RCVS | SETTING VETERINARY STANDARDS

ROYAL COLLEGE OF VETERINARY SURGEONS

INQUIRY RE:

LIBBY MORRIS RVN

DECISION ON FINDING OF FACTS

Facts and Background

1. The charges against the Respondent relate to her conduct on Christmas Day 25 December 2020, when working at the Filham Park Veterinary Clinic in Ivybridge, Devon ("the practice"). She had worked at the practice since she was a student veterinary nurse, and in 2018 had qualified there as a Registered Veterinary Nurse (RVN).

The Charges

1. On 25 December 2020, in relation to Rocky, a German Shepherd dog who had undergone surgery that morning:

(a) left Rocky unattended between approximately 12:15 and 14:30; and/or

(b) made entries in the clinical records for Rocky indicating that you had made those entries at 14:00 or thereabouts when you had not done so; and/or

(c) at 13:41, sent a message to veterinary surgeon AJ which gave the impression that you were describing Rocky's contemporaneous condition and circumstances, when in fact you had not seen Rocky since some time before 12:15;

2. Your conduct in relation to 1(a) and/or 1(b) and/or 1(c) above was potentially detrimental to Rocky's welfare;

3. Your conduct in relation to 1(b) and/or (c) above was:

a. dishonest; and/or

b. misleading

2. At the outset of the hearing, the Respondent admitted the following charges:
   - Charge 1(a), 1(b), 1(c),
   - Charge 2 in relation to 1(a) and 1(b) and 1(c)
   - Charge 3(a) in relation to 1(c)
   - Charge 3(b) in relation to 1(b) and 1(c)
   - The Respondent also admitted that her conduct either individually or cumulatively amounted to disgraceful conduct in a professional respect.

3. The Respondent therefore denied the particular in charge 3(a) in relation to 1(b). That was the sole determination for the Committee on the finding of facts stage.

4. On Christmas Eve 2020, the practice closed at 16:00, from which point Dr Sarah Tompkins MRCVS and Ms Fiona North RVN were on call. In the early hours of Christmas Day, a German Shepherd named Rocky was admitted with Gastric Dilatation and Volvulus (GDV), a bloating and twisting of the stomach. This required emergency surgery. As Dr Tompkins was not experienced in this surgery, she contacted Dr Alan Johnson MRCVS, who had been the second on-call veterinary surgeon for Christmas Eve and was due to be on-call for Christmas Day. Dr Johnson arrived at around 05:45. As it was clear that Rocky would need to stay at the practice, Dr Tompkins texted the Respondent at approximately 05:00, to tell her that she would need to come in for her shift starting at 08:30.

5. Between 06:35 and 08:00, Dr Tompkins performed gastropexy surgery and splenectomy on Rocky, with assistance from Dr Johnson. The surgery went well.

6. The Respondent's shift was due to start at 08:30. At around 08:40, whilst still at home, she called Dr Johnson's phone and Ms North answered it. Ms North told her she needed to come into the Practice, and should hurry. The Respondent arrived at approximately 09:00. She explained that she had been asleep when Dr Tompkins had sent her text, and did not wake up until her alarm had gone off at 08:30. She said that she had set her alarm for 08:30 as she had not expected to come in.

7. Ms North gave a handover to the Respondent, including instructions with regards to Rocky, who remained an in-patient. She explained the surgery that had been performed and she went through the anaesthetic sheet, telling the Respondent when Rocky was next due to be given Methadone

8. Ms North and Dr Tompkins then left the practice.

9. Before the Respondent arrived, another dog had been admitted to the practice: a bull terrier named Ruby, who required surgery for removal of an intestinal foreign body. Shortly after the Respondent arrived at the practice, Dr Johnson proceeded with Ruby's surgery, assisted by the Respondent. The surgery started at 09:30 and ended at 10:40. The surgery was successful, and Dr Johnson took the view that Ruby could

be discharged home with pain relief and monitoring. He telephoned Ruby's owners to let them know, and arrangements were made for them to come and collect her.

10. Dr Johnson then gave the Respondent instructions with regards to caring for Rocky. He said that he verbally told her that she should check Rocky every hour, and if she had any concerns about him, she should call him. Dr Johnson then left the practice, at some point between 11:00 and 11:15.

11. At 11:27, the Respondent sent a WhatsApp message to Dr Johnson, asking whether, once Ruby had been discharged, and after she had done Rocky's checks, she could go home for a couple of hours:

    "Ruby is going in abit, once I have done rockys checks can I go home and come back in couple hours?"

