evidence Mr Hollingdale confirmed that when he examined Patient A's abdomen on the evening of 11 February 2010 he found 'generalised tenderness and rebound tenderness in the right iliac fossa'. His further evidence was that while as a Consultant Orthopaedic Surgeon he had 'no idea what the cause or condition of Patient A's acute abdomen was', he was 'sufficiently concerned' that he wanted 'another, specialised opinion'. In the meantime, Mr Hollingdale arranged for Patient A to have chest and abdominal x-rays, as well as blood tests. He also sought out your assistance and asked you to see Patient A.

27. On the evening of 11 February 2010 you had a clinic at the Clementine from 18:30 to 21:00. The agreed evidence was that at some time around 18:30 that evening Mr Hollingdale spoke to you about Patient A and requested that you go and see Patient A on the ward. It was not disputed that you said to Mr Hollingdale that you would go and see Patient A at the end of your clinic, at around 21:00, and that Mr Hollingdale was satisfied with that course of action. Having concluded your clinic

you went to the ward and examined Patient A. Your evidence was that upon examination Patient A 'looked unwell and was mildly dehydrated'. In your witness statement you went on to state: 'His blood pressure was 160/80 and his pulse was 88 beats per minute. He did not have a fever but was breathing slightly faster than normal. My examination revealed that his abdomen was distended and he was tender over the lower part of the abdomen [...] His bowel sounds were reduced in quantity'. It was accepted that you also reviewed the x-rays requested by Mr Hollingdale that evening. You reviewed Patient A's abdominal x-ray three times (at 21:05, 21:27, and 21:45) as well as his chest x-ray (at 21:28). Your evidence was that the x-ray of Patient A's chest demonstrated, in your view, 'possibly the presence of a small amount of free gas under the diaphragm'. Your view was reflected in the entry you made in Patient A's medical notes.

28. In your entry in Patient A's medical records at 21:10 on the evening of 11 February 2010 you summarised Patient A's condition as 'unwell', 'dry', and 'slightly tachypnoeic'. You recorded Patient A's blood pressure, pulse, and temperature, and next to a representation of the patient's abdomen you wrote 'distended, tympanitic', 'diffusely tender lower abdomen with some guarding', and 'bowel sounds reduced'. In the note, you went on to record '? free gas under the right hemi-diaphragm' and '? perforated viscus e.g. duodenum or colon'. The agreed evidence was that having examined Patient A and reviewed the x-rays you decided to request that a CT scan of Patient A's abdomen and pelvis be carried out the following morning, on Friday 12 February 2010.

29. Your evidence was that you decided to request a CT scan the following morning to either confirm or exclude the presence of a perforation. Your further evidence was that you decided to request a CT scan because it would provide you with 'a better idea of the site of any perforation, the nature of any abnormality and its general effects', to establish whether treatment could be given by an Interventional Radiologist, thereby helping you to minimise the effects of any potential operation. Your evidence was that while the CT scan was being arranged and carried out, 'further management and resuscitative measures could be instituted which would make [Patient A] more comfortable and prepare him physiologically and optimise his condition in case an operation was subsequently necessary'.

30. In respect of your decision to delay the CT scan being carried out until the morning of 12 February 2010, your evidence was that because Patient A presented as being 'dry', he would need to be optimised by means of rehydration before a CT scan with contrast could be performed. Your evidence was that it 'is unwise to do a CT scan on a dehydrated patient, as the contrast or dye that they are given intravenously can cause kidney damage', an opinion supported by Mr Faiz in his evidence and accepted by this tribunal. From your observations of Patient A, you considered that other than being 'dry' his condition was broadly stable.

31. In your witness statement you stated that, in your view, Patient A 'did not demonstrate clinical signs indicating that a scan or operation was required that night: his blood pressure, temperature and pulse and his overall condition were satisfactory'. Your further evidence was that you were 'satisfied that a decision as to whether or not to operate should be made the following day' and that you 'intended and anticipated that the CT scan would be done first thing in the morning on 12 February 2010'. To indicate that, you wrote 'urgent' on the top of the CT scan request form, as well as including on the form the potential diagnoses you recorded in Patient A's medical notes. The agreed evidence was also that you telephoned Dr Tran, an Interventional Radiologist, at 21:28 on the evening of 11 February 2010, to ask if he would be able to report on the CT scan results the following morning. You also asked Dr Tran, if he was able to review the scan results in the morning, whether, if he noticed the presence of an abscess or a collection of fluid that was suitable for drainage, he could proceed to drain it. Dr Tran told you that he would not be at the Clementine until later the following day.

32. Mr Zeiderman, in his first report, dated 12 January 2017, criticised your decision to request a CT scan on 11 February 2010. He stated that a CT scan was not required because, in his opinion, you already had sufficient evidence that Patient A had a perforated viscus and sufficient evidence, therefore, to take Patient A to theatre for a laparotomy that evening. The decision to request a CT scan was, he stated, 'a poor and unnecessary decision' by you. However, the tribunal noted that Mr Zeiderman subsequently softened his position on this point in his second report, dated 1 November 2017, stating that he 'would not be overly critical' of your decision to request a CT scan. Furthermore, the tribunal noted that during his oral evidence Mr Zeiderman accepted that by requesting a CT scan of Patient A's abdomen you had been practising 'safe and cautious medicine'. Mr Zeiderman accepted in his oral evidence that some surgeons in 2010 would have requested a CT scan, but stated that it was not something he would have personally done. He also accepted that there are circumstances in which it is possible to treat a patient with a perforated viscus conservatively, by means of the administration of antibiotics, for example, or by drainage.

33. In relation to the timing of the CT scan, Mr Zeiderman's evidence was consistent. In his first report, he stated that your decision to request a CT scan 'could have been justified if the scan had been performed immediately' and that your 'poor decision' to request the CT scan 'was compounded by delaying [it] until the following day'. Mr Zeiderman went on to state that 'the decision to delay the scan until the following day was a significant error and, in [his] opinion, was seriously below the standard expected of a reasonably competent Consultant General Surgeon'. In his second report, dated 1 November 2017, Mr Zeiderman accepted that the CT scan request form included the word 'urgent'. He referred to a document from the Clementine entitled 'Medical Emergency Imaging Request Procedures' which suggested that it was possible to obtain CT scans urgently and that there was a protocol in place for requesting out-of-hours CT scans in February 2010. He stated

that he remained of the opinion that you 'should have arranged a [CT] scan as soon as practically possible' on the evening of 11 February 2010.

34. Mr Faiz, in his report and oral evidence, drew the tribunal's attention to what he considered many reasonable surgeons would have done in the same situation as you found yourself in with Patient A on 11 February 2010. His evidence was that, 'while variation amongst surgeons might exist regarding the timing of when the CT scan should have taken place', he believed that faced with a patient in Patient A's condition on 11 February 2010, 'many reasonable surgeons' at that time 'would wish to identify the nature of the intra-abdominal pathology prior to undertaking surgery'. His further evidence was that in the circumstances in which you found yourself on the evening of 11 February 2010, that is, 'presented with a patient in a private hospital who was haemodynamically stable with regionalised peritoneal signs and a radiological suspicion (on plain x-ray) of visceral perforation', in his opinion 'many competent practitioners in 2010, under similar circumstances, may have opted to defer any intervention until the following day to give them a chance to optimise the patient and plan subsequent management'.

35. Mr Faiz's opinion, on the basis of the information he was given about Patient A's clinical condition, was that Patient A required optimisation before having a CT scan carried out. His further evidence was that, in his opinion, given Patient A's condition, he would have deferred the CT scan until the morning of 12 February 2010, and would only have expedited the CT scan if Patient A had showed significant clinical signs of deterioration. In addition, Mr Faiz opined that it would be preferable for an Interventional Radiologist or someone with gastro-intestinal radiology experience to interpret and report on the results of any such CT scan and there would be no guarantee of this out-of-hours.

36. To support his opinion, Mr Faiz referred the tribunal to a number of research papers published after 2010 regarding the standard of the provision of emergency colorectal surgery throughout the UK. Mr Faiz's evidence was that in and around 2010 there was, as it was put in the 'Validation of a grading system' paper to which he referred the tribunal, 'a major paradigm shift' in the treatment of patients with acute diverticulitis from 'routine operative intervention to a more conservative approach'.

37. The tribunal accepted Mr Hollingdale's evidence that an accepted professional protocol exists between surgeons that once a surgeon has examined a patient and made a diagnosis, they assume overall responsibility for at least that aspect of that patient's care. As noted above, the tribunal was also satisfied that the 2006 edition of GMP stipulates that all practitioners have an overriding duty to provide good clinical care to their patients. The tribunal was therefore in no doubt that on 11 February 2010 you had a duty to provide good clinical care to Patient A. Having considered all the evidence, the tribunal was satisfied that your decision to request a CT scan on the evening of 11 February 2010 was an appropriate one. Both expert

witnesses agree that requesting a CT scan was 'safe and cautious medicine' and the tribunal was satisfied that your reasons for requesting the scan were in line with the reasons that Mr Faiz said were central to a conservative approach to the management of acute diverticulitis. In particular, the tribunal had regard to the research paper 'Validation of a grading system for complicated diverticulitis in the prediction of need for operative or percutaneous intervention' (2015), in which it is stated as follows:

> 'The current surgical management of complicated acute diverticulitis has seen a major paradigm shift from routine operative intervention to a more conservative approach. This change in practice reflects our increasing understanding of the morbidity and mortality associated with emergency surgery for complicated diverticular disease as well as subsequent interventions attempting to deal with the consequences of the emergency surgery [...]
>
> The increasing adoption of a more conservative approach in complicated diverticular disease has only been possible because of the advances in antibiotic therapy, nutritional support, critical care and interventional radiology. However, it was mainly the widespread availability and accessibility of computed tomography (CT) in the assessment of the acute surgical abdomen that played a major role in the current trends in the management of acute diverticulitis. CT has enabled accurate diagnosis of complicated diverticular disease as well as stratifying disease severity and could therefore help to identify patients who may benefit from non-operative therapy. Furthermore, the use of radiologically guided percutaneous drainage of diverticular abscesses might avoid the need for acute operative intervention. Increasingly, surgical intervention is reserved for patients who have failed conservative treatment, have generalised peritonitis or are haemodynamically unstable.
>
> [...] As a result, the role of CT has become crucial in decision making for patients with acute diverticulitis [....]'

38. The tribunal was not taken to nor provided with any other research-based evidence that would contradict this evidence, and on that basis, having heard cogent evidence from Mr Faiz, the tribunal accepted the findings of that report in this respect.

39. The agreed evidence was that on the evening of 11 February 2010 it would have been possible for you to have arranged for the requested CT scan to be carried out that evening. In February 2010 the Clementine had a 24 hour on-call system whereby a patient could be scanned at any time of the day or night. The agreed evidence of both Ms Hale and Ms Kassam was that even were a radiologist not physically on-site at the Clementine, the capability existed in February 2010 for an

on-call radiologist to review a CT scan and to report on its results remotely. This was the basis for Mr Zeiderman's opinion that notwithstanding the appropriateness of requesting a CT scan on 11 February 2010, having decided to do so you should have arranged for it to have been carried out urgently that evening. Overall, in respect of the issue of the timing of the CT scan, the tribunal preferred Mr Faiz's opinion to Mr Zeiderman's opinion for the reasons set out below.

40. The tribunal favoured Mr Faiz's methodology to that adopted by Mr Zeiderman. The tribunal was satisfied that Mr Zeiderman's view of the urgency with which the CT scan should have been carried out (i.e. as soon as possible on the Thursday evening), was based on the assumption that you *should have known* at that time that Patient A had a perforated viscus. However, the tribunal accepted that your entry in Patient A's medical notes following your examination of him on 11 February 2010 shows that you only *suspected* that Patient A had a perforated viscus at that time. Mr Faiz, on the other hand, approached his report on the basis of what you would have known at the time of acting as you did on the evening of 11 February 2010.

41. Neither Mr Zeiderman nor Mr Faiz had reviewed Patient A's chest and abdominal x-rays when they compiled their respective reports. However, the tribunal was satisfied that unlike Mr Faiz, Mr Zeiderman made certain assumptions about Patient A's x-rays when he compiled his report. The tribunal was satisfied from Mr Zeiderman's evidence that when writing his report he arrived at his own clinical diagnosis on the evidence with which he had been provided, without having seen the relevant x-rays, and concluded that you *should have known* that Patient A had a perforated viscus. The tribunal preferred Mr Faiz's approach in this respect, which he explained had been to base his opinion only on what you recorded you had seen from seeing Patient A's x-rays.

