IN THE ROYAL COLLEGE OF VETERINARY SURGEONS

DISCIPLINARY COMMITTEE

INQUIRY RE:

MR SIEW LOONG NG MRCVS

DECISION OF THE DISCIPLINARY COMMITTEE

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1. The Charge

The Respondent, who was admitted to the Register of Veterinary Surgeons in 1974, faced the following Charges:

That, being registered in the Register of Veterinary Surgeons, and whilst in practice, you:

1. Between 1 July 2020 and 31 August 2020, in relation to Skye S, a collie bitch;

a) Failed to ensure that Skye's wound was adequately cleaned prior to surgery on 9 July 2020;

b) Failed to provide adequate analgesia:

i. Following Skye's admission on 8 July 2020;

ii. Following Skye's surgery on 9 July 2020;

c) Failed to maintain adequate clinical records for Skye in relation to:

i. The examination you performed on 8 July 2020;

ii. The surgery you performed on 9 July 2020;

iii. The procedure you performed on 20 July 2020, and/or

iv. The procedure you performed on 26 August 2020;

2. *Between February 2020 and May 2021, in relation to dogs and/or puppies belonging to Mr. O:*

a) Failed to record what surgery was performed and/or the technique used in cherry eye surgery performed on one or more of six of the puppies on:

i. 3 June 2021, and/or

ii. 18 May 2021;

b) Performed cherry eye surgery by amputation of the Harderian gland when:

i. Cherry eye surgery was not indicated;

ii. No non-surgical treatment had been attempted, and/or

iii. No attempt had been made to surgically reposition the Harderian gland;

c) Failed to record on 18 May 2021 any or any sufficient detail identifying which puppies had been seen and/or received treatment;

d) Failed to record any or any adequate details in relation to Caesarean sections performed on the following animals on the below dates:

i. A Bulldog named "Storm" on 8 July 2020 and 9 June 2021;

ii. A French Bulldog named "Daisy" on 21 February 2021;

iii. An English Bulldog on 24 May 2021;

iv. A French Bulldog named "Mimi" on 22 October 2020;

v. A dog named "Lucy" on an unspecified date;

vi. A dog named "Marnie" on 28 March 2021;

vii. A French Bulldog named "Stella" on 26 June 2020;

viii. A Bulldog named "Vegas" on 2 July 2020;

ix. A Bulldog named "Minnie" on 11 July 2020;

x. An English Bulldog named "Ren" on 27 January 2020, and/or

xi A Bulldog named "Coco" on 2 July 2020.

e) Failed to record which puppy or puppies were examined and/or to make adequately detailed records for an animal which presented on 2 November 2020 described as "fawn male" with "cherry eye";

f) Failed to make adequate records relating to a dog or dogs presented on 3 June 2021 in relation to which it was noted that you had been consulted in relation to a health passport for Ireland, cherry eye, caesarean section/s and passport/s;

g) Failed to make adequate records in relation to litters of puppies which had been vaccinated in order to enable a reliable duplicate vaccination certificate to be supplied if required, in particular:

i. Four puppies presented on 9 June 2021;

ii A French Bulldog named "Blue Boy" on 28 January 2021;

iii Fifteen doses of Nobivac vaccine invoiced as having been issued to a variety of puppies on 2 November 2020;

iv. A puppy vaccination course administered on 12 May 2020 to 3 Chihuahua puppies, and/or

v. Eight puppies vaccinated on 18 May 2021.

3. *In or around April 2021, in relation to a rabbit named Lilly belonging to Ms. D, you:*

a) Failed to make adequate clinical records for Lilly:

i. On 7 or 8 April 21, and/or

ii. On 9 April 21

4. *On 8 May 2021 in relation to Barney, a Labradoodle belonging to Ms. C:*

a) Failed to offer a reasonable range of options for diagnosis and/or treatment, more particularly:

i. immediate treatment with insulin;

ii. hospitalization for further investigations, and/or

iii. referral to a specialist;

b) Amended clinical records for Barney at a later date without making clear that these changes were made retrospectively and in doing so were:

i. dishonest, and/or

ii. misleading;

c) Failed to maintain adequate clinical records for Barney on the following dates:

i. 6 May 2021; and/or

ii 7 May 2021;

5. *Between 3 June 2022 and 6 June 2022 in relation to Moni, a six-year-old Dobermann bitch belonging to Mr. D and Mrs. A S[redacted]:*

a) On 3 June 2022 undertook Caesarean surgery to Moni without:

i. Any trained assistance;

ii. Informing the owner with adequate notice that you did not have any qualified assistance, and/or

iii. Offering the owner referral to an out-of-hours service;

b) Failed to take adequate steps in relation to Moni's deteriorating condition following surgery on 3 June 2022, more particularly failing to:

i. Admit Moni for hospitalization;

ii. Undertake appropriate or adequate further investigation and treatment

and/or

iii Refer Moni for specialist care;

c) Failed to maintain adequate clinical records for Moni on:

i. 26 May 2022;

ii. 3 June 2022;

iii. 4 June 2022;

iv. 5 June 2022;

v. 6 June 2022;

6. *Between May 2020 and 30 June 2021, you:*

a) Intubated patients for caesarean section surgery which had received only sedation and not general anaesthesia;

b) Began caesarean surgery without securing the presence of any adequately trained assistance;

c) Failed to make any or any adequate record in respect of surgeries performed on 25 April 2021;

d) Deleted records of patients:

i. Sisi, and/or

ii Lily;

e) Failed to make adequate records and/or deleted records for caesarean sections for animals as follows:

i. Bella, a nine-month-old French Bulldog;

ii. Betsey, a French Bulldog belonging to Mrs. B[redacted];

iii. Willow, a French Bulldog belonging to Mrs. B[redacted];

iv. Blue, a French Bulldog belonging to Mr. L[redacted], and/or

v. Princess, an animal belonging to Mr. C[redacted].

7. *Your conduct in relation to 6 d) i. and/or ii. was:*

a) dishonest and/or

b) misleading.

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

2. Preliminary Matters

2.1. The Royal College was represented by Mr. Louis Weston, instructed by Capsticks. The Respondent was represented by Mr. Alex Jamieson, instructed by Keogh's.

2.2 At the outset of the hearing the Committee considered an application, made on behalf of the Respondent, that it should defer hearing evidence until Wednesday, 4 June 2025. The application was made because a very substantial amount of further documentary material, comprising practice records, had been disclosed in the preceding week. It was submitted that the Respondent required further time to consider this material. The application was opposed by the College. Mr. Weston submitted that no further time was required; alternatively, that evidence should begin on Tuesday, 3 June 2025.

2.3 After hearing legal advice, the Committee allowed the application. A large amount of further documentary material had been disclosed to the Respondent's advisers in the course of the preceding week. The Committee determined that it was reasonable that further time should be allowed to enable the Respondent and his legal team to consider all the implications of this material. The Committee would therefore begin hearing evidence on 4 June 2025.

2.4 The Committee also allowed an application by the College to amend Charge 3 a) i. by adding the words "*or 8"* to this Charge so that the amended version now read ["*Failed to make adequate clinical records for Lilly*"] i. "*On 7 or 8 April 21*". The application was not opposed by the Respondent.

3. Admissions

The Respondent made the following admissions at the outset of the hearing:

Charge 2 b i-iii.

[*Between February 2020 and May 2021, in relation to dogs and/or puppies belonging to Mr. O]:*

Performed cherry eye surgery by amputation of the Harderian gland when:

i. Cherry eye surgery was not indicated;

ii. No non-surgical treatment had been attempted, and/or

iii. No attempt had been made to surgically reposition the Harderian gland;

Charge 4 b) ii.

[*On 8 May 2021 in relation to Barney, a Labradoodle belonging to Ms. C]:*

Amended clinical records for Barney at a later date without making clear that these changes were made retrospectively and in doing so were:

i. ……

ii. misleading;

Charge 4 c i. & ii.

Failed to maintain adequate clinical records for Barney on the following dates:

i. 6 May 2021; and/or

ii 7 May 2021;

Charge 5 a) i. & iii, b i -iii and c) i-v

[*Between 3 June 2022 and 6 June 2022 in relation to Moni, a six-year-old Dobermann bitch belonging to Mr. D and Mrs. A S[redacted]]:*

a) On 3 June 2022 undertook Caesarean surgery to Moni without:

i. Any trained assistance;

ii. ……..

iii. Offering the owner referral to an out-of-hours service;

b) Failed to take adequate steps in relation to Moni's deteriorating condition following surgery on 3 June 2022, more particularly failing to:

i. Admit Moni for hospitalization;

ii. Undertake appropriate or adequate further investigation and treatment

and/or

iii Refer Moni for specialist care;

c) Failed to maintain adequate clinical records for Moni on:

i. 26 May 2022;

ii. 3 June 2022;

iii. 4 June 2022;

iv. 5 June 2022 and/or,

v. 6 June 2022;

Charge 6 a)

[*Between May 2020 and 30 June 2021, you*]:

a) Intubated patients for caesarean section surgery which had received only sedation and not general anaesthesia;

Charge 6 d i & ii.

Deleted records of patients:

i. Sisi, and/or

ii Lily;

Charge 6 e) i.-v

Failed to make adequate records and/or deleted records for caesarean sections for animals as follows:

i. Bella, a nine-month-old French Bulldog;

ii. Betsey, a French Bulldog belonging to Mrs. B[redacted];

iii. Willow, a French Bulldog belonging to Mrs. B[redacted];

iv. Blue, a French Bulldog belonging to Mr. L[redacted], and/or

v. Princess, an animal belonging to Mr. C[redacted].

