ROYAL COLLEGE OF VETERINARY SURGEONS

INQUIRY RE:

MS JULIA LOUISE CREESE MRCVS (1)

MS ELIZABETH SING MAY LAW MRCVS (2)

DECISION OF THE DISCIPLINARY COMMITTEE ON FACTS

Julia Louise Creese

THAT, being registered in the register of veterinary surgeons and whilst in practice at the Riverside Veterinary Practice in Spalding, Lincolnshire ("the practice"), you:

1. Between 1 July 2016 and 8 November 2017 failed to ensure that there were adequate systems and processes in place for out of hours' care for in-patients;

2. Between 1 July 2016 and 8 November 2017, publicised the practice, or allowed it to be publicised, by way of its website and/or notices, using the terms "24 hour care provided by our vets at our practice" and/or "Care 24/7 for your pets" when such publicity was:

   (i) dishonest, as it suggested that staff were present at the practice 24 hours a day when they were not; and/or

   (ii) misleading, as it suggested that staff were present at the practice 24 hours a day when they were not;

3. Between 1 July 2016 and 8 November 2017, failed to ensure that Penny and Anthony O'Callaghan, the owners of Kiwi, a German Shepherd/wolfhound cross dog, were informed about arrangements at the practice for out of hours' care for in-patients;

AND THAT, in relation to the matters set out above, whether individually or in any combination, you are guilty of disgraceful conduct in a professional respect.

Elizabeth Sing May Law

THAT, being registered in the register of veterinary surgeons and whilst in practice at the Riverside Veterinary Practice in Spalding, Lincolnshire ("the practice"), you:

1. In relation to Kiwi, a German Shepherd/wolfhound cross dog belonging to Penny and Anthony O'Callaghan, having on 7 November 2017 performed surgery to Kiwi to address gastric dilation volvulus:

    (i) failed to obtain informed consent to the entirety of the surgical process and management, to include post-operative aftercare;

    (ii) failed to provide adequate analgesia to Kiwi pre-operatively and/or peri-operatively and/or post-operatively;

    (iii) failed to provide appropriate and/or adequate fluid therapy to Kiwi;

    (iv) failed to offer an appropriate and or adequate post-operative care plan and/or post-operative transfer for Kiwi to another practice;

    (v) failed to inform Mr and Mrs O'Callaghan that there would be nobody present at the practice to provide post-operative monitoring and/or aftercare for Kiwi for approximately seven hours during the night of 7 to 8 November 2017;

    (vi) allowed Kiwi to remain at the practice overnight from 12:30am to 07:45am on 8 November 2017 without adequate monitoring and/or post-operative aftercare;

AND THAT, in relation to the matters set out above, whether individually or in any combination, you are guilty of disgraceful conduct in a professional respect

1. At the outset of the hearing, the First Respondent denied all the charges against her, but the Second Respondent's answers to the charges against her were as follows:

    Charge 1(i) Admitted.

    Charge 1(ii) Denied that she failed to provide adequate analgesia to Kiwi pre-operatively, and/or post operatively, but admitted that she failed to provide adequate analgesia post-operatively, on the basis that there was no visit during the night to assess the need for any further analgesia.

    Charge 1(iii) Denied.

Charge 1 (iv) Admitted.

Charge 1(v) Admitted.

Charge (vi) Admitted.

Factual background

2. Julia Louise Creese MRCVS was at the material time the owner and practice principal of the Riverside Veterinary Practice at Cradge Bank, Spalding, Lincolnshire ("the Practice"). In November 2017, Elizabeth Sing May Law MRCVS was one of four veterinary surgeons working at the Practice.

3. In 2017 the Practice was advertised via a website (www.riversidesurgery.co.uk) and a Facebook page. The website pages contained the following claims:

   a. "24 hour care provided by our vets at our Practice"

   b. "24 hour care is provided at OUR practice, with OUR vets"

4. Similar claims were made on the Practice Facebook page at that time. A sign on the front of the building read "Riverside Vets Care 24/7 for your pets".

5. Mr and Mrs O'Callaghan were the owners of Kiwi, a German Shepherd/Wolfhound cross dog, whose care, treatment and subsequent death is the focus of this case. They also had many other pets at that time, and they had many years' experience as dog owners by 2017. They had moved to Spalding in 2016 and had undertaken on line research to identify a suitable veterinary practice for their animals. They chose to register with the Riverside practice, having seen the publicity and, in particular, the claim that 24/7 care was provided by the Practice. The belief that the Practice would offer care and supervision of inpatients 24 hours a day was a deciding factor in their choice of practice. The O'Callaghans had previously been registered with other veterinary practices, prior to their move to Spalding, and which had provided 24 hour care for in-patients. On the basis of that experience, the O'Callaghans accepted without question the claims made by the Riverside practice as to the level of care that was provided.

6. In November 2017 Kiwi was 11 years old. He had undergone surgery some years earlier and he sometimes had shoulder problems which were being treated by the Practice with Previcox and Tramadol prescribed for his arthritis

7. On 6th November 2017 Kiwi was taken to the practice for a check-up. Mr and Mrs O'Callaghan, were concerned that Kiwi had lost weight recently. They were advised to try giving more food and to return for a further examination the following week.