42. In addition, in his oral evidence Mr Zeiderman conceded that his expressed views regarding the urgency with which Patient A's CT scan should have been carried out were influenced by his overall clinical interpretation of Patient A's clinical condition on the evening of 11 February 2010, which in turn was influenced by Patient A's arterial blood gas ('ABG') results. However, the ABG results on which Mr Zeiderman predicated his opinion were results of blood gases which had not been taken at that time. Further, Mr Faiz was able to provide a much more evidence and research-based opinion regarding the time required to optimise a patient in Patient A's condition on 11 February 2010. While neither expert could provide the tribunal with specific protocol timings for the optimisation of patients with acute diverticulitis in 2010, Mr Zeiderman told the tribunal that a patient in Patient A's condition could be optimised sufficiently to undergo a CT scan in around two hours. However, the tribunal found Mr Faiz's evidence in this respect to be more balanced and again more research-based than Mr Zeiderman's evidence. Mr Faiz said that he had never heard of optimisation taking two hours and that in his experience it usually took longer. He said that most of the protocols since 2010 suggest a window of

approximately six hours for optimisation. He said that in any event with a dehydrated patient optimisation must be done judiciously, as overly rapid rehydration can have an adverse effect on a patient's overall clinical condition.

43. The tribunal considered the methodology and approach of both expert witnesses. The tribunal found Mr Zeiderman's evidence to be less objective overall than the evidence of Mr Faiz. It found Mr Zeiderman's evidence to be primarily focused on and reflective of his own clinical practice, and not that of a reasonable body of general surgeons at the time. The tribunal noted that Mr Zeiderman's first report was not supported by any reference to publications. Mr Faiz's evidence was to a greater extent supported by objective research-based studies from outside his personal practice. In addition, having approached his report on the basis of what you would have known *at the time* of acting as you did, Mr Faiz then considered your actions in light of what a reasonable body of surgeons may have done at the time.

44. In respect of the specific evidence relating to the appropriate timeliness of Patient A's CT scan, the tribunal preferred Mr Faiz's evidence because it was more balanced and research-based than that of Mr Zeiderman's.

45. The tribunal was satisfied that the evidence shows that on the evening of 11 February 2010 Patient A was haemodynamically stable. The tribunal was satisfied that although broadly stable, Patient A was 'dry' and consequently required a degree of optimisation before having a CT scan carried out. The tribunal was also satisfied that the adoption of a conservative approach to a patient with a suspected perforated viscus was appropriate in 2010, that it constituted 'safe and cautious medicine', and that a CT scan formed part of the conservative management. Indeed, from the agreed evidence of your conversation with Dr Tran that evening, the tribunal was satisfied that on the evening of 11 February 2010 you were considering a conservative approach to the treatment of what you suspected to be Patient A's perforated viscus.

46. In the circumstances in which you found yourself on the evening of 11 February 2010 when dealing with Patient A, the tribunal was satisfied that at the time a reasonable body of Consultant Colorectal Surgeons would not have arranged for the requested CT scan to be carried out on 11 February 2010 and would have deferred it being carried out until the morning of 12 February 2010 as you did. The tribunal therefore determined that by deferring the requested CT scan until the following morning you did not, by the accepted clinical standards of 2010, fail to provide good clinical care to Patient A. It therefore found sub-paragraph 1(a) not proved.

b. perform surgery on Patient A, despite being aware of Patient A's perforated viscus; **Found not proved**

47. In considering this sub-paragraph of the allegation, the tribunal first considered whether or not you were aware of Patient A's perforated viscus on 11 February 2010. In its analysis of the evidence and its finding at sub-paragraph 1(a) of the allegation, the tribunal noted your evidence that when you examined Patient A at around 21:00 on the evening of 11 February 2010 and reviewed the x-rays of his chest and abdomen, you thought that there was 'possibly the presence of a small amount of free gas under the diaphragm'. Your evidence in that respect was supported by the contemporaneous entry you made in Patient A's medical notes following your examination that evening, in which you recorded '? free gas under the right hemi-diaphragm' and '? perforated viscus e.g. duodenum or colon', as well as the same information you inputted on the CT scan request form.

48. The tribunal has already noted your evidence that on the evening of 11 February 2010 you did not know definitively that Patient A had a perforated viscus, but that you thought it to be a possibility. The tribunal has accepted that your decision to request a CT scan of Patient A's abdomen and pelvis was based on the fact that you only suspected a perforated viscus and that, in light of Patient A's broadly stable clinical condition, your decision to arrange for the requested CT scan to be carried out on the morning of Friday 12 February 2010 was appropriate and in line with a conservative approach to the management of acute diverticulitis. In your oral evidence to the tribunal, you accepted that while on the evening of 11 February 2010 you were considering other possible working diagnoses, you suspected that a perforated viscus was the most likely diagnosis. You told the tribunal that at that point you thought it 'more than a mere possibility' that Patient A had a perforated viscus. The tribunal noted that while you might have thought it 'more than a mere possibility', in your mind it was still nonetheless only a possibility, and not a definitive diagnosis.

49. Dr Kantor's evidence was that when there is free gas in the abdomen it is, in effect, a 'black and white' situation; that is, the patient either has a perforation or they do not. While overall the tribunal found Dr Kantor to be a credible and reliable witness, it noted that the general consensus amongst other members of staff at the Clementine on 11 February 2010 was that while Patient A may have had a perforated viscus, the perforation was at that time only suspected. Dr Shah's agreed evidence was, for example, that on 11 February 2010 she asked the RMO to try and contact Mr Hollingdale and to get the surgeons involved, as there was 'a suspected perforation to the abdominal viscera'. The tribunal therefore noted that the understanding of Patient A's condition at the Clementine on 11 February 2010 might not have been as 'black and white' as Dr Kantor would have expected it to be.

50. The tribunal noted that in his first report, Mr Zeiderman was equivocal about the extent to which Patient A's diagnosis was confirmed on 11 February 2010; the tribunal found that there was an internal inconsistency, albeit subtle, between Mr Zeiderman's evidence in this respect. In the report, Mr Zeiderman stated that on 11 February 2010 you came to the conclusion 'that it was *most likely* that Patient A

had a perforated viscus' (the emphasis is the tribunal's). Having stated that you came to the conclusion that it was 'most likely' that Patient A had a perforated viscus, he then later went on to state that on 11 February 2010 you 'correctly made the diagnosis of a perforated viscus', which implies that you thought at that time that the diagnosis was definitive. Mr Faiz's view was that there remained some diagnostic uncertainty as to whether there was a perforation. Even if there were, it could have come from a number of sources such as, for example, a perforated duodenal ulcer or a ruptured appendix. In the presence of uncertainty, he stated that he would not have wanted to proceed immediately to surgery.

51. Having considered all the evidence, the tribunal was satisfied, on the balance of probabilities, that on 11 February 2010 you were not satisfied that Patient A had a perforated viscus, albeit you thought it possible that he did. In other words, the tribunal was satisfied that on 11 February 2010 your diagnosis of a perforated viscus was not definitive, and that other members of staff at the Clementine also understood that to be the case. On the evening of 11 February 2010 Patient A was also haemodynamically stable. In those circumstances, the tribunal was satisfied that you did not have a duty to perform surgery on Patient A on 11 February 2010. In any event, having had regard to the expert evidence, and having preferred the opinion of Mr Faiz to that of Mr Zeiderman, the tribunal was satisfied that even had your diagnosis of a perforated viscus been definitive on the evening of 11 February 2010, surgical intervention was not the only appropriate clinical option open to you when providing good clinical care to Patient A.

52. As already noted above in its analysis of the evidence in relation to sub-paragraph 1(a) of the allegation, the tribunal found that Mr Zeiderman's opinion of the urgency in which you should have acted on the evening of 11 February 2010 to have been based on his assumption that you should have known that Patient A had a perforated viscus, as well as his overall interpretation of Patient A's clinical condition on the evening of 11 February 2010, which itself was predicated on the ABG results which did not relate to the date and time of the decision in question. The tribunal has also already expressed its preference for Mr Faiz's methodology and expert opinion because it considered his evidence to be more balanced, objective, and research-based. It also favoured Mr Faiz's approach of considering what you would have known at the time of acting as you did, and then considering your actions in light of what was accepted clinical practice, according to what a reasonable body of surgeons would have done at the time.

53. In respect of sub-paragraph 1(b) of the allegation, the tribunal again preferred Mr Faiz's opinion to Mr Zeiderman's opinion. In his report, Mr Zeiderman stated that having reviewed Patient A's x-rays on 11 February 2010, and having examined the patient, you had enough evidence to take Patient A to theatre. Overall, the tribunal found Mr Zeiderman's evidence about this matter unclear and it was left unsure as to what he based his opinion on. Although Mr Zeiderman said that you had enough evidence on 11 February 2010 to take Patient A to theatre, he did

not provide the tribunal with any objective evidence to support his opinion that the appropriate standard in 2010 was that it should have happened in the timeframe he envisaged. Indeed, the tribunal noted that in his oral evidence Mr Zeiderman accepted that had your diagnosis been definitive, it was nonetheless possible to treat a perforated viscus conservatively, and that it was not always necessary to move to surgery straight away.

54. In contrast, Mr Faiz's clear and consistent evidence was that while some surgeons in 2010 were of the view that operating on a patient with a suspected perforated viscus should be done immediately, in the context of surgical practices and patient pathways in emergency surgery at the time, your decision not to perform surgery on Patient A on the evening of 11 February 2010 was not a failure on your part to provide Patient A with good clinical care. Mr Faiz based his opinion on three contextual factors, namely: 1) the time at which you reviewed Patient A, it being past 21:00; 2) the clinical uncertainty about Patient A's definitive diagnosis on the evening of 11 February 2010; and 3) the fact that Patient A presented as being 'dry' and required a degree of optimisation before any surgery or other invasive procedures could be performed.

55. The tribunal also found Mr Faiz's evidence in this respect to be particularly convincing because he supported his opinion with research-based evidence from outside his own practice. To support his opinion that the adoption of a conservative approach rather than moving straight away to surgical intervention constituted good clinical care, Mr Faiz referred the tribunal to a number of research papers and guidance documents. In addition, Mr Faiz's further evidence was that in the circumstances with which you were faced on the evening of 11 February 2010, in his opinion, it was not unreasonable of you to have opted to defer surgery overnight. His further evidence was that had 'the clinical picture' changed overnight, you could have expedited investigation and/or surgical intervention the next morning. The tribunal found Mr Faiz's evidence in this regard to be objective and well-balanced. Mr Faiz was clear in his evidence that even in 2010, had a colonic perforation been confirmed, then accepted standard practice would have been to move to theatre immediately. Mr Faiz did however qualify this statement, by stating that even then other factors have to be considered before moving to theatre immediately, such as weighing up the risks of the surgery itself, and the likely life-changing post-operative outcomes of even a successful surgical intervention. He also identified hazards associated with operating overnight with theatre staff unsupported by the full resources available during normal working hours.

56. In all the circumstances, the tribunal was not satisfied that on 11 February 2010 you were 'aware' of Patient A's perforated viscus because, at that stage, the perforation was only suspected and its location was not definite. The tribunal was satisfied that even had the perforation been confirmed that evening, performing surgery was not the only course open to you. It was satisfied that it may have been appropriate for you to have managed the condition conservatively, without resorting

to, and subjecting Patient A to, surgical intervention. It therefore determined that your decision not to perform surgery on Patient A on 11 February 2010 was not, by the accepted clinical standards in place at the time, a failure on your part to provide Patient A with good clinical care. It therefore found sub-paragraph 1(b) not proved.

c. initiate resuscitative measures, in that you did not:

i. prescribe antibiotics; **Found not proved**

57. It was not disputed that on 11 February 2010 you did not prescribe antibiotics to Patient A, in that you did not personally write Patient A a prescription for antibiotics. Having considered all the evidence, however, the tribunal was satisfied that you were considering prescribing antibiotics to Patient A on 11 February 2010 and gave instructions for these to be prescribed. The agreed evidence was that having examined Patient A at around 21:00 on the Thursday evening, you asked the Registered Medical Officer ('RMO'), Dr Georgiev, to take a number of steps. Your evidence, supported by the entry you made in Patient A's medical notes, was that you asked the RMO to administer intravenous fluids, to insert a naso-gastric tube, to insert a urinary catheter, to take ABGs and to take blood cultures. The tribunal noted, however, that there was no mention of the prescription of antibiotics in your record in Patient A's medical notes from 11 February 2010.