Following the conclusion of his oral evidence, the Respondent also admitted Charge 7,

Charge 7

Your conduct in relation to 6 d) i. and/or ii. was

a) dishonest and/or,

b) misleading.

4. Background

4.1 In January 2020 the Respondent came out of retirement to take up a locum position as a registered veterinary surgeon at a recently established practice owned by a relative, Mr. SC. The practice, "*The Little Pets*", was established in 2018 at premises leased from the Respondent who had himself advised on matters relating to its establishment and secured planning permission. In 2020 as a result of departures from the practice, Mr. SC required the services of a veterinary surgeon who could provide daily cover. He asked the Respondent if he would be prepared to come out of retirement and work there as a locum and the Respondent agreed. In 2020 the Respondent was the only veterinary surgeon at the practice, but at the beginning of 2021 two newly qualified veterinary surgeons were recruited to assist with a growing amount of business.

4.2 Unfortunately, financial disputes arose between Mr. SC and the Respondent. By the middle of 2021 their relationship had broken down amidst mutual antagonism. The practice owned by Mr. SC ceased to operate at about this time, but the Respondent continued to practise on his own account from the same premises, with the assistance of individuals he had recruited. This Practice became known as Tilsworth Veterinary Practice.

4.3 The matters which form the subject of these proceedings relate to alleged failures to have in place an adequate system of record-keeping in relation to clinical work

carried out at the practice, together with allegedly unacceptable clinical practices in relation to a number of different patients, some specifically identified, others not.

4.4 In relation to record-keeping, the College's position was that inadequate clinical information had been entered on the computerized "*EzyVet*" system. The College did not dispute that some further clinical information was held elsewhere, for example on hard copy consent forms, which were filed at the practice. These often included details of medication prescribed, and procedures undertaken, by the Respondent. However, the College maintained that there was no adequate system in place at the practice to ensure that clinicians and others working there would know when the computerised record needed to be supplemented by information held elsewhere and no system to ensure that retrieval of information held elsewhere was readily achievable.

4.5 In addition, in relation to a clinical record held in respect of Barney, a Labradoodle, and where the Respondent's practice had become the subject of a complaint, the College alleged that the Respondent had retrospectively altered the record, without stating that the alteration was retrospective or dating the alteration. The College alleged that this alteration was dishonest as well as misleading. Further, the College alleged that two other patient records had been deleted from the computerised system and that the Respondent's conduct in so doing was also dishonest and misleading.

4.6 In relation to specific clinical failures, the College alleged failures in respect of a number of patients, including Skye, a Collie, various puppies on which the Respondent had carried out cherry eye surgery which involved removal of the Harderian gland, Barney, a Labradoodle, and Moni, a Dobermann bitch. These failures ranged from failing to clean a wound and provide adequate analgesia, to carrying out cherry eye surgery routinely as a practice of first resort; failing to offer a reasonable range of treatment options to a diabetic patient; and undertaking caesarean surgery without trained assistance, without giving the owner adequate notice of the lack of qualified assistance and failing to offer an appropriate response to this animal's deteriorating condition.

4.7 The College also alleged, in general terms, that between May 2020 and 30 June 2021 the Respondent intubated patients for caesarean section when they had only received sedation and not general anaesthesia and begun caesarean surgery without securing the presence of adequately trained assistance.

5. <u>Evidence of Fact: the College's evidence</u>

5.1 The College called eight witnesses to give oral evidence; two veterinary surgeons, Mr. SC, the owner of "The Little Pets" Veterinary Practice, two members of staff from the Practice and three owners of patients treated at the practice. One of the members of staff who gave evidence was also the owner of an animal treated by the Respondent.

5.2 Dr. AP was a newly qualified veterinary surgeon who began work at the practice in January 2021. She told the Committee that at that time she was very inexperienced and had learned a great deal from the Respondent. To her recollection, the animals upon which the Respondent carried out caesarean surgery were effectively

anaesthetised. She recalled there being about 15 -20 minutes between sedation and intubation. Hard copy consent forms would be completed by the veterinary surgeon and be dealt with by administrative staff. Her practice was to look at the clinical records on the "*EzyVet"* computer system and she said she was not aware of any further system in hard copy. However, if a problem arose, she said that she would dig out the handwritten records. She had never accessed a hard copy record but said that she would have done so if she needed to.

5.3 Dr. LR, also newly qualified, joined the practice at the same time as Dr A.P. He had assisted the Respondent with caesarean sections many times and saw nothing wrong with the anaesthetic procedure. The nursing assistants at the practice were not qualified veterinary nurses but he thought that they were capable. Consent forms were filed and stored by the administrative staff. He couldn't remember any time he needed to look for a consent form.

5.4 Mr. SC told the Committee that he was a chartered accountant and entrepreneur who had decided to set up a veterinary practice. He took advice on this from the Respondent who acted as his mentor on the project and leased to him the premises from which the practice was to operate. He confirmed that he had asked the Respondent to work as a locum at the practice when he needed a veterinary surgeon to cover for staff who had left and envisaged that this arrangement would not be long-term. He became concerned when a member of staff told him in March 2021 that the Respondent had taken £1000 in cash from the safe and had deleted clinical records from the "*EzyVet*" system in relation to a dog called Lily, upon whom a caesarean section had been performed and for which £1,000 had been paid. Further investigation showed that clinical records had also been deleted in respect of another animal, Sisi, who had also undergone a caesarean section.

5.5 Mr. SC said that he received further reports from members of staff that a large number of caesarean sections were being carried out by the Respondent which were not being entered on the practice's computerised record system, and for which consent forms could not be found. When he raised these issues with the Respondent, their relationship became further strained. Subsequent investigation by Mr.SC revealed a number of consent forms for caesarean section surgery which were often undated and not matched by any corresponding record on the "*EsyVet*" computerised system. Consequently, it was impossible to be certain whether surgery had in fact taken place, and if so when and under which veterinary surgeon.

5.6 Mr. SC said that he also received reports from the staff about incidents where the Respondent's clinical practice had become the focus of complaint, in particular about his treatment of Barney, a labradoodle who suffered from diabetes.

5.7 On 17 May 2021 Mr. SC told the Respondent that he was dispensing with his services but the Respondent continued to work at the practice despite this. On 18 June 2021 Mr. SC closed "The Little Pets" practice but the Respondent continued to work from the premises with new staff that he had recruited. The practice was at that stage renamed Tilsworth Veterinary Practice.

5.8 Ms. DM and Ms. ED were both members of staff at The Little Pets Practice. Ms. DM worked there from 30 January 2020 until June 2021 and Ms. ED from 22 March 2021 to June 2021.

5.9 Ms. DM said that during 2020 the Respondent was the only veterinary surgeon working at the practice and that many clients who used the practice were breeders, mainly of Bulldogs, who had known the Respondent during the earlier stages of his career. She had previously worked with the Respondent for a long time at his previous practice. She had had no training. She said that hard copy consent forms were stored and could be found if required and that details of the procedure undertaken and the medication used could be entered on the forms by anyone.

5.10 Ms. DM told the Committee that at some time after March 2020 (during the Covid lockdown) the Respondent told staff at the practice not to register his clients and that he would treat these animals without creating any records. This work was done mainly out of hours. Caesarean sections would be carried out at night, and the breeder would often be in the operating theatre assisting the Respondent when Ms. DM arrived to assist. She said that often she could not find consent forms for these procedures. She thought that, being “out of hours” operations, these were emergency cases.

5.11 Ms. DM also criticized the anaesthetic procedures adopted. She maintained that sedative medication would be given based upon an estimate of the patient’s weight and intubation would begin before the sedative had taken effect. She also said that surgery would begin before the animal was properly anaesthetised.

5.12 In relation to the specific case of Skye, a Collie who was brought to the practice with a compound fracture of the right tibia and fibula, she maintained that she saw that Skye was left in a kennel without the wound being cleaned, despite the fact that she was very dirty through working with cattle, and that she was given very limited pain relief; she thought an injection possibly Synulox, an antibiotic, had been administered and nothing else. This, despite the Respondent being asked by staff whether she should be given additional pain relief.

5.13 Ms. ED worked at The Little Pets Practice for a period of about three months. She received no training beyond an induction and did not feel she was qualified to fill all the roles she was required to undertake. These included assisting at caesarean sections by monitoring anaesthesia and adjusting the anaesthetic machine under direction. She also told the Committee that cherry eye surgery was often carried out before sedation had taken effect.

5.14 She recollected that hard copy consent forms were stored. She was not involved in filing them but could remember the boxes in which they were stored. She could not remember details being written on the forms and said that these would be entered by the veterinary surgeon.

5.15 Ms. ED had had her own pet rabbit, Lily, treated by the Respondent. Unfortunately, the rabbit had died following anaesthesia. She was unhappy about the treatment offered, said that she had not given consent for an anaesthetic and had raised a grievance with Mr. SC and complained to the College.

5.16 Mrs. MC was the owner of a Labradoodle, named Barney. Barney had been subject for some time to recurring episodes involving an upset stomach and loss of appetite. He had for several months been treated conservatively via diet , anti- inflammatory medication and antibiotics but his condition was worsening. He was not eating, was drinking excessively and was frequently urinating in the house. The Respondent became involved in his care on Thursday 6 May 2021, after a blood sample had been taken. Mrs. MC said that he told her on that day that Barney was diabetic but that he would need to establish whether the diabetes was Type 1 or Type 2. He recommended reassessment on the following Monday and a low carbohydrate diet.

