ROYAL COLLEGE OF VETERINARY SURGEONS

-and-

DR ISACO DE ARMAS JIMENEZ (MRCVS)

DISCIPLINARY COMMITTEE DECISION

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1. The Respondent, Dr Isaco De Armas Jimenez faced the following charges:

That, being registered in the Register of Veterinary Surgeons and whilst in practice at Medivet, Kenbury Street, Camberwell London SE5 9BS ("the practice"):

1. On or around 22 April 2022 or 23 April 2022, in relation to a cat named Moustache belonging to AI you:

a) failed to obtain informed consent to sedate/anaesthetise Moustache and/or sedated/anaesthetised Moustache despite AI's instructions or request not to do so;

b) failed to take adequate steps when Moustache required emergency attention;

c) failed to provide adequate details to AI after Moustache's death, more particularly about the administration of sedative/anaesthetic and/or the reasons for treatment given and/or the details surrounding Moustache's death;

2. On or around 22 April 2022 or 23 April 2022, in relation to clinical records for Moustache, you:

a) failed to record details of sedation/anaesthetic given to Moustache;

b) recorded in clinical records for Moustache that when Moustache became cyanotic (i) a tube had been passed in order to intubate and (ii) chest compressions had been given, when he had not been intubated and/or chest compressions had not been given;

c) failed to make adequate clinical records in relation to your differential diagnoses and/or your proposed treatment plan;

3. Your conduct in relation to 2(a) and/or 2(b) above was:

a) dishonest; and/or

b) misleading;

4. Between 22 April 2022 and 23 April 2022, you failed to have in place any Professional Indemnity Insurance;

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.

2. The College was represented by Ms Hanne Stevens. The Respondent attended and was unrepresented but supported by Mr P Attenburrow from the Veterinary Defence Society and Ms S K[redacted], a friend.

Admissions

3. The Respondent admitted the following charges:

- Charges 1(a), 1(b), 1(c), 2(a), 3(a) in relation to 2(a) and 3(b) in relation to 2(a) and 4.

He denied Charges 2(b), 2(c), 3(a) in relation to 2(b) and 3(b) in relation to 2(b).

Background

4. The Respondent faces a series of Allegations relating to his professional conduct as a Veterinary Surgeon and in the treatment of a cat named “Moustache” on or around 22 April or 23 April 2022. At the material time (April 2022), the Respondent was in practice as a locum at Medivet, Kenbury Street, Camberwell London, SE5 9BS.

5. Ms Al was the owner of a male cat named Moustache. She reported concerns to the Royal College of Veterinary Surgeons (RCVS) in June 2022 regarding the treatment of

Moustache on 22 and 23 April 2022. Ms AI took Moustache to Medivet Camberwell (the Practice) late in the evening as she had noticed that he was breathing faster than usual. She described him as a happy and healthy cat the day prior to his admission.

6. Ms AI spoke to the Respondent who told her to bring the cat in that same evening. Ms AI got to the Practice around 22.30/22.40. Ms RG a Registered Veterinary Nurse (RVN) met her and they went into a consultation room.

7. The Respondent used a stethoscope to listen to Moustache's heart and lungs. Ms AI described that the Respondent then went on to take Moustache's rectal temperature using a thermometer despite Ms AI objecting to this. Ms AI described the Respondent ignoring her and carrying on attempts to take the cat's temperature. She said that the Respondent behaved very aggressively towards the cat whilst trying to restrain it for its temperature to be taken.

8. The Respondent was present throughout the consultation but Ms RG was in and out of the consultation room. The Respondent asked Ms RG to help restrain the cat. Moustache continued to struggle, and Ms AI reported that he was 'slumped' and 'flopped on the table' and barely breathing.

9. Ms RG recalled that she noticed that Moustache was 'almost panting'. He was breathing with his jaw wide open. She was concerned that he was open mouth breathing after a temperature check. Moustache was therefore taken by Ms RG to the oxygen tent at the back of the Practice. The door was open so Ms AI stated that she could see what Ms RG was doing.

10. Ms RG stated that Moustache's condition improved whilst he was in the oxygen tent.

11. The Respondent said he was going to perform X-rays, Ms AI agreed to these being taken. Ms AI was not told what may be wrong with Moustache. The Respondent also explained that he was going to conduct blood tests.

12. Ms AI recalled, following the difficulties in taking a rectal temperature, that she was scared and did not trust the Respondent to perform the X-rays safely with anaesthetic. The Respondent said to Ms AI that they could try and take X-rays without anaesthetic. Ms AI said that she specifically said that she did not want Moustache sedated. She said,

"Moustache is my life, he's my world, he's my everything, it will destroy me if anything happened to Moustache. He must not be put at risk, he must not be sedated, I do not want him to be sedated."