58. Your evidence was that you did not refer to the administration of antibiotics in your note, because you first wanted to speak to Mr Hollingdale to discuss and agree on the choice of antibiotics. It was not disputed that you telephoned Mr Hollingdale on the evening of 11 February 2010; while Mr Hollingdale does not recall the detailed content of the call, he does not dispute it took place, and does recall that he indicated that you could give Patient A any antibiotics you wished. Your evidence was that you telephoned Mr Hollingdale to discuss which antibiotics you should prescribe to Patient A, because you did not want those you prescribed to interfere with his recovery from his knee replacement and its associated infection control. Indeed, the tribunal noted that in your entry in Patient A's medical notes from 12 February 2010, you recorded 'Hollingdale knows the results – agreed on antibiotic treatment'. In addition, your further evidence was that you wanted to wait until blood had been taken for culture before giving antibiotics to Patient A, because if antibiotics were given to Patient A prior to the taking of blood for culture, the microbiologist might have had difficulties isolating and identifying any infection present and the particular the type of infective organism, and hence the specific antibiotics required. In all the circumstances, the tribunal was satisfied that on 11 February 2010 you were considering prescribing Patient A antibiotics, and that you intended to do so.

59. Your evidence was that the RMO should have been well aware of the need for antibiotics in Patient A's case, and the type of antibiotics commonly prescribed in such circumstances, without you having instructed him to prescribe them. Your

further evidence was that, in any event, you did instruct the RMO to prescribe antibiotics to Patient A, but you did so verbally having returned home following your telephone call to Mr Hollingdale and having telephoned the RMO at the Clementine from your home. Having been informed by the RMO that he had taken blood for culture, your evidence was that you instructed the RMO to prescribe antibiotics to Patient A.

60. The tribunal has heard much evidence regarding prescribing practices at the Clementine at the time in question. Having considered all the evidence, the tribunal was satisfied that it was widespread and common practice at the time for consultants to rely on RMOs to prescribe medication to their patients. Indeed, the tribunal noted that there was an entry in Patient A's medical records, from 20:45 on 7 February 2010, in which a nurse had written 'for IV cefuroxime RMO to write up'. In addition, Ms Sahota confirmed in oral evidence that consultants would either write up antibiotics or ask the RMO to do it. In particular, the tribunal bore in mind the opinions of the two expert witnesses. On this matter, the tribunal again preferred Mr Faiz's opinion to Mr Zeiderman's opinion. The tribunal found Mr Zeiderman's evidence in this respect to be inconsistent, as explained below, and it consequently afforded his evidence on this matter less weight than it did that of Mr Faiz. In his report, Mr Zeiderman stated that the lack of a prescription for antibiotics on 11 February 2010 was 'a clear omission' and that 'standard treatment for a patient with a perforated intra-abdominal viscus would include the prescription of broad spectrum antibiotics'. However, the tribunal noted that when cross-examined during the course of his oral evidence, Mr Zeiderman accepted that in 2010 it was standard practice for an RMO to prescribe medication on behalf of a consultant. When later re-examined by Mr Williams, Mr Zeiderman appeared to modify his opinion again, stating that standard practice was to write up any prescription on a drug chart, make a relevant entry in the patient's notes, and instruct that the antibiotics not be administered until blood cultures had been taken.

61. The tribunal was therefore satisfied that in 2010 it was standard practice for consultants to instruct RMOs to prescribe antibiotics and that a reasonable body of Consultant Surgeons would have acted as you did at the time, particularly given the requirement to wait for blood cultures to be taken before administering any antibiotics to the patient. The tribunal determined that the lack of an entry in Patient A's notes regarding the antibiotics was a failing on your part. However, the tribunal could not be satisfied on the basis of the evidence it heard, that on the balance of probabilities a reasonable body of Consultant Colorectal Surgeons would not have acted as you did, and instructed the RMO to prescribe antibiotics to Patient A. The tribunal therefore determined that your not prescribing antibiotics to Patient A on the evening of 11 February 2010 was not, by the accepted clinical standards in place in 2010, a failure on your part to provide Patient A with good clinical care. It therefore found sub-paragraph 1(c)(i) not proved.

ii. ensure antibiotics were administered to Patient A; **Found not proved**

~~iii. review the results of Patient A's arterial blood gas measurements.~~ **Withdrawn by the GMC**

62. In its finding at sub-paragraph 1(c)(i), the tribunal determined that it was accepted clinical practice in 2010 for consultants to delegate the responsibility of prescribing antibiotics to their RMOs. In respect of delegating the provision of clinical care, the tribunal had regard to GMP, which states:

> **54** Delegation involves asking a colleague to provide treatment or care on your behalf. Although you will not be accountable for the decisions and actions of those to whom you delegate, you will still be responsible for the overall management of the patient, and accountable for your decision to delegate. When you delegate care or treatment you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved. You must always pass on enough information about the patient and the treatment they need.

63. When interviewed by the police in 2010, you accepted that you did not check to ensure whether the RMO had followed your delegated instructions to administer antibiotics to Patient A. You also went on to accept that it was your responsibility to have ensured that the antibiotics were administered and that you were responsible for Patient A's overall care. However, the tribunal had regard to the circumstances in which you made those comments and accepted that in saying what you did you were recognising your overall responsibility for Patient A. The tribunal accepted that you expected the instructions you had given to the RMO in relation to antibiotics would have been carried out. In respect of the competency of the RMO, you relied on the fact that he had been employed to carry out the duties of an RMO and he had advised you himself that he was trained in bowel surgery. In the circumstances, you had no reason to believe that the RMO was not capable of carrying out your instructions and to that end you had delegated your responsibility for this task to him in accordance with GMP.

64. In addition, the tribunal had regard to the expert evidence, and again preferred Mr Faiz's opinion to that of Mr Zeiderman. In his second report, Mr Zeiderman stated that 'given the possibility of a perforated intra-abdominal viscus' he would have expected you 'to have regularly reviewed Patient A'. He went on to say that he 'would have expected at the very least, a telephone call to the RMO on the evening of 11 February 2010. The purpose of this call would have been to be informed of the results of the tests which he had ordered, and also to determine whether the interventions which he had arranged had had any impact

upon Patient A's clinical progress'. The tribunal found Mr Faiz's evidence to be more balanced. Mr Faiz's evidence was that having delegated a task to an RMO, it would have been standard practice to check whether the RMO had carried out the task only in the event that the instructions in question were complex, or something out of the ordinary. His further evidence was that if an instruction were given to an RMO to carry out a relatively routine task, such as the prescribing or administering of antibiotics, it would not have been standard practice to check with the RMO to ensure that the instructions had been followed. His evidence was that he would consider it 'reasonable practice to delegate such responsibility to an RMO and not expect to personally ensure that this had been undertaken'. Indeed, the tribunal was satisfied that there are logical and practical reasons why the latter would be an unworkable practice.

65. The tribunal has no evidence to suggest that you should not have delegated the prescription of Patient A's antibiotics to the RMO, and it has no evidence that your doing so was inappropriate because the RMO did not have the qualifications, experience, knowledge and skills to provide the care or treatment you required him to carry out. The tribunal therefore determined that your expectation that the RMO would carry out your instructions and administer the antibiotics to Patient A on 11 February 2010 without you having to ensure that they had been was, by the accepted clinical standards of the time, not a failure on your part to provide good clinical care to Patient A. The tribunal therefore found sub-paragraph 1(c)(ii) not proved.

Friday 12 February 2010

Paragraph 2

> On 12 February 2010, you failed to provide good clinical care to Patient A, in that you did not:
>
> a. review Patient A; **Found proved**

66. Having examined Patient A at around 21:00 on the evening of Thursday 11 February 2010 and reviewed his chest and abdominal x-rays, you suspected that he had a perforated viscus, but your diagnosis was not yet definitive. Having arranged for blood to be taken for culture, you also requested an 'urgent' CT scan of Patient A's abdomen and pelvis be arranged to be carried out on the morning of Friday 12 February 2010.

67. The agreed evidence was that at some time around 06:30 on the morning of 12 February 2010, you received a telephone call at home from Ms Sahota regarding Patient A. While your evidence and that of Ms Sahota regarding the content of the conversation you had that morning was more or less consistent, the tribunal noted that there was a different perception from each witness regarding the purpose and

sense of urgency conveyed during it. It was not disputed that when she called you on the morning of 12 February 2010, Ms Sahota told you that Patient A's urine output had dropped during the night and that she had received instructions from the RMO to increase the infusion rate, following which Patient A's urine output had responded positively. Neither was it disputed that Ms Sahota told you that during the night nurses has aspirated brown fluid from Patient A's naso-gastric tube and that, overall, his observations had remained stable. Your evidence was that Ms Sahota did not mention to you that Patient A's overall condition had deteriorated, and that 'neither did she convey any sense of urgency or alarm'. Your further evidence was that it was not unusual for you to receive 'a progress report' by telephone early in the morning, and such a practice was something encouraged by consultants at the Clementine. Ms Sahota's evidence, on the other hand, was that she telephoned you precisely because she was 'concerned' about Patient A, in particular the brown fluid aspirated from the naso-gastric tube. She did concede that it was not unusual for her to telephone consultants directly.

68. The tribunal found Ms Sahota to be a good and helpful witness even if at times she could not remember certain specific details given the passage of time since the events in question took place. She was, for example, willing to concede that she could not remember whether or not she had drawn your attention during the conversation to the fact that Patient A had been given supplemental oxygen during the night. Having considered the evidence, the tribunal was satisfied that Ms Sahota's concerns about Patient A centred mainly on the brown fluid that had been aspirated from his naso-gastric tube during the night. Your evidence was that the brown fluid 'was of no particular significance' and not in itself something of particular concern. Ms Sahota's evidence was that you told her that you would see Patient A that morning once the CT scan had been done.

69. Having considered the documentary evidence, the tribunal was satisfied that there was no written entry in Patient A's medical records which would suggest that you visited Patient A on the morning of Friday 12 February 2010. The next entry following that of your examination of Patient A on the evening of 11 February 2010 was your entry at 16:00 on 12 February 2010. In his report, Mr Zeiderman stated that having not performed a laparotomy on Patient A the previous evening, he would have expected you to have visited Patient A as your 'first task' on the morning of 12 February 2010, particularly as you had been contacted by nursing staff that morning and 'updated with their concerns regarding Patient A's progress'. His further evidence was that 'further review of the observations would have indicated that Patient A was rapidly deteriorating and that time was of the essence'. He went on to state that 'a failure to visit a patient known to have intra-abdominal perforation' would, in his opinion, 'indicate a standard of care seriously below that expected from a reasonably competent consultant general surgeon'. However, the tribunal has already found that on the morning of 12 February 2010 it was not confirmed that Patient A had an intra-abdominal perforation. You suspected a perforated viscus, but had requested the CT scan in order to make your definitive diagnosis.

70. The tribunal had regard to the statement you made for the Coroner's Inquest, dated 7 March 2010, only some weeks after the events in question took place. Your evidence to the Coroner was that on the morning of Friday 12 February 2010 you went to see Patient A at around 09:30 and that when you saw him, although his respiratory rate was elevated, you saw no deterioration in his condition from the previous evening when you had examined him at around 21:00.

71. Ms Wilkins' evidence was that her understanding was that Patient A had deteriorated somewhat overnight and was on hourly observations. She saw Patient A at around 07:30-08:00 on 12 February 2010, and stated that his clinical condition 'appeared to be reasonable' and that he 'was not in undue pain' or vomiting. Her further evidence was that she 'felt that Patient A needed to have a [CT] scan urgently' to such an extent that she took the request form down to the imaging department herself at 08:00. She stated that throughout the day until she went off duty at 15:00, Patient A's clinical condition was 'satisfactory' and to her he 'looked OK'. The evidence of Ms Wilkins, a qualified nurse with a significant number of years' experience, was that 'a close eye' was being kept on Patient A's urinary output, and there was no sign that he was 'in big trouble'. However, the tribunal identified documentary evidence that Patient A's condition had deteriorated to a degree overnight. In your oral evidence, you accepted, looking at the observations today, that Patient A's respiratory rate had increased overnight and there had been a fall in his oxygen saturation levels requiring supplemental oxygen. Mr Faiz's evidence was that this was a 'subtle change' and that Patient A was not, on the morning of 12 February 2010, 'rapidly deteriorating' as Mr Zeiderman had suggested.