8. On the evening of 7th November 2017 the O'Callaghans offered Kiwi additional food but he did not eat it all and sometime after taking the food he started dry heaving. The owners believed that Kiwi had ''bloat'', a condition in which the stomach fills with gas and can become twisted. The O'Callaghans, as experienced dog owners, knew that, if that was the case, urgent veterinary attention was required. They rang the practice number, which provided a mobile number to contact the out of hours (OOH) vet on call.

The Second Respondent arranged to see the O'Callaghan and Kiwi at the surgery at about 8.30pm

9. Mr and Mrs O'Callaghan arrived about 20 minutes before the arranged time and they waited outside the premises in their car. The Practice was closed, and there was no light on in the building. The Second Respondent subsequently arrived, unlocked the premises, turned on the lights and assessed Kiwi in the consultation room. She confirmed the diagnosis of bloat and made attempts, using a needle to remove gas from Kiwi's stomach, but without success. She then used an ultrasound device to scan Kiwi's stomach which was inconclusive. Following this she attempted to pass a stomach tube which again was unsuccessful in relieving the bloat. Kiwi was becoming increasingly distressed and the Second Respondent placed the dog on intravenous fluids and told the O'Callaghans that she would ring the duty nurse, as she would need to give Kiwi a general anaesthetic and would need help.

10. The Second Respondent told the O'Callaghans that she would need to take x-rays, and potentially perform surgery. She explained to the O'Callaghans that Kiwi would need a general anaesthetic for this course of action. She completed the consent form and asked Mrs O'Callaghan to sign to consent to the general anaethetic, X ray and potential surgery which was dependent on the results of the x-rays. The O'Callaghans told the Second Respondent that Kiwi had not reacted well to previous anaesthetics although they did not know why. Mrs O'Callaghan duly signed the consent form. At about this time, the veterinary trainee nurse, Kally Haywood arrived at the Practice. The O'Callaghans went with Kiwi into the back room. They said that he was able to walk into the room, but was getting "really flat".

11. The O'Callaghans left the Practice at about 8:55pm. At about 9.15pm Kiwi was anaesthetised, and x-rays were taken. The Second Respondent telephoned the O'Callaghans at about 9:35pm to report that the x-rays confirmed the diagnosis of gastric dilation volvulus, (GDV) (known as bloat) and that surgery would be required immediately. The O'Callaghans knew that bloat could be fatal, and that rapid surgical intervention was needed.

12. The O'Callaghans had told the Second Respondent that Kiwi had been given Previcox and Tramadol with his food when he had been fed earlier that evening at about 5:15 pm.

13. Once Kiwi was anaesthetised, the Second Respondent was able to decompress Kiwi's stomach with a needle and to pass a stomach tube through which much ingesta came out. Thereafter, the Second Respondent proceeded to perform surgery. She discovered that Kiwi's stomach had returned to its normal position after decompression and emptying via the stomach tube, and was considerably smaller than had been shown on X ray. The Second Respondent noted that there was some blood pooling in the abdomen, and she was concerned that there may have been something else amiss. Accordingly, the Second Respondent asked the nurse to contact the First Respondent, who came to the Practice in order to assist and advice. They were satisfied that the blood pooling was not increasing over time, and considered it likely to be within expectations for the operational procedure and the size of dog. The Second Respondent completed the gastropexy, and the incision was closed. Kiwi

recovered consciousness the tube was removed and a second bag of fluid attached .He was carried to his kennel to complete his recovery.

14. At about 12.10am the Second Respondent rang Mrs O'Callaghan and told her that the surgery was over, that Kiwi was in recovery and that the surgery had gone quite well. The O'Callaghans were asked to ring the Practice at 9am to discuss when Kiwi would be able to come home. The O'Callaghans assert that nothing was said to them during that telephone call, or at any stage of the evening, about what would happen to Kiwi overnight.

15. The Second Respondent and the nurse made a last check on Kiwi at about 12:30 am at which time they say that Kiwi was lifting his head and recovering from the anaesthetic. The second Respondent felt he was stable and could remain on fluids until the following morning. Kiwi was left alone overnight, during which time no visits or checks were made to assess and/or monitor his condition.

16. The veterinary trainee nurse, Kally Haywood, came into the Practice at about 7:45am the following morning, 8 November 2017, and found that Kiwi had died in his kennel. The Second Respondent telephoned Mrs O'Callaghan a short while later and told her that Kiwi had unfortunately passed away in the night. Mrs O'Callaghan asked if Kiwi had been on his own when he died, and the Second Respondent said yes. Mrs O'Callaghan was extremely upset and could not continue the call.

17. Mr O'Callaghan spoke to the Second Respondent later in the day. He was very upset and angry at what had occurred, and asked the second respondent why she had left a dog alone after life threatening surgery. She said that they were a small practice and did not have the staff. Mr O'Callaghan said that he did not care, and that they advertise themselves as providing 24-hour care. Later that day, the O'Callaghans went to the Practice, and had a discussion with the First Respondent about what had happened. Kiwi's body was collected by the crematorium that morning.