13. The Respondent told Ms AI that the fee would be £1,300 and she paid a £500 deposit. She was given two forms by the Respondent. He asked her to sign one. Ms AI could not read them without her glasses (which she did not have with her). She asked what the form to sign said and the Respondent explained it was to consent to the X-ray. She therefore signed it.

14. She was not given copies of any forms. Ms AI stated she was shocked as the contents on the forms were not explained to her by the Respondent and if they had been she would not have signed them**.** She had been unable to read the Declaration on the form.

15. Ms AI asked if she could stay and wait while the X-rays were taken as she stated that she was scared to leave her cat with the Respondent. She was told to go home, and she would be contacted with any updates. Ms AI expected that the Respondent would call her if he was unable to do the X-rays without sedation.

16. Before leaving Ms AI saw Moustache in the oxygen tent, alert and sitting up tall. She said goodbye and left at about 23.50.

17. Sometime later, the Respondent took Moustache out of the oxygen tent to obtain X-rays. He appeared to be breathing normally and was settled. The Respondent decided that Moustache would not be intubated during the X-rays and would instead wear an oxygen mask so that was ready on the table**.** Ms RG recalled that the Respondent administered Alfaxalone to Moustache. She understood that Alfaxalone is a sedative drug. Ms RG could not recall which room they were in when the Respondent administered the Alfaxalone to Moustache as both rooms have the equipment needed. Ms RG was holding Moustache and she saw the Respondent administer the Alfaxalone in front of her. He drew this up and he may have said, "*I'm going to give Alfax now*". Ms RG stated that she was shocked to see Alfaxalone being given to Moustache all in one go, quite fast, by the Respondent. Ms AG thought that he gave the cat around 1.5 millilitres of Alfaxalone.

18. Ms RG stated that she did not think any attempts were made by the Respondent to take X-rays without sedation as Moustache was in the oxygen tent throughout the time before the X-rays were taken.

19. Moustache then started to go to sleep, as expected. Ms RG placed the oxygen mask on him. They were able to take one image which is time stamped at 03.18. Ms RG then noticed that Moustache's gum was going blue. This is a sign that the patient is not oxygenating correctly, and that there is an urgent problem. He was still breathing and had a heartbeat. Ms RG immediately told the Respondent that the cat was going blue.

20. Ms RG said that the Practice did not have any endotracheal (ET) tubes or crash equipment in the X-ray room so she ran to the 'crash box', which was around seven metres away from the X-ray room, gathered equipment and took it back into the X-ray room. She recalled that this would have taken around 30 seconds. She brought with her breathing tubes, a laryngeal scope (which holds the patient's tongue down), adrenaline and syringes in case Moustache's heart had stopped after she ran out of the room.

21. On her return to the X-ray room, Ms RG states that the Respondent was standing next to Moustache who was on the X-ray table. Ms RG recalled that the Respondent then said words to the effect that she was not to worry, there was no point and that the cat was gone. Ms RG had expected to find the Respondent doing chest compressions or trying to open Moustache's mouth/airways, but he was just standing still next to Moustache. She stated that she was shocked, as she had been out of the room for such a short period of time. She recalled that she could not understand why they would not even try to resuscitate Moustache with adrenaline. Ms RG did not think it was possible that the Respondent could have carried out chest compressions while she was getting the crash equipment.

22. The Respondent said that he attempted to resuscitate Moustache and had given chest compressions to him, based on his recollection and the clinical record. He also said he intubated Moustache with an ET tube. Ms RG stated that she had not seen him intubate or give chest compressions to Moustache at any time although she said she was out of the X-Ray room to get the 'crash box' which was 7 metres away for only about 30 seconds. The Respondent said she was out of the room for about a minute or so.

23. At 03:25 the Respondent called Ms AI and told her that her cat was dead. This was a huge shock to Ms AI as she recalled he was alert and well the last time she saw him. Ms AI stated that when she asked how this could have happened, the Respondent said that "he *was taken out of the oxygen tank and put on the X-ray table, and then turned blue and* died". The Respondent did not answer her questions but repeated this same phrase. She stated that she tried to ascertain what had actually happened repeatedly but was not told. Ms AI was distraught after the call. An hour later she decided to go to the Practice to see Moustache's body.

24. Ms RG prepared Moustache for Ms AI to see when she returned. She said that she did not have to remove any ET tube as none had been used. The Respondent said he had used an ET tube and that the nurse must have removed it.

25. When Ms AI returned, Ms RG did not see or hear the Respondent speak to her. The Respondent said that he did not want to speak to Ms AI. Ms RG spoke to her instead. As she was confused about what had happened to Moustache she looked at his file before the end of her shift that night. She stated that she definitely did not see notes about Moustache's death in the file. Ms RG observed that it was noted in the clinical history that the Respondent attempted to intubate Moustache and that he passed an ET tube. Ms RG confirmed that this did not happen.

