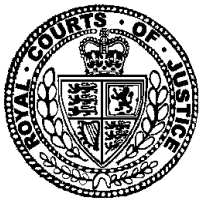

Neutral Citation Number: [2022] EWHC 747 (Admin)

Case No: CO/3464/2021

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 31 March 2022

Before :

MRS JUSTICE LANG DBE

- -

Between :

DANIEL RAVINDRA SUNDAR VEERAVALLI	**Appellant**
- and -	
GENERAL MEDICAL COUNCIL	**Respondent**

- -
- -

Jonathan Caplan QC and Miles Bennett (instructed by **Russell Cooke LLP**) for the **Appellant**
Peter Mant (instructed by **GMC Legal**) for the **Respondent**

Hearing date: 10 March 2022

- -

Approved Judgment

Mrs Justice Lang :

1. The Appellant appeals under section 40 of the Medical Act 1983 ("MA 1983") against the decision of the Medical Practitioners Tribunal ("the Tribunal"), made on 3 September 2021, that his fitness to practise was impaired by misconduct, and that conditions were to be imposed on his registration for a period of 12 months.

Factual summary

2. The Appellant was, at all material times, employed as a Consultant in Obstetrics and Gynaecology at Tameside General Hospital ("the Hospital") by the Tameside and Glossop Integrated Care NHS Foundation Trust ("the Trust").

3. The General Medical Council's ("GMC") fitness to practice proceedings concerned the Appellant's management of Patient A whilst she was in labour. Patient A was admitted to the hospital at 06.50 on the morning of 8 March 2017. Labour had begun and she was experiencing strong and regular contractions. By 07.25, she had full cervical dilation.

4. Patient A's baby (Patient B) was in the breech position, and so delivery was complex. After counselling, she decided to proceed with a vaginal delivery. Progress in the second stage of labour was slow. Administration of the labour-augmenting drug syntocinon (Oxytocin) commenced at 09.11. Patient B's left leg delivered spontaneously at 09.43. The delivery was difficult. Patient B was delivered at 10.28, but showed no signs of life and was pronounced dead 30 minutes later.

5. In July 2018, the Inquest into the death of Patient B recorded that the cause of death was osteo-diastasis of the occipital bone on a background of hypoxia.

6. The Tribunal found that the Appellant had overall responsibility for Patient A's care. At a staff handover meeting, he recommended the administration of syntocinon (a drug to augment contractions in labour) in Patient A's case, without direct clinical review. On later reviewing Patient A, he failed to obtain informed consent for continuation of syntocinon, and failed to identify the suspicious baseline heartrate correctly. He also failed to formulate, and obtain consent for, a safe management plan, in discussion with Patient A and her partner.

7. It is important to make it clear that the GMC did not allege, and the Tribunal did not find, that the Appellant's acts or omissions caused Patient B's death.

8. The Allegations made against the Appellant are set out below, with the Tribunal's determination in respect of each one:

> "**The Tribunal's Overall Determination on the Facts**
>
> 132. The Tribunal has determined the facts as follows:
>
> 1. At all material times you were the Consultant with overall responsibility for Patient A's labour of Patient B. **Determined and found proved**

2. On 8 March 2017 between the hours of 07:50 and 09:11 you:

a. recommended the commencement of syntocinon without direct clinical review of Patient A; **Determined and found proved**

b. failed to:

i. obtain consent for the commencement of syntocinon, in that you did not:

1. discuss your recommendation for the administration of syntocinon with Patient A; **Not proved**

2. explain the:

a. benefits of syntocinon; **Not proved**

b. risks of syntocinon; **Not proved**

3. take into account Patient A's views of syntocinon; **Not proved**

4. obtain verbal consent from Patient A for the commencement of syntocinon; **Not proved**

ii. maintain adequate records, in that you did not:

1. record the reasons to justify your recommendation of the commencement of syntocinon as set out at paragraph 2. a.; **Not proved**

2. formally prescribe syntocinon in the drug chart. **Not proved**

3. On 8 March 2017 at or around 09:15 you reviewed Patient A and you failed to:

a. in the alternative to paragraph 2. b. obtain consent for the continuation of syntocinon, in that you did not:

i. engage in a discussion with Patient A regarding the continuation of syntocinon; **Determined and found proved**

ii. explain the:

1. benefits of syntocinon, including achieving adequate contractions with a view to aim for vaginal delivery of Patient B in breech presentation; **Determined and found proved**

2. risks of syntocinon, including hyper stimulation of the uterus which could lead to fetal compromise; **Determined and found proved. Amended under Rule 17(6)**

iii. ~~3.~~ take into account Patient A's views of syntocinon; **Determined and found proved Amended under Rule 17(6)**

iv. ~~4.~~ obtain verbal consent from Patient A for the continuation of syntocinon; **Determined and found proved Amended under Rule 17(6)**

b. recognise high risk features, including:

i. full cervical dilation since 07:25 with active pushing since 08:12; **Not proved**

ii. breech presentation; **Not proved**

iii. persistent fetal tachycardia for approximately one hour; **Not proved**

c. adequately interpret Patient A's cardiotocographic trace ('CTG'), in that you did not:

i. assess all features of the CTG; **Determined and found proved**

ii. ~~regard~~ take into account the whole clinical picture and progress of labour, including the factors set out at paragraph 3. b.; **Determined and found proved**

Amended under Rule 17(6)

d. follow NICE guidelines, in that you did not undertake a systematic assessment of Patients A and B; **Not proved**

e. communicate your overall impression of the CTG to the delivery team; **Not proved**

f. take appropriate action, including:

i. discussing the interpretation of the CTG findings with:

1. Patient A; **Not proved**

2. the midwifery team; **Not proved**

ii. undertaking a systematic assessment of Patient A by:

1. assessing:

a. the maternal early warning score; **Not proved**

b. maternal hydration; **Not proved**

~~c. excluding possible causes of tachycardia including sepsis;~~ **~~To be determined~~**

2. excluding possible causes of tachycardia including sepsis; **Not proved**
Amended under Rule 17(6)

~~4~~ 3. investigating persistent fetal tachycardia by:

a. checking maternal observations; **Not proved**

b. recommending hydration; **Not proved**

~~3~~ 4. formulating a safe management plan in discussion with Patient A and her partner; **Determined and found proved**

g. stop the use of syntocinon and offering a caesarean section, in light of:

i. a suspicious CTG; **Not proved**

ii. in-coordinate uterine contractions and slow descent; **Not proved**

iii. the factors as set out at paragraph 3. b.; **Not proved**

h. obtain consent for:

i. Patient A's management plan~~, and ensuring shared decision- making,~~ in that you did not discuss with Patient A the: Amended under Rule 17(6)

1. suspicious CTG; **Determined and found proved**

2. factors as set out at paragraph:

a. 3. a. i; **Determined and found proved**

b. 3. a. ii. 1. and 2.; **Determined and found proved**

c. 3. b.; **Determined and found proved in relation to 3bi and 3bii but not proved in relation to 3biii**

ii. vaginal examinations; **Not proved**

i. maintain adequate records, in that you did not sign the CTG or ensure it was signed on your behalf. **Not proved**

> 4. In the alternative, you failed to record discussions that took place with Patient A with regards to consent as set out at paragraph:
>
> a. 2. b. **Not proved**
>
> b. 3. a. **Not proved**"

Appellate jurisdiction

9. Section 40 MA 1983 provides for a right of appeal to the High Court from decisions of tribunals where they have, amongst other things, directed suspension from the medical register. Under section 40(7), the court may on such an appeal:

   a) dismiss the appeal;

   b) allow the appeal and quash the direction appealed against;

   c) substitute for the direction appealed against any other direction or variation which could have been given or made by an MPT; or

   d) remit the case to the Medical Practitioners Tribunal Service to dispose of the case in accordance with the directions of the court.

10. The appeal is governed by CPR part 52 and PD 52D. Under CPR 52.21(3), the question for the court is whether the decision of the Tribunal is "wrong" or "unjust because of a serious procedural or other irregularity in the proceedings in the lower court".