The evidence on behalf of the College

<u>Penny and Anthony O'Callaghan</u>

18. Mrs O'Callaghan contacted the The College on 8 November 2017 (the day after Kiwi was admitted to the Practice) to find out how to make a complaint about what had happened to Kiwi. She was informed that she needed to complain first to the practice in writing, which she did. The O'Callaghans sent a detailed complaint to the practice by email dated 27 November 2017 and a printed copy was delivered by hand.

19. Mr and Mrs O'Callaghan provided witness statements to the College in relation to this matter dated 7 October 2018. These were detailed documents which exhibited the original complaint to the practice and the response they received on 6th December 2017 from the First Respondent. Both Mr and Mrs O'Callaghan gave oral evidence to the Committee. The Committee noted that the O'Callaghans were experienced dog owners, who had made a complaint shortly after the relevant events, a copy of which had been sent to the College.

20. The Committee considers that there is no significant dispute as to the chronology of the events that occurred when Kiwi was admitted to the practice on 7th November 2017, as summarised above. The evidence of the O'Callaghans confirms the underlying facts, so far as they were present or involved. TheO'Callaghans gave evidence as to what happened when they were looking to register their animals, which included Kiwi, and four other dogs,. They searched for local vets online. Following that search, they chose to register with the Practice and said that one of the deciding factors in doing so was because of the claim on their website and Facebook page, which stated *"24 hour care provided by our vets at our practice".*

21. Mrs O'Callaghan said that she registered all their dogs by telephone. She wanted to make sure that they were all registered so that they could go there when needed. She said that the person she spoke to on the phone did not give her any information about the practice's OOH service. Neither did she receive any information after registration by post or by email, or when she attended the practice subsequently. In their responses to the written complaint, the Respondents had set out details of their OOH arrangements. However, Mrs O'Callaghan said that she had sat in the waiting room many times, about 25 in total, and had seen many different posters.But she had never seen anything about OOH arrangements, or anything that stated that animals hospitalised at the practice overnight could be left unmonitored for many hours immediately after major surgery. She does not remember being told anything about the way that the Practice covered OOH work.

22. The main thrust of the complaint made by the O'Callaghans, as outlined in their evidence, was the failure of the Respondents to ensure that Kiwi would be monitored and cared for overnight if needed, and they would be contacted if the dogs health deteriorated. If this was not the case, they should have been given the opportunity for Kiwi to be transferred to another practice, where suitable overnight care could be provided. This was never discussed. Mr O'Callaghan accepted that he did not expect the Practice to be staffed continuously over a 24-hour/7-day period, when no animals were on site as in-patients at the premises. He expected sufficient overnight care would be provided by a vet or veterinary nurse of the Practice, to ensure the welfare of animal in-patients

Professor John Williams FRCVS

23. Professor Williams is a specialist in small animal soft tissue surgery, and has worked in general practice, and at referral practices. In 2016, he was appointed National Surgical Lead at Vets Now, based at the 24/7 Emergency Hospital in Manchester. He is a RCVS recognised specialist in small animal surgery (soft tissue).

24. Professor Williams provided an explanation of the symptoms and diagnosis of GDV in dogs. He went on to express his opinion of the appropriateness and/or adequacy of the treatment provided by the Second Respondent, and her actions in relation to Kiwi and his owners. His evidence is relied upon by the College. Further reference will be made to relevant parts of his evidence, when the Committee is giving its reasons for its Findings on the Facts.

Avnish Ghoorbin

25. Mr Ghoorbin, Solicitor in the professional conduct department of the College, has provided a witness statement, in which he exhibits a number of screenshots taken from the website of the Riverside practice, as at 29 November 2018. This evidence was agreed.

The evidence on behalf of the Respondents

The First Respondent

26. The First Respondent provided a written response to the complaint from the O'Callaghans, which was dated 6 December 2017. In that letter, the First Respondent said this about the OOH service being provided by the Practice:

"Although we do offer a 24-hour emergency service at this practice, rather than using a designated out of hours provider, we are not a hospital and don't have staff on site overnight. Details of the level of cover that we provide is available to read in the waiting room on our practice noticeboard. It is also in the practice welcome letter. I am sorry if you were not aware of this when you registered with the practice in July last year. There was certainly no intention to mislead you into thinking that we were staffed 24 hours. Julie our receptionist does remember registering all your animals and answering all your questions but can't recall whether overnight care was mentioned."

27. In a letter to the College dated 9 March 2018, the First Respondent said this about the OOH service being provided by the Practice:

"We did not advertise the practice to have staff on site 24 hours a day and I do not know why the O'Callaghans thought this was the case. We inform clients of our out of hours arrangements when they join the practice. In addition, the practice noticeboard states our out of hours arrangements and degree of inpatient care as required by the practice standard scheme. This information is also available on our website. We had a practice standards inspection in March 2017, we all worked extremely hard to achieve the RCVS Accredited Practice status. No issues regarding the level of out of hours care and how this information is conveyed to clients was raised at that time and nothing had changed by November when we treated Kiwi. However in order to avoid this situation arising again, we have since altered the wording on the website to try to clarify the extent of our out of hours care and to avoid misinterpretation. We have also added a paragraph to the general anaesthetic consent form highlighting this."

