ROYAL COLLEGE OF VETERINARY SURGEONS

- v -

ANNE MARY MULLEN MRCVS

DECISION OF THE DISCIPLINARY COMMITTEE
ON THE FACTS

The Respondent, who did not attend the hearing of this matter, faced the following Charges as set out in the Notice of Inquiry:

That, being registered in the Register of Veterinary Surgeons, and whilst in practice at Annemull, 106 High St, Aveley, South Ockendon, RM15 4BX, you:

1. Failed to provide adequate information to clients in relation to your out of hours' emergency cover:

(a) over the Easter weekend in April 2019; and/or

(b) on 25 and/or 26 July 2019;

2. In relation to spay surgery on 19 July 2019 to Cleo, a Labrador belonging to GS and EJ:

(a) discharged Cleo on 19 July 2019 when she was unfit to be so discharged;

(b) discharged Cleo with an inappropriate and/or inadequate abdominal dressing;

~~(c) dispensed a non-steroidal anti-inflammatory drug, Meloxicam:~~

~~(i) when that Meloxicam was not in an appropriate container with appropriate labelling; and/or~~

~~(ii) without sufficient instruction to GS and/or EJ as to the administration of that Meloxicam;~~

(d) failed to provide adequate information to GS and/or EJ on discharge of Cleo with regards to:

(i) complication/s during surgery; and/or

(ii) the risk of post-operative haemorrhage; and/or

(iii) arrangements for your out of hours' emergency cover

(e) failed to make adequate clinical records with regards to Cleo;

3. In relation to surgery on 15 October 2019 to Boycie, an English ~~Bull Terrier~~ Bulldog belonging to VL and ZL:

(a) failed to obtain informed consent for anaesthesia and/or surgery to Boycie;

(b) failed to ensure that Boycie had adequate monitoring whilst recovering from anaesthesia;

(c) failed to offer an adequate range of options for Boycie's overnight care between 15 October 2019 and 18 October 2019, including transfer to another practice or transfer home;

(d) left Boycie alone overnight on 15 October 2019 and/or 16 October 2019 and/or 17 October 2019, when Boycie was not in a fit condition to be so left;

(e) failed to provide adequate details to VL and ZL regarding:

(i) information relating to caring for Boycie at home; and/or

(ii) arrangements for your out of hours' emergency cover;

(f) failed to make adequate clinical records with regards to Boycie;

4. With regards to Professional Indemnity Insurance ("PII") requirements, CPD requirements and/or requests from the Royal College of Veterinary Surgeons ("the College"):

(a) Between ~~2~~ 8 April 2019 and 23 October 2020, failed to have in place adequate Professional Indemnity Insurance or equivalent arrangements; and/or

(b) Between 9 April 2020 and 30 October 2020, failed to provide adequate details of your Professional Indemnity Insurance or equivalent arrangements when requested to do so by the College;

(c) Between 9 April 2020 and 30 October 2020, failed to provide adequate details of your CPD when requested to do so by the College;

(d) Between 11 December 2019 and 30 October 2020, failed to respond adequately to reasonable requests from the College for details and/or documents regarding Cleo belonging to GS and EJ;

(e) Between 17 March 2020 and 30 October 2020, failed to respond adequately to reasonable requests from the College for details and/or documents regarding Boycie belonging to VL and ZL;

AND that in relation to the 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 College applied for permission to withdraw Charge 2(c) and to amend the date in Charge 4(a) as reflected in the amended charges above. The Committee accepted the proposed amendments.

2. The charges arise from the Respondent's surgery performed on two dogs in 2019, together with an alleged failure to inform clients about her emergency out of hours' cover, an alleged failure to have in place Professional Indemnity Insurance ("PII") and details of relevant CPD and alleged failures to respond adequately to requests from the College.

3. In relation to the clinical allegations, the College relies on evidence from the owners of the two animals in question, together with evidence from the veterinary surgeons at other practices who saw the dogs soon after they had been discharged from the care of the Respondent. The College has also obtained an expert report from Dr Christine Shield BVM&S MRCVS, who provides an opinion on the Respondent's conduct. Dr Shield is an experienced small animal practitioner, who during the course of her career ran her own surgery single-handedly for seventeen years.

4. A veterinary surgeon and practice manager at a nearby practice provide evidence about the Respondent's alleged failure to inform clients of her out of hours' cover. With regards to the alleged failures to have in place PII and CPD, and alleged failure to respond adequately, the College relies on the evidence of a Solicitor in its Professional Conduct department, together with the College's correspondence with the Respondent.

5. At the outset of the Hearing, the College made written opening submissions to the Committee setting out the College's case, a summary of which is set out below.

The College's case

Charge 2: Cleo GS/EJ

6. In the summer of 2019, GS and his partner EJ decided to take their three-year-old Labrador, Cleo, to be spayed. GS made an appointment with the Respondent for Friday 19 July 2019 and he took Cleo to her practice for the appointment at 9:00am. Both he and EJ went to the practice at around 1:00pm to collect Cleo to take her home.

7. When they went to collect Cleo, the Respondent brought her out, and GS noted that his dog was very sleepy and docile. Although Cleo was walking, she struggled to do so, and appeared to be dragged along by the Respondent. Cleo had two blue bandages on her – a tight one around her abdomen, with wadding underneath it, and the other on her front left leg (photographs of which were before the Committee). The Respondent told GS and

EJ that the operation had gone well. GS asked about the bandages, and the Respondent said that the one around Cleo's abdomen was a "*precaution*" or "*to protect her*" although she did not elaborate, and the other was there because Cleo had knocked her leg.

8. GS and EJ took Cleo home, but for the rest of the day she was unsettled and struggled to walk. By the following morning, Saturday 20 July 2019, Cleo was struggling to stand. GS and EJ were unable to contact the Respondent's practice as it was closed, and so they made their own enquiries about where they could take Cleo. They found the Cherrydown practice in Stanford. GS telephoned them and he was asked to bring Cleo into the practice. He and EJ carried Cleo from their house to the car and drove to the practice. When they arrived, at around 11.00am, Cleo, unusually, would not get out of the car. She could not stand up, and so GS carried her into the practice. They were seen by a veterinary surgeon, who referred them to Cherrydown's Hospital in Basildon.

9. GS and EJ duly took Cleo to Cherrydown in Basildon, arriving at around 11.45am. Cleo was seen by Dr Kim Woods MRCVS. Dr Woods reports that Cleo had a tightly wrapped "*vetwrap*" bandage applied around her caudal abdomen. The bandage was very tight and "*almost like a pressure dressing*". It was not a typical dressing she would have expected post-surgery, it did not appear to have been placed in order to cover the surgical wound and it would not have prevented Cleo interfering with the wound. In Dr Woods' view there was no reason for such a dressing unless there had been haemorrhaging during surgery.

10. Dr Woods recorded in her clinical records as follows:
"*Very flat, QAR, lat recumbency, can raise head when really stimulated, not wanting to walk, body bandage around back end O was told to leave on for 5 days. MM pink and tacky, CRT 2 secs, HR 156 sebpm, weak peripheral pulses, abdo palp limited due to recent sx but appears painful, increased resp depth, guarding. Multifilament skin suture. T-38.1 with blood on thermometer. Unknown protocols used or drugs.*"

11. Given Cleo's presentation, and that she had been non-ambulatory on discharge, Dr Woods took the view she had bled heavily during surgery.