26. The Respondent did not come out to see Ms AI when she asked for him. Ms AI was at the Practice for 2 hours. She recalled that she did not see any other clients or animals.

27. Ms RG told Ms AI that Moustache was taken out of the oxygen tank, the Respondent gave him sedation/anaesthetic and then within minutes he turned blue and died. Ms AI recalled that Ms RG said that the Respondent gave it all in one go. Ms AI recalled that she asked Ms RG if the sedation could have killed Moustache and Ms RG said yes.

28. Ms AI later met with Dr C MRCVS, the Lead Vet at the Practice to discuss what had happened to Moustache and to get the paperwork relating to his clinical records, sedation sheet, blood test and X-ray result. Dr C explained how a sedation drug should be administered to a patient. He said he would not be employing the Respondent again. He apologised and said that Ms AI had the Practice's sympathy and support.

29. Ms AI observed that the clinical notes recorded that Moustache “started going cyanotic” on the X-ray table. There is no reference to sedation or any drugs in the clinical notes. They suggest an attempt was made to intubate Moustache, an ET tube was passed and chest compressions were carried out but Ms RG had told her that this had not happened.

30. When Ms AI met with Dr C, she said that he explained that resuscitation should be attempted for between 5 and 15 minutes. Moustache collapsed at 03:18 and had passed away by 03:20**.** The College alleged that, as witnessed by Ms RG, the Respondent did not make any attempts to resuscitate Moustache.

31. The Respondent had been hired via a locum agency whom Dr C contacted. The agency then sent Dr C an email with the Respondent’s account of events. He did not have any direct communication with the Respondent. The email said

> *“Moustache was seen on the 22nd of april with tachypnea and swallow breathing.*
> *Physical examination revealed harsh sounds on both lung fields but no crackles.*
> *Heart sounded normally, no heart murmour was detected.*
> *Mucous membranes were pink, with normal CRT.*
> *His respiratory pattern was laboured with some respiratory effort.*
> *He was placed on an oxigen cage, an IV catheter was placed and bloods were taken for hematology and biochemistry, results were unremarkable.*
> *His breathing had improved slightly after being on oxygen supplementation for 1 hour.*
> *I decided to take some xrays and to give him a mild sedation with 1.5 ml of Alfaxalone.*
> *We was given oxygen suplementation while taking the radiographs but he started going cyanotic and stopped breathing. We tried to intubate him but his heart had stopped.*
>
> *I realise now that he was not stable enough to be given any sedative and that this could have contributed to him crashing on the xray table,and I'm very sorry about this.”*

32. Dr C cancelled the invoice for the treatment of Moustache as a goodwill gesture and informed Medivet about the complaint. Dr C recalled that Ms RG stated that an anaesthetic chart was not completed for Moustache.

33. Ms RG also stated that in a case where a patient has died, she would expect to have a de-brief with a vet. This did not take place with the Respondent.

34. The College called expert evidence from Dr Christine Shield BVM&S MRCVS. In her report she stated that

"The radiograph shows congestive heart failure, with an enlarged heart and serious. pulmonary oedema. Had Moustache survived this episode and was able to be treated (noting that the clinical notes say on 12 April 2019 (page 3-26 of the bundle, page 66 of the PDF) that "O [owner] cannot tablet") he can reasonably have been expected to live only for a matter of weeks or months, as heart disease in cats usually progresses rapidly."

35. Dr Shield stated in oral evidence that it was likely that Moustache would have appeared healthy to its owner despite this condition and that what was seen on the X-ray was in her experience not due to 'rough handling' by a human or even from a traumatic injury e.g. like a road accident. She said that since Moustache had been left calmly in the oxygen tent, any 'rough handling' by the Respondent if it took place would have had a minimal or no adverse effect on Moustache when Alfaxolone was later administered.

36. Dr Shield also stated that the dose of Alfaxolone was about half the recommended dose for a cat such as Moustache and if that had not been used with any other drugs then it would not have been an excessive amount of medication for Moustache. She said she had not used it as a pre-med or alone for sedation.

37. Dr Shield explained in oral evidence the use of an ET tube and resuscitation. She said that usually the insertion of such an ET tube required two people although it was possible to do it single-handedly.

38. Medivet Head office explained that when the Respondent was booked to work as a locum it was noted that he must have his own Professional Indemnity Insurance (PII) cover in place**.** The Respondent's letter of appointment from Medivet also made this clear to him.

39. In relation to Allegation 4, the Respondent told the College in correspondence

"*At the time of the incident, I have just started locuming. I made a mistake to do some shifts before arranging my VDS cover. I realise now that this was unwise*"

40. In further correspondence with the College, the Respondent admitted this and stated that it was a mistake he now regrets.

41. The Respondent's case was set out in a statement from him. He also gave oral evidence.

42. In his statement he said his recollection of events was not clear due to the passage of time. He said he was not aggressive in handling Moustache but he may have persisted in trying to obtain a rectal temperature as he felt it was important from a clinical point of view. He may have stopped attempting to take Moustache's temperature as it was proving challenging and upsetting for Moustache.