28. The First Respondent has produced a witness statement dated 11 June 2019, in which she made similar points about the paperwork distributed to owners when they registered with the practice, along with information displayed on the website and in the waiting room. This included a welcome pack for owners, which included an overnight care information sheet. As to the charges against her, the First Respondent said that she believed there were adequate systems and processes in place for OOH care for the patient (Charge 1). As to Charge 2, she said that the information provided on the website, noticeboard and welcome pack is intended to inform clients that the Practice provided an OOH service and that this was available to them 24 hours a day. There was never any intention to suggest that staff are present at the Practice 24 hours a day when they were not. It was simply to advise clients that they did not need to contact an alternative practice in the event they required emergency care for their pets. The information provided to clients was not intended to be misleading in any way. However

in the light of this case, she said that the Practice had reviewed all our systems and decided to change the wording on the website and on the consent form in order to ensure that owners could not possibly be mistaken about the services provided by the Practice. As to Charge 3, the First Respondent stated that when the O'Callaghans registered with the Practice, they should have received a welcome pack containing the information for owners confirming the out of hours care arrangements for inpatients.

29. In brief, the evidence of the First Respondent was to the effect that she believed that adequate systems and processes were in place for OOH care for in-patients during the relevant dates. She denied that the website or notices were misleading as suggested, and vigorously denied that she had acted in a dishonest manner. She denied that she failed to ensure that the O'Callaghans were informed about arrangements at the Practice for OOH care.

The Second Respondent

30. The Second Respondent's admissions are as set out above. In the case of Charge 1(ii), there is a partial admission in relation to the failure to provide adequate analgesia to Kiwi post operatively, in that he was not visited or checked overnight so that his condition could be assessed. Charge 1 (iii) is denied.

31. The Second Respondent has provided a written witness statement dated 13 June 2019, which deals with all the allegations against her.

32. When Kiwi was admitted during the evening of 7 November 2017, the Second Respondent performed a full clinical examination and found him to be dull but responsive. He was ambulatory with a bloated abdomen which felt gassy on percussion. On chest auscultation, he was tachycardic but had a regular heart rhythm. He was panting. She diagnosed GDV. She could see that Kiwi was starting to deteriorate in front of her and knew that it was essential to take action as a matter of urgency. She told the O'Callaghans that GDV was a life-threatening emergency and that Kiwi had only a 50-50 chance of survival, taking into consideration his age and his underlying conditions.

33. The Second Respondent was informed by the O'Callaghans that Kiwi had been given his usual analgesics with his evening meal (Previcox and Tramadol). She was also told that Kiwi had experienced problems with general anaesthetic before. Thus, she was aware of the analgesics already in Kiwi's system. She had drawn up buprenorphine as an analgesic, but decided not to use it until after the anaesthetic had worn off because of Kiwi having had issues with anaesthesia before. She did not accept the allegations that she had failed to provide adequate analgesia to Kiwi pre-operatively and/or peri-operatively as the Second Respondent considered that the doses of Previcox and Tramadol would have provided Kiwi with sufficient pain relief.

34. Kiwi, a 47kg German Shepherd cross, had IV fluids administered immediately after the initial consultation and provisional diagnosis. A 1 Litre bag of Hartmans was set to run as fast as gravity allowed. A second 1 litre bag of fluids was administered some 3 hours after the first and following the surgery, when Kiwi had been placed in his kennel. The second bag was turned to maintenance rate, which was about one drop every two seconds. The Second Respondent took the view that this would have lasted until the surgery was re-opened in the morning. She felt that this was sufficient bearing in mind

that Kiwi had not been in very great shock and was ambulatory on admission. He had been diagnosed quite early, and the volvulus resolved spontaneously as soon as the stomach tube was passed and the vital signs recorded on the anaesthetic chart were within normal range.

35. In brief, the Second Respondent argued that her treatment of Kiwi in relation to analgesics and fluids was sufficient and appropriate for the circumstances of the case.

Chelsea Ingamells HRVN

36. Ms Ingamells was the Head Registered Veterinary Nurse at the practice. She gave oral evidence by Skype. She produced a witness statement dated 11 June 2019, which exhibited a short statement that was undated. She said that she remembered a conversation with Mrs O'Callaghan on Saturday, 14 October 2017, when she was helping out at reception. She said that they had a conversation about her being on duty over the weekend, in the course of which she says that she explained how the OOH arrangements worked. As a result, she said that she believed that Mrs O'Callaghan was, and is, aware of the OOH arrangements. She also referred to the arrangements for OOH care being displayed on the staff members board, but said that since the complaint another copy had been added to the practice information board and had been enlarged.

37. She was cross-examined about the various notices that she said had been displayed at the Practice. She claimed that there had always been two notices concerning the OOH arrangements displayed in the waiting area, but contended that one of the notices had recently been enlarged. The Committee was not clear as to how many notices there were, where they were displayed and what the wording was during the relevant period.