12. Dr Woods admitted Cleo to the Cherrydown Vets, took blood samples, and gave her a fluid bolus. It appeared that Cleo's peripheral pulse quality was poor. The plan was to monitor her blood pressure, and, when that was at an appropriate level, to reduce the fluid rate. Dr Woods then handed over care of Cleo to a colleague as she was due to end her shift. She later noted that the results of the blood tests (which arrived after she had left) indicated that Cleo had suffered an acute bleed.

13. At around 5.15pm, Dr Woods' colleague telephoned GS and EJ to update them on Cleo's condition, saying that Cleo was responding well and that she would be monitored closely. At 5:45pm, the kennel nurse reported that Cleo was looking pale. A scan showed free fluid in the abdomen, indicating an active bleed, and Cleo was showing signs of hypovolemic

shock. Cleo's owners were telephoned again and told that Cleo needed to be taken into surgery, but that she had a poor prognosis. Despite the efforts made, Cleo died in theatre.

14. Dr Woods was concerned about what she had seen of Cleo, and made a complaint to the College about the Respondent.

15. Despite numerous requests by the College, the Respondent has never provided a substantive account of what happened with Cleo, and has not provided any clinical records (again, despite requests). This is dealt with by way of a separate charge (charge 4(d), as outlined below).

Charges regarding Cleo

2(a) discharged Cleo on 19 July 2019 when she was unfit to be so discharged

16. The College relies on the description given by GS and EJ, together with the evidence of Dr Woods and the view of the expert witness, Dr Shield. GS explains that Cleo was very sleepy and docile when they went to collect her, and although Cleo was walking, she struggled to do so, and appeared to be dragged along by the Respondent. The expert's view with regards to this is that:
"[Discharge] was at 1pm, only four hours after admission. From GS's account … it appears that after arriving at 9am he spent around 20-30 minutes with Cleo waiting for her pre-medication to take effect. Even if Mrs Mullen had proceeded to operate immediately he left the premises, by the time Cleo was anaesthetised, intubated and clipped, and both surgeon and patient prepared aseptically for surgery, it is unlikely that the procedure could have been completed before 10.15am, quite probably nearer 10.45am. It would be unusual to discharge a patient so soon after major surgery. Most practices would prefer to wait until the anaesthetic medication had largely worn off and the patient was sufficiently recovered to be confident that no complications, such as delayed bleeding, had arisen. We do not know what drugs were given as a premedication and as an anaesthetic, but it is likely that these would still be having an effect at the point of discharge, contributing to Cleo's sleepiness…
… it seems to me that Cleo was discharged from Mrs Mullen's practice far sooner after the operation than her condition and common prudence would justify."

2(b) discharged Cleo with an inappropriate and/or inadequate abdominal dressing

17. The College referred the Committee to the photographs of the dressing and the description given by EJ that she was "*surprised at how tight the bandage seemed*". The Respondent has not provided any explanation as to its purpose. Dr Woods' evidence is that the bandage was "*very tight and almost like a pressure dressing*". It was not a typical dressing she would have expected post-surgery, it did not appear to have been placed in order to cover the surgical wound and it would not have prevented Cleo interfering with the wound.

18. The view of Dr Shield is:

"The dressing does appear to have been uncomfortably tight, judging from … exhibit GS 1... It did not cover the front end of the wound, which can be seen in the close-up photograph… and knowing the anatomy of the region would be unlikely to have covered the rear part. It will have been serving very little useful purpose, and certainly would not have applied the type of abdominal compression that might have been expected to reduce internal bleeding."

2(d) failed to provide adequate information to GS and/or EJ on discharge of Cleo with regards to:

(i) *complication/s during surgery; and/or*
(ii) *the risk of post-operative haemorrhage;*
(iii) *arrangements for your out of hours' emergency cover;*

19. With regards to (d)(i) and (d)(ii) above, the College relied on the evidence of Dr Woods and Dr Shield, to the effect that Cleo clearly sustained a bleed at some point. Dr Woods explains that given Cleo's presentation, and given that she had been non-ambulatory on discharge, her view was that Cleo had bled heavily during surgery. She noted that the blood test results were consistent with an acute bleed. Dr Woods also notes that, with regards to the bandage, there was no reason for such a dressing unless there had been haemorrhaging during surgery. The College relies on the evidence of GS and EJ with regards to the limited advice given to them on discharge, and the absence of information about complications during surgery or the risks of post-operative haemorrhage.

20. In relation to these aspects of the Respondent's conduct, the expert notes as follows:

"…if the Committee concludes that the dressing applied to Cleo was not Mrs Mullen's usual type, and was applied in an attempt to stem internal bleeding, then this could indeed be evidence that the surgery had not gone well. In this case, the appropriate course of action would have been to advise GS of the problem, warn him of the possibility of further bleeding, tell him what to look out for and ensure that he clearly understood how to obtain emergency veterinary attention for Cleo should he be concerned about her condition. Failure to do so would fall far below the standard expected of a reasonably competent veterinary surgeon..."

21. With regards to (d)(iii) above, the College relied on the evidence of GS and EJ. EJ explains that, when discharging Cleo, the Respondent told them that if they had concerns about Cleo at a time when her practice was closed, they should go to a veterinary practice "*at Daneholes roundabout*." Although EJ knew which practice the Respondent meant, when she telephoned it the following day (Saturday 20 July 2019), this other practice was closed. GS's recollection is slightly different: he states that the Respondent said nothing about what they should do or whom they should contact that evening or over the weekend when the practice was closed; nor does he recall seeing such information at the practice.

GS states that he called the Respondent's practice on Saturday 20 July 2019, and although he cannot recall whether there was any message on her answerphone, he recalls that they had to undertake their own research to find a practice that was open and able to see Cleo. The College asserted that on either account, the Respondent failed to provide adequate details about her out of hours' cover.

2(e) failed to make adequate clinical records with regards to Cleo

22. The Respondent has not provided any clinical records for Cleo, whether to Cherrydown Vets or to the College. The College invited the Committee to infer that the notes, being absent, were therefore wholly inadequate. Their inadequacy is reflected in the expert's views as to how helpful they would have been.

23. As Dr Shield notes:
"*We do not know what drugs* [redacted] *were given as a premedication and as an anaesthetic… Mrs Mullen does describe her usual canine anaesthetic protocol in a letter dated 9th March 2020 … but that was in connection with a concern regarding a different patient and we have no evidence as to whether or not that was the protocol actually used for Cleo on the 19th July 2019*".

24. Dr Shield goes on to say that "*Contemporaneous clinical records, anaesthetic records and hospitalisation sheets could be hugely helpful in resolving*" the issue about when the bleed happened, and she describes these as "*essential documents*".

Charge 1: Out of Hours' Cover – April and July 2019

25. The Cherrydown Client Care Manager, Olivia Noble, telephoned the Respondent to ask for copies of Cleo's clinical records. This included calls on Thursday 25 July 2019 and Friday 26 July 2019. These calls went to voicemail. Ms Noble's recollection is that the voicemail message said that the practice was not open, and then went on to give its opening hours. The opening hours were not regular – that is, the practice was not open on the same times each day. The message then went on to say that the practice was a limited service provider. There was also a lot of detail about parking. The message did not, however, say anything about what someone should do if they needed urgent attention for their animal outside the practice's opening hours. Ms Noble's recollection was that there was no option to leave an answerphone message.