43. He was confident he had explained his differential diagnosis and what was required in order to try and establish a diagnosis as he would always do this. He said that he would have explained to Ms AI that it may be necessary to sedate Moustache in order to obtain a chest X-ray because Moustache was a fractious cat. He accepted that she had told him she did not want Moustache sedated. He said that the consent form did not refer to sedation or anaesthesia in the part marked proposed treatment although it referred to the risks of anaesthesia but he accepted that he had not obtained Ms AI's informed consent regarding sedation.

44. The Respondent said he was certain he did not give Moustache any pre-medication. He said once it became clear that he could not X-ray Moustache without sedation he gave him a small dose of Alfaxolone intravenously. He could not remember the dose given but he was certain he would not have given him a large bolus quickly. He accepted that he had not recorded the use of Alfaxolone nor the dose in Moustache's clinical record. He said the reference to 1.5ml made in his email response to Mr C (via the locum agency) was made without the benefit of reviewing the clinical record. He accepted the use of Alfaxolone was with the benefit of hindsight an error of judgement in a cat with breathing difficulties and he offered his sincere apologies to Ms AI. He also accepted that not advising her of its use may be viewed as dishonest and as a result he was at risk of bringing the Veterinary profession into disrepute.

45. Regarding the clinical record, he said "*I find it difficult to believe I would have written the fact that an ET tube was placed and chest compressions were carried out if this was not the case. I accept that in my initial response to Mr C* [redacted] *I mentioned that intubation was attempted, implying it was not achieved however again this was written without the benefit of viewing the clinical records."* He said he would not fabricate clinical records and that the notes as recorded are accurate.

46. In oral evidence he confirmed his admissions and also said that he had made a mistake in agreeing to do the X-ray without sedation to Ms AI. He agreed that he did not have the consent of Ms AI to sedate Moustache despite the consent forms having been completed.

47. He maintained that he had done chest compressions whilst Ms RG was out of the room at the 'crash box' and that he had also inserted an ET tube into Moustache whilst she was out of the room. He agreed that he had attempted to resuscitate Moustache for about 'one minute or so' and that by the time Ms RG had returned he had stopped because he believed that Moustache was dead.

48. He agreed that he chose not to see Ms IA when she returned and that he should have done so.

49. He denied lying in the clinical record about intubation and chest compressions.

50. He said he recalled there was an ET tube (one which was the correct size) which was in the X-ray room. He said he used this but he accepted that he should have made more efforts to resuscitate Moustache and that was the reason he had made the admissions he had to the charges. He denied lying in the clinical record to say a tube had been used to intubate when it had not and he said that he had given some chest compressions in the minute or so before Ms RG returned. He denied that in writing what he had in the notes he had been dishonest or misleading.

51. The Respondent said he completed his notes at the end of his shift after Ms RG had left. He said he had not focused in his notes on the differential diagnoses and the treatment plan because Moustache had died. He admitted that his failure to record these matters in the notes was inadequate.

52. The Respondent agreed that in previous correspondence with the College or with Mr C he had not given any detail about intubation or chest compressions as he had in his oral evidence.

53. Ms S K[redacted] RVN gave oral evidence about having worked with the Respondent and his good character. She said they had done several night shifts together and that the Respondent had acted compassionately and explained matters to her as an RVN and others. She said that she had seen him explain matters to others with a friendly and

understanding approach and that he adapted well towards animals if they were fractious or nervous.

Decision on Facts

54. The Committee considered all the documentary and oral evidence. It considered carefully the Respondent's evidence and took into account in his favour the good character evidence he had called and submitted.

Allegation 2(b) : recorded in clinical records for Moustache that when Moustache became cyanotic (i) a tube had been passed in order to intubate and (ii) chest compressions had been given, when he had not been intubated and/or chest compressions had not been given.

55. The Committee considered carefully the evidence of the Respondent and Ms RG RVN. It also took into account the clinical record and notes and emails made by both witnesses following the events on 22/23 April 2022.

56. The clinical notes recorded "*attempted to intubate, there was copious amount of mucous in the throat. Managed to pass et tube and started giving him chest compressions but he stopped breathing and his heart stopped. Passed away at 3:20am".*

57. Ms RG was clear that she had not seen the Respondent give any chest compressions or intubate Moustache at any time, although she agreed she was out of the room for a short period of time after Moustache became cyanotic to get equipment from the 'crash box' which she said was about 7 metres away.

58. The Respondent stated he had done some chest compressions whilst Ms RG was out of the room. The Committee decided that it was possible that he could have done some chest compressions in that short period of time unseen by Ms RG. It therefore was not satisfied so that it was sure that chest compressions had not been given. It considered giving of chest compressions to be the likely practice of any veterinary surgeon when faced with a patient that 'crashed'.