11. Although appeals under section 40 MA 1983 are by way of rehearing, by virtue of paragraph 19.1 PD 52D, they are not conducted as rehearings in the full sense where the appellate court hears evidence and reaches a decision unconstrained by the conclusion of the lower court. Save in exceptional cases, the court will not hear evidence and it will accord appropriate respect to the primary findings of fact made by the first instance panel which heard the witnesses give evidence.

12. In *Meadow v General Medical Council* [2007] QB 462, Auld LJ said at [197]:

> "On an appeal from a determination by the GMC, acting formerly and in this case through the FPP, or now under the new statutory regime, whatever label is given to the section 40 test, it is plain from the authorities that the court must have in mind and give such weight as is appropriate in the circumstances to the following factors:
>
> (i) The body from whom the appeal lies is a specialist tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserve respect.
>
> (ii) The tribunal had the benefit, which the court normally does not, of hearing and seeing the witnesses on both sides.

> (iii) The questions of primary and secondary fact and the overall value judgment to be made by the tribunal, especially the last, are akin to jury questions to which there may reasonably be different answers."

13. In *Raschid v General Medical Council* [2007] 1 WLR 1460, which was an appeal against sanction, Laws LJ said after reviewing the authorities:

> "19. ... the fact that a principal purpose of the panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice, particular force is given to the need to accord special respect to the judgment of the professional decision-making body in the shape of the panel. That I think is reflected in the last citation I need give. It consists in Lord Millett's observations in *Ghosh v General Medical Council* [2001] 1 WLR 1915, 1923, para 34:
>
> > 'The board will afford an appropriate measure of respect to the judgment of the committee whether the practitioner's failings amount to serious professional misconduct and on the measures necessary to maintain professional standards and provide adequate protection to the public. But the board will not defer to the committee's judgment more than is warranted by the circumstances.'
>
> 20. These strands in the learning then, as it seems to me, constitute the essential approach to be applied by the High Court on a section 40 appeal. The approach they commend does not emasculate the High Court's role in section 40 appeals. The High Court will correct material errors of fact and of course of law and it will exercise a judgment, though distinctly and firmly a secondary judgment, as to the application of the principles to the facts of the case."

14. The Appellant relied in particular upon the judgment of the Court of Appeal in *Sastry v General Medical Council* [2021] EWCA Civ 623 where Nicola Davies LJ summarised the principles to be derived from the authorities at [101] – [112]:

> "101. The breadth of the section 40 appeal and the appellate nature of the court's jurisdiction was recognised by the Judicial Committee of the Privy Council in *Ghosh* and set out at [33] and [34] of the judgment of the Board given by Lord Millett. At [33] Lord Millett noted that the statutory right of appeal of medical practitioners under section 40 of the 1983 Act "does not limit or qualify the right of the appeal or the jurisdiction of the Board in any respect. The Board's jurisdiction is appellate, not supervisory. The appeal is by way of a rehearing in which the Board is fully entitled to substitute its own decision for that of the committee."

102. Derived from *Ghosh* are the following points as to the nature and extent of the section 40 appeal and the approach of the appellate court:

i) an unqualified statutory right of appeal by medical practitioners pursuant to section 40 of the 1983 Act;

ii) the jurisdiction of the court is appellate, not supervisory;

iii) the appeal is by way of a rehearing in which the court is fully entitled to substitute its own decision for that of the Tribunal;

iv) the appellate court will not defer to the judgment of the Tribunal more than is warranted by the circumstances;

v) the appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate;

vi) in the latter event, the appellate court should substitute some other penalty or remit the case to the Tribunal for reconsideration.

103. The courts have accepted that some degree of deference will be accorded to the judgment of the Tribunal but, as was observed by Lord Millett at [34] in *Ghosh*, "the Board will not defer to the Committee's judgment more than is warranted by the circumstances". In *Preiss*, at [27], Lord Cooke stated that the appropriate degree of deference will depend on the circumstances of the case. Laws LJ in *Raschid and Fatnani*, in accepting that the learning of the Privy Council constituted the essential approach to be applied by the High Court on a section 40 appeal, stated that on such an appeal material errors of fact and law will be corrected and the court will exercise judgment but it is a secondary judgment as to the application of the principles to the facts of the case ([20]). In *Cheatle* Cranston J accepted that the degree of deference to be accorded to the Tribunal would depend on the circumstances, one factor being the composition of the Tribunal. He accepted the appellant's submission that he could not be "completely blind" to a composition which comprised three lay members and two medical members.

104. In *Khan* at [36] Lord Wilson, having accepted that an appellate court must approach a challenge to the sanction imposed by a professional disciplinary committee with diffidence, approved the approach and test identified by Lord Millett at [34] of *Ghosh*.

105. It follows from the above that the Judicial Committee of the Privy Council in *Ghosh*, approved by the Supreme Court in *Khan*, had identified the test on section 40 appeals as being whether the sanction was "wrong" and the approach at the hearing, which was appellate and not supervisory, as being whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate.

106. In *Jagjivan* the court considered the correct approach to appeals under section 40A. At [39] Sharp LJ accepted that the "well-settled principles" developed in relation to section 40 appeals "as appropriately modified, can be applied to section 40A appeals." At [40], Sharp LJ acknowledged that the appellate court will approach Tribunals' determinations as to misconduct or impairment and what is necessary to maintain public confidence and proper standards in the profession and sanctions with diffidence. However, at [40(vi)], citing [36] of *Khan* and the observations of Lord Millett at [34] of *Ghosh*, she identified matters such as dishonesty or sexual misconduct as being matters where the court is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal.

107. The court in *Bawa-Garba* (a section 40A appeal) at [60] identified the task of the High Court on an appeal pursuant to section 40 or section 40A as being whether the decision of the MPT is "wrong". At [67] the court identified the approach of the appellate court as being supervisory in nature, in particular in respect of an evaluative decision, whether it fell "outside the bounds of what the adjudicative body could properly and reasonably decide". It was this approach which was followed by the judge in the appeal of Dr Sastry and which led to the ground of appeal upon which Leggatt LJ granted permission. In so granting, Leggatt LJ stated that there was a real issue as to whether the judge deferred unduly to the Panel's view by approaching the appeal, in effect, as a challenge to the exercise of a discretion when arguably the judge was required to exercise her own judgment as to whether the sanction imposed was excessive and disproportionate. The words and reasoning of Leggatt LJ reflect the approach of the court to section 40 appeals identified in *Ghosh* and approved in *Khan*.

108. We endorse the approach of the court in *Bawa-Garba*, as appropriate to the review jurisdiction applicable in section 40A appeals. We regard the approach of the court in section 40 appeals, as identified in *Ghosh* and approved in *Khan*, as appropriate in section 40 appeals which are by way of a rehearing.

> 109. We agree with the observations of Cranston J in *Cheatle* that, given the gravity of the issues, it is not sufficient for intervention to turn on the more confined grounds of public law review such as irrationality. The distinction between a rehearing and a review may vary depending upon the nature and facts of the particular case but the distinction remains and it is there for a good reason. To limit a section 40 appeal to what is no more than a review would, in our judgment, undermine the breadth of the right conferred upon a medical practitioner by section 40 and impose inappropriate limits on the approach hitherto identified by the Judicial Committee of the Privy Council in *Ghosh* and approved by the Supreme Court in *Khan*.
>
> 110. Accordingly, we agree with the view expressed by Leggatt LJ that the judge, in the section 40 appeal of Dr Sastry, was required to exercise her own judgment as to whether the sanction imposed was excessive and disproportionate. It follows from the above that we do not agree with her observation at [66] that when it comes "to an evaluation of clinical behaviour and the treatment of patients … a court is totally ill- equipped to arrive at a view of what public protection and reputation of the profession requires. It would be wrong to substitute its own untutored view for that of a panel drawn from the profession in question." As has been previously recognised, a court is able to arrive at a view of what public protection and the reputation of the profession requires. To describe the view of the court as being "untutored" pays no or little regard to the ability of an appellate court to evaluate issues of public protection and the reputation of the medical profession and to its role, demonstrated in previous cases, in deciding whether the sanction imposed was necessary and appropriate in the public interest or was excessive or disproportionate.
>
> 111. Further, reliance upon the MPT as drawn "from the profession in question" may not be appropriate. Only one member of the MPT is a member of the medical profession and in this case his area of expertise was not that of the appellant.
>
> 112. Appropriate deference is to be paid to the determinations of the MPT in section 40 appeals but the court must not abrogate its own duty in deciding whether the sanction imposed was wrong; that is, was it appropriate and necessary in the public interest. In this case the judge failed to conduct any analysis of whether the sanction imposed was appropriate and necessary in the public interest or whether the sanction was excessive and disproportionate, and therefore impermissibly deferred to the MPT."