26. Dr Woods had previously been involved in a situation over the Easter bank holiday in 2019[1], when an owner had brought their animal to Cherrydown Vets because they were unable to contact the Respondent out of hours. Dr Woods thought this was strange, and so had telephoned the Respondent's practice herself. She heard a woman's voice on an answer machine message which said "*I am on holiday for a week*", or words to that effect.

[1] Easter Sunday was 21 April in 2019

The message did not go on to direct clients anywhere else if their animals needed veterinary attention. Dr Woods rang back to listen to the message again, just to be sure, and confirmed that there was nothing in the message to indicate who an owner should contact if they needed help during the Respondent's holiday.

27. The College relies on the evidence of NA to show that the Respondent was practising at around the time these enquiries were made (namely between April 2019 and October 2019).

Charge 3: Boycie

28. In October 2019, dog breeders ZL and VL decided that one of their English Bulldog, Boycie, should have surgery to correct "*cherry eye*". Boycie was about four months old at the time. ZL telephoned the Respondent and made an appointment for Tuesday 15 October 2019. They did not discuss the surgery during the call, and did not, for example, discuss the risks of the surgery or any details other than the practicalities of bringing Boycie in for the operation.

29. ZL took Boycie to the practice for the surgery. When in the waiting room, he spoke to a man who had brought his dog in for dental surgery that same day. When ZL spoke to the Respondent, there was again no discussion about any of the risks of the surgery or the anaesthetic. She did not give him any kind of printed information, nor ask him to sign a consent form.

30. ZL then left the practice. Later the same day, the Respondent telephoned him and said Boycie had not reacted well to the anaesthetic. She said that every time she tried to bring him round from the anaesthetic, Boycie was "*paddling*" his legs, which was something dogs did when having fits. She said that, because of this, she had "*put him back to sleep*" and that she would call ZL when she had tried to wake him up again.

31. Towards the evening, the Respondent called ZL again and said that Boycie was still paddling his legs when she tried to bring him round from the anaesthetic. She said she would keep him in overnight, and pop back into the practice later during the evening to check on him. It was clear from what she said that Boycie would be left on his own at the practice when she was not there. The Respondent did not give ZL any other options for Boycie's care overnight. She did not say that he could be taken somewhere else, or that there were any alternatives to her proposed course of action.

32. The Respondent kept Boycie overnight at her practice for the next three days, without anyone with him during the nights. She made telephone calls to VL and ZL during this period, to update them on how Boycie was doing. She did not, however, mention any alternatives to Boycie staying overnight at the practice, for example transferring him to another practice or discharging him home to the care of his owners. The Respondent

mentioned during one of the calls that if Boycie did not improve, then euthanasia would be an option. ZL recalls that the Respondent frequently apologised for what had happened, saying that things like this "*could happen*".

33. During the morning of Friday 18 October 2019, the Respondent telephoned VL and ZL and told them that Boycie's progress had been "*two steps forward, one step back*". She said he was not licking at any food or eating it, and she was back to syringe feeding him and also syringing him water. She said that they should collect Boycie, that he could stand for a little while on his own, but that he was still very weak and so his recovery was going to be a slow process. She said it would be best if Boycie was to go home, as she was not going to be there over the weekend.

34. Later that day, VL and ZL went to collect Boycie. When they saw him, they were "*gobsmacked*" at his condition. He was lying on the floor. They had to help lift him up and support him (with help from the Respondent), but as soon as they took any support away, he would fall over. He could not eat for himself, and his jaws did not work properly. ZL also noticed that Boycie's breathing was poor.

35. The Respondent gave VL and ZL some diazepam to give to Boycie at night in case he did not settle. She said that they could email her over the weekend, and that they should keep her updated by email on Boycie's progress. She said that they did not need any follow-up appointments, that his recovery would be a slow process, and that if he did not improve then he would need to be euthanased. The Respondent did not give them any instructions or advice about how to help Boycie once he was at home.

36. The owners spent a lot of time trying to help Boycie get the strength back in his legs to help him walk. After a while, they began to realise Boycie was blind. They were also concerned about his hearing, as he was not responding to them when they called. On Sunday 20 October 2019, VL sent the Respondent an email asking her if Boycie was blind. Although they received a reply, the Respondent did not answer this particular question. On 23 October 2019, VL sent another email to the Respondent, giving her an update on Boycie's condition, again asking if Boycie was blind. The Respondent replied the following day, saying that she had thought Boycie could see when he was with her.

37. During the week following his discharge, VL and ZL continued to look after Boycie and to try to do all they could to help him. They decided to go to another veterinary practice to have him checked. They had gone to the Wylie Veterinary Centre (Wylies vets) in the past, and made an appointment for 27 October 2019. VL made a call to the Respondent's practice to let her know that they were taking Boycie to another practice. Wylies vets requested a copy of Boycie's notes, and the Respondent sent over a Word document consisting of a typed report covering the period 15 to 18 October 2019. This included the following:

"*Turn off Isoflo/ oxygen. Coughed out ET tube.*
Placed in lateral recumbancy in cage in operating theatre. Tongue forward.
Appeared to be breathing normally and withdrew tongue into mouth.
Proceed with surgery on another patient. Boycie was within view at all times.
When finished (small dog dental) Boycie coughed while still in lateral recumbancy.
On examination, very pale/ cyanosed.
Reintubated – put on oxygen.
Opted to reverse Sedator with 0.1 Atipam.
Coughed out ET tube within minutes
10 to 15 minutes later became vocal / paddling.
Unsure if epileptic-like episode or ketamine reaction.
Obs for 15 to 20 mins but became worse so gave regular (from 10 to 30 minute) 2ml doses Propofol x 20. 0.5 mls Diazepam (10mg/2ml) x3
Diazepam or Propofol given I/V to sedate whenever he started to twitch.
Advise owner poor prognosis if cannot control this sign.
6pm set up infusion of 20 mls Propofol in 500mls saline.
11pm calmer"

38. At Wylies vets, Boycie was seen by vet Dr Vanessa Nicola-Le Mer CertVOphthel MRCVS, who diagnosed "*post general anaesthetic respiratory complication and central damages associated with prolonged hypoxia*". Dr Nicola-Le Mer was impressed by the way VL and ZL had nursed Boycie. She discussed continuing care and the option of euthanasia.

39. Boycie was able to improve gradually. By July 2020, he was still blind, but he could hear. He could also eat and drink by himself, and enjoyed "*small gallops around the garden*", although he could be scared by loud noises.

40. The Respondent has provided a response to the College in relation to Boycie. Her account (dated 9 March 2020), stated that Boycie's case had been one of the most challenging of her career. She stated that her practice was "*deliberately low tech*" and *"minimal but fit for purpose*"; and that her clinical records were, "*concise but professional*". She stated that Boycie's induction and surgery were "*uneventful*" and that when he was recovering, she had been within two metres of Boycie at all times. She stated that when she was "*finishing the next patient*" Boycie had given "*a slight cough noise*". She said he had an unusually pale mouth and tongue, so she had immediately re-intubated, putting him on oxygen. She said that she reversed the sedation and he then became agitated and started to paddle. She thought it might have been a reaction to ketamine. She said that referral or transfer to another practice was "*not an option*" as a result of his "*ever changing signs*" on Tuesday; and that thereafter she had kept him at the practice as he was stable and she had "*experience with a variety of cases*".