72. Your evidence was that you 'would have reviewed Patient A' at some time between your arrival at the Clementine and your attendance in the endoscopy suite at 10:00. The tribunal has neither seen nor heard any evidence from any of the nursing staff or other healthcare professionals who were working on the Blenheim Ward on the morning of 12 February 2010 to support your account that you visited Patient A at that time. Indeed, your own evidence was that you do not recall seeing any of the nursing staff when you saw Patient A that morning. To support that point, you refer to the geography and layout of the Blenheim Ward, which is an L-shaped ward with some 15-20 private rooms. Your evidence was that because of the way you entered and left the ward, you did not need to pass the nurse's station before reaching Patient A's private room. In respect of why you did not record your visit to Patient A on the morning of 12 February 2010 in the medical records, your evidence was that on the days that you do private work, it was your practice 'to visit wards and pop in to see patients just to see how they are'. You accepted, however, that you should have made a note in the case of Patient A even though, in your opinion, 'his condition was relatively stable'. In all the circumstances and including your usual practice, and taking your good character into account, the tribunal was satisfied on the balance of probabilities that it was more likely than not that you did visit Patient A on the ward on the morning of 12 February 2010.

73. Having determined that it was more likely than not that you did visit Patient A on the ward on the morning of 12 February 2010, the tribunal went on to consider whether the interaction you had with Patient A that morning constituted a review. In this regard, the tribunal accepted the evidence of both expert witnesses that a review of a patient has a number of structured elements to it; a review is not a cursory or passive interaction between practitioner and patient. Having considered the evidence, the tribunal was satisfied that a review of a patient would include, but not be limited to: performing any necessary examinations; reviewing any laboratory results; checking the patient's observations; speaking to nursing and ward staff; and reviewing the patient's drug chart. While the tribunal accepted that not every contact between a practitioner and patient would include all of the elements listed here, it was nonetheless satisfied that a review of a patient must be something more than just having sight of the patient, and a brief exchange about their progress. Mr Faiz's evidence was that it would also be standard practice to 'review any overnight investigations, communicate with staff, and document any plans in the patient notes'. Mr Zeiderman agreed.

74. You accept that you should have recorded that you visited Patient A on the morning of 12 February 2010, but you also stated that it was your typical practice to 'visit and pop in to see' your patients 'to see how they were doing'. Your evidence was that on the morning of 12 February 2010 you 'would not have reviewed Patient A's notes or the drug chart because these were kept on a trolley at the nurse's station, which was some distance away from Patient A's room, or taken by nurses doing their rounds into the rooms of other patients'. You went on to state that you 'would have reviewed [Patient A's] observation charts if they were by his bed, which is where they would usually be kept' but that, after all this time, you 'do not now have a specific memory of doing so'.

75. On the morning of 12 February 2010 you suspected that Patient A had a perforated viscus and the tribunal was satisfied that in those circumstances you had a duty to familiarise yourself with Patient A's condition, to conduct a proper review of his condition, and to record the findings of your review in the patient's records. Again taking into account your usual practice and having regard to the careful note that you made of previous examinations carried out on Patient A, the tribunal found that, on the balance of probabilities, that had you carried out a review as required you would have made a note of it.

76. Mr Faiz's evidence concerning the duty to review patients was that in 2010 there may have been circumstances, for example in NHS hospitals, where not every service was set up so that consultants were free to examine patients themselves first thing the following day, and therefore might be reliant on other members of the team to do so. Mr Faiz did, however, concede that most surgeons would try to review patients themselves. The circumstances in this case were that you did not

have any competing priorities that morning which would have prevented you from carrying out a review of Patient A.

77. In the circumstances in which you found yourself on the morning of 12 February 2010, the tribunal was satisfied that a reasonable body of Consultant Colorectal Surgeons would have reviewed Patient A, and not simply have 'visited' or 'popped in to see him' as you did. The tribunal found that you had a duty to review Patient A on the morning of 12 February 2010 and that no reasonable body of Consultant Colorectal Surgeons would have failed to carry out a review. The tribunal determined that by not reviewing Patient A on the morning of 12 February 2010, you failed, by the accepted clinical standards in 2010, to provide good clinical care to Patient A. The tribunal therefore found sub-paragraph 2(a) of the allegation proved.

b. make immediate arrangements to perform urgent surgery on Patient A;
Found not proved

78. The tribunal has found that on the morning of 12 February 2010 you visited Patient A on the ward but failed to review him. At that time, you suspected that Patient A had a perforated viscus and you did not yet have the result of the requested CT scan. The agreed evidence was that at around 08:00 that morning Ms Wilkins took the CT scan request form to the imaging department, because she thought Patient A required a scan urgently despite his overall clinical condition appearing reasonable. Your evidence was that having seen Patient A on the ward at around 09:30 with the CT scan results not yet available, you telephoned the imaging department at about 10:00, to make sure that they had received the request form and to find out when the scan would be done. You were told that the CT scan would take place later that morning. Your evidence was that you 'had intended and anticipated that a scan marked urgent would be done first thing in the morning' but were 'not concerned about having to wait another couple of hours' because when you had seen Patient A that morning 'he had looked OK'. Your further evidence was that you assumed that the nurses allocated to Patient A's care were monitoring him on a regular basis, something which, having considered the evidence, the tribunal accepted was in fact the case.

79. The agreed evidence was that you finished your morning endoscopy session at around 10:45. You then spent time writing your notes, speaking to members of the nursing staff and to the patient you had just completed the procedure on. Your further evidence was that you then saw another of your patients on another ward, before leaving the Clementine and returning home at around 11:30. The agreed evidence was also that at 11:20 that morning Patient A's CT scan was carried out, and it was interpreted and reported on by Dr Kantor. It was also agreed that at some time around lunchtime on 12 February 2010 Mr Hollingdale went to the imaging department to enquire about Patient A's CT scan. Dr Kantor's evidence was that between 12:41 and 13:39 he and Mr Hollingdale viewed the CT scan in the Radiologist Reporting Office. It was further agreed that at 13:42 on 12 February

2010 you spoke to Mr Hollingdale on the telephone, while you were driving back to the Clementine for your afternoon list, and that he told you that Patient A's CT scan had been done, and that it showed signs of a sigmoid perforation. It was also not disputed that upon arriving at the Clementine that lunchtime, shortly after your telephone conversation with Mr Hollingdale, you met Dr Kantor in the car park at the Clementine as he was leaving and Dr Kantor told you that 'your chap upstairs has a perf, I've sent a report'.

80. In his report, Mr Zeiderman criticises your actions on 12 February 2010 because it was not until 16:00 that you saw Patient A and arrangements were made for him to be taken to theatre. In Mr Zeiderman's opinion, your findings on 11 February 2010 should have mandated an immediate laparotomy and the delay in Patient A having surgery was unacceptable and 'a significant failing' on your part. The delay in making immediate arrangements to perform surgery on Patient A was, in his opinion, seriously below the standard expected of a reasonably competent Consultant General Surgeon. However, in respect of sub-paragraph 2(b) and the allegation that by not making immediate arrangements on 12 February 2010 to perform urgent surgery on Patient A you failed to provide him with good clinical care, the tribunal again preferred the opinion of Mr Faiz to that of Mr Zeiderman for the reasons given below.

81. Mr Faiz's evidence was that having seen Patient A on the morning of 12 February 2010, and while awaiting the results of the CT scan that morning, you were 'presented with the options of persisting with the scan or abandoning [it] and making arrangements to perform urgent surgery'. Mr Faiz's evidence, which was supported by objective evidence of the accepted clinical standards of the time, was that your decision to await the CT scan results before making immediate arrangements for surgery was not a failure on your part. Mr Faiz's evidence, which the tribunal found to be clear, balanced, and a well-reasoned opinion based on research based evidence, was that while Patient A remained broadly physiologically stable, it was reasonable to want to await the results of the CT scan. Although he said that given the likelihood that Patient A required surgery 'most surgeons would make arrangements for surgery alongside awaiting imaging', his further evidence was that only a significant deterioration in the patient's condition would require immediate arrangements be made to perform urgent surgery. It was, he stated, reasonable of you to have awaited the result of the CT scan on the morning of 12 February 2010, with the expectation that it would be performed and reported on within a reasonable timeframe.

82. In this respect, the tribunal found Mr Faiz's evidence to be particularly persuasive. Mr Faiz told the tribunal that while it is intuitive to think that the longer a patient with a potentially life-threatening condition is left untreated, the more likely it is that the condition will worsen, such intuitive thinking is not in fact made out on the scientific evidence. Mr Faiz's evidence was that in 2010, in his experience, delays in performing emergency laparotomies would have been usual. Mr Faiz qualified his

opinion by referring the tribunal back to the research-based evidence produced for the purpose of this hearing as in the paragraph below.

83. Having considered all the evidence, including the scientific evidence to which Mr Faiz referred it, the tribunal was satisfied that in 2010, delays in performing urgent colorectal surgery were widespread and commonplace. In addition, in his report Mr Zeiderman referred the tribunal to a report published by the National Confidential Enquiry into Patient Outcome and Death ('NCEPOD') in November 2015. It identified 'remediable factors in the clinical and organisational care' of patients aged 16 or over with sepsis, the body's generalised response to infection. In particular, the tribunal noted that in the foreword to the report, the NCEPOD Chair stated that the report showed that it was 'hard to escape the conclusion that an appropriate sense of urgency is lacking in far too many cases'. It also noted what the NCEPOD report had to say about the sources of infection and their control. The tribunal found this evidence to be particularly persuasive. The NCEPOD report states that of the patients studied, in those 'in whom a source was amenable to control the reviewers were of the opinion that control was delayed in 43%'. The tribunal was therefore satisfied that in many emergency colorectal cases before 2015, a lack of urgency was not unusual.

84. In addition, that there was a general lack of urgency in 2010 in respect of patients requiring urgent laparotomies was also supported by the findings of the paper entitled 'Variations in mortality after emergency laparotomy: the first report of the UK Emergency Laparotomy Network', published in 2012. That paper makes it clear that prior to 2012, patients requiring emergency laparotomies experienced delays between being admitted to hospital and being booked for surgery, and between being booked for surgery and being actually operated on. The tribunal noted that in respect of delays between being admitted to hospital and being booked for surgery, the median range was one day, with an interquartile range (IQR) of 0-4 days, which means that prior to 2012 25% of patients requiring emergency laparotomies waited more than four days between being admitted to hospital and being booked for surgery. In respect of delays between being booked for surgery and actually being operated on, the tribunal noted that the median range was four hours, and that the IQR was 2-11.2 hours, which means that prior to 2012 25% of patients requiring urgent laparotomies waited more than 11.2 hours between being booked for surgery and being actually operated on.

85. Applying the clinical standards in operation at the time, the tribunal was satisfied that Mr Faiz's opinion that in 2010 a reasonable body of surgeons would have opted not to make immediate arrangements to perform urgent surgery on Patient A on 12 February 2010 was supported by objective research, and in addition to reasons it has already set out elsewhere in this determination, it found Mr Faiz's evidence to be more persuasive than Mr Zeiderman's in this regard.

86. In any event, having considered the evidence, the tribunal was satisfied that having been informed of the CT scan result at around 13:40 on 12 February 2010, you did make proactive steps to make immediate arrangements to perform urgent surgery on Patient A. The evidence shows that following your telephone conversation with Mr Hollingdale at 13:42, you telephoned the operating theatre office at 13:47. While it has not been possible to identify who it was that you spoke to, the tribunal was satisfied on the basis of the documentary evidence which shows phone calls from you to the theatre at that time, that you did indeed make contact, and that the purpose of that contact would be to put the theatre team on notice that you needed an operating theatre and supporting team. Your evidence was that as a result of the conversation you were left with the impression that there would not be a suitable theatre available until about 18:00 that evening. Your further evidence was that you were content with that timescale as you had not been alerted to any concerns about Patient A or as to any deterioration in his condition. It was not disputed that at that stage on Friday 12 February 2010 you did not yet have an anaesthetist who could assist you with Patient A's laparotomy.

87. Mr Faiz's evidence was that most surgeons at the time and in the circumstances in which you found yourself, would have set the wheels in motion to perform surgery on Patient A before receiving the results of the CT scan. However, in the context of your decision to defer the carrying out of the CT scan until the morning of 12 February 2010, the tribunal was satisfied that it was appropriate for you to have awaited its results before making further arrangements. The research papers that this tribunal has seen clearly demonstrate that in 2010 there were what would now be viewed as significant delays in patient pathways for patients requiring emergency care throughout the UK.