Julie Carter

38. Ms Carter had been a receptionist at the practice for over 12 years. She gave oral evidence by skype. She said that she had first learned about the complaint in the First Respondent's letter dated 6 December 2017 (at para 25 above) where it was stated that she remembered registering Mrs O'Callaghan, but could not remember whether overnight care was mentioned. She then said that it was brought to her attention that the O'Callaghan had registered on a Saturday when she was not working so she could not have carried out the registration. She accepted this.

39. Ms Carter produced a statement dated 1 November 2018, in which she stated that she remembered a conversation with Mrs O'Callaghan in person and before she registered, when she had made enquiries about OOH care and what happened if an animal was an in-patient overnight. She accepted under cross examination that she could have confused Mrs O'Callaghan with someone else as she saw so many people at reception.

Kally Haywood RVN

40. At the date of the incident Ms Haywood was a trainee RVN, and subsequently qualified in 2018, after the date of this incident. She gave oral evidence by Skype. She was the nurse who assisted the Second Respondent in relation to the surgery on Kiwi. She produced a statement dated 9 March 2018 and a witness statement dated 5 September 2018.

41. In both statements, Ms Haywood gave her recollection of events when she was assisting with the surgery on Kiwi. She said that she was responsible for completing an anaesthetic sheet for this operation, on which she recorded Kiwi's heart rate, respiratory rate, mucus membranes colour etc. This sheet was before the Committee. Both Respondents said that they had seen Ms Haywood filling out an anaesthetic sheet contemporaneously.

42. In her first statement, Ms Haywood said that, following the surgery, Kiwi regained consciousness fairly quickly. He was placed into right lateral recumbency in the kennel and a blanket was placed over him. She stated that at this time his mucus membranes were pink with a capillary refill time of less than two seconds, Kiwi's heart rate was 92 bpm and his respiratory rate was 20 bpm. In response to a question from the Committee, Ms Haywood said that she had taken these figures from the anaesthetic chart. However, the last time on the chart was 10/10 (which should have read 11/10), and Ms Haywood was unable to explain where these parameters had come from. She accepted that there should have been a continuation anaesthetic sheet. In her statement Ms Haywood said that Buprenorphine was given to Kiwi as a pre-med. She accepted in cross examination that she may have got that wrong.

43. In general terms, Ms Haywood confirmed the Second Respondent's account of events.

Mr Charles Williams BVM&S MRCVS

44. The Respondents relied on the expert evidence of Mr Williams, who has worked in mixed, small animal and equine practices around the UK and abroad until 2001 when he became a joint partner at Springfield vets, Midhurst, West Sussex. This is a purely small animal, first opinion veterinary practice, which takes on a comprehensive range of first opinion medical and surgical cases.

45. Further reference will be made to the relevant parts of Mr Williams' evidence when the Committee gives its reasons for its Findings on the Facts.

Assessment of the witnesses except the experts

46. The Committee was impressed by the evidence of Mr and Mrs O'Callaghan. They were experienced, knowledgeable and caring owners, who obviously put the welfare of their animals, including Kiwi, at the forefront of their lives. Their complaint was made almost immediately after the events which led to Kiwi's death, and was made in considerable detail. The Committee found that their evidence was clear, consistent, cogent and credible. Their evidence is accepted by the Committee. Where their evidence is in conflict with any of the witnesses called on behalf of the Respondents, the Committee prefers the account of the O'Callaghans.

47. So far as the First Respondent is concerned, the Committee considered that, as the owner of the practice, she had tried to assist the Committee. The Committee does not doubt that she believed that the systems and processes in place for inpatients at the

Practice were sufficient, and had not caused any problems in the past. Nevertheless, the wording of notices on the website and for display in the Practice were modified after this incident, so as to remove any possibility of misunderstanding. It is, of course, for the Committee to decide whether it considers that the systems and processes were adequate, whether the website and/or notices were misleading, or whether the First Respondent acted dishonestly. It is for the Committee to decide whether the First Respondent was at fault in failing to ensure that the O'Callaghans were informed about the arrangements at the practice for OOH care for inpatients.

48. So far as the Second Respondent is concerned, she is to be commended for the admissions that she has made in relation to the majority of the Charges. The Committee considered that she tried to assist in the evidence that she gave about the matters of fact that are in dispute. The Committee considered that the Second Respondent was defensive in relation to the disputed allegations but has no doubt that she was truly upset by the fact that Kiwi had passed away, and accepted her responsibility for failing to ensure that he was checked or monitored overnight. Although there is little dispute about the chronology of what occurred during this incident, it is for the Committee to decide as to whether it considers that the Second Respondent was at fault in relation to the disputed allegations.

49. So far as Ms Ingamells is concerned, the Committee noted that Ms Carter asserted that Ms Ingamells registered Mrs O'Callaghan with the practice, when Ms Ingamells gave no such evidence. The alleged conversation with Mrs O'Callaghan on 14 October 2017 was not put to Mrs O'Callaghan when she gave her evidence. However Mrs O'Callaghan had given clear evidence that nobody gave her information about the OOH arrangements at the Practice at any time and the Committee accepted this. So far as the evidence of this witness as to the notices displayed at the Practice, the Committee had some concern as to the reliability of Ms Ingamells' evidence on this point.