Charges in relation to Boycie

3(a) *failed to obtain informed consent for anaesthesia and/or surgery to Boycie*;

41. The College relies on the evidence of ZL and VL. ZL explains that in his conversations (both over the telephone and in person) with the Respondent, she did not explain the risks of surgery or the anaesthetic, and he did not sign a consent form. VL did not have any direct contact with the Respondent before the surgery, so cannot have given consent.

42. The Respondent's comments on consent are as follows (her account dated 9 March 2020): "*Clients are asked if they understand that they are giving permission to give their pet a general anaesthetic and that there are risks with every anaesthetic and surgical procedure. They are reminded that some surgical procedures carry more risks than others (not in Boycie's case*)."

43. These comments are general in nature; they do not refer to what actually happened in relation to any conversations she had about Boycie. There is no consent form, nor contemporaneous notes to support any suggestion that ZL was warned of risks of the surgery or anaesthetic. The College invited the Committee to accept ZL's evidence on this point, and be sure that no informed consent was obtained.

44. Dr Shield comments:
"Cherry eye surgery, even when performed by a specialist, carries a risk of recurrence of the problem which the owner needs to be aware of. VL at least seems to have been unaware of this, expressing surprise (paragraph 75 of her statement) when the cherry eye reappeared "a couple of months" after the operation. Any anaesthesia of an English Bulldog carries additional risks, due to their respiratory deformities…
If ZL's description of the process is accepted, in the absence of any coherent account by Mrs Mullen and in the absence of any signed consent form, it appears that the process of consent was rudimentary and unlikely to have been properly informed. Given the risk of complications with both the anaesthetic and with the procedure itself, my opinion is that this fell below the standard expected of a reasonably competent veterinary surgeon but did not fall far below that standard."

3(b) *failed to ensure that Boycie had adequate monitoring whilst recovering from anaesthesia;*

45. Dr Nicola-Le Mer notes that she made a diagnosis of "*post general anaesthetic respiratory complication and central damages associated with prolonged hypoxia"*, and the Respondent herself states that the difficulty arose during recovery from the anaesthetic, rather than during surgery itself. The Respondent's account is that she was dealing with another patient whilst Boycie recovered. The College asserts that she should not have turned her attention to another patient and left Boycie to recover alone, even if she were nearby.

46. Dr Shield states:

"*Boycie's cherry eye operation and the dental procedure on a small dog described by ZL… and by Mrs Mullen herself … are both procedures which can be carried out by a competent surgeon without assistance, as neither requires full aseptic technique. It would however be foolhardy to leave an English Bulldog without undivided attention until fully recovered from anaesthesia and able to hold his head up unassisted, and I would regard such conduct as falling below the standard expected of a reasonably competent veterinary surgeon….*

… Mrs Mullen gives an account of subsequent events in a letter dated 9th March 2020 .. and while she says 'I was less than 2 metres from him at all times' and 'I was less than 1 metre from him so I opened [his] cage …' she makes no mention of any other person there to assist her, to monitor the anaesthetics or to supervise recovering patients. It is not possible for her to have simultaneously performed a dental procedure, monitored the anaesthetic for that patient and given Boycie's recovery the attention it required without additional help. I make no criticism of Mrs Mullen in performing these two particular surgical procedures without assistance, if indeed she did so, but to proceed with another surgical procedure before an English Bulldog patient was fully conscious and holding his own head up was highly inadvisable….

I have to conclude that leaving an English Bulldog recovering from anaesthesia while conducting a surgical procedure on a different patient, albeit in the same room, was conduct which fell below the standard expected of a reasonably competent veterinary surgeon. Mrs Mullen says that Boycie was within her sight at all times and clearly believed, albeit (with hindsight) wrongly, that she would notice if he was getting into difficulties and would be able to intervene."

3(c) failed to offer an adequate range of options for Boycie's overnight care between 15 October 2019 and 18 October 2019, including transfer to another practice or transfer home;

3(d) left Boycie alone overnight on 15 October 2019 and/or 16 October 2019 and/or 17 October 2019, when Boycie was not in a fit condition to be so left;

47. The College relies on the evidence of ZL and VL to the effect that they were not given any alternative options with regards to Boycie's overnight care. The Respondent suggests that Boycie was too unstable to transfer on the first night, and that after the first night she was experienced in coping with such a patient. The College asserts that this should not have precluded the owners being offered alternatives. Additionally, the College alleges that given Boycie's condition, he should never have been left alone overnight.

48. Dr Shield states:

"… it is highly undesirable to leave an animal in such a state of high dependency alone for so long. After urinating or defaecating his skin will have remained soiled for many hours, with the risk of painful scalding. Unable to drink without assistance, he will have been

uncomfortably thirsty by the morning. He could have had further seizures and ended up in his cage in a position where he could not breathe. At one point he did become trapped in the bars of his cage (paragraph 18 of VL's statement, and paragraph 20 of ZL's statement) and, while he suffered no injury as a result, he could easily have done so and he will have been in pain and distress for an unknown number of hours until Mrs Mullen arrived to free him…

Alternative arrangements would have been either to transfer Boycie's care to the Wylie Veterinary Centre or another practice where he could have received round the clock care from qualified nursing staff, or to return him to his owners overnight, to be re-admitted in the morning. Clearly the [redacted] *could have offered no medical care, but he was receiving none anyway while alone. Either of these options would have been preferable to leaving Boycie alone and unsupervised, yet these possibilities were never offered, according to both VL… and ZL…"*

Mrs Mullen says in her letter of the 9 March 2020.. *"that 'Referral or transport to another centre was not an option due to his ever-changing signs on Tuesday'. While that may well have been the case before Boycie stabilised at about 7pm… he could have been transferred after that. If he was deemed too unwell to travel, he was also too unwell to have been left alone all night…"*

3(e) failed to provide adequate details to VL and ZL regarding:
(i) information relating to caring for Boycie at home; and/or
(ii) arrangements for your out of hours' emergency cover;

49. As above, the College relies on the evidence of ZL and VL to the effect that they were given no information regarding how to care for Boycie at home, and were very much left to their own devices, without veterinary support to deal with a very challenging case. Although the Respondent told ZL and VL that they could email her, she did not provide any information about seeking emergency out of hours' care for Boycie.

50. Dr Shield's view is:
"*It appears that Mrs Mullen offered the* [redacted] *no advice or information as to how to care for him at home following discharge, nor any information about how they could obtain urgent veterinary attention for him if they were concerned about his condition while she was away over the weekend following his discharge. She had said that the* [redacted] *could contact her by email… and indeed they did so, but that would be no substitute for hands-on attention had that been required."*

3(f) failed to make adequate clinical records with regards to Boycie

51. The only notes available regarding Boycie are in the Word document provided to Wylies vets, which appears to have been written in retrospect (as it includes a comment to the effect that the owners had worked hard on Boycie over the past week). There are no contemporaneous notes of the surgery, nor of the recovery, nor are there hospitalisation

sheets or records regarding the three nights when Boycie remained at the Respondent's practice. The College asserts that the absence of contemporaneous clinical records is of concern.