5.17 Mrs. MC was sufficiently concerned by Barney's condition to bring him back to the surgery the following day. She said that at that appointment the Respondent prescribed some medication (in fact, Dexafort which, in his oral evidence, he acknowledged was contra-indicated in light of his diabetes' diagnosis) and gave him an injection to settle his stomach. Barney's condition continued to worsen and Mrs. MC attended the Practice again on Saturday, by which time, she said, she had to carry Barney into the consulting room. She told the Committee that she had a conversation with the Respondent in which he told her that he was pretty sure that Barney had cancer, that a scan would be of limited value in the circumstances and implied that euthanasia was the appropriate course. Mrs. MC said that she was very upset by this but accepted that her appointment for the following Monday would become an appointment for euthanasia. She took Barney home for the weekend so that her family could say good bye to him. She said that the Respondent provided her with some antibiotics to help Barney through the weekend.

5.18 Mrs. MC said that Barney remained poorly over the weekend but was much better on Monday. She cancelled the euthanasia appointment that she had made and arranged with Dr AP for further tests to be carried out. These did not support a diagnosis of cancer but confirmed the presence of diabetes. Mrs. MC produced a letter of complaint and an email chain of her correspondence with the Practice over this period which reflected concerns about the advice she had received from the Respondent.

5.19 Mrs. AS owned a Dobermann bitch called Moni. The Respondent had previously been involved with the care of this patient during earlier pregnancies. In her first pregnancy she had required an Oxytocin injection to bring her labour to a satisfactory conclusion and during her second pregnancy she required a caesarean section. She was pregnant with her third litter and the Respondent had provided Mrs. AS with two syringes of Oxytocin in view of previous difficulties and the impending Bank Holiday weekend.

5.20 On 3 June 2022 (the late Queen's Jubilee weekend) Moni successfully delivered six puppies but then ran into difficulties. Mrs. AS administered Oxytocin and tried, initially without success, to contact the Respondent. She did manage to make contact with an out of hours veterinary service who advised her to bring Moni in if there had been no further developments within an hour. During this period the Respondent returned Mrs. AS's earlier call and advised further Oxytocin. This did not produce improvement, so the Respondent advised that Moni should be brought to him. Mrs.AS said that he did not tell her that he was not on call at that time, nor that he

would have no one to assist him at the Practice should that be required. She arrived at the surgery with her husband and the Respondent asked her to accompany Moni into the operating theatre. When she got there, Mrs. AS realised that there was no other assistance present and she held Moni on the floor while an anaesthetic was administered. Her husband was called in to help lift Moni onto the operating table. Subsequently, she and her husband assisted in the delivery and care of six puppies.

5.21 In her witness statement prepared for these proceedings, Mrs. AS set out the postoperative history. Moni did not recover well from the caesarean section and her condition subsequently deteriorated. Mrs. AS contacted the Respondent on 4 June, and he advised that the patient's condition was to be expected after the delivery of a large litter. Subsequent telephone communications took place on 5 June. By 6 June Mrs.AS had become so concerned that she brought Moni into the Practice. A blood test was undertaken, and the Respondent administered three injections, an antibiotic, a steroid and an anti-emetic. He reassured Mrs. AS.

5.22 Moni's condition continued to deteriorate through the day on 6 June and the Respondent advised by telephone that Mrs. AS should wait for the antibiotics to take effect. After Moni had been found collapsed on the floor, the Respondent said that he would put her on a drip the following day. Mrs. AS and her husband decided to seek a second opinion and contacted an out of hours practice. At that practice Moni was admitted immediately and subsequently received intensive care specialist treatment which included insulin for diabetes, the removal of her womb due to infection, medical support for sepsis and a blood transfusion. Mrs. AS submitted a complaint to the College about the advice and treatment given by the Respondent.

5.23 Mr. DS, told the Committee that it took about 20 minutes to drive Moni from their home to the Practice and the out of hours veterinary service was a similar distance away from their home, perhaps 25 minutes' drive.

5.24 The Committee read a number of witness statements by agreement. These related to the care that Moni, the Dobermann bitch, was given following her admission to the emergency vet service. They were uncontroversial.

5.25 The Committee was also provided with a very large volume of documents, comprising practice records and correspondence.

6. <u>Evidence of fact: the Respondent's evidence</u>.

6.1 The Respondent gave oral evidence. He told the Committee that he qualified as a veterinary surgeon in 1974. In 2018 he helped his relative, Mr. SC to set up "The Little Pets" Veterinary Practice. The Respondent provided the premises and advised. He said that he also provided funding. At the beginning of 2020 he agreed to take up a full -time locum position at the practice. Over the next 18 months his relationship with Mr. SC deteriorated amidst financial disputes. The Respondent maintained that he was not being paid rent, or his salary, and he decided to take cash, which was being paid by clients of the practice, to reimburse himself for moneys that he believed he was owed.

6.2 The Respondent accepted that the clinical records he made were brief. He usually only made a note on the "*EzyVet*" system of anything abnormal. If a patient was

admitted for surgery a consent form was prepared, and the Respondent asked his assistant to write details of the procedure and any drugs given. In his witness statement the Respondent said that these details would then be entered onto the "*Ezyvet"* system by another member of staff but in oral evidence he accepted that he did not check whether the necessary details had in fact been entered. Consent forms were stored in plastic drawers in the office, not by reference to the identity of the patient but in date order. When the drawer was full the forms were transferred to a box or lever arch file and continued to be stored in date order. The Respondent said that if he needed to see one of the forms, he would ask an assistant to find it for him and they would do so. He also said that forms were completed for puppies which needed to be microchipped and these forms were stored in the same way.

6.3 The Respondent maintained that in relation to "out of hours" work the full record was kept on a hard copy consent form in the form of handwritten notes, some of which were retained in the practice and some kept in his house next door to the practice. He accepted that creating two separate clinical records for one animal *"was not the preferable way of keeping records*" and that "*my clinical records are at best brief and on occasions are inadequate*". He said that he understood that the way in which he kept records created a risk that the two pieces of the record would not be put together and said that he now had a process to ensure that *"the computer record is the complete record"*.

6.4 The Respondent told the Committee that he had for many years been involved with breeders of Bulldogs. Although he was aware that there were treatment modalities in cases of "cherry eye" which did not involve amputation of the Harderian gland, he did not consider these options to be effective and he did not believe that amputation of the Harderian gland had a significant impact upon lacrimal function. He was therefore content to amputate the Harderian gland as a treatment of first resort and this was the only treatment he offered. He said that he explained the implications of amputation to new clients but many of his clients were Bulldog breeders who knew of the implications and were keen to have the procedure carried out.

6.5 In relation to his treatment of Skye, a Collie, the Respondent denied that he had failed to clean her wound or offer adequate analgesia. He referred the Committee to a radiograph taken at the time at which he says he heavily sedated the patient, clipped and cleaned the wound and splinted and bandaged it. He pointed to the successful outcome of the surgery he had undertaken. The Respondent accepted that he saw Skye again on the 20th of July and that a screw from the plate he had placed to stabilize the fracture had become loose and was protruding from Skye's leg. The Respondent stated that he was able to remove this with Skye simply being held on her lead by the owner and that no anesthesia was required for this. The Respondent further explained that, following the loss of this screw, he decided to replace the plate stabilizing the fracture with a longer plate to offer more anchorage of the plate to the bone; this operation took place on the 26th of August 2020.

6.6 In relation to Barney, the Labradoodle, the Respondent said that he first became involved when he saw this patient on Thursday 6 May 2021 and concluded, on the basis of blood test results, that Barney was diabetic. He advised a low carbohydrate diet and said that further tests of urine and blood were required prior to reassessment

on Monday 10 May. When he saw Barney the following day, he said that the dog did not present with any visible clinical signs although the client was reporting lack of appetite, vomiting and diarrhoea, so he prescribed medication, *Cerenia*, to deal with vomiting, *Dexafort*, an anti-inflammatory, and *Synulox* to treat a possible infection. When he saw Barney again, on Saturday 8 May, he said that he did not want to start insulin treatment over the weekend in case it caused an adverse reaction and decided to wait until Monday, 10 May, to better assess the effects of the change to a low carbohydrate diet and the response to antibiotics. He accepted that there had been some discussion of the possibility of a tumour but he said that he had not found any growth when he had palpated the dog and denied that he had implied that euthanasia was the appropriate outcome. He further stated that he could diagnose cancer just by looking at an animal. He said that when he found that Mrs. MC was unhappy to pay the consultation fee, he offered to do x-rays and blood samples straightaway so that insulin treatment could begin on Saturday if necessary (depending on the blood sample results). He said Mrs. MC had refused that offer.

6.7 The Respondent accepted that he had retrospectively altered the clinical record of the consultation on 8 May 2021. He had done this on 14 May 2021. He said that he wanted to provide a more detailed record of the advice he had given at the consultation. He said that he knew at that time that Mrs. MC was giving what he considered to be an incorrect account of his advice and he wished to provide clarity. He said that it never occurred to him that he was doing anything wrong and his intention was not to mislead or deceive in any way.

6.8 In relation to Moni, the Dobermann, the Respondent said that when Mrs. AS had first contacted him about the difficulties Moni was experiencing in delivering her litter, he advised a further dose of Oxytocin and to wait for an hour. When no change had occurred, he advised her to bring Moni to the surgery so that he could examine her. He said that he opened up the surgery himself in preparation and upon examining Moni realised that there were puppies higher up in her uterus. He said that he administered another injection of Oxytocin but there was still no sign of progress so he advised Mrs. AS that there may be something amiss and that he would perform a caesarean section as an emergency. He explained that he did not have anyone to help with the procedure and would need the owners' assistance to get Moni on to the operating table. He then delivered six puppies with the assistance of Mrs. AS and discharged Moni.