12. Dr Johnson replied that she could. Their conversation continued by WhatsApp. He told her not to leave Rocky for more than 90 minutes. He asked when she would be going and she replied that she would probably go after she had checked Rocky at 14:00. Dr Johnson told her that this was all right, but that she should be back by 16:00, and she confirmed that she would be.

13. In fact, the Respondent did not wait until 14:00, but instead, after discharging Ruby to her owners, she simply left the practice at around 12:15/12:30, without telling Dr Johnson, thereby leaving Rocky unattended. This was recorded and later seen by her colleagues - on the practice's CCTV footage.

14. Before the Respondent left she made entries in Rocky's records, recording the time as 14:00, when it was not yet 12:30. These included a note that Rocky had been offered food and water, but was not interested, and that he had a pain score of 5 (which would mean that he did not require Methadone). She made a note in the records to recheck in two hours.

15. Rocky was then left alone at the practice from around 12:15/12:30. Dr Johnson believed that the Respondent was at the practice with Rocky at this time, and that she would not be leaving him until shortly after 14:00. He therefore made arrangements to come into the practice in the mid-afternoon, to fill the gap in Rocky's monitoring which he believed would be created after the Respondent had left.

16. At 13:40, when preparing to come into the practice, Dr Johnson sent a message to the Respondent to ask how Rocky was, and explained that he would be coming into the Practice between 14:00 and 16:00.

17. The Respondent, who at this point was at home, and had been for some time, replied to say that Rocky was doing well, and gave Dr Johnson the observations taken at 12:00/12:15 which gave the clear impression of being contemporaneous:

    "He good, pain score 5 so no methadone given, fluids now 2x maintenance Don't forget to do the alarm when you go x".

18. Dr Johnson explained that if Rocky's pain score had been 6 or above, then pain relief would have been given. He was satisfied that, as the score was 5, no pain relief was necessary at that point. He was of course unaware that no pain score had actually been assessed at 14:00. He planned to go into the practice at 15:00 to make sure Rocky was not left alone for too long.

19. In the meantime, the Respondent had taken a call from a client with a concern about their hamster, and she had made arrangements for the hamster to be brought into the practice. Dr Johnson therefore decided to come in earlier than planned, at 14:30, in order to see Rocky before then attending to the hamster.

20. When Dr Johnson arrived at 14:30, he found Rocky to in a poor condition: he was in lateral recumbency, moribund, hypertensive, his heart rate was 200 and he was "*generally in a very bad way*". Dr Johnson was concerned that the heart rate indicated that he was in pain. He thought Rocky had last been seen by the Respondent at 14:00, and he was concerned that there must have been a swift deterioration since then, given what the Respondent had reported.

21. Dr Johnson then dealt with the hamster, before doing further checks on Rocky at 15:00. He administered Methadone to Rocky at 15:00 and did further checks again on him at 15:30.

22. At about 16:00, the Respondent returned. By this time, she had been away for just over three and half hours. Rocky was in a concerning condition and Dr Johnson gave him further pain relief and an anti-nausea drug. He instructed the Respondent to check on Rocky every hour. He then left the Practice at around 16:30, returning shortly before 18:00 as the Respondent had called him to express concern about Rocky's continuing decline. When Dr Johnson returned, he found Rocky to be clinically worse. He performed an ECG and identified arrhythmia, for which he gave Rocky Lidocaine. Unfortunately, Rocky arrested shortly afterwards and died at around 18:30.

23. Dr Johnson remained concerned about Rocky's apparent swift deterioration from 14:00 and according to the hospitalisation sheets, there had been no checks on Rocky between 11:00 and 14:00. He therefore arranged a mortality and morbidity meeting with a veterinary colleague.

24. On 27 December 2020, the Respondent was back at the Practice working a night shift. In the early evening she sent a message to a colleague, Mr Raymond Male RVN. She asked if she could have the code to access the Practice's CCTV as she had heard some noises outside and was concerned about potential intruders. Mr Male did not wish to give her the code, but offered to come to the practice. The Respondent then told him that she had accessed the CCTV and that things had been sorted out and he did not need to attend.

25. In the following few days, Mr Male became aware that Rocky had died at the practice on Christmas Day, and knew that the Respondent had been on-call. He wondered whether this had been a reason for her to ask about the CCTV. He later watched the CCTV footage for Christmas Day (which was then wiped as a matter of routine after 28 days). The footage showed the Respondent leaving the Practice at around 12:15

and driving off. He spoke to Dr Johnson about this, and Dr Johnson showed Mr Male the message sent to him on Christmas Day at 13:41, saying that Rocky was "good" with a pain score of 5.