52. Dr Shield notes:

"*Although … Mrs Mullen says that Boycie's condition stabilised at about 7pm on the 15th October 2019, we have no evidence as to what time she left the practice that night, how long elapsed after the last paddling episode that she witnessed before she considered him to have stabilised, and whether or not he had further episodes while alone…*

The clinical notes supplied by Mrs Mullen to the Wylie Veterinary Centre… appear to have been written after the event, likely in response to the Wylie Veterinary Centre's request for Boycie's clinical records. They are not a print-out from a computerised practice management system or hand-written notes on an index card, and include phrases such as 'Proceed with surgery on another patient. Boycie was within view at all times' which would be consistent with a narrative account of events written with hindsight but not with a clinical record…

Contemporaneous clinical notes, anaesthetic monitoring sheets and hospitalisation records would be of great help in determining such vitally important matters as whether Boycie was in lateral or sternal recumbency, was he able to lift his head and did he appear to be fully conscious at the time when Mrs Mullen decided to divert her attention to her other patient."

Charge 4: absence of PII and CPD and failure to respond adequately to the College's requests

4(a): Between 8 April 2019 and 23 October 2020, failed to have in place adequate Professional Indemnity Insurance or equivalent arrangements: and/or

53. On 27 October 2020, the College wrote to the Respondent identifying another concern, namely that between 8 April 2019 and 23 October 2020, she had practised veterinary surgery without PII or without having equivalent arrangements in place. She was asked for her comments on this concern. Despite some vague suggestion over the telephone with Ms Neary and Mr Ghoorbin of the College that she had "equivalent arrangements", the Respondent has not provided any evidence of this. She has not provided any insurance certificate, nor evidence of a ring-fenced, readily available sum specifically allocated to deal with any financial claims made by clients, nor any set procedure for dealing with those claims. The College alleges that a proper inference can be drawn from her failure to provide the details, to the effect that she had no PII or equivalent arrangements in place.

54. The College relies on the evidence of NA to prove that the Respondent was practising in April 2019 and June 2019; the evidence of GS and EJ to prove that she was practising in July 2019; the evidence of VL and ZL to prove that she was practising in October 2019;

and the evidence of YC to prove that she was practising in April 2020. In these circumstances, she would have required PII or equivalent arrangements.

4(b) Between 9 April 2020 and 30 October 2020 failed to provide adequate details of your PII or equivalent arrangements, when asked to do so by the College

4(c) Between 9 April 2020 and 30 October 2020 failed to provide adequate details of your CPD when asked to do so by the College

55. The Respondent has not provided adequate information relating to her PII or equivalent arrangements. Her assertion that she had "*equivalent arrangements*" in place, made over the telephone late in the day and without further explanation, detail or supporting documentary or financial evidence, is insufficient. Additionally, she has never provided any detail regarding her CPD. Her failure to provide the information was despite requests on:

- 9 April 2020
- 30 April 2020
- 18 May 2020
- 19 May 2020
- 8 June 2020
- 29 June 2020
- 16 July 2020
- 29 July 2020

4(d) Between 11 December 2019 and 30 October 2020 failed to respond adequately to reasonable requests from the College for details and/or documents regarding Cleo

56. The College has never received any detailed information from the Respondent with regards to Cleo's surgery (despite frequent requests), and has never received from her any clinical records for Cleo or similar documents. There have been comments made by the Respondent, but these amount largely to assaults on the integrity of the College's staff and Dr Woods. She has never provided an account of what happened during or immediately after the surgery. She has therefore not provided an adequate response in relation to the requests made, including for specific documents. This is despite requests for comments and/or documents made on:

- 11 December 2019
- 4 February 2020
- 11 February 2020
- 21 February 2020
- 30 April 2020
- 15 May 2020
- 19 May 2020

- 8 June 2020
- 29 June 2020
- 16 July 2020
- 29 July 2020

4(e) Between 17 March 2020 and 30 October 2020 failed to respond adequately to reasonable requests from the College for details and/or documents regarding Boycie

57. Similarly, the Respondent has not provided an adequate response to requests for information relating to Boycie. She has referred to the challenges involved in the case, and has provided some details regarding her approach to Boycie, but none of the documents requested have been provided. This includes a copy of the "case note", copy emails and photographs, a full set of the original clinical records, hospitalisation sheets, general anaesthetic charts and a consent form. This failure to provide information is despite requests for comments and/or documents made on:

- 15 January 2020
- 21 February 2020
- 17 March 2020
- 15 April 2020
- 28 April 2020
- 18 May 2020

58. The College invited the Committee to find the facts proved to the relevant standard, namely so that it is sure.

The evidence before the Committee

59. The Committee received evidence in the form of written witness statements with exhibits from the following witnesses. Those marked with an asterisk gave oral evidence to the Committee either in person or by video link.

- GS *
- EJ*
- Dr Kim Ann Woods MVB MRCVS*
- Olivia Noble*
- VL*
- ZL*
- Dr Vanessa Anne Clotilde Nicola-Le Mer CertVOphthal MRCVS*

- NA
- YC*
- Robert Girling*
- Dr Christine Fiona Shield BVM&S MRCVS*

60. All the witnesses who were called to give evidence verified their witness statements, and answered questions from the members of the Committee.

61. The Committee also received an expert report from Dr Shield.

62. The Committee considers that all of the witnesses who gave evidence at this hearing gave cogent, reliable and credible evidence. When witnesses were asked questions by the Committee to clarify their evidence, they either reinforced the evidence contained in their witness statements, or explained relevant matters in more detail where required. The Committee accepted the evidence of those witnesses.

63. The Committee found the expert report of Dr Shield to be of assistance. Dr Shield gave oral evidence to the Committee in which she expanded on and explained several of her statements and opinions. The Committee agreed with her evidence, except where otherwise stated.

RCVS v Mullen – Decision of the Disciplinary Committee on Facts

64. The Disciplinary Committee has read and considered all the witness statements, and documents in the Inquiry Bundle. It has read and considered the written submissions by the College at the opening of the hearing. The Committee has accepted the advice of the Legal Assessor as to the relevant principles to be applied by the Committee in reaching its decision on the facts. In particular, the Committee was advised that it is for the College to prove the facts set out in the Charges, and the standard of proof is that the Committee must be satisfied so that it is sure that the relevant Charges have been proved. The Committee must consider each of the Charges separately.

65. The Committee will consider Charge 2 before Charge 1, which is the order adopted by the College in its opening submissions, and which is a logical order to address the Charges.

Charge 2

In relation to spay surgery on 19 July 2019 to Cleo, a Labrador belonging to GS and EJ:
2(a) discharged Cleo on 19 July 2019 when she was unfit to be so discharged;

66. The evidence of GS was that the Respondent brought Cleo out for discharge where GS and his partner EJ were standing. Cleo did walk out, but it was clear she was very sleepy and was light on her feet. She seemed very docile and it seemed that walking was a struggle. It was almost as though she was being dragged. They said that "She did not look very happy, although perhaps that is not surprising given that she had just had an operation". In his oral evidence, GS stated that Cleo was reluctant to walk, was sad, didn't look up and showed no excitement.

67. The evidence of EJ was that Cleo did walk out with the Respondent, but very slowly. It seemed that she was very sleepy and she seemed just about ok. In her oral evidence, EJ said that Cleo was lethargic, unbalanced, slow and unsteady. She did wag her tail, but just stood still. The Respondent was holding Cleo to maintain Cleo's balance.