6.9 The Respondent said that Moni was understandably weak on discharge as she had delivered a large litter of puppies. But he judged that it was appropriate to discharge her, particularly as there were six earlier puppies waiting to be fed at home. His recollection was that Mrs. AS told him on the following day that Moni was not too bad and that when he spoke to Mrs. AS a day later he did not recall her describing Moni as "*that sick*". He said that he offered to see her out of hours and when he saw Moni on Monday, 6 June, she seemed to be quite happy. Tests revealed that Moni was suffering from gestational diabetes and he suspected that she might be suffering from pancreatitis. He felt that the best course was to treat pancreatitis and that Moni should remain at home with her puppies. He said that he was going to conduct further blood tests the following day to see how she had responded and adapt his treatment plan accordingly. Mrs. AS rang the practice again at about 7 pm on

Monday 6 June, but, according to the Respondent, said that Moni was now looking better, and was "*lying peacefully*". The Respondent said there was no suggestion that Moni was vomiting blood. He was not asked to see her that evening and did not see her again.

6.10 In relation to the general matters alleged against him at Charge 6, the Respondent said that his procedure when carrying out caesarean surgery was to deeply sedate prior to intubation and then to administer a gaseous anaesthetic prior to surgery.

6.11 He said that he would only attempt caesarean surgery without a second suitably trained person in an emergency.

6.12 He accepted that records were not made on the practice computerised system in relation to ten caesarean sections that he had performed on Sunday, 25 April 2021. He said that a signed consent form had been obtained from each owner and that records were kept on the consent form. He did not enter details on the practice system because he said that his arrangement with Mr. SC was that the money from work undertaken "out of hours" would come directly to him.

6.13. The Respondent said that he had deleted records relating to Lily and Sisi because these caesarean sections were covered, he said, by his "out of hours" arrangement with Mr. SC but for some reason had been entered on the practice system. He accepted, when shown the record, that these procedures had in fact not been undertaken "out of hours" as he had maintained but had been conducted during normal practice hours. He maintained during his evidence that he had deleted records because he did not wish clients to be charged twice and that Mr. SC knew that he was taking money from the practice safe to compensate him for work that he had done and to reimburse him for money that he was owed.

6.14 The Respondent produced a substantial number of testimonials which set out the opinions of the authors as to his competence and honesty

6.15 The Committee also read some witness statements which were unchallenged from Skye's owner, Mr. JS, and from Ms. ET and Mr. NL. The latter two witness statements dealt with the systems operated at the practice after the closure of "The Little Vets" in June 2021.

6.16 Mr. JS recalled taking Skye to see the Respondent after a cow had fallen on her, causing what he suspected was a fracture of one of Skye's hind legs. He recalled the Respondent administering an injection and taking a radiograph. He recalled leaving Skye at the practice and returning a few days later by which time the fracture had been repaired. In his witness statement he recalled that Skye did not appear to be in any pain at any stage and the site of the surgery was never infected. Later one of the screws securing the plate in her leg worked loose and began to protrude and the Respondent subsequently removed it.

7. <u>Expert evidence</u>

7.1 The Committee received expert evidence from Dr. Christine Shield MRCVS and Mr. Charles Williams MRCVS. Both experts had prepared reports and had produced a Joint Report setting out areas of agreement and disagreement. Each gave oral evidence to the Committee. The Committee was assisted by their evidence. Much of

their evidence was concerned with the extent to which, if at all, the Respondent's alleged or admitted conduct fell short of appropriate expectations and was therefore chiefly relevant to a later stage of these proceedings. The Committee will refer to it at this stage if relevant when considering the individual charges.

8. The Committee's findings of fact: Preliminary.

8.1 The Committee received helpful written and oral closing submissions from Counsel. The Committee accepted the legal advice it received.

8.2 The Committee accepted all of the admissions made by the Respondent and found those matters Proved by Admission.

8.3 Before considering the remaining outstanding Charges the Committee considered that it was necessary to record that this case had a very unusual history. In the week before the hearing was due to begin, a very substantial quantity of Practice records in the form of hard copy consent forms and other documentation was disclosed by Mr.SC, who said that he had not previously appreciated that the contents of a box of documents held by him were hard copy clinical records. They put a different complexion upon the case in relation to the existing record-keeping Charges. They led the College to offer the following Concession [the Concession]:

"The College's position on review of the Late Material [is that] it is apparent that it was common at the Practice for manuscript notes to be made on Consent and other forms which included details of drugs and other matters.

The College accepts that this is the position that Mr. Ng has maintained and that such records made by him had been lost.

The College will not therefore challenge Mr. Ng's case that he made a record of treatment to animals on such documents (the Documentary Records) and nor will the College pursue any allegation that Mr. Ng has destroyed such records.

Further, in relation to the Late Disclosure [the College] will not make any allegation that the Documentary Records did not sufficiently record details of treatment given and/or medicines prescribed to the patients the subject of those documentary records".

8.4 The existing Charges, formulated before these documents came to light, remained unamended in the light of the Concession. Mr. Weston made clear when he opened the College's case that the criticism of the Respondent's record keeping no longer rested upon the alleged inadequacy of detail in the relevant records but was rather a criticism of the adequacy of the record-keeping procedures in the Practice; in particular, the maintenance of two separate sets of clinical records, one computerised and one not, which were imperfectly connected and, in the case of the hard copy records, not readily accessible to those who might need to, or benefit from, seeing the complete clinical record.

8.5 This modification of the College's position required the Committee to consider in relation to each record-keeping Charge whether the wording of the Charge was appropriate to include the criticism of the system upon which the College now advanced its case.

8.6 The revised position also enabled the Committee to consider each record-keeping Charge by reference to its finding in relation to the adequacy or otherwise of the system adopted in the Practice, as the same system applied to each of the individual record-keeping Charges. Both parties had adopted this approach in their written closing submissions.

9. <u>The record keeping system at "The Little Pets" Practice.</u>

9.1 The Committee therefore first considered the evidence it had heard in relation to the record-keeping system at the Practice. The Respondent himself accepted both in his oral evidence and in his written communications with the College that his record-keeping left much to be desired. He did not ensure that a sufficiently detailed clinical record was entered on the "*EzyVet"* system and he did not check the entries made by unqualified staff on any hard copy record.

9.2 For obvious reasons, any system in which the clinical record is divided into parts which are then stored in different places is less satisfactory than a system in which all of the record is stored in one place. The Committee then considered the extent to which the nature of the arrangements in place at "The Little Vets" was understood by relevant clinicians and whether such clinicians would be able to access relevant records within a relatively short period of time in the ordinary course of their work.

9.3 Dr AP told the Committee that she was not aware of where consent forms were stored and was also not aware of what information the Respondent was recording on the consent forms. She said that she would look at clinical records on "*EzyVet*" and was not aware of any supplementary record system in hard copy, although she did say that if there was a problem she would dig out the handwritten records. This answer is difficult to reconcile with the state of ignorance about these records revealed by her other answers. There was no suggestion in her evidence that the Respondent had explained to her the potential relevance of hard copy paper records and no suggestion that she had in fact ever looked at previous consent forms.

9.4 Dr LR also told the Committee that he could not remember any time when he had looked at a previous consent form and there was no suggestion from him that he had been told by the Respondent of the information recorded in hard copy or what he needed to do to access such information.

9.5 The Committee was sure that neither of the clinicians who began work at the Practice in January 2021 was aware that the clinical records on "*EzyVet"* could only be regarded as complete if supplemented by hard copy records held in date order in box files in drawers at the Practice.

9.6 Of the staff members at the Practice who gave evidence, Ms. ED could not remember details being written on consent forms. She knew that such forms were stored but was not involved in filing them.

9.7 Ms. DM told the Committee that details of procedures and medications were entered on the consent form by anyone who happened to be assisting at the procedure and, if there was time, would be transferred on to the "*EzyVet*" system, particularly if the notes had been written by the veterinary surgeon. It was common ground that there were no registered veterinary nurses working at the Practice and Ms. DM said that

she had received no training. The Respondent did not suggest in his evidence that he had ever checked to see whether information being entered in hard copy by his assistants was correct and whether the details were in fact being transferred onto "*EzyVet*".

9.8 On the basis of all the evidence it had heard the Committee was sure that "The Little Pets" Veterinary Practice was equipped with a modern computerised system designed to retain complete clinical records. In fact, complete clinical records were not entered into this system but were held in part on the system and in part in hard copy elsewhere. The Respondent did not supervise what was entered on the system or in hard copy and did not explain to other clinicians the arrangements under which clinical information was being kept.

9.9 While some staff at the Practice may have been aware of the fact that information might also be recorded on paper documents stored at the practice, it was evident that they would have no way of knowing whether, in any particular case, the "*EzyVet*" record was incomplete and that the paper documents needed to be located and consulted. This situation amounted to inadequate maintenance of clinical records.

10. <u>The Charges which remain to be resolved</u>.

10.1 1. *Between 1 July 2020 and 31 August 2020, in relation to Skye S, a collie bitch*:

a) Failed to ensure that Skye's wound was adequately cleaned prior to surgery on 9 July 2020.

In view of the specific date alleged in this Charge, the Committee needed first to consider whether surgery had taken place on 9 July 2020. The available contemporaneous records indicate that surgery took place on 10 July. The clinical record states that on 9 July Skye was treated as follows: "*x-rayed fractured tibia, cleaned and bandaged, given Metacam injection*". On 10 July an invoice was raised for surgery to "*Repair broken leg*" and one night of hospitalization was also billed.

The support for surgery taking place on 9 July is derived from the evidence of Ms. DM and she accepted in oral evidence that she could not be sure about the precise date. Her evidence is insufficient to displace the dates suggested by the clinical and financial record and the Committee does not regard the witness statement of Mr. JS, prepared many years after the event, as useful on this particular point.