15. In *Gupta v General Medical Council* [2001] UKPC 61, [2002] 1 WLR 1691, the Judicial Committee of the Privy Council considered the appellate court's approach to the findings of fact made by a committee, as follows:

> "10. The decisions in *Ghosh* and *Preiss* are a reminder of the scope of the jurisdiction of this Board in appeals from professional conduct or practices committees. They do indeed emphasise that the Board's role is truly appellate, but they also draw attention to the obvious fact that the appeals are conducted on the basis of the transcript of the hearing and that, unless exceptionally, witnesses are not recalled. In this respect these appeals are similar to many other appeals in both civil and criminal cases from a judge, jury or other body who has seen and heard the witnesses. In all such cases the appeal court readily acknowledges that the first instance body enjoys an advantage which the appeal court does not have, precisely because that body is in a better position to judge the credibility and reliability of the evidence given by the witnesses. In some appeals that advantage may not be significant since the witnesses' credibility and reliability are not in issue. But in many cases the advantage is very significant and the appeal court recognises that it should accordingly be slow to interfere with the decisions on matters of fact taken by the first instance body. This reluctance to interfere is not due to any lack of jurisdiction to do so. Rather, in exercising its full jurisdiction, the appeal court acknowledges that, if the first instance body has observed the witnesses and weighed their evidence, its decision on such matters is more likely to be correct than any decision of a court which cannot deploy those factors when assessing the position. In considering appeals on matters of fact from the various professional conduct committees, the Board must inevitably follow the same general approach. Which means that, where acute issues arise as to the credibility or reliability of the evidence given before such a committee, the Board, duly exercising its appellate function, will tend to be unable properly to differ from the decisions as to fact reached by the committee except in the kinds of situation described by Lord Thankerton in the well-known passage in *Thomas v Thomas* [1947] AC 484, 487–488."

16. The Respondent relied upon the principles set out by Morris J. in *Byrne v General Medical Council* [2021] EWHC 2237 (Admin) as follows:

> "11. The issue is as to the circumstances in which an appeal court will interfere with findings of fact made by the court or decision maker below. This is an issue which has been the subject of detailed judicial analysis in a substantial number of authorities and where the formulation of the test to be applied has not been uniform; the differences between formulations are fine. I do not propose to go over this ground again in detail, but rather seek to synthesise the principles and to draw together from these authorities a number of propositions.
>
> 12. First, the degree of deference shown to the court below will differ depending on the nature of the issue below; namely

whether the issue is one of primary fact, of secondary fact, or rather an evaluative judgment of many factors: *Assicurazioni Generali* at §§16 to 20…

13. Secondly, the governing principle remains that set out in *Gupta* §10 referring to *Thomas v Thomas*. The starting point is that the appeal court will be very slow to interfere with findings of primary fact of the court below. The reasons for this are that the court below has had the advantage of having seen and heard the witnesses, and more generally has total familiarity with the evidence in the case. A further reason for this approach is the trial judge's more general expertise in making determinations of fact: see *Gupta*, and *McGraddie v McGraddie* at §§3 to 4. I accept that the most recent Supreme Court cases interpreting *Thomas v. Thomas* (namely *McGraddie* and *Henerson v Foxworth)* are relevant. Even though they were cases of "review" rather than "rehearing", there is little distinction between the two types of cases for present purposes (see paragraph 16 below).

14. Thirdly, in exceptional circumstances, the appeal court will interfere with findings of primary fact below. (However the reference to "virtually unassailable" in *Southall* at §47 is not to be read as meaning "practically impossible", for the reasons given in *Dutta* at §22.)

15. Fourthly, the circumstances in which the appeal court will interfere with primary findings of fact have been formulated in a number of different ways, as follows:

- where "any advantage enjoyed by the trial judge by reason of having seen and heard the witnesses could not be sufficient to explain or justify the trial judge's conclusions": per Lord Thankerton in *Thomas v Thomas* approved in *Gupta*;

- findings "sufficiently out of the tune with the evidence to indicate with reasonable certainty that the evidence had been misread" per Lord Hailsham in *Libman*;

- findings "plainly wrong or so out of tune with the evidence properly read as to be unreasonable": per *(sic)* in *Casey* at §6 and Warby J (as he then was) in *Dutta* at §21(7);

- where there is "no evidence to support a … finding of fact or the trial judge's finding was one which no reasonable judge could have reached": per Lord Briggs in *Perry* after analysis of *McGraddie* and *Henderson*.

In my judgment, the distinction between these last two formulations is a fine one. To the extent that there is a difference, I will adopt, in the Appellant's favour, the former…

> 16. Fifthly, I consider that, whilst noting the observations of Warby J in *Dutta* at §21(1), on the balance of authority there is little or no relevant distinction to be drawn between "review" and "rehearing", when considering the degree of deference to be shown to findings of primary fact: *Assicurazioni* §§13, 15 and 23. *Du Pont* at §§94 and 98 is not clear authority to the contrary. Rather it supports the proposition that there may be a relevant difference when the court is considering findings of evaluative judgment or secondary or inferential findings of fact, where the court will show less deference on a rehearing that on a review. Nevertheless if less deference is to be shown in a case of rehearing (such as the present case), then, again I will assume this in the Appellant's favour."

Grounds of appeal

17. The Appellant's pleaded grounds of appeal were as follows:

i) The Tribunal's findings on the Allegations were wrong and irrational.

ii) The determination on misconduct was wrong because:

a) Prior to completion of the handover, it was not clear that the Appellant was designated as the consultant on call. He did not instruct that syntocinon be administered. He did not see Patient A prior to the administration of syntocinon, and by the time he saw her, he made the reasonable assumption that it had been prescribed and that Patient A had consented.

b) Even on the facts found proved by the Tribunal, the adverse findings were very limited and related to deficiencies in obtaining consent and communication at a single point in time after the administration of syntocinon by another.

c) The Tribunal failed to focus on the facts that it had found proved and relied on the opinion of the expert Dr Rao who had based his conclusions on the gravity of the Appellant's conduct on shortcomings which the Tribunal had not accepted.

d) The Tribunal failed to apply the law on misconduct properly and/or reached an erroneous conclusion.

e) The determination on impairment was wrong principally for the reasons set out in Grounds 1 and 2.

Ground 1: Determination on the Facts

Allegation 1(a)

18. Before the Tribunal, and in his Grounds of Appeal to the High Court, the Appellant disputed that he was, at all material times, the Consultant with overall responsibility for Patient A. Without prior warning, at the oral hearing, Mr Caplan QC announced that he was no longer pursuing the challenge to this finding.

19. In my view, this finding was a significant part of the context in which the other Allegations fell to be considered. The Tribunal found that, in order for the Appellant to have been the Consultant with overall responsibility for Patient A at all material times, he would have to have been the Consultant at the time of the commencement of administration of syntocinon at 09.11.

20. The Appellant's evidence was that Dr Minas was acting as the on-call Consultant until about 09.15. The Appellant only took over as the on-call Consultant at 09.15, when Dr Minas was asked to cover for an absent Registrar instead. The Tribunal rejected the Appellant's evidence on this point, preferring the evidence of the other doctors, to the effect that the Appellant became the on-call Consultant at the start of the doctors' handover meeting at 09.00. The Tribunal's detailed findings are at paragraphs 22 to 37 of the Determination on the Facts ("the Facts").