68. The owners were advised to collect Cleo from the Respondent's surgery at about 1pm on 19 July 2019, which on a timeline suggested by Dr Shield would have been about two hours after her surgery. The College's expert witness, Dr Shield, was of the opinion that it would be unusual to discharge a patient so soon after major surgery. Most practitioners would prefer to wait until the anaesthetic medication had largely worn off and the patient was sufficiently recovered to be confident that there were no apparent complications. Dr Shield was of the opinion that Cleo was discharged from the Respondent's practice far sooner after the operation than her condition and common prudence would justify. The Committee agree with that opinion, and is of the view that no reasonably competent veterinary surgeon would have discharged Cleo so soon after major surgery.

69. The Committee is satisfied so that it is sure that Cleo was discharged on 19 July 2019 when she was unfit to be so discharged.

70. Accordingly, the Committee finds Charge 2(a) proved.

2(b) discharged Cleo with an inappropriate and/or inadequate abdominal dressing

71. When Cleo was brought out to the owners at about 1pm, they saw that she had two blue bandages on – one around her abdomen and the other on her front left leg. The Committee has seen photographs of Cleo with the bandages in place taken at some point between discharge from the Respondent and admission to Cherrydown Vets the following day. There is also a photograph of a bloodied pad which came had come out of the bandaging. The evidence of GS is that when the Respondent came out with Cleo what she said was *'short and sweet'.* She said that the operation had gone well. GS asked the Respondent about the bandages and she said the one around the abdomen was a precaution. He assumed she meant a precaution against infection, although the Respondent did not say this.

72. The evidence of EJ was that the bandage around Cleo's abdomen was very tight, and had wadding underneath. She was surprised at how tight the bandage seemed, but thought that the Respondent must be happy with it, and that it was supposed to be like that. She said that the Respondent told her that the bandage around Cleo's abdomen was just there to protect her. She did not say what it was to protect Cleo from, but EJ assumed she meant to protect Cleo from infection.

73. Dr Shield observed that the dressing around the abdomen appeared uncomfortably tight as shown in the photographs. It did not cover the front end of the wound, and certainly would not have applied the type of abdominal compression that might have been expected if the intention was to reduce internal bleeding. It would have been serving very little useful purpose in that regard. Dr Shield considered that the dressing served no useful purpose on day one, still less over any subsequent days.

74. The Committee is unclear as to the purpose of the abdominal dressing. It considers that a possible purpose may have been to protect the wound by the use of the pad. As the pad came away soon after discharge it did not succeed. The Committee also considered that the dressing may have been applied to reduce the chance of bleeding inside the abdomen by applying external pressure. The Committee has concluded that the dressing on the abdomen was both inappropriate and inadequate for either of those scenarios.

75. The Committee is satisfied so that it is sure that Cleo was discharged with an inappropriate and/or inadequate dressing.

76. Accordingly, the Committee finds Charge 2(b) proved.

77. Charge 2(c) was withdrawn at the commencement of the hearing.

2(d) failed to provide adequate information to GS and/or EJ on discharge of Cleo with regards to:

(i) *complication/s during surgery; and/or*
(ii) *the risk of post-operative haemorrhage; and/or*
(iii)*arrangements for your out of hours' emergency cover*

78. In relation to Charge 2(d)(i), the College relies on the evidence of Dr Woods, who treated Cleo when she was taken to Cherrydown Vets, and the opinion of Dr Shield. Both witnesses concluded that Cleo sustained an internal bleed at some point. It was the view of Dr Woods that Cleo had bled heavily during surgery, and she suggested that the blood test results were consistent with an acute bleed. Dr Shield referred to blood tests taken at Cherrydown Vets and concluded that results showed that the bleed had occurred some hours beforehand. However, she could not be sure whether the bleed had occurred during surgery or later. It is clear to the Committee that Cleo did sustain an internal bleed at some

point, but the Committee does not consider that there is sufficient evidence from which it can reasonably be inferred that this bleed occurred during surgery or prior to discharge by the Respondent. In particular, the Committee does not consider that the blood tests provide conclusive evidence as to the timing of any bleed.

79. Accordingly, the Committee is unable to be satisfied so that it is sure that there were complications during surgery.

80. Accordingly, the Committee does not find Charge 2(d)(i) proved and it must be dismissed.

81. In relation to Charge 2(d)(ii), the Committee considered that this Charge is particularly specific, and only relates to post-operative haemorrhage. The evidence of EJ was that the Respondent said that the owners should take Cleo home, and that "*she would perk up".* The Respondent said that they should give Cleo some food. Dr Shield expressed the opinion that the owners should have been told that there were signs to look out for such as if Cleo became sleepy, or miserable, and that such a general piece of advice would cover the possibility of post-operative haemorrhage, although not specifically described in such terms.

82. The owners of Cleo had been told by the Respondent that the surgery went well, and this is reflected in the advice given to the owners about the dog perking up. The Respondent told the owners that she should take it easy and for there to be no exercise for a couple of days, she should be fed and if Cleo needed attention when her practice was closed, they should go elsewhere. The Respondent provided written instructions about exercise, when Cleo could have food, be bathed and when the bandage should be taken off. She circled the relevant information and added extra handwritten information although the owners could not remember now what was written. Having provided general post-operative care advice the Committee is not satisfied that the Respondent should have been required to provide specific information relating to the risk of post-operative haemorrhage as, according to the Respondent, the surgery had gone well and the Committee has insufficient evidence to dispute this.

83. From the evidence the Committee is unable to be satisfied so that it is sure that the Respondent should have given specific advice about a possible post-operative haemorrhage.

84. Accordingly, the Committee does not find Charge 2(d)(ii) proved and it must be dismissed.

85. In relation to Charge 2(d)(iii), the evidence of GS is that the Respondent said nothing about what they should do or who they should contact if they had concerns about Cleo that evening (which was a Friday) or over the weekend when the practice was closed. GS does not remember ever seeing any information about what the arrangements were for how to contact the Respondent or any other vet when the practice was closed. GS does not

remember seeing information about this at all, for example on a noticeboard inside or outside the practice or on the door to the practice.

86. The evidence of EJ was that the Respondent told her that if they needed attention for Cleo when her practice was shut, then they should go to another practice, which was at *'Daneholes roundabout'* in Blackshots. EJ discovered that this practice was called All Animals Vet clinic, and knew where it was. However, when the owners rang that clinic on the following day, it was shut. Consequently, the owners had to make their own enquiries as to a veterinary practice that was open over the weekend.

87. It appears from the evidence that the Respondent had an informal agreement with the Wylie Veterinary Centre to provide out of hours cover for her practice. There was no written contract. Dr Shield comments that this arrangement is of no value if clients were unaware of it, and the Respondent did not tell them about it. In the view of Dr Shield, the information about the Respondent's out of hours' arrangements should have been included on her answerphone message and on a post-operative guidance sheet. She was of the view that anything else is wholly inadequate. The Committee is in agreement with this assessment.