Although this finding would be enough to dispose of this allegation, the Committee considered that, in fairness to the Respondent and in view of the evidence it had heard, it should address the substance of the allegation. The Committee has already referred to the clinical record which indicates that the wound was cleaned. The Committee also noted that the surgery carried out by the Respondent was successful and that there was no suggestion of infection taking hold. Skye was a working cattle dog who would inevitably have become dirty in the course of her work. In the absence of adequate cleaning, infection was highly likely. All of this evidence supports the Respondent's assertion that he cleaned the wound

The Committee therefore finds Charge 1 a) Not Proved.

10.2 *b) Failed to provide adequate analgesia:*

i. Following Skye's admission on 8 July 2020 and/or

ii. Following Skye's surgery on 9 July 2020.

The Committee's previous observations with regard to specific dates are repeated. On the basis of the documentary evidence it seems likely that Skye's admission was on 9 July and surgery on 10 July.

The support for the allegation that insufficient analgesia was provided is to be found in the evidence of Ms. DM. The Committee has reservations about the reliability of that evidence. Ms. DM admitted in oral evidence that her initial account of this incident, in which she had alleged that the Respondent had given no medication and had refused to refer Skye, in the teeth of the owner's requests, had been exaggerated. Later her account in her witness statement was that "*I think Michael [the Respondent] gave Skye an injection (possibly Synulox)*".

The clinical record states that an injection of Metacam was given on admission. Dr Shield was of the view that this could be sufficient pain relief in certain circumstances.

The Committee had the benefit of a radiograph showing the fracture. Mr. Williams told the Committee that it was very unlikely, although possible, that a radiograph of this type could have been obtained if Skye had been in significant pain.

The Respondent's evidence was that he had given sedative drugs in the form of *Sedator* and *Torbugesic*, as well as an antibiotic in the form of *Sinulox* following Skye's admission. Following surgery Skye was discharged with a course of non-steroidal anti-inflammatory drugs. There was no contemporary documentary evidence of this.

The owner, Mr. JS, recalled that he had been provided with a handful of tablets when Skye was discharged. In his statement he wrote: "*At no stage did Skye present as being in any pain whatsoever.*"

In these circumstances the balance of the evidence strongly suggests that adequate analgesia was administered both following admission and following surgery. There is no basis upon which the Committee could be sure that adequate analgesia was not administered.

The Committee therefore finds Charge 1 b) i. and ii. Not Proved

10.3 *c) Failed to maintain adequate clinical records for Skye in relation to:*

i. The examination you performed on 8 July 2020;

ii. The Surgery you performed on 9 July 2020;

iii. The procedure you performed on 20 July 2020;

iv. The procedure you performed on 26 August 2020;

Sub-paragraphs i and ii. must be found Not Proved on the basis that the Committee cannot be sure that, respectively, an examination and surgery was carried out on 8 or 9 July 2020.

The Committee is satisfied that the procedures described in paragraph 6.5 were carried out on 20 July 2020 and 26 August 2020 and that adequate clinical records were not maintained in respect of these procedures for the reasons it has explained in Paragraph 9 above.

The Committee therefore finds Charge 1 c) i.and ii. Not Proved.

The Committee finds Charge 1 c) iii. and iv. Proved.

10.4. *2) Between February 2020 and May 2021, in relation to dogs and/or puppies belonging to Mr. O.*

a) Failed to record what surgery was performed and/or the technique used in cherry eye surgery performed on one or more of the six of the puppies on

i. 3 June 2021, and/or

ii. 18 May 2021

The Committee concluded that that this Charge relates to what was recorded in the record rather than to the maintenance of an adequate system of record keeping. It was thus covered by the College's Concession that "*Further in relation to the Late Disclosure [the College] will not make any allegation that the Documentary Records did not sufficiently record details of treatment given and/or medicines prescribed to the patients the subject of those Documentary Records".*

The Committee therefore finds Charge 2 a) i. and ii. Not Proved.

10.5 *c) Failed to record on 18 May 2021 any or any sufficient detail identifying which puppies had been seen and/or received treatment.*

The Committee concluded that this Charge relates to what was recorded in the record rather than to the maintenance of an adequate record-keeping system. It was therefore covered by the Concession.

The Committee therefore finds Charge 2 c) Not proved

10.6 *d) Failed to record any or any adequate details in relation to Caesarean sections performed on the following animals on the below dates*; [there follows a list of 11 animals and dates]

The Committee concluded that this Charge relates to what was recorded in the record rather than to the maintenance of an adequate record-keeping system. It was therefore covered by the Concession.

The Committee therefore finds Charge 2 d) Not Proved.

10.7 *e) Failed to record which puppy or puppies were examined and/or to make adequately detailed records for an animal which presented on 2 November 2020 described as "fawn male" with "cherry eye".*

The Committee concluded that this Charge relates to what was recorded in the record rather than to the maintenance of an adequate record-keeping system. It was therefore covered by the Concession.

The Committee therefore finds Charge 2 e) Not Proved.

10.8 *f) Failed to make adequate records relating to a dog or dogs presented on 3 June 2021 in relation to which it was noted that you had been consulted in relation to a health passport for Ireland, cherry eye, caesarean section/s and passports/s.*

The Committee concluded that this Charge relates to the maintenance of an adequate system of record-keeping; in particular, that the phrase "*failed to make adequate records*" includes an obligation to have in place an appropriately maintained system of record-keeping. The Committee is sure that such a system was not in place in relation to the matters specified in this Charge for the reasons set out in Paragraph 9 above.

The Committee therefore finds Charge 2 f) Proved.

10.9 *g) Failed to make adequate records in relation to litters of puppies which had been vaccinated in order to enable a reliable duplicate vaccination certificate to be supplied if required, in particular:* [there follows a sequence of five separate dates on which a variety of such failures is alleged].

The Committee concluded that this Charge relates to the maintenance of an adequate system of record-keeping; in particular, that the phrase "*Failed to make adequate records*" includes an obligation to have in place an appropriately maintained system of record-keeping. The Committee is sure that such a system was not in place in relation to the matters specified in this Charge for the reasons set out in Paragraph 9 above.

The Committee therefore finds Charge 2 g) Proved in its entirety.

10.10 *3. In or around April 2021, in relation to a rabbit named Lilly belonging to Ms. D, You:*

a) Failed to make adequate clinical records for Lilly:

i. On 7 or 8 April 2021 and/or

ii. On 9 April 2021

The Committee concluded that this Charge relates to the maintenance of an adequate system of record-keeping for the same reasons as those set out in paragraphs 10.8 and 10.9 above.

There was no evidence that the Respondent saw Lilly on 7 April 2021.

The Committee is sure that an adequate record-keeping system was not in place in relation to the appointments of 8 and 9 April 2021, for the reasons set out in Paragraph 9 above.

The Committee therefore finds Charge 3 a) i. and ii. Proved in relation to appointments on 8 and 9 April 2021.

10.11 *4. On 8 May 2021 in relation to Barney, a Labradoodle, belonging to Ms. C:*

a) Failed to offer a reasonable range of options for diagnosis and/or treatment, more particularly:

i. immediate treatment with insulin;

ii.hospitalisation for further investigations;

iii. referral to a specialist.

On Saturday, 8 May 2021 Mrs. MC brought Barney, her Labradoodle, into "The Little Pets" Practice for the third day in succession. Barney's long-standing health issues had worsened in the preceding days and there is no dispute that the Respondent had arrived at a firm diagnosis of diabetes on Thursday 6 May 2021. There is a dispute between Mrs. MC and the Respondent as to Barney's presentation, with Mrs. MC stating that he was so weak that he had to be carried into the consultation and the Respondent stating that Barney walked into the surgery and had improved slightly. There is agreement between Mrs. MC and the Respondent that the possibility of cancer was discussed, though there is dispute as to the way in which this subject was introduced and whether the Respondent was implying that euthanasia would be the appropriate course of action. Importantly, the Respondent does not suggest that, at the consultation itself and before any dispute about the bill which, he says, occurred at the receptionist's desk outside, he offered any of the alternatives set out in this Charge as a reasonable option for diagnosis and/or treatment. He says that he did not want to start treatment with insulin until Monday 10 May when the effects of the change to a low-carbohydrate diet and the response to antibiotics could be better assessed. The fact that none of the options set out in the Charge was offered at the consultation itself is consistent with Mrs. MC's account.

Dr Shield's view, expressed in her report, is that each of the options set out would have been reasonable courses of action and a failure to offer any constitutes conduct falling far below that of a reasonably competent veterinary surgeon. Mr. Williams agreed.

It was clear to the Committee, from such clinical records that do exist for Barney, that it would have been obvious to the Respondent that Barney's health was deteriorating. The Respondent had seen Barney on three occasions on successive days and recorded worsening symptoms; had blood test results on the 6th of May and urine on the 8th, all showing elevated glucose levels. It was clear to the Committee and, it concluded, it should have been clear to the Respondent that his treatment plan of a low carbohydrate diet, anti-inflammatories & anti-emetics was not working. In fact, the Respondent's administration of Dexafort, a gluco-neogenic steroid, was contra-indicated and likely worsened Barney's already unstable diabetes. The Committee accepted the experts' evidence and concluded that the Respondent's duty was to then provide the owner with other reasonable treatment options at that consultation on the 8th of May 2021.

After the consultation had concluded, the Respondent says that he came out of the consulting room to find Mrs. MC expressing her dissatisfaction and refusing to pay the bill. The Respondent said that, at that point, *"I offered to do the X-Rays and the blood samples straightaway so that we could begin insulin treatment that Saturday if necessary (depending on the blood sample results)".* In her oral evidence Mrs. MC very strongly disputed this.