21. It was accepted that the Appellant was the on-call Consultant overnight until 08.00 on 8 March. In that capacity, he had been telephoned at home at about 07.50 by Dr Schofield, a Speciality Trainee in Obstetrics and Gynaecology. She informed the Appellant of Patient A's breech presentation and her preference for a vaginal delivery.

22. As a result, the Appellant attended the Hospital earlier than planned, at about 08.15, but in the event he did not see Patient A, as she was then under the care of Dr Minas. Dr Minas was qualified as a Consultant, but he was undertaking *ad hoc* locum shifts at the Hospital as a middle grade Registrar. It was accepted that Dr Minas had been asked to cover as Consultant from 08.00 to 09.00, as the Appellant was not due to start work until 09.00.

23. Due to staff shortages and non-attendance of a Registrar, the shifts for 8 March were in a state of flux. Dr Mahmood, who was responsible for organising the shift rotas, attended the doctors' handover meeting at 09.00 and told the Appellant that he was the designated Consultant and Dr Minas was the designated Registrar. His evidence, which was accepted by the Tribunal, was set out in the Facts as follows:

> "28. Dr Mahmood explained that, at around 09.00, the staffing levels became clear and so he went to the labour ward doctors' handover to ensure that it was clear which doctor was undertaking which role. He stated:
>
> > "I told Dr Veeravalli that he was the designated Consultant that day and told Dr Minas that he was the designated Registrar and checked they were both happy with this arrangement. Of course, this would be the appropriate

> allocation of roles as Dr Veeravalli had agreed the night before to cover as Consultant and was the substantive senior Consultant at our Hospital and Dr Minas was the locum….. "
>
> 29. Dr Mahmood's evidence was that he was at the handover for around five minutes. He stated that after ensuring that both Dr Veeravalli and Dr Minas were clear about their respective roles and that there were no other rota gaps, he left, at around 09.10, as he had an outpatients' clinic starting around 09.15."

24. The Tribunal also noted that other members of staff at the handover, including Dr Minas and Dr Schofield, were under the impression that the Appellant, not Dr Minas, was the Consultant for that shift (Facts, paragraph 35).

Allegation 2(a)

25. The Appellant submitted that it was wrong/irrational/unfair for the Tribunal to find that the Appellant recommended the commencement of syntocinon without direct clinical review of Patient A.

26. The Appellant's evidence was that, at the handover meeting at 09.00 on 8 March, the senior midwife Ms Fowler asked whether she could administer syntocinon as Patient A wished to achieve a vaginal delivery but her contractions had slowed down and almost stopped. There was a discussion among the team. The Appellant contributed his view, which was that in these circumstances syntocinon could be administered with caution and under Consultant supervision, consistently with Trust guidelines. He did not recommend the commencement of syntocinon, and he was not the on-call Consultant during the meeting.

27. The Tribunal considered the evidence of others who were present at the handover meeting (Facts, paragraphs 40 – 44):

> "40. Dr Schofield was unequivocal that the recommendation to commence syntocinon did not come from her. In her evidence, she stated that at some time before 09:00, she had a conversation with Ms Fowler who advised that Patient A's contractions had slowed down. She stated that Ms Fowler asked her about augmenting the contractions with syntocinon. She stated that she advised Ms Fowler that she would not use syntocinon to augment a fully dilated vaginal breech delivery and said that Ms Fowler accepted this and went back to her managerial duties.
>
> 41. Dr Schofield stated that at the 09:00 handover she spoke to Dr Veeravalli about Patient A, and informed him that she was the patient they had discussed on the phone earlier and who wanted to try for a vaginal breech birth. Dr Schofield stated:
>
> > '… Dr Veeravalli requested that the patient be given Syntocinon (Oxytocin)… I said words to the effect of ''are

> you sure about that?'' (i.e because of everything that I had just discussed at the handover) and he replied ''yes''….
>
> …. After the handover, I left my shift. At around 09:08am I saw Ms Fowler in the treatment room, and I stated that Dr Veeravalli wanted the Syntocinon (Oxytocin) to be commenced as per his decision at departmental handover.
>
> I told Ms Fowler this, in light of our previous conversation where I advised that I would not recommend the use of Syntocinon (Oxytocin) in the augmentation of vaginal breech deliveries. Ms Fowler stated that she was already preparing the Syntocinon (Oxytocin) as per Dr Veeravalli's request…
>
> …to my knowledge, Dr Veeravalli was not on the labour ward until the 09:00am handover and had not physically reviewed the patient prior to the handover. As far as I'm aware, Dr Veeravalli's decision to prescribe Syntocinon (Oxytocin) was made before physically seeing the patient…''

42. The Tribunal noted that Dr Schofield's evidence is supported by that of Dr Misiura. In her statement, Dr Misiura stated that the decision to commence syntocinon was made by Dr Veeravalli:

> '…I do recall that Dr Veervalli requested that a syntocinon infusion be commenced, and Valerie Fowler left to prepare the infusion.
>
> ... I can't recall there being any concern expressed about the commencement of syntocinon, I just recall it being discussed generally.
>
> Although it is difficult to recall now, at the time I wrote the coroner's statement, I remember being very sure that Dr Veeravalli requested the syntocinon infusion and I remember Valerie Fowler leaving to prepare the infusion…'

43. Dr Minas was also adamant that he did not recommend the commencement of syntocinon. In his witness statement he stated that:

> ''…At around 8:45am, Ms Fowler asked me words to the effect of ''what do you think about giving syntocinon to this patient?''. I said that I would not, as the baby was breech… I was not asked to prescribe syntocinon at any point and did not do so either verbally or by way of written prescription. I have been trained not to use syntocinon on breech babies, therefore would not do so…

> …Shortly after Dr Veeravalli took over the role of Consultant, he was asked by Midwife Valerie Fowler the same question, whether the patient should be given syntocinon to enhance her contractions. From my recollection, Dr Veeravalli said words to the effect of ‘‘yes’’. This conversation took place in the handover area, around 9am…’’

44. In Ms Fowler's evidence she stated that she went to speak to Dr Veeravalli regarding Patient A. She stated that she thought the handover had finished at this point and she told Dr Veeravalli that Patient A's contractions had reduced in strength and that Patient A was fully dilated. She stated:

> "Dr Veeravalli said words to the effect of "lets start oxytocin". I responded with words to the effect of "do you really want to give syntocinon on a breech where she's only had premature twins at 27 weeks?". He said words to the effect of "yes…that's the only way we're going to get contractions".
>
> …
>
> Dr Veeravalli gave the instruction to commence syntocinon without physically seeing or examining the patient. I will never forgive myself for not telling Dr Veeravalli to come in and see/examine the patient. He should have done a vaginal examination then decided for himself. This is what would usually be done for a breech delivery. It is not every day you have a vaginal breech delivery and they are more risky than regular births.
>
> I also heard Dr Schofield also challenge Dr Veeravalli with words to the effect of "really, are you sure you want to start syntocinon?". This was said in front of me. I think again, this was after the formal handover had finished and it was an informal discussion about this particular patient.
>
> After challenging Dr Veeravalli and him maintaining his instruction, I went to prepare the bag of syntocinon and brought it into the delivery room. I commenced the oxytocin drip at 9:11am…""

28. The Tribunal noted the agreed opinion of the two experts (Dr Rao and Dr Jarvis) was that, whilst syntocinon was not universally recommended, it could be used in specific circumstances, with the agreement of a Consultant Obstetrician and the consent of the mother, and it was widely used (Facts, paragraph 47).

29. The experts also agreed that the Trust's guideline of July 2015 stated "Syntocinon augmentation may be used with caution but only after discussion with the on-call Consultant" (Facts, paragraph 48).