88. Having considered all the evidence, the tribunal was satisfied that once you had the results of the CT scan and a perforation was confirmed, you did make immediate arrangements to perform surgery, even if you did not immediately perform the surgery itself. The tribunal determined that in 2010, faced with the same circumstances as you, a reasonable body of competent Consultant General Surgeons would have acted as you did, and would not have performed surgery immediately on Patient A on 12 February 2010. You did not make immediate arrangements to perform surgery on Patient A on 12 February 2010 but, by the accepted clinical standards in 2010, that was not a failure on your part to provide good clinical care to Patient A. The tribunal therefore found sub-paragraph 2(b) not proved.

c. give clinical priority to Patient A in that you did not:

i. arrange to perform laparotomy surgery before you completed your clinic; **Found not proved**

89. During the evening of 12 February 2010 you had a clinic at the Clementine. The documentary evidence also shows that your clinic was scheduled for 16:00-19:00 and that you had five slots that day, at 17:15, 17:45, 18:15 and 18:45. Prior to that clinic, you carried out a planned colonoscopy, assisted by Dr Whitehead as the anaesthetist, at 14:30. It was not disputed that you arrived at the hospital around 13:45-14:00, having spoken to Mr Hollingdale while en route, and having spoken to Dr Kantor upon your arrival in the car park. Your evidence was that having been informed of Patient A's CT scan results during that period, you knew that conservative management was not now appropriate, and that surgical intervention would be required. The evidence was that you telephoned the operating theatre office within minutes of finding out the results of the CT scan, at 13:47, to advise that you needed to book a theatre and that you would need a supporting team.

90. You do not recall who it was that you spoke to during that conversation, but your evidence was that you asked the nurse what the position was with regard to theatre usage and availability for the next few hours, and that you were left with the impression that there would not be a suitable theatre available until about 18:00 or 19:00 that evening. Your further evidence was that you were content with that timescale, as you had not been alerted to any concerns about Patient A or to any deterioration in his condition. You stated that you were sure that you would have asked the nurse to hold the slot for you so that it would not be lost. You have no recollection of whether or not you suggested that the nurse book a specific time for Patient A to have his surgery, but you do not believe that you would have done at 13:47, because you did not yet have an anaesthetist.

91. The tribunal heard evidence from Dr Whitehead and found her to be a credible and reliable witness. Her recollection of specific details about the events and her involvement in them remained particularly vivid given the passage of time since they took place although at times she was not so clear and where she was not she said so. Dr Whitehead's evidence, which was consistent with your account and supported by your telephone records, was that while she was preparing medication for the colonoscopy procedure she received a telephone call from you (at 13:52) in which you told her that you had a laparotomy to do that same evening at 'around 19:00'. Both yours and Dr Whitehead's evidence was that you then asked her if she could assist you with that operation, but she told you that she was unable to commit to doing so. The tribunal noted that there was an inconsistency in the evidence before it regarding Dr Whitehead's understanding of the proposed timing of the operation and the documentary records and the understanding of other witnesses.

92. The evidence of Mr Rodrigues was that he had been instructed to prepare a theatre for an emergency laparotomy earlier that afternoon. There is also a note in Patient A's nursing records, at 14:30 on 12 February 2010, stating 'CT results obtained – for [...] theatre 6pm for laparotomy'. In addition, the tribunal also had regard to Ms Lenihan's evidence. The tribunal found Ms Lenihan to be a credible and

reliable witness overall, although she did have some difficulty in recollection given the passage of time since the events in question took place. Ms Lenihan's evidence was that between 14:00 and 14:40 she went to the ward to see Patient A. The agreed evidence was that Ms Wilkins told Ms Lenihan that Patient A would need a bed in the ITU after his operation and Ms Lenihan then went to the ITU in person to ensure that a bed had been booked for Patient A. There, she obtained the telephone number for Dr Wares, the on-call Intensive Care Consultant, and upon returning to the ward encountered Mr Hollingdale, to whom she gave Dr Wares' telephone number. Having considered the documentary evidence, the tribunal noted that Mr Hollingdale was in theatre at 14:20, so it was satisfied that Ms Lenihan met him before that time. Ms Lenihan's further evidence was that she then went to the theatre department and spoke to Ms Williams, who told her that you had booked a theatre slot for Patient A for 18:00. Ms Salmorin's evidence was that the first time she became aware Patient A was going to have surgery was when she received a telephone call from you at 16:00 that afternoon. The tribunal was therefore satisfied, on the balance of probabilities, that you spoke to the theatre office at 13:47 and that a theatre slot was provisionally identified for 18:00.

93. Your and Dr Whitehead's consistent evidence, again supported by your telephone records, was that following your telephone conversation at 13:52, and before Dr Whitehead went to the endoscopy suite, she took steps on your behalf to identify the current anaesthetists who worked at the Clementine. It was agreed evidence that Dr Whitehead identified that Dr Makram was working in theatre four at the Clementine that afternoon, and that Dr Wrigley was also working in theatre two that afternoon, assisting Mr Hollingdale. Dr Whitehead contacted both Dr Makram and Dr Wrigley on your behalf, and both told her that they were unable to assist with Patient A's laparotomy that evening. Your evidence, supported by your telephone records, was that after Dr Whitehead had told you that she could not assist with Patient A's laparotomy that evening, and upon your arrival at the endoscopy suite, you started to contact other possible anaesthetists by telephone. The records show that you made attempts over a ten minute period between 13:56 and 14:06 on 12 February 2010 to contact four different anaesthetists (Dr Makram, Dr Barker, Dr Rao, and Dr Ali) but to no avail; you were only able to speak directly to Dr Ali, who told you that she was unable to assist you that evening. It was not disputed that following those attempts, you went on to carry out the planned endoscopy procedure.

94. The agreed evidence was that following the completion of the endoscopy procedure at around 15:30, Dr Whitehead spoke to Dr Wrigley again, this time in person, and while Dr Wrigley was not available he suggested to Dr Whitehead that Dr Vishwanatha might be. Dr Wrigley spoke to Dr Vishwanatha, who said that he would be available at 19:00 after he had completed an elective procedure for which he was already booked. The consistent evidence of both Dr Whitehead and you was that Dr Whitehead told you at around 16:00 that afternoon that Dr Vishwanatha

would be available to anaesthetise Patient A. Your evidence was that, having secured the services of an anaesthetist, you visited Patient A on the ward.

95. It was not disputed that you reviewed Patient A on the ward at 16:00 on the afternoon of 12 February 2010 and you recorded this in Patient A's notes. Your evidence was that having looked at the observation chart, you noted Patient A's pain score was three, and that his temperature was 37 degrees. You recorded that his breathing seemed to have improved. You also noted that you had reviewed the blood tests and in your oral evidence you said that they confirmed the presence of sepsis, but not septic shock. You went on to record a slight reduction in urine output, and you gave instructions for Patient A's fluid input to be increased. Having reviewed Patient A, you concluded that Patient A was unwell but that there was no indication that he had deteriorated to such an extent that you needed to try and accelerate the start time for his operation. You then telephoned the theatre office again to confirm that following your previous telephone conversation at 13:47, you now wished to book the theatre for 19:00 having now secured an anaesthetist for that time.

96. The tribunal has seen and heard evidence about the nature and content of your telephone call to the theatre office at around 16:00 on 12 February 2010. In particular, the tribunal noted the inconsistencies between the evidence of Ms Williams and Ms Salmorin about it. The evidence of Ms Williams was that at around 16:00 Ms Salmorin told her that you had called the theatre office and requested a theatre slot for 19:00 for a laparotomy. Ms Williams' evidence was that she then spoke to you from the theatre office, you requested a 19:00 slot. Her evidence was that while she did not remember 'word for word' what you said to her on the telephone, she did recall you saying that you had said that you had seen a patient, and that you also requested a slot for the laparotomy at 19:00. In her oral evidence to the tribunal, Ms Williams was very confused about the timings of the events on the afternoon of 12 February 2010.

97. While the tribunal attaches no criticism to Ms Williams' poor recollection of events given the significant passage of time since the events in question took place, it could not place much weight on her evidence. Ms Salmorin's evidence was that she received a telephone call from you at 16:00 and that this was the first time she became aware that Patient A was going to have surgery. The tribunal was satisfied that it was Ms Salmorin whom you told that you wanted to book a slot for 19:00, and that your request for that slot came having been informed of Dr Vishwanatha's likely availability that evening. Ms Salmorin's evidence was that when you spoke to her at around 16:00 that afternoon, you did not mention at any time that the operation was urgent, and neither did you make it sound as if it were urgent. Her evidence was that you just requested a slot for 19:00.

98. Having considered all the evidence, the tribunal was satisfied, on the balance of probabilities, that on 12 February 2010 you would have been prepared to perform

laparotomy surgery before you completed your clinic. The tribunal made this finding because you provisionally made arrangements for Patient A to go to theatre from 18:00, which was before your clinic was scheduled to conclude at 19:00. The tribunal noted that the documentary evidence shows that operating theatres one and three at the Clementine would have been available to you before 18:00 on 12 February 2010. The tribunal also heard evidence from both Ms Salmorin and Dr Whitehead, about the way in which theatre booking took place at the Clementine in February 2010, in that the booking took place through the coordinators office on paper records which this tribunal does not have at its disposal to consider. There is no evidence to confirm the *content* of the first call you made to the theatre department at 13:47; there is evidence that you made a second call to the theatre office at 16:00, to confirm a slot for 19:00, which was when you understood that Dr Vishwanatha would be available to assist you with Patient A's laparotomy – something you only found out at 16:00 that evening.

99. The tribunal noted that the implication of the GMC's case in respect of sub-paragraph 2(c)(i) of the allegation, is that because you did not arrange to perform laparotomy surgery before you completed your clinic on 12 February 2010 you failed to provide good clinical care to Patient A because you did not prioritise his surgery over your elective commitments. However, the tribunal was not satisfied that the facts in respect of this sub-paragraph are made out to the required standard. Having had regard to all the evidence, the tribunal was satisfied that you provisionally booked a theatre slot for Patient A's laparotomy around 18:00, when you spoke to theatre at 13:47. At that time you did not have an anaesthetist. You then took steps throughout the afternoon of 12 February 2010 to source an anaesthetist, enlisting Dr Whitehead to assist you in that task, and eventually securing Dr Vishwanatha to assist you, who told Dr Whitehead that he would be available at 19:00. You then telephoned the theatre office again, at 16:00, to confirm that you wanted a slot for 19:00 that evening. Having had regard to the documentary evidence before it, in particular the entry in the nurse's record which records that Patient A was 'for theatre around 18:00 for laparotomy' and the evidence of Ms B that she too had been advised her father was to go to theatre around that time, the tribunal was satisfied on the balance of probabilities, that you did initially arrange to perform laparotomy surgery before you completed your clinic on 12 February 2010.

100. With respect to Patient A's clinical condition on the afternoon of 12 February 2010, the tribunal was satisfied that throughout that afternoon Patient A's blood pressure and urine output remained stable. Mr Faiz's evidence, which the tribunal accepted, was that he had 'no doubt that any reasonable surgeon would even in 2010 have prioritised Patient A within the context of physiological deterioration'. The tribunal has neither seen nor heard any evidence that you were contacted by any of the numerous professionals who came into contact with Patient A that afternoon raising any concerns about Patient A's condition. The tribunal has a significant amount of evidence before it, from a number of different witnesses, to suggest that Patient A remained broadly stable throughout the afternoon of 12 February 2010.

Mr Faiz's evidence was that, according to the documentary evidence, Patient A remained 'broadly physiologically stable throughout prior to 18:00'. Furthermore, there is evidence to suggest that other individuals involved in Patient A's care such as, for example, Ms Lenihan, did not have any concerns about Patient A's condition that afternoon and were content with what they understood your initial plan to be – to operate on Patient A at 18:00 that evening.

101. In light of the delays in emergency colorectal surgery throughout the UK in general in 2010, the tribunal determined that, at the time, it was more likely than not that a reasonable body of competent General Colorectal Surgeons would have acted as you did on the afternoon of 12 February 2010. The tribunal was satisfied that by not arranging to perform laparotomy surgery before you completed your clinic on 12 February 2010 you did not fail, by the accepted clinical standards of the time, to provide good clinical care to Patient A. The tribunal therefore found sub-paragraph 2(c)(i) not proved.

ii. return to Patient A until you had completed your afternoon list.
Found not proved

102. Having considered the evidence, the tribunal was satisfied that having been informed of the result of Patient A's CT scan at around lunchtime on 12 February 2010, the degree of urgency in which you were acting changed. The tribunal accepted that it was common practice at the time to not always take proactive steps while awaiting the results of a CT scan, but it was satisfied that having been informed of the CT scan results, you set about booking a theatre and sourcing an anaesthetist, enlisting the help of Dr Whitehead in relation to the latter.