The Committee is sure that no such offer was made by the Respondent. It was evident to the Committee that Mrs. MC had found the way in which Barney had been treated emotionally demanding. Mr. Jamieson submitted that in such circumstances misunderstandings and failures of recollection could easily occur. While appreciating this, the Committee also noted that Mrs. MC's account appeared at a very early stage in the letters and emails she was writing to the Practice at the time. What is apparent from that correspondence, beginning on 11 May 2021, and which included complaints that no treatment had been prescribed and that antibiotics were not working, is that Mrs. MC was becoming increasingly concerned that Barney's condition was deteriorating and there appeared to be no additional treatment or diagnostic interventions offered. The Committee noted that, when insulin therapy was prescribed by Dr AP on 13th May 2021, it commenced that same day; 5 days after Barney was seen by the Respondent for this appointment. The Committee also noted that Mrs. MC's evidence was that she continued to give insulin therapy to Barney for a further 3 years beyond that date. In the Committee's judgment it is inconceivable that, if an offer of an X-ray, or immediate treatment with insulin, had been made on 8 May 2021 it would not have been accepted.

The Committee therefore finds Charge 4 a) Proved.

10.12 *b) Amended clinical records for Barney at a later date without making clear that these changes were made retrospectively and in so doing were:*

i. dishonest, and/or

ii misleading.

The Respondent admitted at the outset that the retrospective amendments that he made to the clinical records were misleading.

The original clinical note in respect of the appointment of 8 May 2021 appears as follows:

"GETTING WORST OWNER REUCTED TO DO XRAY ETV AS IT IS POSSIBLY A GROWRTH"

The amended note, made on 14 May 2021, appears as follows:

"GETTING WORST OWNER REUCTED TO DO XRAY OR START treatment with insulin. owner worries that dog is off colour for some time and worries of growth somewhere,, discuss that they may be a possibility of growth but need more test to diagnose as dog has D NOW AND LETHAGIC poss of infection.treat and the reexamined Monday

US GLUCOSE ++++ and also bs on Friday shows high glucose. See on Monday to start treatment with insulin if glucose still high after diet of low carbohydrate".

The Respondent said that his purpose in amending the note was to ensure that an accurate version of the consultation appeared in the records. He therefore expanded the original note. He knew when he amended the note that Mrs. MC was complaining. He did not think to state that his amendment was retrospective and did not believe he was doing anything wrong.

When deciding whether the Respondent's conduct was dishonest, the Committee had regard to the approach mandated by *Ivey v Genting* [2017] UKSC 67. The Respondent is a veterinary surgeon of very considerable experience. He must have known that the purpose of a clinical record is to provide an accurate contemporaneous summary of the important parts of any consultation, without adjustment in the light of later events. If any future adjustment is appropriate , it must be clearly marked with the date on which it is made.

The Committee concluded that in expanding the text of the record, without making clear that the additional text had been added at a later date, the Respondent was aware that he was producing a misleading note. The Committee noted that the additional text, which included a reference to the owner being reluctant to start treatment with insulin, appeared to be a response to Ms. MC's complaint that no adequate therapeutic intervention had been undertaken. Following the Committee's reasoning at paragraph 10.11 the Committee concluded that this was not an honest account of the conversation that took place with Mrs. MC.

The Committee concluded that an ordinary decent person would regard the Respondent's alteration of this clinical record as dishonest.

The Committee therefore finds Charge 4 b i. Proved.

10.13 *5. Between 3 June 2022 and 6 June 2022 in relation to Moni, a six year old Dobermann bitch belonging to Mr. D and Mrs. A S[redacted]:*

a) On 3 June 2022 undertook caesarean surgery to Moni without:

i……...

ii. Informing the owner with adequate notice that you did not have any qualified assistance, and/or

iii……

There was no dispute that the Respondent had undertaken caesarean surgery without informing Mrs.AS, with whom he had been in telephone contact, that he would be in the Practice by himself. The absence of qualified assistance was not known to her until she had actually arrived at the surgery and entered the operating theatre. The Respondent's position was that it was only after Moni and her owners had arrived at the surgery, and not before, that he realised that an emergency caesarean operation needed to be undertaken.

The Committee noted the Respondent's previous treatments of Moni. This was her third pregnancy. During the first pregnancy the Respondent advised Oxytocin. During the second he carried out a caesarean section. He had seen Mrs. AS two days before 3 June and had provided her with two 2 ml Oxytocin syringes. Mrs. AS stated that she was also told by an individual at the practice to contact the Respondent if difficulties arose and provided with the Respondent's mobile telephone number. Difficulties did arise and the Respondent, who returned her call, initially advised further Oxytocin and some 30 minutes later, in a subsequent call ,advised Mrs. AS to bring Moni into the surgery.

In the Committee's judgment, in view of this history, it must have been apparent to the Respondent by, at the very latest, the second telephone call with Mrs.AS on 3 June 2021 that there was every chance that a caesarean intervention would be needed. The Committee is sure that the Respondent should have advised Mrs. AS at that point that he was without assistance in the surgery and that a caesarean section might well be required. It would have been appropriate then to refer her to an out-of-hours service which was properly staffed to undertake the procedure. The Committee heard evidence that there was such a service and that Moni could have been driven there in the same time as it took to reach "The Little Pets" Practice.

The Committee therefore finds Charge 5 a) ii. Proved

10.14. *6. Between May 2020 and 30 June 2021, you:*

b) Began caesarean surgery without securing the presence of any adequately trained assistance.

The Committee noted the very general terms in which this allegation was framed. In addition to the lack of specificity, the Committee noted that it was not based on the evidence of either of the other two veterinary surgeons who worked at the Practice in 2021. They did not criticise the procedures adopted by the Respondent.

The Respondent's evidence was that the only time that he would attempt a caesarean section surgery without a suitably trained person would be in an emergency, that is where, in his clinical judgment, the life of the bitch or the lives of the puppies was at risk if the surgery was not performed immediately.

The evidence of Ms. DM and Ms. ED, relied upon by the College in this connection, was based upon their experience of attending when they were called out to assist out of hours.

The Committee was sure that there were occasions on which the Respondent had begun caesarian sections without securing the presence of adequately trained assistance. It was unclear to what extent such activity was undertaken in the context of an emergency.

As a matter of strict fact, the Committee therefore finds this Charge Proved, but the context in which such activity took place will require further consideration in the next stage of these proceedings.

The Committee therefore finds Charge 6 b) Proved.

10.15 *c) Failed to make any or any adequate record in respect of surgeries performed on 25 April 2021;*

The Respondent accepted that he did not enter records relating to surgeries performed on 25 April 2021 onto the computerised record system. He said that he kept paper records. He said that he did not enter records on the computer system because of financial arrangements relating to "out-of-hours" work, and 25 April was a Sunday.

The Respondent's failure to enter an appropriate record on the "*Ezyvet"* system is not within the terms of the Concession. The omission of a record on "*EzyVet*" meant that

there was no adequate record of treatment carried out in the surgery at the Practice on 25 April 2021.

The Committee therefore finds Charge 6 c) Proved.

11. Disgraceful conduct in a professional respect.

11.1 Both Counsel produced helpful written and oral submissions. Mr. Jamieson told the Committee that the Respondent accepted that his actions amounted to disgraceful conduct in a professional respect. The Committee accepted the legal advice it received.

11.2 The Committee recognised that any finding of disgraceful conduct in a professional respect rested upon a judgment that the conduct in question fell far short of the standards expected of a registered veterinary surgeon. Any such judgment needed to be based on the evidence it had heard during the earlier part of these proceedings. In exercising its judgement at this stage, the Committee derived much assistance from the expert evidence received during the earlier part of the proceedings.

11.3 Both Counsel had indicated that there were three major themes which underlay the Charges that the Committee had found Proved. These themes were:

a) deficiencies in clinical care;

b) deficiencies in the Respondent's system of record-keeping;

c) Dishonesty.

The Committee intended to address each of these themes in turn.

12 Deficiencies in clinical care

12.1 The Committee's factual findings concerned two identified animals, the Respondent's approach to cherry eye surgery and his clinical practice in relation to intubation and caesarean surgery.

12.2 The Committee first considered the standard of the Respondent's care of Barney, the Labradoodle. In this case the Respondent had made a firm diagnosis of diabetes on Thursday, 6 May 2021, but had failed to offer a reasonable range of options for treatment two days later despite the owner attending the surgery on 7 and 8 May because of her concern that Barney's condition was deteriorating. The Respondent accepted in his evidence that Mrs. MC told him, on 8 May, that Barney's condition was getting worse and the Committee has found that none of the reasonable options for treatment was offered to her at that stage. Dr Shield's opinion was that such a failure would fall far below the standards expected of a competent veterinary surgeon. Mr. Williams agreed. The Committee accepted their assessment.

12.3 In the case of Moni, the Dobermann, the Respondent had undertaken caesarean surgery without trained assistance, without offering the owner adequate notice that he had no such assistance and without offering referral to an out of hours service. He had also failed to take adequate steps in relation to Moni's deteriorating condition post-surgery. He failed to admit Moni for hospitalisation for further investigation and treatment and failed to refer Moni for specialist care. Dr Shield was of the view that

these failures fell far below the standards expected. Mr. Williams considered that undertaking the caesarean section without assistance and failing to inform the owners that he had no assistance or to refer Moni to an out of hours service was not below the requisite standard. He considered the failure to take adequate steps in relation to Moni's deteriorating condition, below standard but not far below.