50. The Committee considered that Ms Carter did her best to help but that her evidence was unclear on some points and she was trying to recall events which occurred a long time ago. The Committee did not feel that it could rely on her evidence.

51. The Committee found that Ms Haywood's recollection of events was not completely reliable on some key points. She was unable to remember whether or not a pre-med drug had been given to Kiwi. She was unable to explanation as to where the post - operative observations that she referred to in her first statement came from, having regard to the fact that the last entry on the anaesthetic sheet was at 11.10pm. The Committee took this into account in deciding what weight to attach to her evidence

The Committee's Decision as to the Facts

52. The Committee took careful note of all the written and oral evidence provided by the Witness for the College, and for the Respondents, and the submissions made on behalf of both of the parties. The Committee considered that, having regard to all the evidence, the Second Respondent's admissions as to the facts were properly made. The Committee accepted the advice of the Legal Assessor.

<u>The First Respondent</u>

53. The Committee considers that all the Charges against the First Respondent are matters for the Committee to decide and are not matters for expert evidence.

Charge 1

54. The dates in the Charge spanned the period from the date when the O'Callaghans registered Kiwi at the Practice until the date of Kiwi's death. The Committee has considered, in particular, the evidence of the O'Callaghans, and the evidence of the First Respondent as to these matters. The evidence of the First Respondent summarised in paragraphs 25 to 28 above relates to the systems and processes that were in place for out of hours care for in-patients.So far as the O'Callaghans were concerned, they had used the OOH system once before in relation to another dog, Daisy, although this was an OOH consultation with a veterinary surgeon over the weekend, and during daylight hours. It is accepted that the O'Callaghans had no previous experience of OOH arrangements involving in-patient treatment overnight.

55. The Committee considers that the Practice did have in place systems and processes for OOH care for in-patients, as follows. The pet owner would call the main Practice landline, this would be e diverted to a mobile number used by the relevant veterinary surgeon on call ("the VS"), who would make a judgement as to whether it was necessary for the pet to be brought in to the Practice. If that was thought to be necessary, the VS would make a decision as to what was required. If it was necessary to admit a pet for overnight inpatient treatment, then the necessary arrangements would be made, and assistance from a veterinary nurse, or another VS could be provided if required. It was for the responsibility of the VS to decide what overnight care was required in any particular case, whether by constant care or visits during the night to check on the progress and welfare of the patient. The First Respondent said that if care or visits during the night were required then they would be provided by the Practice.

56. There is no evidence of repeated or ignored failures of these systems and processes. It is admitted that the decision in this case to leave Kiwi alone without a visit or visits to check his welfare was flawed. In addition, the O'Callaghans had not been told that Kiwi would be left alone and unattended, and they were not given the option to transfer him to a practice with 24-hour staffed care. In the view of the Committee, this was not a failure of systems and processes, but an incorrect decision being made by the VS.

57. In the view of the Committee, the fact that the Practice changed the wording of the relevant website notices, and/or notices for display in the Practice does not prove that the previous systems and processes were inadequate. In addition, the Committee considers that the Practice was entitled to place some reliance on the fact that it's systems and processes had been inspected and assessed by the Department, and considered adequate by the RCVS Practice Standards Scheme in March 2017.

58. Accordingly, the Committee does not find the First Respondent failed to ensure that there were adequate systems and processes in place for OOH care for inpatients between the relevant dates. This Charge is dismissed.

Charge 2

59. This Charge has to be read in its entirety. There is no doubt that the First Respondent publicised the Practice or allowed it to be publicised, by way of its website and/or notices using the terms *"24 hour care provided by our vets at our practice"* and/or *"Care 24/7 for your pets".* The Charge asserts that such publicity was dishonest and/or misleading, *"as it suggested that staff were present at the practice 24 hours a day when they were not".*

60. In her witness statement dated 11 June 2019, the First Respondent said that the information provided on the website, noticeboard and welcome pack was intended to inform clients that the practice provided an out of hours service and that this was available to them 24 hours a day. There was never any intention to suggest that staff were present at the practice 24 hours a day when they were not. It was simply to advise clients they did not need to contact an alternative practice in the event they required emergency care for their pets. The information provided to clients was not intended to be misleading in any way.

61. Mrs O'Callaghan thought that 24/7 care meant that care could be provided 24 hours a day if required, but not that it meant the Practice was permanently staffed. Mr O'Callaghan said that he thought that 24/7 care meant that the Practice needed to be open as required, but he did not think that it meant that it would be necessary for someone to be there at all times irrespective of whether or not an animal required treatment.

62. The Committee has considered the evidence with great care and does not agree that the relevant publicity suggested that staff were present at the Practice 24 hours a day when they were not. The Committee accepts the First Respondent's explanation as to the intended and correct meaning to be attached to the relevant publicity and that the O'Callaghans agreed with that explanation. The Committee considers that the Practice was also entitled to rely on the fact that it was passed by the RCVS Practice Standards Scheme as referred to above.

63. The Committee does not find that the relevant publicity statements were misleading as alleged in paragraph 2(ii) of the Charge It follows that the Committee is satisfied that the allegation in paragraph 2(i) that the First Respondent has acted dishonestly is without merit or justification. The First Respondent is a woman of good character. She has produced several testimonials as to her honesty and integrity. She is entitled to leave this hearing with her reputation for honesty and integrity intact. Charge 2 is dismissed in its entirety.