26. On Monday 11 January 2021, Mr Male spoke to the Respondent, telling her he was concerned that there was no record of any observations for Rocky between 11:00 and 14:00. The Respondent replied that she had monitored Rocky during that period but had not recorded the observations. Mr Male asked whether she was sure that this was the case and whether she was telling the truth, to which she replied that this was what had happened. He told her that they had CCTV footage and she replied that she knew this. Mr Male then ended the meeting, but about two minutes later, the Respondent came back into the room and said the reason for the absence of observations was that she and Dr Johnson had been operating on another patient at the time. Mr Male told her that he had looked at the anaesthetic chart for the other patient and seen that surgery had ended at 10.40.

27. The Respondent then sent a message to Dr Johnson asking if he had said anything to Mr Male about Christmas Day. He said that he had done so, and told her to be open and honest. She said she had been, and then complained that she was, "*so over being permanently judged here. I work my fucking ass off and all I get is shit in return*".

28. On 13 January 2021, the Respondent asked to see Mr Male, and the two of them went into the nurse's flat to talk. The Respondent immediately said that she had not been honest with him about what had happened on Christmas Day. She said she had left the building after discharging Ruby around 12:00 and was aware that there was CCTV evidence of this. Mr Male said that she admitted that the 14:00 entries on the clinical records for Rocky were false, as she had not been at the practice at that time.

29. There was then an internal investigation at the practice. At a disciplinary meeting on 27 January 2021, with Ms Jennifer Stone RVN, the Respondent admitted that she had left the practice on Christmas Day earlier than she had told Dr Johnson. She stated that the observations she had recorded for Rocky were correct but they had not been taken at 14:00. She said she recorded the observations before she had left i.e. between 12:15/12:30. She said she had left because of family pressure, and she accepted that if she had stayed then Rocky would have had better monitoring. She said she felt very guilty and was sorry.

30. The Respondent was dismissed from her employment.

31. On 3 February 2021, the Respondent sent an email to the practice saying she wished to appeal against this decision. She stated that she had decided to go home earlier on Christmas Day, and come back earlier, but accepted that she had not told Dr Johnson this, and that she should have done. She said that she had pre-written the time of 14:00 in Rocky's records before she had decided to go, and then she had forgotten to change it to the time when she had actually taken and entered the observations. She did not address the message she had sent to Dr Johnson at 13:40.

32. On 4 February 2021, there was an appeal hearing, heard by Sam Blackman RVN. In the appeal meeting the Respondent repeated that she had forgotten to change the

time of 14:00 because she had written that time to remind her to carry out observations at that time and that she not changed the time when she carried out the observations by mistake. The appeal was dismissed.

33. She later made that same assertion about writing the time of 14:00 as a prompt and then forgetting to change it to 12:00 to the College in a letter dated 14 June 2021.

34. The matter was reported to the College, and the Respondent was asked for her comments. On 14 June 2021, she wrote to the College, setting out an account similar to that contained in her email of 3 February 2021.

35. There was no dispute between the parties that the Respondent had filled in the observations on the clinical records before leaving nor was there any dispute that she had left the practice around 12:15/12:30.

The College's case on Charge 3(a) in relation to 1(b)

36. In summary, Ms Curtis on behalf of the College submitted that the Respondent in making those entries at 14:00 in the records, was acting dishonestly to cover her tracks, so as to make it look like she was still at the practice with Rocky at 14:00 even though she knew she would not be there at that time.

37. She submitted that not only were the clinical records and the message misleading, but they were also deliberately misleading, and therefore dishonest. She submitted that in making the entries at 14:00, the Respondent intended to be dishonest at the time she wrote the entries so that anyone reading the records would not know she had left the practice earlier.

38. The College relied on evidence from five witnesses including Dr Johnson and Mr Male. Mr Male stated that it was not his practice to write times into a clinical record as a prompt. Dr Johnson stated that he had seen some nurses write in the hour as a prompt on clinical records. Mr Male said it was possible that the Respondent had mentioned the explanation about pre-written timings when he had met with her on 13 January 2021, although he had not written it down in the meeting note.

39. Ms Curtis submitted that it was wholly implausible that the Respondent would have written 14:00 as a prompt. Further, she submitted that if the Respondent had written the time in as a prompt she would have written other prompts in the records and there were none. She also submitted that even if the Respondent had written the time in as a prompt she would have changed the time to the correct time when she came to fill in the observations for Dr Johnson which he made at 15:00.