59. As regards intubation, the Committee was satisfied so that it was sure, that the Respondent had not intubated Moustache and that no ET tube was used by him. It noted that Ms RG, who it found to be a credible witness, said in her evidence that she had not had to remove any tube before preparing Moustache to be seen by Ms AI. The Committee also decided that the use of an ET tube would not have gone unnoticed by Ms RG and that had an ET tube have been used, Ms RG would have been remembered it.

60. Furthermore, the Committee concluded that the account given by the Respondent was not credible, regarding how he had found an ET tube in the X-ray room, which was the correct size for Moustache (out of approximately fifteen different-sized ET tubes likely to be available in a veterinary practice). Further his detailed account was not one which he had described prior to giving oral evidence to anyone who had sought his account of events in writing. The Committee concluded the account was therefore untrue.

61. The Committee considered that it was more likely that in circumstances described the Respondent would have waited for Ms RG to return with equipment from the crash box if he was going to intubate Moustache and that he would have sought her assistance to intubate as it was a 'two person' job which Dr Shield had described.

62. Further the Committee considered that the Respondent would not have had sufficient time to intubate Moustache in the time that Ms RG was not present. The Committee also accepted the detailed evidence given by Dr Shield regarding the process of intubation and resuscitation and it noted that the process of intubation required some time which would in the Committee's view have been longer than the Respondent had available whilst Ms RG was out of the room at the 'crash box'.

63. The Committee therefore concluded that the Respondent had not intubated Moustache, and that he had written that he had in the clinical record to cover up what he had not done.

64. The Committee was therefore sure that when the Respondent had recorded in clinical notes for Moustache (i) 'a tube had been passed in order to intubate' Moustache had in fact not been intubated. It therefore found Charge 2(b)(i) proved.

65. Since it was unsure as to whether the Respondent had given chest compressions for a short period whilst Ms RG was out of the room as he said he had, the Committee found

Charge 2(b)(ii) unproved. It noted that in any event the Respondent had admitted that he had failed to take adequate steps when Moustache required emergency attention (Charge 1(b).

Allegation 3(a) in relation to 2(b) – Dishonesty

66. The Committee concluded that when the Respondent wrote in the records that 'managed to pass ET tube' he had done so deliberately and dishonestly in order to cover up the fact that he had not intubated Moustache and not taken sufficient steps when he required emergency attention. It found that his conduct in writing these assertions in the clinical record when he had not carried out intubation was dishonest applying the test for dishonesty set out in the case of Ivey v Genting Casinos (UK) Ltd trading as Crockfords [2017] UKSC 67.

67. The Committee therefore found this Charge proved.

Allegation 3(b) in relation to 2(b) - Misleading

68. Having decided that the Respondent had recorded in clinical notes for Moustache that when Moustache became cyanotic (i) a tube had been passed in order to intubate, when he had not been intubated, and that this was dishonest it follows that such conduct was also misleading.

69. The Committee therefore found this Charge proved.

Allegation 2(c) : failed to make adequate clinical records in relation to your differential diagnoses and/or your proposed treatment plan

70. The Committee noted that the Respondent accepted in evidence that he had not written in the clinical records any differential diagnoses and any proposed treatment plan and that he had admitted these parts when he gave oral evidence despite having denied it when the charge was put to him at the start of the hearing.

71. The Committee accepted the Respondent's account that he had written the clinical notes at the end of his shift after Ms RG had gone. The notes included a record of the time of death of Moustache so it was likely he had written them when he said.

72. The Committee was not persuaded that at the time the Respondent was writing the notes, after Moustache had died, that he did in fact have a duty to specify differential diagnoses or a treatment plan because Moustache had already died. Moustache had started down a diagnostic pathway (blood, X-ray) when he died. As such, the time had not been reached where informed differential diagnoses had been arrived at, let alone a treatment plan. In the Committee's view, it is therefore not reasonable for these to be created post-mortem. It did find that the results from the X-ray should have been documented in the clinical history.

73. Although Dr Shield had opined on this charge in her oral evidence and in her written report on this charge, stating that the Respondent had such a duty and the absence of any note suggested a failure to make an adequate note in that regard. The Committee observed that when she had opined on this in her written report she had referred to "*failed to make adequate clinical records in relation to Moustache's clinical condition and/or your clinical findings and/or your differential diagnoses and/or your proposed treatment plan".* The Committee noted that parts of the wording she had opined on were not replicated in Charge 2(c), specifically in relation to '*clinical condition*' or '*clinical findings'*. Her written opinion was predicated on the need for these matters to be included had Moustache survived.