Charge 3

64. This Charge alleges that the First Respondent failed to ensure that the O'Callaghans were informed about arrangements at the practice for out of hours care for inpatients. The Committee considers that this allegation suggests that the First Respondent has to bear personal responsibility for the fact that, in this case, the O'Callaghans were not informed by the Second Respondent about the arrangements for the overnight care of Kiwi. The Committee considers that this places an unrealistic burden on the owner of a practice.

65. The First Respondent asserts, in her witness statement dated 11 June 2019, that when the O'Callaghans registered with the Practice, they would have received a welcome

pack containing the information sheet for owners confirming the OOH care arrangements for inpatients. The Committee has already stated that it accepts that the O'Callaghans did not receive a welcome pack, or any other information as to the OOH arrangements. What the First Respondent should perhaps have said is that the O'Callaghans should have received a welcome pack containing OOH care arrangements for inpatients. This was the system in place, and through human error, it did not work. In the view of the Committee, the responsibility for the fact that the system did not work in this case cannot reasonably be laid at the door of the First Respondent. This was a systems failure, not a personal failure on the part of the First Respondent as owner of the Practice.

66. Accordingly, the Committee has found that this Charge not proved. Charge 3 is dismissed.

The Second Respondent

67. The Second Respondent has admitted several of the charges as outlined above. Accordingly, the Committee only has to make findings of facts in relation to Charge 1(ii) and 1 (iii).

Charge 1 (ii)

68. The evidence of the Second Respondent is that the O'Callaghans confirmed to her that Kiwi had been given his usual analgesics (Previcox and Tramadol) with his evening meal at about 5.15pm. She said that she was, therefore, aware that Kiwi already had the benefit of pain relief at the time that he was admitted. She was also told by the O'Callaghans that Kiwi had previously experienced problems with general anaesthesia. The Second Respondent explained Kiwi had a life threatening condition. Mrs O'Callaghan signed the consent form permitting ''general anaesthetic, x-ray, ex-laparotomy, treat GDV, decompress stomach and gastropexy''.

69. The Second Respondent said that she knew that Previcox lasted for 24 hours, and gave consideration to the Tramadol, which Kiwi had been on long-term. She had initially drawn up Buprenorphine to give to Kiwi, but once the O'Callaghans had told her that he had previous issues with general anaesthesia, she did not want to risk giving this as the O'Callaghans did not know what caused his adverse reaction. Her plan was to give the Buprenorphine once the effects of the anaesthetic were out of his system and she could do a better pain assessment. She says that Kiwi was showing no signs of being in pain or discomfort immediately post operatively. She considered that the oral analgesics given to Kiwi earlier in the day would still have been in his system and, combined with no signs of pain when she left the dog. She considered that Kiwi had sufficient analgesia to last until the following morning when the nurse arrived.

70. Professor Williams, in his report for the College, stated that GDV is a very painful condition, and performing major surgery would increase the level of pain in the patient. He said that, in his opinion, major abdominal surgery such as correcting GDV must have suitable and adequate pain relief before and after surgery. Although Prof Williams considered the fact that Kiwi had been given Tramadol some 4 hours prior to

surgery, in his report he did not refer to the fact that Kiwi had also been given Previcox. In oral evidence he did acknowledge that Previcox gave some background pain relief but this would not be sufficient. In his opinion in view of the nature of this condition and the surgery, Kiwi needed to receive analgesia by injection.

71. Mr Williams, in his report for the Respondents, dealt with the effect of both Previcox (as above) and Tramadol, which he said might reasonably be assumed by the Second Respondent to provide some pain relief during surgery, and to be effective until about 2am. While he does not dispute that Kiwi could have been given more pain relief in the form of Buprenorphine or Methadone, he considered that in this case, the Second Respondent's decision not to do so was reasonable in the light of the painkillers already consumed by Kiwi. He also considered that the decision not to give additional pain relief in the peri-operative period was reasonable as anaesthesia was in itself a painkiller.

72. Given that the effect of Tramadol would have worn off in either the early hours of the next morning, or earlier, but that Previcox would still be active, Mr Williams considered that Kiwi's post-operative pain may have been minimal under the effect of Previcox alone, although he acknowledged that he would have given pain relief "reflexively" based on the condition and the operation. However, he considered that a visit to Kiwi in the early hours of the morning should have been made in order to assess his level of pain so that additional pain relief could have been given if seen fit. Deciding not to visit Kiwi in order to assess his level of pain in the hours between surgery and the following morning, in the opinion of Mr Williams, fell below the standard of a reasonably competent veterinary surgeon. The Second Respondent has admitted that this was the case.

73. The Committee considered the oral and written evidence of both Prof Williams and Mr Williams The Committee has no doubt that, at the time of the initial consultation, Kiwi would have been in severe pain as a result of him suffering from GDV, and it considered that he should have been given adequate pain relief at the time of, or soon after, his admission. Accordingly, the Committee finds that the Second Respondent failed to provide adequate analgesia to Kiwi preoperatively.