103. There is no evidence that Patient A showed significant signs of deterioration over the afternoon of 12 February 2010; no one contacted you to raise concerns about his condition, and all the nursing staff who saw him on the ward that afternoon have reported that Patient A was stable. You did not then review Patient A until 16:00, following which you confirmed the theatre booking for 19:00 that evening. The tribunal found that it would have been preferable for you to have reviewed the patient having been informed of the CT scan results, but it accepted, in light of your evidence and the records of the nursing staff, that there was at that time no indication for you to do so.

104. In its analysis of the evidence and its finding above at sub-paragraph 2(c)(i) of the allegation, the tribunal found that while you did not arrange to perform laparotomy surgery before you completed your clinic on 12 February 2010, your not doing so was coincidental and to some degree out of your control. The tribunal found that your actions did not indicate that you had not given clinical priority to Patient A and, by extension, that you failed to provide Patient A with good clinical care. Your evidence was that by around 16:30 on 12 February 2010 you had sourced an anaesthetist, Dr Vishwanatha, booked a theatre for 19:00 when you understood

Dr Vishwanatha would be available to assist you with Patient A's laparotomy, and had also contacted the stoma nurse, the ITU, and the laboratory to advise them of the procedure. You had also reviewed Patient A on the ward at 16:00.

105. It was not disputed, as a fact, that you did not return to Patient A on the afternoon of Friday 12 February 2010 before you had completed your afternoon list. What was disputed, was whether by not doing so, you failed, by the accepted clinical standards of the time, to provide good clinical care to Patient A. Your evidence was, in effect, that you saw no need to return to Patient A before completing your afternoon list because by that point there was nothing further for you to do until the start time for the laparotomy which was provisionally scheduled for 18:00. In addition, your further evidence was that because you had not been given any indication that his physiological condition had deteriorated, you did not need to return. Your further evidence was that had Patient A's clinical condition changed and had you been informed, your actions would have been different.

106. Having considered all the evidence, the tribunal was satisfied that during the afternoon of 12 February 2010 you would have returned to Patient A before you completed your afternoon list had you been asked to. It was satisfied that Patient A, according to those who were caring for him, did not display any signs of deterioration during the afternoon which would warrant your earlier return to him. The evidence from the nursing staff in this respect is consistent. Mr Podaan, for example, who cared for Patient A throughout the day on 12 February 2010, was told by Ms Lenihan to monitor Patient A closely throughout the day and while Mr Podaan's evidence was that Patient A was 'very unwell' at the start of his shift, by the end of it Patient A's condition had not deteriorated. His further evidence was that at no time during the day was he so unhappy with Patient A's condition that he felt the need to call someone. His evidence was that had Patient A's condition deteriorated, he would have called the ITU or the RMO.

107. In addition, Ms Curran also saw Patient A on 12 February 2010, when she reviewed him on the ward at around 15:20. Her agreed evidence was that Patient A's last documented modified early warning score (MEWS) was three from observations taken twenty minutes previously. Her further evidence was that Patient A was alert and communicating well and that his only complaint at that time was being thirsty and uncomfortable. Shortly afterwards, Ms Curran returned again to see Patient A, and following a fifteen minute conversation with him was satisfied that his care was being managed by the ward staff. Ms Curran's further agreed evidence was that at around 17:00, she telephoned the ward and spoke to Nurse Sousa, who informed her that Patient A's condition remained stable, that he was passing adequate volumes of urine, and that his MEWS was unchanged. Ms Curran telephoned the ward again at 19:00, and was again informed that Patient A's condition remained as it had been earlier in the day. Ms Lenihan, for her part, left the Clementine at 17:00 on 12 February 2010, satisfied that while Patient A was

'poorly', she was happy with the proposed treatment plan, on the basis that Patient A was going to surgery at 18:00.

108. Mr Faiz's evidence was that had there been any clinical concerns about Patient A throughout 12 February 2010, he would have expected those to have been communicated to you by the ward staff or the RMO. Given the absence of any information passed to you to suggest that Patient A's clinical condition had deteriorated to any significant degree, or at all, Mr Faiz's evidence was that he would not therefore be 'overly critical' of you for not personally attending the ward immediately after having been informed of the CT scan results and instead reviewing Patient A at 16:00. Mr Faiz went on to refer to the attempts you and Dr Whitehead were making throughout the early part of the afternoon of 12 February 2010 to source an anaesthetist who would be available to assist you with Patient A's laparotomy that evening.

109. The tribunal accepted that on 12 February 2010 you did not return to Patient A until you had completed your afternoon list. In respect of this allegation, the GMC has not proved to the required standard that a reasonable body of competent Consultant Colorectal Surgeons would not have acted as you did. While you did not physically return to Patient A before completing your afternoon list, the tribunal was satisfied that you did nonetheless accord him clinical priority, as evidenced by the number of actions you undertook immediately after having been informed of the results of the CT scan that lunchtime. The tribunal was therefore satisfied that while you did not return to Patient A before completing your afternoon list, you did not, by the accepted clinical standards of the time, fail to provide good clinical care to Patient A. It therefore found sub-paragraph 2(c)(ii) not proved.

d. source an Anaesthetist for Patient A's surgery, in that you did not:

i. break into a colleagues list; **Found not proved**

110. It was not disputed that in 2010 a general principle existed that it was possible, when required, to 'break into' a colleague's surgical list. Both expert witnesses agreed that this was the case in 2010 as now, and they both agreed that it was usual for that principle to be enacted when a surgeon was faced with an acute emergency patient requiring immediate surgical intervention, or a patient whose life was in immediate danger. The tribunal has no evidence that in 2010 a formal 'break in' policy existed at the Clementine. In your police interview in 2010 you said that you did not know of any break in policy at the Clementine. However, since then and in oral evidence you accept that, as a general principle, you knew that it was possible to break into a colleague's surgical list. Irrespective of whether or not a formal break in policy existed at the Clementine in February 2010, having had regard to all the evidence, the tribunal was satisfied that there was a general acceptance amongst staff working at the Clementine in February 2010 that 'breaking into' a colleague's surgical list was possible.

111. However, the tribunal noted that the consensus amongst staff at the Clementine was that the practice of breaking into a colleague's list was extremely rare in their experience. The tribunal noted that some of the witnesses understood the word 'emergency' to mean different things, in that they understood an 'emergency' to be any patient who is admitted to the Clementine for a hurriedly planned elective procedure, whether or not that procedure is life-threatening. However, in respect of breaking into surgical lists, the evidence of Mr Rodrigues, Ms Salmorin and Ms Williams was that it was an extremely rare occurrence at the Clementine. The tribunal noted, for example, Ms Williams' evidence that she had only had to break into a surgical list once in around twenty-two years.

112. It was not disputed that Dr Vishwanatha arrived at the Clementine at around 18:00 on 12 February 2010. The agreed evidence was that when Dr Vishwanatha arrived at the hospital, you spoke to him on the telephone before he saw Patient A in order to carry out his pre-operative assessment. Your evidence was that you explained Patient A's history to Dr Vishwanatha, and told him that given the diagnosis you would be grateful if he could be operated on as soon as possible. Your evidence was that Dr Vishwanatha told you that he was scheduled to carry out a short gynaecological procedure but that he would be free to assist you after then. Your evidence was that during the course of that telephone conversation Dr Vishwanatha made no suggestion that you should, at that point, try to find another anaesthetist. It was not disputed that before carrying out his planned procedure that evening, Dr Vishwanatha saw Patient A on the ward and carried out the pre-operative assessment. Dr Vishwanatha's evidence was that he then spoke to you again, this time in person, and told you that he thought that you should arrange for another anaesthetist to carry out Patient A's operation as Dr Vishwanatha was not available until he had completed the planned gynaecological procedure, and because, having seen Patient A and done the pre-operative assessment, Dr Vishwanatha thought it better that Patient A's operation be done as soon as possible.

113. In respect of the timing of that conversation between you and Dr Vishwanatha, the tribunal has heard conflicting accounts. Dr Vishwanatha's evidence was that the conversation took place just after he had seen Patient A on the ward and had done the pre-operative assessment. Your evidence was that the conversation took place later than that, at around 19:45-20:00. The evidence of Ms Salmorin was that at 19:00 she went to theatre two, where Dr Vishwanatha was working as the anaesthetist, to see when he would be finished. Dr Vishwanatha said it would be 1-2 hours and you agreed to wait. In her oral evidence she recalled Dr Vishwanatha and you speaking face to face. She could not recall the content of the conversation but did recall it took place later than when she had spoken to Dr Vishwanatha in theatre two. Dr Vishwanatha's evidence was that he said he would be available once he had finished his pre-arranged case. He did not say he would be ready by 19:00 or give any timing. He agreed that when he carried out his

pre-operative assessment of Patient A, Ms B was present. In her statement to the Coroner, dated 6 July 2010, Ms B stated that Dr Viswanatha had told Patient A that he would be called to theatre 'about 18:00 or before 18:30 anyway'. On balance, the tribunal preferred your account to that of Dr Vishwanatha. Your evidence about the timing of the conversation was clearer, more consistent, and, in all the circumstances, more plausible to the tribunal. By contrast, the tribunal found Dr Vishwanatha not to be reliable as a witness. When questioned during the course of his oral evidence he could not answer all the questions put to him, he was unable to recall specific details of events on 12 February 2010 and he talked about 'collective evidence'.

114. While the tribunal noted inconsistencies in your evidence about whether or not you knew of the break-in-policy at the Clementine, the tribunal was satisfied that irrespective of the existence of a formal break-in-policy at the hospital, you were aware that in extreme cases of bleeding, for example, breaking into a colleague's list was an accepted and established practice across hospitals generally. Your consistent evidence was that, on the afternoon and early evening of Friday 12 February 2010, you did not consider that Patient A's clinical condition warranted breaking into a colleague's list for his urgent laparotomy. Your evidence in this regard is supported by that of Dr Whitehead.

115. While acknowledging that in February 2010 there was a problem with the provision of on-call anaesthetists at the Clementine, in his report Mr Zeiderman criticised your actions and inactions on 12 February 2010. His evidence was that on 12 February 2010 Patient A was not stable, and that you should have broken into a colleague's list in order to source an anaesthetist to assist with Patient A's urgent laparotomy. Mr Zeiderman's oral evidence was that he thought Patient A was in 'severe trouble' on the morning of 12 February 2010 and that, in his view, it was clear that Patient A's observations and results in the afternoon were significantly abnormal, sufficient to warrant you expediting surgical intervention and breaking into a colleague's list to source an anaesthetist, rather than waiting for and relying on Dr Vishwanatha.

116. Mr Faiz, on the other hand, told the tribunal that, in his view, which was supported by objective evidence from outside his own personal practice, at the time that you acted as you did, by not breaking into a colleague's surgical list, many Consultant Colorectal Surgeons in 2010 would have acted in the same way that you did. The tribunal again found Mr Faiz's evidence to be more balanced than Mr Zeiderman's in this respect. The tribunal has already broadly accepted Mr Faiz's evidence that delays in patient pathways for patients presenting with acute abdominal problems in February 2010 were widespread and common. Referring the tribunal to the scientific evidence, Mr Faiz stated that there was, in 2010, a general consensus that there is a spectrum of sepsis from sepsis through to severe sepsis and, finally, through to the condition of septic shock. Mr Faiz's evidence, supported by the scientific evidence, was that while sepsis is in general time-critical, it is only

once a patient has been confirmed as being in septic shock that steps must be taken to perform urgent surgery. The tribunal also found Mr Faiz's evidence to be balanced, because while he noted that Patient A demonstrated some evidence of organ dysfunction on 12 February 2010, the liver function tests reported that day did not have an equivalent result against which to be compared to and that could not, in itself, suggest that Patient A's clinical condition had deteriorated significantly.