74. Accordingly, the Committee questioned Dr Shield about Charge 2(c) when she gave evidence. She confirmed that in her view a locum veterinary surgeon had an obligation to record such matters in the clinical record so that any further Veterinary surgeon taking over the care of Moustache at a later date would know what had happened. However, her written and oral opinion did not take into account that at the time of writing the clinical notes Moustache had died. The Committee therefore decided that despite the Respondent's admissions to this charge whilst he was giving evidence and Dr Shield's opinion, that no account had been taken of the fact that the Respondent had no duty to

include differential diagnoses and a treatment plan in the clinical notes after Moustache had died.

75. It therefore found Charge 2(c) not proved.

76. The Committee therefore found the following charges proved:

- Charges 1(a), 1(b), 1(c), 2(a), 3(a) in relation to 2(a) and 3(b) in relation to 2(a) and Charge 4.
- Charge 2(b)(i)
- Charge 3(a) in relation to Charge 2(b)(i)
- Charge 3(b) in relation to Charge 2(b)(i)

77. The Committee found the following charge not proved

- Charge 2(b)(ii)
- Charge 2(c)

DISGRACEFUL CONDUCT IN A PROFESSIONAL RESPECT

78. The Respondent admitted disgraceful conduct at the start of the hearing when the charges were read to him. He made no further oral submissions on disgraceful conduct in a professional respect.

79. The College made submissions that there were the following aggravating factors in this case which were relevant to any determination on disgraceful conduct in a professional respect.

- b. Risk of injury to an animal or human
- c. Dishonesty, lack of probity or integrity

80. Dr Shield was of the opinion that the conduct of the Respondent fell far below that to be expected of a reasonably competent veterinary surgeon as regards:

- Sedating Moustache for radiography in the absence of his owner's informed consent (Allegation 1 (a))
- Failing to make any attempt to resuscitate Moustache when he became cyanotic (Allegation 1(b))
- Failing to record the details of sedation/anaesthesia given to Moustache (Allegation 2 (a))
- Recording that he had attempted to resuscitate Moustache when he did not do so (Allegation 2 (b))

81. Dr Shield was of the opinion that the conduct of the Respondent fell below that to be expected of a reasonably competent veterinary surgeon as regards:

- Failing to provide adequate details to Ms AI before and/or after Moustache's death, more particularly the results of tests and/or the administration of sedative/anaesthetic and/or the reasons for treatment given and/or the details surrounding Moustache's death and /or the likely cause of death (Allegation 1(c))

82. Dr Shields stated overall, that when viewing all of the issues cumulatively in respect of this case, should the Committee find the facts proven on each, it was her opinion that the Respondent's conduct fell far below that to be expected of a reasonably competent veterinary surgeon.

83. In summary the College submitted that the Respondent's conduct ran contrary to a number of fundamental principles of the profession: the promotion of animal welfare, the failure to obtain informed consent and honesty. It constituted both a breach of trust and an abuse of the Respondent's position with regards to access to veterinary medicines. It had the potential to undermine the integrity of clinical records in relation to Moustache. In the College's submission, the behaviour fell far short of the conduct expected of a member of the profession and amounts to disgraceful conduct in a professional respect.

Decision on Disgraceful Conduct in a Professional Respect

84. The Committee took into account the admission by the Respondent and the submissions of the College regarding disgraceful conduct in a professional respect.

85. The Committee noted the The RCVS Code of Conduct for Veterinary Surgeons (the Code) provides the following which are relevant to this case and which the Respondent breached

- *1.1 Veterinary surgeons must make animal health and welfare their first consideration when attending to animals*

- *1.3 Veterinary surgeons must provide veterinary care that is appropriate and adequate*

- *2.1 Veterinary surgeons must be open and honest with clients and respect their needs and requirements*

- *2.4 Veterinary surgeons must communicate effectively with clients, including in written and spoken English, and ensure informed consent is obtained before treatments or procedures are carried out.*

- *Section 11.2 of the supporting guidance to the RCVS Code of Professional Conduct for Veterinary Surgeons says*

  Informed consent, which is an essential part of any contract, can only be given by a client who has had the opportunity to consider a range of reasonable treatment options (including euthanasia and the option to monitor the animals without further tests or treatment), with associated fee estimates, and had the significance and main risks explained to them. In all cases, unless it would cause a delay that would adversely affect the animal's welfare (i.e., in an emergency) the client's consent to treatment must be obtained. For non-urgent procedures, where possible, the consent discussion should take place in advance of the treatment.

- *Section 11.6 says that "Consent forms should be viewed as an aid to consent, in conjunction with a discussion with the client".*

- *2.5 Veterinary surgeons must keep clear, accurate and detailed clinical and client records.*

- *3.4 Veterinary surgeons must ensure that all their professional activities are covered by professional indemnity insurance or equivalent arrangements.*

- *6.5 Veterinary surgeons must not engage in any activity or behaviour that would be likely to bring the profession into disrepute or undermine public confidence in the profession*.