88. In these circumstances, the Committee is satisfied so that it is sure that the Respondent failed to provide adequate information as to the arrangements for her out of hours' emergency cover, as required in the RCVS Code of Professional Conduct (the Code) sections 3.23-3.27**.**

89. Accordingly, the Committee finds Charge 2(d)(iii) proved.

2(e) failed to make adequate clinical records with regard to Cleo

90. The Respondent has not provided any clinical records for Cleo, whether to Cherrydown Vets or to the College. The College invited the Committee to infer that the notes, being absent, were therefore wholly inadequate. Dr Shield states that contemporaneous clinical records, anaesthetic records and hospitalisation sheets could be hugely helpful in resolving the issue about when the bleed happened, and she describes these as essential documents. In addition, she states that it is not known what drugs were given as a pre-medication and as an anaesthetic.

91. The Committee notes that the College made repeated requests for comments and/or documents relating to Cleo on no fewer than 11 occasions, namely 11 December 2019, 4 February 2020, 11 February 2020, 21 February 2020, 13 April 2020, 15 May 2020, 19 May 2020, 8 June 2020, 29 June 2020, 16 July 2020 and 29 July 2020. No clinical records in relation to Cleo were ever forthcoming.

92. The Committee considers that it is entitled to infer from these facts that the Respondent must have failed to make any, or any adequate, clinical records in relation to Cleo. The Committee concludes that there can be no other reasonable explanation for their absence.

93. The Committee is satisfied so that it is sure that the Respondent failed to make adequate clinical records with regards to Cleo.

94. Accordingly, the Committee finds Charge 2(e) proved.

Charge 1

1 Failed to provide adequate information to clients in relation to your out of hours' emergency cover:

(a) *over the Easter weekend in April 2019, and/or*

(b) *on 25 and/or 26 July 2019.*

95. As to Charges 1(a) and (b), the Committee refers to the submissions of the College relating to this charge, which are set out in paragraphs 25 to 27 above. The Committee repeats the evidence referred to in those paragraphs and accepts that evidence for the reasons set out.

96. Therefore the Committee is satisfied so that it is sure that the Respondent failed to provide adequate information to clients in relation to her out of hours' emergency cover over the Easter weekend in April 2019, and on 25 and/or 26 July 2019.

97. Accordingly, the Committee finds Charges 1(a) and (b) proved.

Charge 3

98. The Committee corrected the typographical error in the stem of Charge 3 that Boycie is an English Bulldog not an English Bull Terrier.

3 In relation to surgery on 15 October 2019 to Boycie, an English Bulldog belonging to VL and ZL:

(a) *failed to obtain informed consent for anaesthesia and/or surgery to Boycie*

99. The evidence of ZL is that on 15 October 2019 he took Boycie to the Respondent's practice himself. He went into a room at the practice with Boycie, the Respondent weighed him and gave him an anaesthetic injection. They all waited in the room, but Boycie was not getting drowsy. The Respondent said this sometimes happened, and she would give him another injection, which she did. She said that ZL should go back to the waiting room with Boycie.

Having waited, he went into a room where the Respondent was, and put Boycie on the table. He was told to come back to the practice to collect the dog at around 1pm. ZL states that there was no discussion while he was with the Respondent about any of the risks of the surgery or the anaesthetic or anything else. She did not give him any kind of printed information to look at and she did not ask him to sign a consent form.

100. Dr Shield explains that the Code makes it clear that informed consent for a procedure involves the client being made aware of what the procedure entails and what the alternatives are, together with the associated risks benefits and costs. Section 11.2 of the Code explains in some detail what is required for informed consent. The Respondent stated in an email to the College dated 9 March 2020 that clients are asked if they understand that they are giving her permission to give their pet a general anaesthetic and that there are risks with every anaesthetic and surgical procedure. Although by bringing Boycie to the surgery ZL was giving basic consent to Boycie having cherry eye surgery and left his dog at the practice for that purpose, Dr Shield considers that the process of consent was rudimentary and unlikely to have been properly informed.

101. Having considered all of the evidence and the opinion of Dr Shield, the Committee is satisfied so that it is sure that the Respondent failed to obtain informed consent for anaesthesia and/or surgery to Boycie.

102. Accordingly, the Committee finds Charge 3(a) proved.

3(b) failed to ensure that Boycie had adequate monitoring whilst recovering from anaesthesia

103. As Boycie was recovering from the anaesthetic, the Respondent began surgery on another patient. At the relevant time, the Respondent said she was monitoring Boycie whilst operating on that other patient. In notes sent by the Respondent to Wylie Veterinary Centre on 27 October 2019, she said that Boycie was in view at all times. When she *"had finished"* with the other patient, Boycie coughed while still in lateral recumbency. She noted that, on examination, he was *"very pale/cyanosed"*. In comparison, in the notes sent to the College on 9 March 2020, the Respondent said that she was less than 2 metres from Boycie at all times. She saw him breathe normally over the next 15/20 minutes. When she was *"finishing"* with the next patient he gave a slight cough noise. She was less than 1 metre from him so she opened the cage, checked his mouth/tongue which were *"unusually pale, not pink or cyanosed as I might have expected"*. This is a different account from the account given to Wylie Vets where she described Boycie as *"very pale/cyanosed"*. In other words, the two sets of notes differ. In any event, the Committee finds that neither set of notes was contemporaneous.

104. Dr Shield is of the view that the procedures carried out on Boycie and the other patient can be carried out by a competent surgeon separately without assistance. However, she

considers that "*it would be foolhardy to leave an English Bulldog without undivided attention until it has fully recovered from anaesthesia and able to hold his head up unassisted".*

105. The Committee concludes that, whilst recovering from the anaesthetic, Boycie suffered from post-operative hypoxia, and consequential brain damage, leading to blindness. The Committee finds so that it is sure that this was caused by the Respondent failing to ensure that Boycie had adequate monitoring whilst recovering from the anaesthetic.

106. Accordingly, the Committee finds Charge 3(b) proved.

3(c) failed to offer an adequate range of options for Boycie's overnight care between 15 October 2019 and 18 October 2019, including transfer to another practice or transfer home;

107. The evidence of VL is that at no point during any of the calls that the owners had with the Respondent while Boycie was an inpatient did she give them the option of having Boycie referred to another practice so that he could be cared for overnight. VL repeated this in her oral evidence. The evidence of ZL is that the Respondent did not give them any other options for Boycie's care overnight. The Respondent did not say that he could take his dog somewhere else, or whether there were any alternatives. All she said was *"I'd like to keep him in"*. VL stated that he thought that if there was something wrong with him, then the vets was the best place for Boycie to be kept overnight.

108. Dr Shield was of the view that it was highly undesirable to leave Boycie in such a state of high dependency, alone for such long periods. At one point, he did become trapped in the bars of his cage, and, whilst it appears that he suffered no physical injuries as a result, he could easily have done so. He would have been in pain and distress for an unknown number of hours until the Respondent arrived to free him. Dr Shield states that alternative arrangements would have been either to transfer Boycie's care to Wylie Veterinary Centre, or another practice where he could have received round-the-clock care from qualified staff, or to return him to the care of his owners overnight, to be readmitted the following morning. Clearly the owners could have offered no medical care, but Boycie was receiving none anyway whilst alone overnight. Either of those options would have been preferable to leaving Boycie alone and unsupervised, yet according to the owners these possibilities were never offered by the Respondent.

109. The Committee agrees with Dr Shield so that it is sure that the Respondent failed to offer an adequate range of options for Boycies overnight care between 15 October 2019 and 18 October 2019, including transfer to another practice or transfer home.