117. During his oral evidence, Mr Zeiderman took the tribunal to a range of clinical indicators and suggested that these were indicative of Patient A's condition deteriorating to such an extent that it would warrant breaking into a colleague's surgical list. Mr Faiz's evidence was that the two critical signs to indicate a patient is going into septic shock are a drop in blood pressure and a drop in urinary output. In oral evidence much was made by Mr Zeiderman of Patient A's white blood cell count on the afternoon and evening of Friday 12 February 2010. Mr Faiz did not agree with Mr Zeiderman's opinion. Neither expert mentioned Patient A's white blood cell count in their report, and neither expert provided objective, research-based evidence, to support their opinions on this matter. The tribunal therefore gave little weight to that discrete issue, and it was satisfied that the most important factor to consider in respect of Patient A's clinical condition that afternoon and evening was his blood pressure and his urinary output; the tribunal accepted Mr Faiz's evidence that without having been informed that there had been a significant drop either on the afternoon/evening of 12 February 2010, Patient A's condition did not meet the threshold for breaking into a colleague's surgical list.

118. Having accepted Mr Faiz's evidence in this regard, the tribunal was satisfied that throughout the afternoon and evening of 12 February 2010 Patient A remained physiologically stable broadly speaking. At no point were you made aware of any concerns about his condition, and at no point were you contacted by nursing or ward staff to say that Patient A's condition had deteriorated. Patient A's blood pressure and urinary output remained stable. In all the circumstances, the tribunal was satisfied that when you decided not to break into a colleague's list in order to source an anaesthetist on the evening of 12 February 2010 you were acting as many reasonably competent Consultant Colorectal Surgeons would have acted at the time. The tribunal was satisfied that on the Friday evening, when it became apparent to you that breaking into a colleague's surgical list was a potential course of action, the opportunity to do was not viable as the gynaecological procedure was already underway. You were left with no choice but to wait for Dr Vishwanatha's elective procedure to finish, which it did at around 21:00. The tribunal therefore determined that by not breaking into a colleague's list to source an anaesthetist you did not, by the accepted clinical standards of the time, fail to provide Patient A with good clinical care. It therefore found sub-paragraph 2(d)(i) not proved.

~~ii. ask for help to try and find an Anaesthetist.~~ **Withdrawn by the GMC**

Record of Determinations –
Medical Practitioners Tribunal

Determination on Application for the Tribunal to Revisit its Factual Finding at Sub-Paragraph 2(a) - 06/03/2018

Mr Sellu:

The Context of the Application

1. On Thursday 1 March 2018 the tribunal announced its findings of fact. It announced sub-paragraph 2(a) of the allegation as 'found proved'. Sub-paragraph 2(a) of the allegation is that:

> **Paragraph 2**
>
> On 12 February 2010, you failed to provide good clinical care to Patient A, in that you did not:
>
> a. review Patient A;

2. In respect of its finding in relation to sub-paragraph 2(a) of the allegation, the tribunal's reasoning is set out in full in its determination on the facts at paragraphs 66-77; the tribunal does not intend to set out those reasons in their entirety here. In summary, the tribunal was satisfied, on the balance of probabilities, that you visited Patient A on the morning of Friday 12 February 2010, but it was not satisfied that your interaction with Patient A that morning constituted 'a review'. The tribunal determined that by not 'reviewing' Patient A on the morning of 12 February 2010 you failed to provide good clinical care to him.

3. On Friday 2 March 2018 Mr Stern told the tribunal that both he, on your behalf, and Mr Williams, on behalf of the GMC, agreed that there was 'an error in general terms', in the tribunal's finding at sub-paragraph 2(a). Mr Stern told the tribunal that it was agreed by the parties that the GMC had advanced, conducted, and closed its case in respect of sub-paragraph 2(a) on the basis that you did not attend or see Patient A on the morning of 12 February 2010, and no more than that. Mr Stern told the tribunal that it was agreed by the parties that the tribunal had not been required to make any qualitative assessment of your interaction with Patient A that morning, as it had gone on to do. That is, Mr Stern submitted that having found that you did visit Patient A on the morning of 12 February 2010, the tribunal should have ended there, and found sub-paragraph 2(a) 'not proved'. Both Mr Stern and Mr Williams agreed, and told the tribunal, that in these circumstances the question of whether the tribunal had jurisdiction to revisit its finding at sub-paragraph 2(a) arose. Mr Williams told the tribunal that Mr Stern had identified some authorities that he thought might be relevant to that question and that both parties accepted that it was a 'novel' point which would benefit from some 'mature reflection'. It was therefore agreed with the tribunal that the hearing would adjourn until Monday 5 March 2018.

4. On Monday 5 March 2018 the tribunal heard submissions from both parties on this matter.

Submissions on Your Behalf

5. In the course of his submissions on your behalf, Mr Stern set out in detail what he perceived to be the relevant law, and referred to the judgments in the following cases in particular:

Fajemisin v GDC [2013] EWHC 3501 (Admin);

TZ v GMC [2015] EWHC 1001 (Admin); and

Chaudhuri v GMC [2015] EWHC 6621 (Admin).

6. Mr Stern began by submitting that it was agreed between the parties that the tribunal had made a mistake in its finding at sub-paragraph 2(a) of the allegation, because it had found that sub-paragraph proved on a different factual basis than that on which it had been pursued by the GMC. He submitted that the allegation as it had been advanced by the GMC only required the tribunal to analyse the circumstantial evidence relating to whether or not you attended to see Patient A on the morning of 12 February 2010; the tribunal was not required to carry out a clinical assessment as to what a review involves and whether or not you carried out an adequate review.

7. Mr Stern submitted that in the circumstances a 'clear breach of natural justice' had occurred, because at no stage had the tribunal sought to amend the allegation in either form or substance (permissible under Rule 17(6), provided that 'the amendment can be made without injustice'), and consequently neither party had had notice of the allegation 'found proved', had made submissions about it, or had dealt with the point by way of evidence.

8. Mr Stern went on to remind the tribunal that when Mr Williams applied to amend the allegation on day twelve of this hearing, by withdrawing sub-paragraphs 1(c)(iii) and 2(d)(ii), he had indicated that the GMC had considered applying to add the word 'adequate' to sub-paragraph 2(d)(ii) rather than applying to withdraw it, but it had considered that to apply for the former at that stage in the proceedings would be unfair, even though it would not have involved any further evidence and could have been dealt with in submissions. Mr Stern went on to submit that if that suggested amendment was considered unfair, it could also only be unfair for the tribunal to 'amend' the allegation as he submitted it had.

9. Referring to the judgment in the case of *TZ v GMC*, Mr Stern told the tribunal that it is clear, and agreed between the parties, that having announced its findings under Rule 17(2)(j), that was the end of the fact finding stage and that no further

evidence could now be admitted to reargue its findings. He submitted that there has to be finality to decisions, and he accepted that in a hearing before a medical practitioners tribunal that finality is reached when the tribunal's findings of fact are announced. Indeed, Mr Stern emphasised that by making the application he was not seeking to re-open the facts by calling further evidence or making further submissions about the facts alleged.

10. However, referring to the judgments in the cases of *Fajemisin v GDC* and *Chaudhuri v GMC* to demonstrate the evolution of the principle, Mr Stern went on to submit that there appeared to be 'an extremely limited basis' upon which a public body such as this tribunal might have 'a narrow jurisdiction' to be able to review and/or correct any decision that it has made, namely in circumstances where it had made 'a fundamental mistake of fact'. He submitted that, on the basis of the judgments referred to, having made 'a fundamental mistake of fact' the tribunal would have an inherent power to correct the fundamental mistake made, if the correction of that mistake was 'obvious' and did not result in injustice.

11. In support of those submissions, Mr Stern referred the tribunal in some detail to *Fajemisin v GDC*, and in particular the following remarks by Keith J in its headnote:

> '*Held*, dismissing the appeal, that the jurisdiction of a public body to revisit a previous decision was not limited to the making of corrections under an equivalent of the slip rule to rectify accidental errors which did not substantially affect the rights of the parties or the decision taken; that rather, it was also open to a public body to revisit and revoke a decision made under a fundamental mistake as to the underlying facts; that such jurisdiction was available in respect of all decisions and was not circumscribed by an artificial distinction between judicial and administrative decisions; that the decision to remove the dentist's name from the register had been made in the mistaken belief that there were no extant fitness to practise proceedings, and absent that fundamental mistake of fact, the decision would not have been taken; that, therefore, it had been open to the registrar to revisit and reverse that decision once the true factual position became apparent; and that, accordingly, the dentist's name had properly remained on the register with the result that the PCC had retained jurisdiction to adjudicate on the fitness to practise proceedings'.

12. In respect of *Fajemisin v GDC*, Mr Stern also referred the tribunal in particular to those sections of the judgment in which Keith J adopted principles set out in: *Akewushola v Secretary of State for the Home Department* [2000] I WLR 2295; *R (Jenkinson) v NMC* [2009] EWHC 1111 (Admin); *R (B) v NMC* [2012] EWHC 1264 (Admin) and *Porteous v. West Dorset District Council* [2004] EWCA Civ 244. In respect of the last of these, Keith J stated in *Fajemisin v GDC* that it is:

'authority for the proposition that, in addition to cases in which a public body can revisit a previous decision under the equivalent of the slip rule, a public body can revisit a decision which was made in ignorance of the true facts when the factual basis on which it had proceeded amounted to a fundamental mistake of fact'.

13. Mr Stern also referred the tribunal to remarks made by Haddon-Cave J in *Chaudhuri v GMC*, in which he adopted principles established earlier in both *Porteous v. West Dorset District Council* and *Fajemisin v GDC*:

'46 [...] In my view, the inherent jurisdiction of public bodies to revisit previous decisions is not limited simply to correcting slips or minor errors which do not substantially affect the rights of the parties or the decision taken; on the contrary, public bodies have the inherent or implied power themselves to revisit and revoke *any* decision vitiated by a fundamental mistake as to the underlying facts upon which the decision in question was predicated.

Broad corrective principle

47 I have no doubt that such a broad corrective principle exists in administrative law. Public bodies must have the power themselves to correct their own decisions based on a fundamental mistake of fact. To suggest otherwise would be to allow process to triumph over common sense. There is no sense in requiring wasteful resort to the courts to correct such obvious mistakes. Administrative law should be based on common sense.

48 The vitiating effect of fundamental mistakes of fact is well recognised in other areas of law [....] Even the High Court has the power to reopen its own appeal procedure to prevent real injustice [....]

49 A broad corrective principle of the nature described above is consonant with the principles of proportionality and utility. It is also consonant with the emerging principle of "good administration" in administrative law [....] Not to have such a principle would be inimical to good administration.

50 In my view, the law is correctly stated in the current edition of *Wade & Forsyth, Administrative Law,* the 11th edition (2014), at p. 192:

"Even where such powers are not expressly conferred, it seems that statutory tribunals have power to correct slips and to set aside judgments obtained by fraud or based on a fundamental mistake of fact."

> 51 The principle would naturally operate subject to the ordinary principles of fairness in administrative law (*e.g.* legitimate expectation and the rights of persons action to their detriment in reliance upon such decisions).'

14. Having set out the basis for the 'broad corrective principle' that a public body has a power to review and correct a decision if that decision arose out of 'a fundamental mistake of fact', Mr Stern went on to submit that by making its finding at sub-paragraph 2(a) of the allegation on material which was not relevant to that sub-paragraph as alleged, the tribunal had made such 'a fundamental error of fact and/or law' because it had either:

> 1) mistakenly believed that the facts that it set out were capable of constituting a finding in relation to 2(a) when no such allegation had been made or fully dealt with;
>
> 2) wrongly taken into account facts that were not relevant to 2(a) as it is alleged; and/or
>
> 3) erred in believing that it could place its own interpretation on 2(a), without informing the parties of that interpretation which was one that differed from that presented and dealt with by parties.

15. Mr Stern submitted that having made 'a fundamental mistake of fact', the tribunal has an inherent power to review and correct its finding at sub-paragraph 2(a). He further submitted that correcting the tribunal's finding would:

> 1) require no alteration or reconsideration of any fact – the tribunal's finding that you did see Patient A at the relevant time makes the result unequivocal;
>
> 2) cause no injustice to anyone, and would be the appropriate and fair result of the submissions made by both parties;
>
> 3) prevent a miscarriage of justice, in that leaving sub-paragraph 2(a) as 'proved' would result in a fact found proved which in the factual findings should be 'not proved'; and
>
> 4) not be fatal because of the absence of a Rule allowing alteration of a decision.

16. Mr Stern concluded by submitting that the tribunal's finding at sub-paragraph 2(a) was based on a fundamental mistake of fact and that, consequently, the tribunal has a broad corrective power that should be exercised for the reasons set

out above, and that, accordingly, sub-paragraph 2(a) should be announced as having been found 'not proved'.