40. Ms Curtis also relied on the fact that the Respondent did not give this explanation for not being dishonest about the time she had written the records until she wrote her email of 3 February 2021. This was despite having several earlier opportunities to do so, including at the disciplinary hearing on 27 January 2021. She also referred the Committee to the cross which the Respondent had marked under 14:00 in the medication section of the hospitalisation sheet to indicate no methadone given at this time.

41. Ms Curtis further on the fact that the Respondent had asked to access the CCTV shortly after 25 December 2020 because she was seeking to check the evidence and see if she had been recorded leaving the practice earlier than she had said she left.

The Respondent's case on Charge 3(a) in relation to 1(b)

42. The Respondent denies being dishonest in respect of the entries in the clinical records. She states that she made the entries recording 14:00 as a prompt/aide memoir to herself so that she would remember to record the observations at 14.00 and that she therefore made a mistake when she did not change the time when she filled in the notes earlier before 12:15/12:30.

43. The Respondent gave evidence that she wrote 14:00 in three clinical records: on the hospitalisation sheet and in the comments section (of the hospitalisation sheet) and on the pain score sheet. The Respondent said when writing those times she did so earlier on to prompt her to record observations later on at 14:00. She said that was something that she did regularly and, although she has changed her practice since this case, she was never advised not to do that or told that it was bad practice. She said it would be common practice to find boxes drawn in clinical records at relevant times particularly in relation to timings for administering medication. She said she decided to do the checks earlier than her planned time of 14:00. She said when she recorded the observations at an earlier time she did not realise that she had done so under the time of 14:00 which she had pre-written and so she did not think about changing the time to the correct time. She admitted that was a mistake. The Respondent also placed a cross in the pre-printed 14:00 column indicating that no Methadone had been administered at that time. She was not able to say when she had entered the cross but it must have been before the recording that Methadone was administered by Dr Johnson at 15:00.

44. The Respondent relied on the evidence given by Dr Johnson that he was aware of timings being written in clinical records as a prompt to carry out a clinical check. He said that this was a common practice. The Respondent further relied on the evidence given by Mr Blackman who recalled that the Respondent had given the explanation of pre-writing the time in relation to the three clinical records.

45. In summary, the Respondent's counsel, Mr Jamieson submitted that the Respondent had only denied a small part of the case and that her reason for doing so was likely to be because she had made a mistake rather than because she had been dishonest.

46. Mr Jamieson also submitted that it was possible that the Respondent had given her explanation at an earlier time to Mr Male despite the fact he had not recorded it in writing. Mr Jamieson submitted that the Respondent had not had the opportunity to fully explain herself in the disciplinary hearing because it only lasted 18 minutes and she been in her car alone because it took place during Covid restrictions.

47. Mr Jamieson further submitted that the evidence relating to the CCTV was speculative and the Respondent had provided evidence which supported that she was looking at

CCTV on 27 December 2020 because she was in the practice alone and she was worried about possible intruders being outside.

The Committee's findings on Charge 3(a) in relation to 1(b)

48. The Committee noted that the Respondent accepted when giving evidence that she had made a cross in the hospitalisation record under the pre-printed time of 14:00 to indicate she had not given Rocky Methadone at that time. It considered that to be compelling evidence that the Respondent must have noticed what time she put that cross on as it was in a pre-printed time column and which was before the later tick of administering Methadone by Dr Johnson at 15:00. There was no evidence that the Respondent had put the cross in at a later time and the Respondent could have recorded that entry at the accurate time. Since she had chosen 14:00 she must have done that before leaving the practice and she must have known it was the wrong time.

49. Further, the Committee was satisfied so that it was sure, that when the Respondent entered the other observations with a timing of 14:00 before leaving the practice she did so dishonestly on three clinical records. It rejected her explanation that when she recorded those observations and time of 14:00 she made a mistake. It also rejected her explanation that she did not notice that the time was wrongly pre-written by her as 14:00. In support of its finding the Committee considered that when Ms Morris wrote in those entries she had the opportunity to amend the time if it was pre-written. When she returned to the practice she had a further opportunity to amend the time if it was wrong and she had not done so then either. It therefore found it wholly implausible that she would not have noticed the errors in timing in four entries in three records either at the time she wrote each record or when she recorded Dr Johnson's later 15:00 observations. The Committee therefore decided that the Respondent had written the timings of 14:00 and observations before leaving the practice just before 12:15/12:30 deliberately to mislead and be dishonest about when she had last checked Rocky and left the practice.