110. Accordingly, the Committee finds Charge 3(c) proved.

(d) left Boycie alone overnight on 15 October 2019 and/or 16 October 2019 and/or 17 October 2019, when Boycie was not in a fit condition to be so left;

111. The evidence of VL and ZL is that they were advised to leave Boycie at the Respondent's surgery overnight on the dates set out in the Charge. The Committee relies again on the evidence set out in relation to Charge 3(c). Dr Shield points out that the Respondent stated in a letter of 9 March 2020 that referral or transport to another centre was not an option due to Boycie's ever-changing signs on Tuesday, 15 October 2019. Dr Shield states that, while that may well have been the case before Boycie stabilised at about 7pm that day, he could have been transferred after that. If he was deemed too unwell to travel, he was also too unwell to have been left alone all night.

112. The Committee considered all the evidence in relation to this Charge and is satisfied so that it is sure that the Respondent left Boycie alone overnight over the three dates specified, when he was not in a fit condition to be so left.

113. Accordingly, the Committee finds Charge 3(d) proved.

3(e) failed to provide adequate details to VL and ZL regarding:

(i) *information relating to caring for Boycie at home; and/or*

(ii) *arrangements for your out of hours' emergency cover;*

114. As to Charge 3(e)(i), the evidence of the owners was that they were in shock at the condition Boycie was in when he was brought out for collection from the surgery. From what the Respondent had been telling them over the past few days, that Boycie had been standing and had been lapping food, they thought that perhaps he was just a bit lazy, but he could do these things, and just needed help or encouragement. However, they were *'gobsmacked'* when they saw the condition he was in. He could not eat, drink, stand and toileted where he lay. Given the condition he was in when they saw him that day, they did not believe that the reports they had been given over the past days could have been true.

115. The evidence of the owners is that the Respondent demonstrated certain feeding techniques that she had been using, including hand-feeding soggy biscuits into the dog's mouth and then using a syringe to administer water. The Respondent gave Boycie an antibiotic injection, and also gave the owners Diazepam, which she said they could give him if he did not settle at night. They were given no other information relating to caring for Boycie at home.

116. Dr Shield provided a supplemental report to the Committee during the hearing, setting out the areas where she was of the view that advice should have been given to the owners. This covered aspects of hydration, nutrition, hygiene, pressure sores, and possible referral to a physiotherapist, which she considered would have been important for the care of Boycie at home.

117. The Committee has also seen videos showing a sling/harness which the owners had used to try to assist Boycie to walk at home, but this had been done on their own initiatives.

118. The Committee accepts all of the evidence, and the opinion of Dr Shield in relation to this Charge. The Committee is satisfied so that it is sure that the Respondent failed to provide adequate details to VL and ZL regarding information relating to caring for Boycie at home.

119. Accordingly, the Committee finds Charge 3(e)(i) proved.

120. As to Charge 3(e)(ii), the evidence of ZL is that the Respondent said that they could email her over the weekend, and that they should keep her updated by email on Boycie's progress. She said that she did not need to see him again, and they did not make any further appointments to bring him back to see her. She said his recovery would be a slow process, and that if he did not improve then he would need to be put down. She did not give them any instructions or advice about how to help Boycie once they got him home.

121. The evidence of VL is that they knew that the Respondent would not be available in person over the weekend. She stated *'I do not remember (the Respondent) giving us any information about what to do if we needed advice over the weekend, or if we could contact her. I do not remember her giving us any printed information about how to care for Boycie or who to contact if we needed help. She did not give us any information about any other practices we could take Boycie to, and she did not offer to refer him to another practice. (The Respondent) told us that she was not experienced in dealing with dogs in the condition that Boycie was in, [and] she did not offer to refer us to another vet who did have that experience'.*

122. The Committee notes that the owners were able to contact the Respondent over the weekend by email, but observes that it took the Respondent about four hours to respond to an email with various queries sent in at 10:26am on Sunday, 20 October 2019. Those queries included asking if Boycie was blind. The Respondent did not directly answer this query but made some suggestions in relation to other requests for advice.

123. The Committee accepts the evidence of the owners in relation to this Charge, and is satisfied so that it is sure that the Respondent failed to provide adequate details to VL and ZL about arrangements for out of hours' emergency cover.

124. Accordingly, the Committee finds Charge 3(e)(ii) proved.

3(f) failed to make adequate clinical records with regards to Boycie

125. The Respondent provided two sets of notes in relation to Boycie, namely the set sent to Wylie Vets on 27 October 2019 and the set emailed to the College on 9 March 2020. These are referred to in paragraph 90 above. The Committee repeats what is said in that paragraph. It is clear to the Committee that these notes were not contemporaneous clinical notes, and that the later notes differed from the earlier ones, as set out in paragraph 103.

126. The Committee is satisfied so that it is sure that the Respondent failed to make adequate clinical records with regard to Boycie.

127. Accordingly, the Committee finds Charge 3(f) proved.

Charge 4

With regards to Professional Indemnity Insurance ("PII") requirements, CPD requirements and/or requests from the Royal College of Veterinary Surgeons ("the College"):

4(a) Between 8 April 2019 and 23 October 2020, failed to have in place adequate Professional Indemnity Insurance or equivalent arrangements; and/or

128. The Committee relied on the evidence of Mr Girling and the exhibits to his statement in relation to the interactions between the College and the Respondent. The Committee sought clarification for the dates within the charge and was satisfied that the Respondent was practising between the dates set out in the Charge. Despite numerous attempts by the College to obtain details of the Respondent's PII or equivalent arrangements, no evidence was forthcoming from the Respondent.

129. The Committee was satisfied so that it was sure that the Respondent failed to have in place PII or equivalent arrangements as charges.

130. Accordingly, the Committee finds Charge 4(a) proved.

(b) Between 9 April 2020 and 30 October 2020, failed to provide adequate details of your Professional Indemnity Insurance or equivalent arrangements when requested to do so by the College;

128. Having found Charge 4 (a) proved, Charge 4 (b) falls away as it is charged in the alternative.

(c) Between 9 April 2020 and 30 October 2020, failed to provide adequate details of your CPD when requested to do so by the College;

129. The Committee notes that the Respondent was registered at the RCVS at the relevant time. The Respondent failed to provide any details of her CPD when requested to do so by the College on numerous occasions as particularised in paragraph 55.

130. The Committee is satisfied so that it is sure that this Charge is made out.

131. Accordingly, the Committee finds Charge 4 (c) proved.

(d) Between 11 December 2019 and 30 October 2020, failed to respond adequately to reasonable requests from the College for details and/or documents regarding Cleo belonging to GS and EJ;

(e) Between 17 March 2020 and 30 October 2020, failed to respond adequately to reasonable requests from the College for details and/or documents regarding Boycie belonging to VL and ZL;

129. Despite numerous attempts by the College to obtain details and/or documents relating to Cleo and Boycie the Respondent failed to respond adequately. Particulars of those requests are set out at paragraphs 56 and 57.

130. The Committee is satisfied so that it is sure that on the dates charged the Respondent failed to respond adequately to reasonable requests from the College for details and/or documents regarding Cleo and Boycie.

131. Accordingly, the Committee finds Charges 4(d) and 4(e) proved.

Disciplinary Committee
4 February 2022