30. The Tribunal's findings were as follows (Facts, paragraphs 49 – 51):

> "49. The Tribunal considered the consistent evidence of Dr Schofield, Dr Minas, Dr Misiura and Ms Fowler suggests that Dr Veeravalli did request the commencement of syntocinon. It considered that it was unlikely that Dr Schofield or Dr Minas made the recommendation. The Tribunal noted that Dr Veeravalli accepted that he advised that syntocinon could be given in the circumstances and under Consultant supervision as per his understanding of the Trust's guidelines. The Tribunal considered this to amount to a recommendation which perhaps was made in the context of answering a question raised by Ms Fowler at the handover (the evidence suggests she had previously asked both Dr Schofield and Dr Minas for their opinions regarding syntocinon).
>
> 50. While the Tribunal considered that Dr Veeravalli assented to and effectively recommended that syntocinon could be used, it concluded that it was likely his recommendation was effectively a decision in principle, not a decision that it should be commenced without reviewing Patient A or obtaining proper consent. It accepted that he would have reviewed the patient as was his practice.
>
> 51. Nevertheless, the Tribunal determined that, as a matter of fact, he did recommend the commencement of syntocinon, and he did so at a time when there had not been a direct clinical review of Patient A."

31. On this basis, the Tribunal found Allegation 2(a) proved. In my judgment, the Tribunal was clearly entitled to accept the consistent evidence of the Appellant's colleagues which contradicted the Appellant's account.

32. The Appellant submitted that the Tribunal's decision was inconsistent with its findings on Allegation 2(b) that the Appellant had not decided or instructed that the syntocinon should be commenced without review or consent. However, this submission was based upon an incorrect interpretation of Allegation 2(a). As the Tribunal explained (Facts, paragraph 38):

> "38. The Tribunal read this paragraph of the Allegation to be that Dr Veeravalli recommended the commencement of synotcinon [*sic*] and had done so without having made a direct clinical review of Patient A; rather than that his recommendation was to start the syntocinon and to do so without directly clinically reviewing Patient A."

33. The Tribunal's interpretation of Allegation 2(a) was a reasonable one. On the Tribunal's interpretation there was no inconsistency between the decision that the allegation was proved and the finding that the recommendation was one made "in principle".

Allegation 3(a)

34. The Appellant submitted that the Tribunal was wrong/irrational/unfair to find that when the Appellant attended Patient A at 09.15, he failed to obtain her consent for the continuation of syntocinon, which would have entailed explaining its risks and benefits, and taking into account her views.

35. The Appellant submitted that it was unclear why he was under an obligation to obtain consent for the continuation of syntocinon if the drug had been prescribed by Dr Minas only minutes before (the midwife, Ms Fowler, said that she believed she had seen a prescription from Dr Minas).

36. On my reading of the Facts, the Tribunal accepted Dr Minas' evidence that he did not recommend the commencement of syntocinon at any stage, nor did he prescribe it, either verbally or in writing (Facts, paragraph 43). The Tribunal made clear findings, at Facts, paragraph 71, that it would have been "unreasonable" and "illogical" for the Appellant to assume that the prescription was written up before the handover meeting, as the decision to prescribe had not been made at that stage. After the handover meeting, the Appellant and Dr Minas attended Patient A, and as she was the first patient they saw, there had been no opportunity for Dr Minas to obtain the patient's consent. The Appellant acknowledged that he was surprised to see that the infusion of syntocinon had already commenced when he and Dr Minas attended Patient A at 09.15. This should have prompted him to consider the matter more carefully and realise that Dr Minas could not possibly have spoken to Patient A and obtained her consent.

37. Accordingly, the Tribunal was entitled to find that at this stage "there was a duty on Dr Veeravalli to engage in a discussion with Patient A regarding syntocinon and for him to obtain Patient A's verbal consent for its continuation" (Facts, paragraph 71). As the Tribunal explained at Facts, paragraph 69, this would have included an explanation of the benefits and risks of administering syntocinon in a breech birth. In my view the Tribunal's reasons for its findings were clear and adequate.

38. At paragraph 65 of the Facts, when the Tribunal referred to the reasonable expectation that Dr Minas, not the Appellant, would formally prescribe syntocinon in the drug chart, it was referring to the usual division of duties between a Consultant and a Registrar, in the context of Allegation 2(b)(ii), which alleged that the Appellant failed to maintain adequate records by not formally prescribing syntocinon in the drug chart prior to its administration at 09.11. This was a different issue.

39. The Appellant further submitted that the Tribunal made a contrary finding at Facts, paragraph 115, when it found, under Allegation 3(g), that there was no duty on the Appellant to stop the administration of syntocinon at 09.15; that the original reason for administering it was not inappropriate; and that it should be reviewed in 15 minutes.

40. However, the finding that the Appellant was not under a duty to stop the infusion was based on a narrow assessment of whether the management plan to continue the administration and review in 15 minutes was reasonable from a clinical perspective (without regard to the issue of consent). The fact that the management plan did not fall outside the bounds of what was clinically reasonable did not vitiate the need for consent, especially where the plan was risky, and alternative less-risky options were available.

Allegation 3(c)

41. The Appellant submitted that the Tribunal's findings on Allegation 3(c) were wrong/irrational/unfair. The sole failure was that when the Appellant later made up his notes at 13.40 he mis-recorded the foetal heart rate as 160bpm as opposed to 170bpm (as at 09.15). The Appellant was recording from memory at 13.40 the basal rate over a period of time and not the specific rate at 09.15. There was no finding that this had any bearing on the management of Patient A whom both the Appellant and Dr Minas had agreed to review within 15 minutes because of uncomplicated tachycardia which they had observed.

42. The Tribunal's findings were as follows (Facts, paragraph 77 – 81):

> "77. The Tribunal considered whether Dr Veervalli failed to adequately interpret Patient A's CTG by not assessing all the features of the CTG and taking into account the whole clinical picture and progress of labour including the high risk features set out at paragraph 3b.
>
> 78. The Tribunal noted that the experts identified the core features of a CTG which form part of a systematic review are the fetal heart rate, beat-to-beat variability, decelerations and acceleration. Having had regard to Dr Veeravalli's entry in Patient A's medical records in relation to his attendance at 09:15, the Tribunal noted that he identified just three of these features but mis-recorded the base rate. On this basis, the Tribunal was not satisfied he assessed all the features of the CTG.
>
> 79. Accordingly, the Tribunal found paragraph 3ci proved.
>
> 80. The Tribunal then considered paragraph 3cii. Given its determination in relation to paragraph 3b of the Allegation, it did not find this matter proved on the basis of those features set out at paragraph 3b of the Allegation. However, this paragraph of the Allegation refers to taking into account the whole clinical picture and the Tribunal has noted that Dr Veeravalli's notes record that at 09:15, the CTG shows a baseline of 160, there being no concerns identified. However, the Tribunal had regard to the expert evidence in this case which showed that the baseline at 09:15 was 170 and not 160 and hence was suspicious. By failing to identify this error, the Tribunal found that Dr Veeravalli failed to take into account the whole clinical picture and, as such, the Tribunal found the factual Allegation proved albeit not in relation to the factors set out at paragraph 3b.
>
> 81. Accordingly, the Tribunal found paragraph 3cii proved."

43. In my judgment, the Tribunal was entitled to rely on the Appellant's record of the baseline heartrate as an accurate reflection of what the Appellant understood the position to be at that time. A baseline heartrate of 160 was not suspicious, whereas a

baseline heartrate of 170 was suspicious. There was no contemporaneous evidence that the Appellant considered the trace to be suspicious, nor that he addressed this concern.

44. The Appellant's submission that the mis-recording of the baseline heartrate had no bearing on the management of Patient A is unarguable. The Tribunal found that the Appellant failed to take account of the whole clinical picture. These failings contributed to the finding under Allegation 3(f)(ii)(4) that the Appellant failed to formulate a safe management plan in discussion with Patient A and her partner (Facts, paragraphs 110-113).

45. The Tribunal's finding that Allegation 3(b) – failure to recognise high risk features of the labour, including persistent tachycardia for approximately one hour - was not proved was not inconsistent with the finding on Allegation 3(c). The Tribunal found, at Facts paragraphs 75-76:

> "75. In Dr Veeravalli's evidence, he stated that he was aware of these matters but he did not accept that the CTG tracing at 09:15 could be described as showing a tachycardia which had been persistent for an hour. The Tribunal noted that, while it is accepted that at 09:15 there was fetal tachycardia, the experts did not agree as to whether it had been persistent for one hour. Having regard to the expert evidence of Mr Jarvis that there is no definition of a 'persistent fetal tachycardia', the Tribunal could not be satisfied on the balance of probabilities that there was a persistent fetal tachycardia for approximately one hour and so it did not conclude that there was a failure on Dr Veeravalli's part to recognise this.
>
> 76. Accordingly, the Tribunal found paragraphs 3bi-iii not proved."