12.4 The Committee prefers the opinion of Dr Shield. Mr. Williams emphasised that the Respondent was dealing with an emergency when he undertook caesarean surgery in the circumstances outlined in the Charge. He does not appear to have addressed the Respondent's own role in creating a situation in which an emergency had to be faced with no trained assistance. The Committee accepts Dr. Shield's opinion that "*Mr. Ng's choice to deliberately place Moni and her owners in this unsatisfactory and hazardous situation, with predictable risks to her health, in my opinion was conduct falling far below that to be expected of a reasonably competent veterinary surgeon."*

12.5 The Committee also prefers Dr. Shield's view in relation to the failure to address Moni's deteriorating condition. Both experts agreed that Moni's symptoms warranted some action, whether through hospitalization, further investigation or referral to specialist care. The Respondent did none of these things. Mr. Williams based his view on his analysis that, given the evidence, it was impossible to know "*at what point it was obvious that urgent intervention was required*". Dr Shield based her opinion upon the fact that no appropriate or adequate action was taken over a period of days in the face of continued deterioration and the owners' alarm. She wrote: "*Had the S[redacted]s not lost faith in Mr. Ng and sought help for their dog elsewhere, it is almost certain that she would have died".* The Committee considers that Dr Shield's view takes proper account of the reality of Moni's deteriorating condition, which, in the Committee's judgment, should certainly have stimulated a much more proactive response than simply changing an antibiotic and reassuring the owners that Moni needed more time to recover.

12.6 In relation to Cherry eye surgery, the Committee considered that Charge 2 b i. needed to be considered separately from Charges 2 b ii. and 2 b iii. Charge 2 b i. relates to the performance of surgery that was not indicated, i.e. bilateral removal of the Harderian gland when only one eye was affected by a prolapsed gland. Dr Shield considered such actions to fall far below appropriate standards. Mr. Williams, in his report, maintained that it would be below, but not far below, standard "*as, whilst I believe that it should be avoided , there is some, albeit weak justification to do so; in particular doing it to prevent the apparently normal looking harderian gland from prolapsing in the near future in a dog known to be susceptible (as it is known to have the condition in the other eye)."* In his oral evidence, however, he appeared to accept that this practice was now "*outwith*" the standards of the veterinary profession. The Committee heard no evidence to suggest that this was the practice of a responsible body of veterinary surgeons.

12.7 Mr. Weston drew the Committee's attention to guidance produced by the College in April 2023 which stated that " *Veterinary surgeons and veterinary nurses should be aware that UK animal welfare legislation legally restricts mutilations to animals (i.e procedures which interfere with sensitive tissue or bone structure) unless they are*

carried out for the purpose of medical treatment". Mr. Jamieson's response was that the Respondent's actions in this context were for medical treatment.

12.8 It is not necessary for the Committee to resolve that particular issue for present purposes. The Respondent has admitted to carrying out surgery that was not indicated and in the Committee's judgment that falls far below the standard expected of a competent veterinary surgeon. That accords with the evidence of Dr. Shield. The "*weak justification"* for such surgery initially advanced by Mr. Williams, but not sustained in his oral evidence, does not impact upon the Committee's judgment. The Respondent himself assured the Committee that he no longer undertakes bilateral removals when these are not clinically indicated.

12.9 When considering sub-paragraphs ii and iii, the Committee bore in mind the evidence of Ms. ED and Ms.DM that the puppies operated on by the Respondent were very young, perhaps two to three months old. Dr. Shield came to the same conclusion, drawing an inference from the association in the clinical records of these puppies with puppies receiving their first or second vaccination. Dr Shield could "*think of no good reason to operate on cherry eye in a young puppy*". She would always expect to see a clinical history demonstrating that non-surgical treatment, such as replacing the gland manually, had been tried and failed and at least one previous attempt to reposition the gland surgically. She considered that the Respondent was routinely offering amputation as a treatment of first resort which in her opinion would be far below standard.

12.10 Mr. Williams was of the view that a failure to attempt a non-surgical solution was below standard because of the age of the puppies. He was also of the opinion that a failure to attempt to surgically reposition the harderian gland was also below standard.

12.11 Mr. Jamieson referred the Committee to *Bolam v Friern Hospital Management Committee* [1957] 1 WLR and drew the Committee's attention to three publications in support of a submission that, in 2020 and 2021, the Respondent's approach to cherry eye surgery was shared by a responsible body of veterinary opinion. The Committee did not attach weight to a short leaflet produced by the Bulldog Breeders Council. No sources were given for the opinions expressed and the authorship of the leaflet was unknown. The Open Letter which appeared in *Veterinary Times* in July 2024 ,written by the Chairman of the British Association of Veterinary Ophthalmologists, requesting that veterinary surgeons refrain from the practice of excising the Harderian gland in Bulldog puppies save in situations where "*there is absolutely no other option*" does not, in the Committee's view, indicate that this was the practice of a responsible body of veterinary surgeons; rather, the letter demonstrates that a problem was occurring, "*following pressure from Bulldog breeders*" which needed to be addressed because of the problematic implications of these excisions. The scientific paper, "*An Evidence-Based Rapid Review of Surgical Techniques for Correction of Prolapsed Nictitans Glands in Dogs"*, published in August 2018, noted that *"Although gland excision was formerly the mainstay of treatment, removal is now discouraged due to concerns of subsequent development of dry eye (keratoconjunctivitis sicca: KCS)".* The paper was directed towards a review of surgical techniques rather than evaluating the circumstances in in which excisions had been carried out.

12.12 The Committee reminded itself that it was only concerned with the particular circumstances of the Respondent's individual practice. He was routinely operating on very young puppies and he made it clear in his evidence that he did not regard any other type of treatment as to be recommended or attempted. The Committee accepts the view of Dr Shield that there was no good reason to carry out this procedure on very young puppies and, in those circumstances, judges that the Respondent's amputation of the harderian gland when no non- surgical treatment had been attempted, and no attempt had been made to surgically reposition the Harderian gland, to be far below the standards expected of a reasonably competent veterinary surgeon.

12.13 The Committee next considered its finding that the Respondent had begun caesarean surgery without securing the presence of any adequately trained assistance. As the Committee made clear in its Determination on facts, the circumstances in which this activity was carried out were not clear. The charge related to out of hours work and the main witness called by the College in this connection regarded the procedures as emergencies. As was common ground, the *Code of Professional Conduct for Veterinary Surgeons* ["the Code"] permits a veterinary surgeon to proceed without assistance in an emergency. In the Committee's judgment it is for the College to show that the Respondent was not acting in an emergency when he began the caesarean sections to which this charge relates. On the basis of the evidence it heard the Committee cannot be sure that the Respondent was not acting in an emergency. Accordingly, the Committee does not find that its factual finding on this charge can support a finding of disgraceful conduct in a professional respect.

12.14 The Committee also considered the Respondent's admission that he intubated patients for caesarean section surgery which had received only sedation and not general anaesthesia. Dr Shield judged the Respondent's practice to be far below the appropriate standards if the Committee accepted the evidence of Ms. DM in this respect. The Committee has significant reservations about the evidence of Ms. DM, which it has already expressed in its findings in relation to Charge 1. Ms. DM accepted that she had exaggerated her evidence in the complaint that she made to the College. Mr. Williams concluded that the Respondent's practice was not below standard. This was also the view of Dr Shield, if Ms. DM's evidence in this respect was not accepted.

12.15 The Committee considered that it was appropriate to treat the evidence of Ms. DM with caution. Accordingly, it concluded that the Respondent's practice in this respect was not below standard.

12.16 In relation to deficiencies in clinical care, the Committee therefore finds that the Respondent's care of Barney, the Labradoodle, and Moni, the Dobermann, amounted to disgraceful conduct in a professional respect. So too did his performance of cherry eye surgery by amputation of the Harderian gland. Each of these deficiencies involved actual injury to animals.

13. <u>Deficiencies in record-keeping</u>

13.1 The record-keeping arrangements adopted by the Respondent could, in the Committee's judgment, properly be described as haphazard. There was no systematic linkage between what was entered onto the "*EzyVet"* computerised system and what was included on hard copy consent forms and other paper documentation. The Respondent said that his own practice was to record what he considered to be abnormal but he did not supervise what was recorded, either on "EzyVet" or on hard copy. Newly qualified clinicians at the Practice had never accessed the hard copy records and so were, in all likelihood, proceeding to treat animals on the basis of incomplete records. Untrained staff could not be expected to know on a case by case basis when it might be necessary to search for paper records to ensure they had an animal's complete history.

13.2 Mr. Williams based his view as to the seriousness of the Respondent's deviation from appropriate standards("below") on the fact that no animal was shown to have come to harm. However, the Respondent's record-keeping system inevitably exposed animals to a continuing risk of harm on the basis that clinicians were treating those animals without being in possession of the full clinical record. In addition, the Respondent admitted taking paper records home and storing them there, where they would be unavailable to anyone else at the practice. Dr Shield was of the view that unless the paper record system was known to staff at the practice and readily accessible, the record-keeping system was far below the standard to be expected.

13.3 The Committee preferred the view of Dr. Shield. The Committee was of the view that the arrangements in place at "The Little Vets" gave rise to an obvious and continuing risk that important information would be overlooked. This was sufficient to justify a finding of disgraceful conduct in a professional respect.

14. <u>Dishonesty</u>

14.1 The Committee was concerned with three findings of dishonesty, all connected to interference with clinical records. One finding related to the amendment of a record in the light of a complaint. Two others (admitted following the conclusion of the Respondent's evidence) related to the deletion of two records, relating to treatment given to two dogs, from the Practice computer in circumstances that, on the Respondent's account, were connected to a financial dispute with the Practice owner. In relation to these deletions, the Committee noted that the Respondent had initially maintained in evidence that he was entitled to act as he did because he was offering treatment "out of hours". In fact, the treatment offered was within normal working hours.