86. The Committee also noted from the Disciplinary Committee's Procedure Guidance (updated in August 2020) (paragraph 76) provides:

"*Proven dishonesty has been held to come at the 'top end' of the spectrum of gravity of disgraceful conduct in a professional respect. In such cases, the gravity of the matter may flow from the possible consequences of the dishonesty as well as the dishonesty itself. The Privy Council has, in a case involving dishonesty, provided guidance on the distinction between removal and suspension from the register".*

87. The Committee decided in respect of Charge 1(a), that individually this amounted to disgraceful conduct in a professional respect. It concluded that at the time the Respondent saw Moustache there was no clinical imperative on the Respondent to sedate and X-ray Moustache and the Respondent's decision to do so, in direct contravention of Ms IA's wishes, was serious misconduct which fell far below that to be expected of a reasonably competent veterinary surgeon.

88. The Committee decided in respect of Charge 1(b) that the Respondent's failure to take adequate steps when Moustache required emergency attention was in contravention of the guiding principles of the Code requiring veterinary surgeons to make animal welfare their first consideration when attending to animals. The Committee therefore agreed with the opinion of Dr Shield and found this to be conduct which fell far below the standard to be expected of a reasonably competent veterinary surgeon.

89. The Committee noted the opinion of Dr Shield regarding Charge 1(c), failing to provide adequate details to Ms AI after Moustache's death, as conduct which fell below the standard to be reasonably expected. However, the Committee decided that this was misconduct which fell far below the standard, because the consequential sequence of this failure exacerbated the disregard the Respondent had for Ms AI's wishes (Charge 1(a)). This, and his decision when he spoke to her not to answer questions to explain Moustache's death and his later refusal to speak to her when she attended the practice leaving RVN Ms RG to do so, was conduct which was in the Committee's judgment serious and fell far below what was to be expected. Furthermore, the Committee took into account that this type of conduct undermined the reputation of the veterinary profession.

90. The Committee agreed with the opinion of Dr Shield regarding both Charges 2(a), 3(a) in relation to 2(a) and 3(b) in relation to 2(a). It determined that his dishonest and misleading actions by failing to record the details of the sedation and anaesthesia was done with a view to seeking to cover up his wrongdoing and must have caused Ms AI undue upset because she could not understand why her cat had died.

91. Furthermore, the Committee decided that his failure to record the sedation in the clinical record was serious because it was in direct contravention of the Code and the need for such clinical records to be an accurate representation of what had happened when an animal was under the care of a veterinary surgeon.

92. The Committee had found Charge 2(b)(i) and Charge 3(a) in relation to Charge 2(b)(i) and Charge 3(b) in relation to Charge 2(b)(i) proved in relation to the Respondent. It was satisfied that he had not intubated Moustache but had dishonestly and misleadingly concocted the clinical records to cover up what he had not done. The Committee agreed

with Dr Shield that such conduct once proved fell far below the standard of what was to be expected of a competent veterinary surgeon.

93. Finally in respect of Charge 4, the Committee noted that the Respondent had no insurance in place at the time he took on the locum shift and when he treated Moustache. The purpose of PII was for veterinary surgeons to cover compensation claims in the event that an allegation of negligence is made. It agreed with the opinion of Dr Shield who stated that this failure was conduct which fell below the standard to be expected of a competent veterinary surgeon.

94. It follows therefore that cumulatively, having considered the above matters and reasons set out, the Committee decided that the Respondent's actions amounted to disgraceful conduct in a professional respect.

SANCTION

95. The College made no representations on sanction but confirmed that the Respondent had no previous disciplinary history.

96. The Committee took into account the statement and submissions provided by the Respondent. It noted that he asked the Committee to impose a warning or reprimand or if that was considered not appropriate, a short suspension.

97. The Committee also took into account the oral evidence from Ms K[redacted] RVN and the supportive testimonials and character references before it. It also referred to the Disciplinary Committee Guidance and paid regard to those sections referring to dishonesty, the need to be consistent whilst also paying regard to the specific facts of this case.

98. In summary, the Respondent asked the Committee to take into consideration the following matters in mitigation:

- He unreservedly respected and accepted the findings of the Committee
- This was a single isolated incident.

- He had no adverse disciplinary record with the RCVS or any other professional regulator.
- He had suffered greatly from the consequences of his actions…. it had adversely affected both his personal relationships and those with family members. [redacted]
- He was terrified he might lose the opportunity to continue in his chosen vocation that he enjoyed and was so proud of.
- He very much regretted bringing the veterinary profession, which he cherished, into disrepute.
- The public finding of conduct disgraceful in a professional respect, which he unreservedly accepted, brings him deep shame.
- He had shown considerable insight into his actions
- He had learnt so much from this process
- He had immediate regret following the events of the night in question
- There is no risk of a repetition.
- He had moved away from locum and night work.