46. Thus, the basis of the finding on Allegation 3(b) was that the Tribunal was not satisfied that there had been persistent tachycardia for approximately one hour. However, that was not part of the allegation under Allegation 3(c).

Allegations 3(f)(ii)(4) and 3(h)(i)

47. The Appellant submitted that the Tribunal's findings were wrong or irrational because they were based on the Tribunal's flawed findings in respect of Allegations 3(a) and (c). As I have not accepted the Appellant's submissions on Allegations 3(a) and (c), it follows that this ground must also fail.

Delay

48. The Appellant submitted that the delay of 4 months between the conclusion of the evidence and the issuing of the determination was highly undesirable as memory fades with the passage of time and issues such as demeanour of a witness are more difficult to recall.

49. The Tribunal commenced their deliberations immediately after hearing submission on Friday 16 April 2021 and continued them for a full day on Monday 19 April 2021. They reconvened on 12 and 13 August 2021 to complete their deliberations and write up their determination, which was handed down on 31 August 2021. I do not consider this to be unreasonable delay given the nature of the case and the difficulties in co-ordinating a meeting between three independent Tribunal members who have other diary commitments. Moreover, the detailed determination on the facts does not suggest that the memories of the members of the Tribunal were impaired.

50. Therefore, for the reasons set out above, I conclude that the Appellant has failed to establish that the Tribunal's findings of fact were wrong or irrational or unfair. Ground 1 does not succeed.

Ground 2: Misconduct

51. The Tribunal found that the Appellant's failings amounted to serious professional misconduct. In particular, the failure to obtain consent constituted a serious departure from the GMC's *Consent Guidance* and *Good Medical Practice*.

52. The Appellant submitted that the Tribunal's Determination on Impairment did not cite any case law on the meaning of the misconduct. The implication was that the Tribunal had not properly directed itself in law.

53. In my judgment, this submission is without foundation. The Tribunal received submissions on the relevant legal tests from counsel for the GMC (Transcript, Day 14, pages 1-2). The legally-qualified Chair then gave appropriate directions on the issue of serious misconduct, which the parties accepted, as follows (Transcript Day 14, pages 13-14):

> "I turn to the advice that I give my colleagues. We have now reached a stage set out in Rule 17(2)(l) of the rules where we have to consider the question of whether Dr Veeravalli's fitness to practise is currently impaired and, as Ms Johnson has quite rightly said – I will only deal with these matters very briefly because she has dealt with them – it is a two-stage process, the first of which is to decide whether or not the matters that have been found proved and those matters only amount to misconduct, which case law has repeatedly said should amount to a serious falling short of the standard expected. As she said, there is no burden or standard of proof to be applied to findings of misconduct or impairment and they remain matters of judgement for us alone.
>
> Ms Johnson said there has been no definition of "misconduct" given, but there was some very helpful guidance given in the case of *Roylance v GMC*, in that,
>
> > "Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found

> by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances."

In that regard, we should have regard to the standards set out in the GMC's *Good medical practice*. I would remind you, of course, that matters of purely personal mitigation are not relevant at this stage.

A single negligent act or omission is less likely to cross the threshold of misconduct than multiple acts or omissions, but a single negligent act or omission, if particularly grave, might be characterised as misconduct. As both advocates, I think, agree, it is an accepted position that the kind of serious misconduct required is sometimes described as misconduct that would be regarded as deplorable by fellow practitioners. The assessment of seriousness is a matter for us to consider in the light of all the evidence before us and the submissions made.

In the case of *Remedy UK v GMC*, it was said that,

> "Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession".

Of course, it is only the first limb of that that concerns us in this particular case as it relates to conduct within the course of his clinical practice.

In reaching our decision we should have regard to all the evidence before us, including any experts' evidence who have given their opinions in relation to the seriousness of Dr Veeravalli's failings as have been found proved. Subject to finding that misconduct has been found proved and, if not, it would therefore follow that fitness to practise cannot be impaired by reason of misconduct, but if misconduct is found proved, then we need to go on to proceed to the second part of the exercise and consider whether his fitness to practise is currently impaired as a result of that."

54. At the hearing before me, the Respondent referred to *R (Calheam) v General Medical Council* [2007] EWHC 2606 (Admin), per Jackson J. at [39], in support of the propositions that: (i) negligent acts or omissions which are particularly serious may amount to "misconduct"; and (ii) a single negligent act or omission, if particularly grave, could be characterised as "misconduct".

55. The Appellant did not dispute these propositions of law, but argued that, in this case, all the adverse findings related to a single point in time when the administration of syntocinon had already commenced; the plan to continue and review in 15 minutes was not unreasonable and the options for a discussion about consent were limited. The Appellant did not fail to recognise the high-risk features of the labour. His failings were an honest but unreasonable assumption that Patient A had been counselled about the use of syntocinon by Dr Minas. Finally, many of the Allegations were unproved.

56. In my view, the Appellant's submissions did not accurately reflect the Tribunal's findings of fact. The Tribunal did not accept the Appellant's evidence in respect of Dr Minas. It found, on the balance of probabilities, that it was unlikely that the Appellant did not realise that Patient A had not been counselled by Dr Minas and so had not given informed consent. Further, the Tribunal found that, although the Appellant had recognised some high-risk features of the labour, he had made a substantive error in failing to identify correctly the baseline heartrate at 09.15, which at 170 should have been identified as "suspicious".

57. The Appellant's submissions also failed to acknowledge the seriousness of his failings, in particular, his failure to discuss the options with Patient A and obtain her informed consent to a risky procedure. Patient A never consented to the administration of syntocinon and the fact that the management plan was clinically justifiable did not excuse or mitigate the Appellant's failure to obtain consent, especially as the risks of augmenting labour were high and alternatives were available, including caesarean section. The fact that Dr Schofield had discussed the option of a caesarean section with Patient A at about 07.30, and Patient A was in second stage labour, did not mean that she could not, or should not, have been counselled about her options by the Appellant at 09.15, as labour was progressing slowly and with difficulty.

58. The Tribunal's conclusions on misconduct were as follows:

> "14. The Tribunal reminded itself of the evidence given during the hearing so far and its findings that Dr Veeravalli recommended the commencement of syntocinon, albeit in principle, without direct clinical review of Patient A and his failure to obtain informed consent from Patient A for the continued use of syntocinon. Dr Veeravalli also failed to engage in a discussion with Patient A and explain the risks and benefits of the use of syntocinon. Dr Veeravalli failed to adequately interpret Patient A's cardiotocographic 'CTG' and formulate a safe management plan in discussion with Patient A and her partner. Furthermore, Dr Veeravalli failed to obtain consent from Patient A for her management plan.
>
> 15. The Tribunal had regard to Dr Rao's report which stated:
>
> > 'the standard of care provided by Dr Veeravalli in regard to obtaining informed verbal consent, documentation of the consent and discussion in the context of shared decision making was seriously below the standard expected of a reasonably competent consultant in obstetrics and gynaecology.'

16. The Tribunal had regard to the GMC Consent: patients and doctors making decisions together (2008) ('GMC Consent Guidance') which was in force at the time of the incident in question which sets out the significance and importance of consent in patient care. It considered the following paragraphs to be relevant:

'3 For a relationship between doctor and patient to be effective, it should be a partnership based on openness, trust and good communication. Each person has a role to play in making decisions about treatment or care.

5 If patients have capacity to make decisions for themselves, a basic model applies:

a…

b The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.

c The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one. They also have the right to accept or refuse an option for a reason that may seem irrational to the doctor, or for no reason at all.

d…

7 The exchange of information between doctor and patient is central to good decision-making. How much information you share with "patients will vary, depending on their individual circumstances. You should tailor your approach to discussions with patients according to:

a their needs, wishes and priorities

b their level of knowledge about, and understanding of, their condition, prognosis and the treatment options

c the nature of their condition

d the complexity of the treatment, and

e the nature and level of risk associated with the investigation or treatment.'