14.2 Dishonesty is inevitably conduct which falls far below the standards expected of a registered veterinary surgeon. Honesty and Integrity provide one of the Five Core Principles contained in the Code. Honesty bears significantly on other core principles, such as Professional Accountability and Client trust.

14.3 The dishonesty in this case is particularly concerning because it relates to the integrity of clinical records.

14.4 Accordingly, findings of dishonesty such as those made here must inevitably lead to a finding of disgraceful conduct in a professional respect.

15. Therefore, the Committee finds that the Respondent was guilty of disgraceful conduct in a professional respect.

16. Sanction

16.1 Mr. Weston drew the Committee's attention to a letter of advice sent to the Respondent on 2 March 2023 by the Preliminary Investigation Committee ["PIC"]. The advice related to a complaint made against him in May 2021. The PIC reminded the Respondent of the *Code's* requirement to communicate effectively with clients, to ensure that informed consent was obtained for surgical procedures and to keep clear, accurate and detailed clinical and client records.

16.2 The Respondent read a statement that he had prepared. He said that he accepted the Committee's findings and now understood that he had behaved dishonestly in the respects set out in the Charges. He said that he had reached this conclusion through reflection during the hearing. He spoke of his sense of shame and regret at the way in which he had allowed the financial dispute with his relative to influence his behaviour. He assured the Committee that he would never behave in that way again. [redacted]

16.3 The Respondent accepted that his treatment of Barney and Moni was inadequate and that he had allowed his treatment of Cherry Eye to become seriously out of date. He said that he had changed his practice in relation to this issue. He now adopted a conservative approach if he had to deal with a case of Cherry Eye. He no longer saw litters of puppies with Cherry Eye. He also said that he had instituted a system at Tilsworth Veterinary Clinic by which all recording is kept in the computer system including scanning hard copies records and making notes of telephone conversations. He has engaged extra help to ensure this is done.

16.4 The Committee also received oral evidence from three witnesses who spoke to the Respondent's character. Two of the witnesses, Mr. JR and Mrs. LH were clients who were very satisfied with the veterinary services provided by the Respondent and who told the Committee that they trusted him. One had become his accountant. The other spoke of the sensitivity with which he had treated her dying dog. The third witness was the Practice Manager at Tilsworth Veterinary Clinic, Ms. ET. She had known the Respondent from childhood and spoke of a happy working environment in a busy practice.

16.5 Mr. Jamieson made written and oral submissions. He referred the Committee to *Sawati v General Medical Council* [2022] EWHC 283 (Admin) in support of a submission that the fact that the Respondent's evidence in relation to allegations of dishonesty had been rejected was not a decisive consideration when assessing the Respondent's insight into his conduct. He referred the Committee to the guidance given in *Sawati.* The Committee accepted this submission. He reminded the Committee that the Respondent's dishonest conduct had all occurred within a period of about three months at a time of great stress and that the Respondent had been in practice as a veterinary surgeon for, at the time, almost fifty years without any previous regulatory involvement.

16.6 Mr. Jamieson referred to the oral and written testimonial evidence and submitted that there was a public interest in allowing a respected veterinary surgeon to return to practice where that was possible. He submitted that the appropriate sanction was one of suspension.

16.7 The Committee accepted the legal advice it had received. The Committee was reminded of the importance of applying the principles contained in the Sanctions Guidance and of the need to act proportionately.

16.8 The Committee first considered aggravating factors. As previously noted, the Respondent's conduct had caused harm to animals and created also a risk of harm to animals.

16.9 In relation to the charges of dishonesty, the Committee noted that there were three instances of dishonest behaviour in relation to clinical records. The amendment of the clinical record in Barney's case was particularly serious. This alteration was made at a time when the Respondent knew that Barney's owner was dissatisfied with the treatment Barney had received and was complaining about the lack of therapeutic intervention. The alteration presented a false account of the owner's attitude towards immediate therapeutic intervention. Conduct of this kind was liable to damage trust in the profession.

16.10 Turning to mitigating factors, the Committee had regard to [redacted] the sense of pressure occasioned by his financial dispute with his relative. The Committee also recognised that the Respondent had been in practice for a very long time and was highly thought of by those who had provided testimonial evidence. However, the Committee did not consider that these mitigating factors substantially reduced the seriousness of the Respondent's misconduct.

16.11 The Committee was required to consider not only issues relating to probity but also the Respondent's clinical standards. The Respondent had said that he now realised that his treatment of Barney and Moni was " inadequate" and that he had changed his practice in relation to the treatment of Cherry Eye. The Committee had reservations about the veracity of this latter statement which directly conflicted with his oral evidence given to the Committee just over a week ago when he was deeply sceptical about any alternative treatment to excision. Further, there was little detail before the Committee to show that the Respondent had deeply reflected on the very serious failings in his clinical practice and taken appropriate steps to ensure that such failings were unlikely to recur. The Committee noted that his treatment of Moni occurred in June 2022, long after he had established his own team at Tilsworth Veterinary Practice.

16.12 The Respondent's treatment of two dogs suffering from diabetes was far below the standard expected of a reasonably competent first opinion veterinary surgeon and had produced an understandable sense of grievance and frustration in the owners of the animals concerned. Both animals had come close to death as a result of the Respondent's failure to offer the intervention that should have been offered by a first opinion veterinary surgeon.

16.13 The Respondent's practice in relation to the treatment of Cherry Eye was deeply concerning and many years out of date. The Committee noted that the Respondent had sought as recently as during his evidence at the first stage of these proceedings to maintain that the way in which he offered unilateral excision of the Harderian gland as his only treatment was entirely justified. His preparedness to offer bilateral excisions to clients who asked for that to be done was an even more serious departure from appropriate standards as it involved surgery on young puppies and when there was no presenting symptom to be addressed in the unaffected eye.

16.14 There was very little in the Respondent's CPD record which suggested that he had systematically attempted to address these deficiencies in his clinical practice. The Committee therefore regarded with reservation the Respondent's assertions that all had now changed in respect of these areas of his clinical practice, with the implication that repetition of clinical failings was unlikely.

16.15 The Committee acknowledged the Respondent's assertions that he now understood his failings and his expressions of remorse for the harm he had caused. The Committee accepted that these indicated the beginnings of insight.

16.16 The Committee considered the available sanctions in ascending order of seriousness.

16.17 The case was much too serious to be disposed of by taking no further action.

16.18 The Committee did not consider that any useful purpose would be served by postponing sanction.

16.19 The Committee also considered that the case was much too serious to be dealt with by way of warning or reprimand. The misconduct in this case is not at the lower end of the spectrum of seriousness and the Committee was unable to conclude that there was no future risk to animals.

16.20 The Committee next considered a suspension order. The Committee noted that the Sanctions Guidance states (at paragraph 71) that:

Suspension may be appropriate where some or all of the following apply:

a) The misconduct is serious but a lesser sanction is inappropriate and the conduct in question falls short of being fundamentally incompatible with remaining on the register;

b) The respondent veterinary surgeon has insight into the seriousness of the misconduct and there is no significant risk of repeat behaviour;

c) The respondent veterinary surgeon is fit to return to practice (after the period of suspension)

16.21 In the Committee's judgement the only factor of those set out above that could be said to be present in this case, and that in a limited way, was the beginning of insight.

16.22 The Committee therefore went on to consider the sanction of Removal from the Register. It recognised that this might be directed where the respondent veterinary

surgeon's behaviour is so serious that removal is the only means of protecting animals and the wider public interest.

16.23 The *Guidance* makes clear that "*Proven dishonesty has been held to come at the 'top end' of the spectrum of gravity of disgraceful conduct in a professional respect".*

16.24 The *Guidance* also provides a number of examples where Removal *may* be appropriate when the behaviour in question is fundamentally incompatible with being a veterinary surgeon. Of relevance to the present case are the following:

a. Serious departure from professional standards set out in the RCVS Code of Professional Conduct for Veterinary Surgeons;

b. Deliberate or reckless disregard for the professional standards as set out in the RCVS Code;

c. Causing serious harm (or causing a risk of harm) to animals….;

g. Dishonesty……particularly where persistent or concealed;

h. Putting his/her own interests before the welfare of animals.

16.25 In the Committee's judgement the Respondent's behaviour had involved serious departures from the *Code* and a deliberate or reckless disregard for professional standards. It had caused serious harm to animals. The *Code* provides, at Paragraphs 1.1 and 1.3, that:

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

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

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

The Respondent's clinical practice violated all of these critical requirements. He also carried out unnecessary bilateral excisions of the Harderian gland and where this was done at the request of clients this was, in the Committee' s judgment, an example of his putting his own interests before the health or welfare of animals. His method of keeping records showed, at best, a casual approach to an element of practice which is vital to the welfare of animals under a veterinary surgeon's care.

16.26 The *Code* also provides that:

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

and:

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

The Respondent's dishonesty, and most especially in his alteration of Barney's clinical record, was a fundamental departure from these precepts.

16.27 For these reasons the Committee has concluded that the Respondent's behaviour was fundamentally incompatible with being a veterinary surgeon. In view of the nature and gravity of the Committee's findings in this case, Removal from the Register is necessary to ensure the protection of animals and the maintenance of public confidence in the profession and the regulatory process.

16.28 The Committee therefore directs that the Respondent's name is removed from the Register of Veterinary Surgeons.

DISCIPLINARY COMMITTEE

19 JUNE 2025