Submissions on Behalf of the GMC

17. Mr Williams submitted that it was common ground between the parties that the GMC had pursued sub-paragraph 2(a) of the allegation on the basis that you did not see Patient A at all on the morning of 12 February 2010. He submitted that his criticism of the tribunal's finding was not that there was no evidential basis for it, but because it had found sub-paragraph 2(a) 'proved' on a basis which the GMC had not pursued and which, therefore, neither he nor Mr Stern had addressed. He went on to say that had the parties been aware that the tribunal was interpreting sub-paragraph 2(a) of the allegation in the manner that it did, then both he and Mr Stern could potentially have dealt with the relevant evidence differently.

18. Referring to the judgment in the case of *PSA v NMC & Jozi* [2015] EWHC 764 (Admin), Mr Williams submitted that it was clear, and agreed between the parties, that, in principle, it is permissible for a tribunal to make a factual finding on an alternative basis to the case as advanced by the GMC. In addition, he submitted that the same judgment makes it clear that it was open to the tribunal to seek to amend the allegation even at a late stage in the proceedings. He submitted, however, that to find a fact proved on an alternative basis to that on which it had been advanced by the GMC, was a matter of natural justice. Had the tribunal been considering the alleged fact on a different basis to that on which it had been put, then both parties should have been 'put on notice' of that intention. He submitted that not to do so was unfair. Referring to the tribunal's private deliberations in camera, Mr Williams submitted that had it become apparent during the course of those deliberations that the tribunal was considering 'a different semantic interpretation' of the wording of sub-paragraph 2(a) to the parties, then the matter was one of procedural fairness, as both parties should have been told that the tribunal was interpreting the sub-paragraph in the way it did.

19. Accepting the legal principles as set out by Mr Stern in the course of his submissions, Mr Williams went on to submit that while the GMC accepted that a 'mistake' had arisen in the tribunal's finding at sub-paragraph 2(a), the GMC did not consider that the 'mistake' made by the tribunal constituted 'a fundamental mistake as to the underlying facts' as envisaged by the relevant authorities (cf. in particular *Fajemisin v GDC* and *Chaudhuri v GMC*). Mr Williams submitted that what had occurred was not that the tribunal had made 'a fundamental mistake of fact', but that it had, by not putting the parties on notice of the way in which it was interpreting the wording of sub-paragraph 2(a), created 'a procedural unfairness' which was 'an offence to natural justice'. Accepting that the question of what constitutes 'a review' was 'in the evidential arena' during the course of the fact finding stage, Mr Williams submitted that you and your legal representatives had not had 'express notice' that the tribunal was interpreting sub-paragraph 2(a) in the way

that it did and that you and they should have had. If the tribunal had made 'a mistake', Mr Williams submitted that the mistake was that the tribunal had created 'a procedural unfairness' and that, in those circumstances, the tribunal does not have jurisdiction, however narrow or limited, to revisit its finding at sub-paragraph 2(a).

The Legal Assessor's Advice

20. The legal assessor reminded the tribunal that both parties agreed that the tribunal had made a finding in respect of sub-paragraph 2(a) on a different factual basis to that on which the GMC had pursued that sub-paragraph of the allegation. She reminded the tribunal of the positions outlined by Mr Stern and Mr Williams respectively in their submissions.

21. The legal assessor went on to advise the tribunal that it is at liberty to accept or reject the submissions made by Mr Stern but that its decision either way must be based on what its understanding of sub-paragraph 2(a) was when it went in camera to deliberate on the facts: from the GMC's opening of the case, from the evidence it heard throughout the fact finding stage, and from the GMC's closing submissions. She advised the tribunal that if it were to find that its understanding prior to announcing its findings had been that the GMC had advanced its case in respect of sub-paragraph 2(a) only on the basis that you did not go to see Patient A on the morning of 12 February 2010, then the tribunal should accept Mr Stern's submissions because it had then gone on to make findings of fact on a basis that was not invited, as this would be a procedural error.

22. The legal assessor then went on to advise that if the tribunal was always of the understanding that sub-paragraph 2(a) had been pursued on a different basis, and that understanding was based on the tribunal's understanding of the way in which the case was put, then in the absence of anything else that may have led the tribunal to a different understanding the tribunal will not have fallen into error, notwithstanding that the parties say that was how they intended the tribunal to understand the case. In those circumstances, the legal assessor advised the tribunal that it would not be required to take any further action and unless the parties were to ask for time to consider further applications the tribunal would then move on to consider whether or not, on the basis of the fact 'found proved', your fitness to practise is impaired by reason of your misconduct.

23. The legal assessor advised the tribunal that if, however, the tribunal knew that the GMC had advanced their case in respect of sub-paragraph 2(a) on the basis that you did not see Patient A on the morning of 12 February 2010 but even so went on to decide the matter on a different basis without first raising this with parties, then the tribunal would have to consider whether it is able to take any further action to provide a remedy for the error or whether it is prohibited from doing so under the Rules.

24. The legal assessor agreed with both parties that the Rules do not expressly provide the tribunal with a power to revisit findings of fact it has already announced and that *TZ v GMC* shows that once a tribunal's findings have been announced that is the end of the fact finding stage. Referring to the authorities from case law set out by Mr Stern in the course of his submissions and agreed upon by Mr Williams (cf. *Fajemisin v GDC* and *Chaudhuri v GMC*), the legal assessor advised the tribunal that any power the tribunal has to revisit and correct a finding that has already been announced are 'very restricted'. She went on to say that in light of the relevant authorities as they had been set out, she agreed with Mr Williams' submission that if the tribunal did err and change the basis upon which it made its finding at sub-paragraph 2(a), without putting the parties on notice of its intention to do so, then that would amount to 'a procedural error' and not 'a fundamental mistake of fact'. In those circumstances, the legal assessor advised the tribunal that it would be unable to rely on the 'broad corrective principle' that Mr Stern and Mr Williams had set out, and it would not have the jurisdiction or power to revisit and reconsider its finding.

25. Having retired in camera the tribunal required clarification from Mr Williams regarding one part of his submissions, namely that if the tribunal finds that it had misunderstood the way in which the GMC had advanced its case in respect of sub-paragraph 2(a), he would consider, in light of the relevant authorities, that it had made 'a fundamental mistake of fact'. Mr Williams told the tribunal that in those circumstances he would. Having heard Mr Williams' response on that discrete matter, the legal assessor went on to advise the tribunal that, in her view, had the tribunal misunderstood the basis of the GMC's case in respect of sub-paragraph 2(a) throughout the fact finding stage, then it would still have no power to revisit its decision because the cases referred to (cf. *Fajemisin v GDC* and *Chaudhuri v GMC*) were not applicable to the 'mistake' in this case. She advised the tribunal that the 'mistake' it had made would be a mistake of fact based on its understanding of how the GMC had advanced its case and that the mistakes of fact in the two cases relied on by Mr Stern related to mistakes of fact about the factual evidence of each case relevant to the decision to be made by the person taking it.

26. The legal assessor told the tribunal that it was her view that the factual bases of the two cases referred to were significantly different than that before this tribunal, which is one that cannot be said to have been anticipated under the legal principles established in the authorities relied on. Consequently, she advised the tribunal that it was her view that those authorities (cf. *Fajemisin v GDC* and *Chaudhuri v GMC*) could not be relied upon, given the circumstances of this case, to permit the tribunal to determine that it has the power to revisit its decision as already announced.

The Tribunal's Decision

27. In accordance with the legal assessor's advice, the tribunal first considered what it had understood the GMC's case to be in respect of sub-paragraph 2(a). The tribunal had regard to its note of Mr Williams' opening, and it noted that in it

Mr Williams used the verb 'to review' in respect of sub-paragraph 2(a). In addition, the tribunal had regard to the wording of sub-paragraph 2(a) and it was satisfied that it refers to you not having 'reviewed' Patient A. The tribunal also noted that it had heard evidence, and indeed asked specific questions about, what constitutes 'a review'. Moreover, the tribunal also had regard to Mr Williams' closing submissions and it was satisfied that throughout those submissions Mr Williams again used the verb 'to review'. The tribunal was therefore satisfied that there was some ambiguity surrounding the wording of sub-paragraph 2(a) as it was alleged by the GMC, in that it specifically refers to you not 'reviewing' Patient A on the morning of 12 February 2010, and not to you having not 'visited', 'seen', or 'attended to' Patient A that morning as it was now agreed the GMC's case in fact was. Moreover, the tribunal was satisfied that in the context of this case and the interactions between a practitioner and patient, the verb 'review' had a specific meaning which was more than just 'having sight' of the patient concerned. The tribunal therefore conducted its whole approach to considering sub-paragraph 2(a) on that basis.

28. Having now heard the submissions of both parties and the agreed submission that the GMC had not advanced its case in the way in which the tribunal believed it to have done, the tribunal accepted, having now had the position made clear to it and having re-examined its understanding of the allegation put, that it had misinterpreted the GMC's case in respect of sub-paragraph 2(a). The tribunal was satisfied that it had not changed its understanding of the GMC's case as suggested but had instead interpreted it incorrectly from the outset. The tribunal was therefore satisfied that no procedural error had occurred. However, the tribunal was satisfied that in making its finding as it did, it had made an error.

29. Having determined that by making its finding in the way that it did the tribunal had made an error, it then went on to consider whether its error amounted to 'a fundamental mistake of fact' as envisaged by the judgments in the cases of *Fajemisin v GDC* and *Chaudhuri v GMC* and whether, as a consequence, it has a power to revisit its finding at sub-paragraph 2(a) and to correct it. It was satisfied that by unknowingly interpreting sub-paragraph 2(a) differently to the parties throughout the fact finding stage, it had made 'a fundamental mistake of fact'.

30. The tribunal found that while the circumstances the authorities referred to were in substance different to the circumstances of this case and not directly analogous, it was satisfied nevertheless that the same principles did apply in this case. While the tribunal did not err in making its finding on an incorrect interpretation of objective facts such as, for example, a date or year, it was satisfied that, as set out in *Chaudhuri v GMC*, it had nonetheless made 'a fundamental mistake as to the underlying facts upon which the decision in question was predicated'. That is, the tribunal was satisfied that it had made 'a fundamental mistake' and that the 'underlying fact' about which it had made its error and upon which it had predicated its decision, was that the GMC had advanced its case in the way in which the tribunal had understood it to have done. Having established this,

the tribunal went on to consider whether or not the authorities brought to its attention gave it an exceptional power to revisit its decision as already announced and correct the mistake made. It considered the advice of the legal assessor that these authorities were not applicable for the reasons set out above. However, the tribunal determined not to follow the legal assessor's advice in this one respect, as it was satisfied that in these specific circumstances it was entitled to rely on the inherent and implied power it has to revisit and/or correct the decision in accordance with the authorities cited.

31. The tribunal accepted that while, in the specific circumstances in which it now finds itself, it does have an inherent power to revisit its decision and correct it, that inherent power is very limited and 'narrow'. Nonetheless, in all the circumstances the tribunal was satisfied that correcting its decision at sub-paragraph 2(a) would: 1) not require it to reconsider any of the facts alleged; 2) not require that parties call any new evidence or make further submissions on the facts alleged; 3) be an 'obvious' decision in that the tribunal has already found that you did visit Patient A on the morning of 12 February 2010; and 4) be in accordance with natural justice and the principles of fairness.

32. The tribunal therefore determined that in the specific circumstances of this case, it had made 'a fundamental mistake of fact' and had the inherent power, albeit on a very narrow jurisdiction, to revisit its finding at sub-paragraph 2(a) and to correct it without 'requiring wasteful resort to the courts to correct such obvious mistakes'. The tribunal determined to exercise its narrow jurisdiction in this regard. The tribunal has already found, on the balance of probabilities, that you did visit Patient A on the ward on the morning of 12 February 2010. It therefore found sub-paragraph 2(a) not proved.

33. Having now found all of the alleged facts not proved, there is no basis on which this tribunal can proceed to consider whether or not your fitness to practise is impaired.

Determination on the Revocation of the Interim Order – 06/03/2018

Mr Sellu:

1. Having now found and announced all of the alleged facts 'not proved', there is no basis on which this tribunal can proceed to consider whether or not your fitness to practise is impaired.

2. Mr Williams told the tribunal that there is currently an interim order in place on your registration and that it should be revoked.

3. In light of its findings, the tribunal agreed. The interim order currently in place on your registration is thereby revoked with immediate effect.

4. That concludes this case.

Confirmed
Date 06 March 2018

Ms Gill Mullen, Chair