50. Although the Committee accepted that there was some evidence that clinical records might be pre-populated to prompt an observation or medication administration it did not consider this to be the case here because the Respondent had also admitted that she had marked a cross on the hospitalisation sheet under a pre-printed time of 14:00. The Committee was therefore satisfied that when writing her observations at an earlier time than 14:00, she did so dishonestly because she would have had to have looked at the pre-printed time column to find the time to mark the cross. It did not accept that she made a mistake or that she mistakenly failed to amend the time.

51. Further, the Committee accepted the College's submission that if the Respondent's usual practice was to pre-write timings as a prompt there was no other evidence to support that nor did the records show any other prompts made by the Respondent for Rocky.

52. The Committee also concluded that if the Respondent was checking Rocky as she said she was in between her recorded check of 11:00 and her last check before leaving the practice at around 12:15/12:30, then she would most likely have recorded those additional checks in the clinical records. Since she had not, this was another reason

why it considered that the Respondent was dishonest about saying she had written 14:00 as a prompt. If she had done those additional checks she should have recorded them and would have been alerted to any pre-written time of 14:00. It noted that Rocky was her only inpatient that afternoon.

53. Furthermore, although the Committee noted that there was some evidence that nursing staff might write an hourly time in to prompt a check, it was not persuaded that at the time a veterinary nurse recorded an observation against a pre-written time, the veterinary nurse would fail to notice on three separate sheets that the observation was recorded against an incorrect time. The Committee considered the whole purpose of recording observations was to record the time they took place alongside the observation.

54. The Committee decided that although Mr Male when giving evidence about events which took place in 2021 had said it may have been possible that Ms Morris had told him about her explanation of writing the timing of 14:00 as a prompt and not changing it by mistake, there was in fact no written record of her saying that before 3 February 2021 by Mr Male or anyone else. The Committee was therefore not persuaded that the Respondent had given that explanation before she had set it out in her email dated 3 February 2021 after her dismissal. It therefore found her suggestion that she had done so untrue. The fact she had also given two other explanations when first confronted by Mr Male on 11 January 2021: 'that she had monitored Rocky during that period but had not recorded the observations' and then later 'that the reason for the absence of observations was that she and Dr Johnson had been operating on another patient at the time' were further reasons why the Committee did not accept her third explanation which she advanced in her email of 3 February 2021. The Committee concluded that if the third later explanation was true the Respondent would have most likely advanced it straight away and not provided two other explanations which were untrue.

55. Although the Respondent said she did not have an opportunity to give her explanation at an earlier stage, the Committee was not persuaded that was the case. It considered that had the Respondent wanted to admit her mistake earlier she could have done so at the disciplinary hearing or at any time before e.g. when she spoke to Mr Male. It noted that the Respondent said she told Mr Male in the meeting of 13 January 2021 but that she did not think he understood. The Committee considered that had the Respondent wanted to admit her mistake earlier there would have been no reason why Mr Male would not have recorded that in his written notes of the meeting which were made closer to the time of the events than when he gave his oral evidence. It noted that the Respondent did not say that she told anyone else about her mistake either.

56. Furthermore the Committee noted that the Respondent's defence to dishonesty, that she had pre-written 14:00 and that she had failed to amend it by mistake, had been asserted to her previous employer and also in her written response to the College. It was obviously serious for her to admit that she had been dishonest to her regulator when she had been asked for her explanation.

57. The Committee applied the test for dishonesty as set out in the case of Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC. It concluded for the reasons set out

above that the Respondent had acted dishonestly when making the entries in the clinical records at 14:00, when she had not done so, as she would have known that time to be incorrect when she made those entries. It rejected her explanation that she had made a mistake or that she had pre-written in the time of 14:00. Further it also decided that her conduct would be seen as objectively dishonest by the standards of ordinary decent people.

58. The Committee was therefore satisfied that when the Respondent made entries in the clinical records for Rocky indicating that she had made those entries at 14:00 when she had not done so, she did so to cover up the fact that she had left the practice at an earlier time and that by doing so she had acted dishonestly.

59. The Committee considered the character testimonials that were provided to it in so far as they related to the Respondent's honesty. Whilst taking them into consideration the Committee found them to be of little assistance to their decision at this stage of the proceedings.

60. Finally, the Committee was not persuaded that the Respondent had looked at the CCTV footage from 25 December 2020 on 27 December 2020 as Mr Male suspected. There was no evidence to show she had done so or that she had tampered with any CCTV and she did not dispute the timings which others had noticed of her leaving the practice around 12:15/12:30. It therefore found little value in the evidence about the CCTV.

61. The Committee therefore found Charge 3(a) in relation to 1(b) proved.

Disciplinary Committee
29 March 2023