17. Where there have been serious departures from expected standards of conduct and behaviour, this can constitute misconduct as identified by reference to *Good Medical Practice (2013 Edition) ('GMP')*. The Tribunal considered the following paragraphs to be most relevant:

'15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient.

b…

c…

17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.

31 You must listen to patients, take account of their views, and respond honestly to their questions.

32 You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.

49 You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:

a their condition, its likely progression and the options for treatment, including associated risks and uncertainties

b the progress of their care, and your role and responsibilities in the team

c…

d…'

18. The Tribunal considered that Dr Veeravalli's failure to question why Patient A was being administered syntocinon was

> significant as he was the Consultant in charge at the relevant time. It noted that the handover took place at approximately 09:00 and that Dr Veeravalli prioritised Patient A's review, attending with Dr Minas. The Tribunal did not accept Mr Holl-Allen's submission that the circumstances in which Dr Veeravalli found himself were particularly unusual or out of the ordinary.
>
> 19. The Tribunal considered that Dr Veeravalli failed to exchange the appropriate information with Patient A for her to make decisions about her care. It considered that it was not acceptable for Dr Veeravalli to acknowledge that syntocinon had been administered and continue administering it without consulting with Patient A. The Tribunal took the view that obtaining consent was particularly important in the management of Patient A given the options available to her and the risks involved by the use of syntocinon in a breach birth. In failing to adequately interpret Patient A's CTG, Dr Veeravalli did not take into account the full clinical picture in order to obtain informed consent from Patient A and to discuss her management plan with her.
>
> 20. The Tribunal was of the view that Dr Veeravalli's actions in failing to obtain consent from Patient A constituted a serious departure from the paragraphs of GMP and the GMC Consent Guidance as identified. It concluded that Dr Veeravalli's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct. It considered that the culmination of Dr Veeravalli's actions regarding the overall management of Patient A amounted to a serious failure. The Tribunal was therefore satisfied that the facts found proved amounted to misconduct."

59. In my judgment, neither the Allegations, nor the Tribunal's findings, made the error of focussing on the tragic outcome, instead of the facts found proved. The Tribunal undertook a detailed and careful analysis of the facts, and evaluated them against the legal test of serious misconduct.

60. I do not consider that the Tribunal erred in relying upon Dr Rao's opinion about the gravity of the misconduct because it was based on shortcomings that the Tribunal did not accept. I find it inconceivable that this specialist Tribunal either forgot or overlooked the fact that it had not upheld all of Dr Rao's criticisms. However, the core concerns that formed the basis of Dr Rao's conclusion in part 2 of his report that the standard of care in respect of consent fell seriously below expected standards were substantially upheld by the Tribunal. Further, the gravamen of the conduct addressed in part of Dr Rao's report was not materially diminished by exclusion of the individual concerns found not proved by the Tribunal. Although the Tribunal determined the Appellant had no opportunity to obtain Patient A's consent before the administration of syntocinon began, it found that the Appellant was under an obligation to obtain Patient A's consent a few minutes later when he attended her. Although the Tribunal found that there was no duty on the Appellant to discuss interpretation of the CTG generally,

it found that there was a duty to discuss the suspicious baseline heartrate with Patient A as part of obtaining consent for the management plan. Thus, Dr Rao's essential concern that important aspects of the CTG were not discussed with Patient A was upheld by the Tribunal.

61. In any event, on my reading of the Tribunal's determination, it would have concluded that the Appellant's failings amounted to serious misconduct, even if it had given no weight to Dr Rao's conclusions. The Tribunal analysed the Appellant's conduct against the GMC's *Consent Guidance* and *Good Medical Practice*, and reached its own independent assessment of seriousness.

62. In conclusion, the Tribunal applied the correct legal tests, and exercised its specialist judgment, in determining whether the Appellant's conduct amounted to serious misconduct. In my view, its judgment was reasonable, and the Appellant has not succeeded in identifying any error in the Tribunal's approach.

Ground 3: Impairment

63. The Tribunal concluded that the Appellant's fitness to practise was currently impaired because he lacked insight into his personal failings, instead blaming the failings of the system and others. The Tribunal was not satisfied by the evidence of remediation, particularly on the issue of consent, and concluded that there remained a risk of repetition in the future.

64. The legally-qualified Chair gave appropriate directions on impairment, which the parties accepted, as follow (Transcript Day 14, pages 15-17):

> "Impairment generally refers to the suitability of a doctor to remain on the register without any restriction. We should bear in mind that, even if we have established that there has been a breach required by the standards established by the GMC, it does not automatically follow that a doctor's fitness to practise is impaired. It remains a separate and discrete judgement for us to make. Again, as I indicated before, there is no burden or standard of proof to be applied.
>
> As Ms Johnson quite rightly states, in reaching our decision we should bear in mind the overarching objective as set out in section 1 of the Medical Act, which she has referred to and I'm not going to repeat here, although I can, of course, further during the course of our deliberations. I would emphasise the importance of considering the objective as a whole; that we should not give excessive weight to any one limb.
>
> I'd like to turn to the question of considering the relationship between a doctor denying or contesting allegations and its impact on the question of insight. It potentially has impact on the question of sanction, but we're not at that stage.

Some guidance was given in the recent case of *Sayer v The General Osteopathic Council* [2021] EWHC 370 (Admin). It set out a number of principles that we may find helpful in considering how the question of denial of the allegations sits with the question of insight to be considered. It was said in that case that,

> "(1) Insight is concerned with future risk of repetition. To this extent, it is to be distinguished from remorse for the past conduct.
>
> (2) Denial of misconduct is not a reason to increase sanction".

That does not have any relevance at this particular stage, but also,

> "(3) It is wrong to equate maintenance of innocence with lack of insight. Denial of misconduct is not an absolute bar to a finding of insight. [Similarly] Admitting misconduct is not a condition precedent to establishing that the [doctor] understands the gravity of the offending [whether or not he is] is unlikely to repeat it."

That echoes a previous case of *Karwal*, which again confirms that it's not a condition precedent to make admissions for insight to be established. A doctor's understanding and attitude towards underlying allegations is a matter that can properly be taken into account when weighing up insight. Where a doctor continues to deny impropriety, it makes it more difficult for them to be able to demonstrate insight, it was also said, and to a degree it is a difficulty that Dr Veeravalli states, so I would touch on the point now.

Again, in the recent 2021 case of *Towuaghantse v GMC* it was said that,

> "the absence of any significant gap between the findings of fact and the commencement of the impairment and sanctions phases means that it is unrealistic to expect a registrant who has unsuccessfully defended the fact-finding phase then almost immediately in the impairment phase to demonstrate full remediation by fully accepting in a genuinely sincere manner everything found against him".

….

In considering whether or not Dr Veeravalli has developed sufficient insight, I would advise you that the High Court has rejected the position that insight or remorse can only be established if a doctor has given oral evidence to demonstrate it. All the evidence before us needs to be considered, including the

live evidence we have heard and the entirety of the content of the bundle that has been provided for our benefit.

It is possible for a doctor to demonstrate insight in a variety of ways, even where conduct has been disputed. In considering fitness to practise I would also refer you to the case of Grant that Ms Johnson has quite properly referred to, and I know that she has touched on the case but hasn't necessarily referred to the details of – I call it a test; it is not necessarily a test; it is an approach that should be taken by tribunals but I will repeat them, as much as anything for Dr Veeravalli's benefit, although I know my colleagues will be familiar with it.

In considering the question of impairment, we should consider the following: whether or not Dr Veeravalli, firstly,

> "has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
>
> b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
>
> c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession."

……

We should also consider the wider public interest in considering impaired fitness to practise and I make reference to the observations of Cox J, in the Fifth Shipman Report in which she stated that,

> "In determining whether or not a practitioner's fitness to practise is impaired by reason of misconduct, the relevant tribunal should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances".