74. So far as the peri-operative period is concerned, the Committee considers that the Second Respondent would have been entitled to consider that Kiwi would have received sufficient pain relief by virtue of the effect of the anaesthesia. Accordingly, the Committee considers that the College has not proved that the Second Respondent failed to provide adequate analgesia during the perioperative period. This aspect of the charge is dismissed.

75. So far as the post operative period is concerned, the Committee accepts the opinion of Mr Williams that the opiate pain relief would have worn off during the night, and Kiwi should have been assessed as to his need for further pain relief, together with an assessment as to his overall condition. In the opinion of the Committee, the Second Respondent should have given post-operative pain relief in any event after significant and painful surgery. This is because Kiwi would be likely to suffer serious pain after the effect of the anaesthesia had worn off. In the view of the Committee, this should have been done in addition to such visits during the night which would have been considered necessary, having regard to the condition of Kiwi when he was examined.

Thus, the Committee considers that the admission of the Second Respondent in relation to the post operative period is too limited, and the Committee is satisfied so that it is sure that the allegation in this Charge relating to the post operative period is proved on the basis set out above.

Charge 1 (iii)

76. The evidence of the Second Respondent is that, when Kiwi had first been administered IV fluids, he was placed on a 1 litre bag and it was set to run as fast as gravity allowed. She says that Ms Haywood changed the drip bag after the surgery, and after Kiwi had been placed in his kennel, as the first bag had run out. She says that the second bag was turned to maintenance rate, which was about one drop every two seconds. She considered that this would have lasted Kiwi well into the next morning. Prior to leaving at about 12:30 am, the Second Respondent asserts that Kiwi was lifting his head and recovering from the anaesthetic. She felt he was stable and could remain on maintenance level fluids until the following morning. She did not have any concerns about Kiwi when she left the practice.

77. The evidence of Ms Haywood is that she arrived at the Practice at about 9pm, when she saw that Kiwi was already set up with a bag of fluids. She confirms the account of the Second Respondent about the changing of the first bag of fluids, and the renewal of a 1 litre bag of fluids after the completion of surgery.

78. Professor Williams, in his report, notes that Kiwi only received 1 L of fluid between 8.30pm and 11:45 pm, which he said was less than a quarter of what he should have received during the first hour. He said that, when the second bag of fluid was attached at 11:45 pm, the assumption was that it would run for seven hours. In his opinion, in cases of GDV, a post operative fluid rate of 5ml/kg/hr should be given for 24 hours after surgery. Kiwi was a 47.1 kg dog, and, if the fluid rate had been set to this, it would have run out in 4.25 hours. His opinion was that this was wholly inadequate and inappropriate fluid therapy for a case of GDV, where there is the risk of acute kidney injury because of low blood pressure and where tissue perfusion is already severely compromised by the disease process.

79. Mr Williams, in his report, stated that it was known that Kiwi received 1 L of fluids between approximately 8:45 PM (according to the Second Respondent's witness statement) and 11:45 pm (according to Ms Haywood's witness statement) suggesting a rate of approximately 7ml/kg/hr. Mr Williams is of the opinion that, if Kiwi had been only mildly clinically compromised as recorded on the anaesthetic chart and witness statements suggest, the amount that Professor Williams suggests should have been given (approximately 4 L) would be unnecessarily high. Had Kiwi needed more fluids by the time of induction of anaesthesia, Mr Williams considers that Kiwi would not have had such reasonable clinical parameters, as recorded on the anaesthetic chart.

80. So far as the post anaesthetic period is concerned, Mr Williams states that, if a maintenance rate of approximately 3ml/kg/hr (an acceptable mid-range fluid maintenance rate) have been chosen, the fluids would had been expected to run for seven hours before Kiwi was to be checked next. It was his opinion that the Second Respondent's decisions regarding the volume of fluid administration did not fall below the standard of a reasonably competent veterinary surgeon. However, Mr Williams

considered that the assumption that the fluids would run uninterrupted for seven hours was flawed, and that Kiwi should have been checked in order amongst other things to have his fluid therapy assessed. In his opinion, the decision not to check Kiwi during the night fell below the standard expected of a reasonably competent veterinary surgeon.

81. The Committee accepts the evidence of the Second Respondent that the first bag of fluids was set to run at the rate of gravity, namely a shock rate. The Committee would have expected that more than 1 litre of fluids would have been used at that rate in the period from about 8.45pm and 11.45pm.

82. However, so far as the post operative stage is concerned, the Committee has no doubt that it was unreasonable to leave Kiwi alone overnight. The Committee accepts the opinion of Mr Williams that the assumption that the fluids would run uninterrupted for seven hours was flawed, and that Kiwi should have been checked in order, amongst other things to have his fluid therapy assessed. The decision not to check Kiwi during the night falls below the standard of a reasonably competent veterinary surgeon. The Committee finds that, by failing to ensure that Kiwi was assessed for his fluid needs, the second Respondent failed to provide appropriate and/or adequate fluid therapy to Kiwi. Accordingly, Charge 1(iii) is found proved.

DISCIPLINARY COMMITTEE
24 JUNE 2019