99. The Respondent asked the Committee to sanction him leniently, believing that he still had a positive contribution to make to the veterinary profession. He said that he was currently employed full time as a Lead Vet in a busy practice. He said the practice is aware of this Hearing and the charges against him and have been very supportive. They had given him some time off.

100. The Respondent also put before the Committee other Sanction decisions which he said were similar to his own case and involved findings of dishonesty. He asked the Committee to consider those in order to make a similarly lenient finding.

The Committee's Decision on Sanction

101. The Committee found the following aggravating factor, taking care not to find dishonesty or breach of trust as aggravating factors since both of those were part of the charges it had found proven:

a. Actual injury to an animal or human.

102. The Respondent had chosen to sedate Moustache and although he had a heart condition which was evident from the X-ray, the sedation of Moustache which immediately preceded his death. This had caused extreme grief and upset to Ms AI which was exacerbated by the fact that the Respondent would not explain to her what had happened or that he had acted against her wishes until he later admitted in an email to Mr C that he had sedated Moustache.

103. The Committee found the following mitigating factors:

- The Respondent had no previous disciplinary history
- The Respondent had worked at the time of this incident for approximately eight years as a veterinary surgeon in the United Kingdom without complaint
- He had made admissions regarding most of the charges
- He had made subsequent efforts to avoid repetition by no longer working night shifts or locuming.
- The incident related to one animal.

104. The Committee determined that the Respondent had shown some appreciable insight and remorse into his behaviour in his emails, written statement and submissions. It appeared to the Committee that the disciplinary hearing had been a salutary experience for him.

105. The Committee noted that there were positive character references about the Respondent and his work although the Committee might have benefitted from a reference from his current employer.

106. The Committee assessed that the dishonesty it had found in this case was in the middle to upper end of the scale of dishonesty because it involved dishonesty in relation to Ms AI, emergency procedures not carried out, and in respect of clinical records.

107. The Committee first considered whether a sanction of no further action was appropriate. It decided a sanction was necessary for a case which was so serious. It then went on to consider if judgment should be postponed. Since there was no invitation to postpone judgment and there was no good reason to do so, it decided to consider the available sanctions in ascending order of seriousness.

108. The Committee decided that a reprimand or warning was not appropriate in this case where the Respondent had sought to cover up his wrongdoing and where he had not made full admissions with full insight. It concluded that such a sanction would not protect the wider public interest or indicate how serious the Committee found the misconduct in this case to be. Further such a sanction was appropriate for conduct which was at the lower end of the spectrum of gravity. Although the Respondent had provided cases of dishonesty where there was a sanction of a reprimand or warning, the Committee noted that in this case there were not full admissions regarding the Respondent's dishonesty and that he had specifically gone against Ms AI's express wishes not to sedate Moustache. It therefore considered that this case was distinguishable on its facts from the cases put before it.[1]

109. The Committee considered whether in this case the appropriate and proportionate sanction was a sanction of suspension and if the misconduct overall in this case was sufficiently serious to warrant more than a reprimand but not sufficiently serious to justify removal from the register. It noted that the Disciplinary Committee Procedure Guidance stated that "*Suspension has a deterrent effect and can be used to send a signal to the veterinary surgeon, the profession and the public about what is regarded as disgraceful conduct in a professional respect."*

110. The Committee decided that the Respondent's work record, which was without criticism both before and after this incident, and the fact that he had taken these

[1] Gurrin, Briggs, Evans and Surdila

proceeding seriously and expressed admissions and remorse were sufficient factors to persuade the Committee that he was unlikely to repeat similar conduct in the future.

111. The Committee did consider whether a sanction of removal was more appropriate but it concluded that a sanction of removal was punitive and not proportionate. Whilst the misconduct in this case involved breaches of the RCVS Code as set out above, caused serious harm to both Moustache and Ms Al and involved dishonesty which was concealed, the Committee decided that a lengthy suspension could take account of the seriousness of these matters and meet the wider public interest.

112. The Committee noted that the Disciplinary Committee Procedure Guidance stated at paragraph 74 " *that a disciplinary committee should not feel bound to remove from the register: An otherwise competent and useful [practitioner] who presents no danger to the public in order to satisfy [public] demand for blame and punishment".*

113. In deciding on this period of suspension the Committee took into account both the mitigating and aggravating factors set out above and all of the mitigation the Respondent had put before it. It was not persuaded that a shorter period of suspension would properly reflect the seriousness of the proven misconduct. It concluded that this period of suspension had a deterrent effect and sent a signal as to how serious the Committee had found the misconduct to be. It also took into account the Respondent's remorse and insight.

114. However, in order that the wider public interest was upheld and to reflect the Committee's view regarding the seriousness of the proven misconduct the Committee determined that the proportionate sanction and period of suspension should be a suspension order of 8 months.

115. The Committee therefore directs the Registrar to suspend the Respondent's registration for 8 months.