I also make reference to the case of *Yeong v GMC*, with which I'm sure my colleagues will be familiar, in which it was said,

> "In looking forward, the FTPP is required to take account of such matters as the insight of the practitioner into the source of his misconduct, any remedial steps which have been taken and the risk of recurrence of such misconduct. It is required

> to have regard to evidence about these matters which has arisen since the alleged misconduct occurred."
>
> That, in a sense, reflects the principle that came out of the well-established case of *Cohen v GMC* in 2008, as Ms Johnson touched upon, albeit not by name, but the principles are whether or not the doctor's failings are remediable: whether they have been remediated and whether it is – the test was in fact "highly unlikely"; I know, Ms Johnson, you referred to "unlikely" – highly unlikely that they would be repeated.
>
> In considering whether a doctor's failings are remediable, a doctor who is guilty of misconduct may be able to demonstrate that his fitness to practise is not impaired because of learning, training, change of attitude or other experience that has occurred between the time when the misconduct occurred and the time of the hearing when his fitness to practise has to be considered. In that context we are entitled to take into account all the information that is before us. Again, in considering the question of insight, I have made reference to the recent Sayer case and also *Karwal*, but I would also make reference to the case of *GMC v Nwachuku* and whether we should consider there is evidence before us that demonstrates that Dr Veeravalli has accepted responsibility for his conduct and has taken steps to ensure that there is no repetition of it.
>
> We should take into account his attitude to the allegations, any admissions of responsibility and there is some reference to that in the reflection document that we have received. That responsibility for any misconduct is a relevant factor for us to consider in determining whether or not his fitness to practise is impaired.
>
> Finally, while remediation and the likelihood of repetition are important factors rightly to be taken into account in reaching our decision, they should be weighed into the balance against each of the three elements of the overarching principle that has been referred to. Can I just add this, in the event that current impairment is not found, I would remind you that it remains open to us to consider the question of an imposition of a warning. That is, of course, subject to hearing representations of the parties and should not be considered at this stage and is not open to us in the event that we find his fitness to practise is impaired.
>
> That is the advice that I give my colleagues. I invite any comments from either counsel in case I have either misinterpreted the law or I have missed out any aspects of it that you feel my colleagues should be advised about."

65. After considering evidence and submissions, the Tribunal's conclusions on impairment were as follows:

"22. In determining whether Dr Veeravalli's fitness to practise is currently impaired, the Tribunal considered whether there was any evidence of insight and remediation on the part of Dr Veeravalli and whether there was a likelihood of him repeating his misconduct in future.

23. The Tribunal was mindful that a denial of the factual allegations does not preclude a doctor from being able to demonstrate his developed insight. However, the Tribunal has considered whether Dr Veeravalli has demonstrated that he has accepted responsibility for his conduct and whether he had taken steps to ensure that there would be no repetition of it.

24. The Tribunal considered the contents of Dr Veeravalli's written reflections, dated 5 February 2021 in which he stated:

> 'After reflecting on this incident for the last 4 years and doing and taking several remedial actions, I realise that in this tragic incident factors like, the staff shortages, miscommunication, rota changes and confusion among the junior medical and nursing staff and other human factors played a major role.
>
> I take the full responsibility as the named consultant on-call from 09.15 hours until after delivery. All my team on that day worked very hard and well, and wanted to do their best to patient A.
>
> There was no disagreement among the team members in the management of the patient as clearly brought out by the Trust internal investigation.
>
> After doing various modules on the leadership, team work, effective communication, situational awareness and other relevant courses now I can clearly see the misperception amongst the team members and the way different team members had seen and received the information at the time of the discussions during the hand over. This was in-turn due to last minute changes in the Consultant rota twice that day, once at 0800 hours and again at 0915 hours and that these changes were not being communicated to all the team members.
>
> I think all the staff including myself, became task oriented and got fixated on the idea of giving patient A vaginal delivery, and lost the situational awareness. I also think that the counselling regarding the risk of C section at full dilatation, did not help and go well with the couple as they were under the impression that believed that C Section is more dangerous, than the vaginal delivery as expressed by both the Patient A and her partner in their statements.'

> 25. The Tribunal also had regard to the positive testimonials from fellow professionals that Dr Veeravalli had provided who spoke positively about his competence and professionalism.
>
> 26. With regard to Dr Veeravalli's insight into his actions, the Tribunal took into account that four years have passed since the events that concerned an isolated incident and there was no evidence before it of a repetition of the shortcomings that have brought him before this Tribunal. However, it noted that although Dr Veeravalli had taken overall responsibility as the consultant in charge of the team, it had not been provided with sufficient meaningful evidence that he has accepted any personal responsibility for his actions and the impact that his failings have had on Patient A. It therefore considered that Dr Veeravalli has demonstrated little insight in relation to his personal failings as opposed to his generic responsibility as the Consultant in charge.
>
> 27. With regard to Dr Veeravalli's remediation, the Tribunal acknowledged that Dr Veeravalli had provided evidence of completing a 'Decision making and consent: new guidance from the GMC' webinar on 21 January 2021. However, the Tribunal noted that Dr Veeravalli had not acknowledged the importance of taking consent within his reflections dated 5 February 2021. The Tribunal was mindful that Dr Veeravalli had not repeated his conduct since the events in question and noted that Dr Veeravalli's Responsible Officer, Mr Brendan Ryan, who provided a statement that Dr Veeravalli had reflected on the case. It nevertheless concluded that on the basis that Dr Veeravalli had not demonstrated recognition and acceptance of his personal shortcomings but had instead reflected on the failings of the system and of others, it could not be satisfied that it was highly unlikely that his failings would be repeated.
>
> 28. The Tribunal therefore determined that the need to protect, promote and maintain the health, safety and well-being of the public; promote and maintain proper professional standards and conduct for members of the medical profession; and to promote and maintain public confidence, would be undermined if a finding of impairment were not made in this case."

66. The Appellant submitted that the Tribunal's finding on impairment was wrong for the reasons relied upon in his challenge to the findings of fact, and the determination that the Appellant's conduct amounted to serious misconduct. I have already considered and rejected those challenges.

67. The Appellant further submitted that this was an isolated lapse in an otherwise unblemished career, many of the Allegations were not proved, and there was no evidence of any current risk to the public nor any future risk of repetition. The positive testimonials spoke to his competence and professionalism. Therefore the Tribunal's conclusion that the necessity to maintain proper standards and to maintain the confidence of the public required a finding of current impairment was wrong and

unreasonable. The Appellant's insight was demonstrated by the courses he attended and the Tribunal simply failed to take account of the courses that the Appellant attended on the issue of consent.

68. In my judgment, the Tribunal was entitled to conclude, on the basis of the evidence before them, that the Appellant demonstrated little insight in relation to his personal failings, as opposed to his generic responsibility as the Consultant in charge. Instead, he had reflected on the failings of the system and the failings of his colleagues. The Tribunal expressly took into account the Appellant's attendance at one webinar entitled 'Decision making and consent: new guidance from the GMC'. However, it also noted the absence of any acknowledgment of the importance of obtaining informed consent in the Appellant's Reflections.

69. As a specialist Tribunal, Members were well equipped to evaluate the evidence, and I consider that their conclusions on the issue of insight, remediation and the risk of repetition were both reasonable and appropriate. The Tribunal applied the law correctly, and made an exercise of judgment which was open to them. Whilst the Appellant disagrees with the Tribunal's conclusion on impairment, he has failed to identify any respect in which its determination was wrong.

Sanction

70. In determining the appropriate sanction, the Tribunal had regard to the mitigating features, namely, that this was an isolated incident over a short period of time, and did not represent a deliberate disregard for the patient's care. He had no history of previous disciplinary proceedings, and he had been practising without restriction or incident for 4 years since this incident. For these reasons the Tribunal concluded that an order for suspension, as sought by the GMC, would be a disproportionate outcome.

71. The Tribunal concluded that an order for conditions for 12 months was a proportionate sanction which would enable the Appellant to demonstrate developing insight and further remediation to a future reviewing tribunal. Amongst other matters, the conditions required him to design a Personal Development Plan to address the deficiencies in his practice identified in this case.

72. The Appellant did not rely on any separate grounds of appeal against sanction.

Conclusion

73. For the reasons set out above, the appeal is dismissed.