ROYAL COLLEGE OF VETERINARY SURGEONS

INQUIRY RE:

KATHARINE SARAH POWER MRCVS

CHARGES
AS AMENDED BY AGREEMENT AT CASE MANAGEMENT CONFERENCE

That, being registered in the Register of Veterinary Surgeons, and whilst in practice at Vets1, Kings Lynn, Norfolk:

(A) In relation to laryngeal surgery performed by you on 29 March 2018 to Harvey ("the March 2018 surgery"), a Tibetan Terrier belonging to TC, you:

1) Between 29 January 2018 and 1 April 2018, failed to provide appropriate and adequate care to Harvey, more particularly in that you:

   a) failed to undertake adequate investigations and/or reviews and/or assessments of Harvey before proceeding to the March 2018 surgery;

   b) failed to offer a referral for Harvey and/or to give adequate consideration to such a referral prior to the March 2018 surgery;

   c) failed to undertake pre-operative radiographs before proceeding to the March 2018 surgery;

   d) failed to perform the surgery appropriately in that you (i) made the incision further down the neck than was appropriate (ii) dissected excessive tissue; and (iii) inappropriately placed sutures in a position that engaged the left side of the cricoid cartilage;

   e) undertook the March 2018 surgery when it was outside your competence;

   f) failed to ensure that Harvey was hospitalised overnight from 29 March 2018 to 30 March 2018 following the March 2018 surgery;

   g) discharged Harvey to his owner's care on 29 March 2018 when Harvey was unfit to be so discharged;

2) Between 29 January 2018 and 30 March 2018, failed:

   a) adequately to communicate the extent of risks and or complications of the March 2018 surgery;

   b) adequately to communicate the alternative options to the March 2018 surgery;

c) to obtain fully informed consent to the March 2018 surgery;

3) Prior to the surgery, failed to communicate adequately with TC with regards to Harvey, and/or exerted undue pressure on TC and/or TC's husband in relation to going ahead with the March 2018 surgery, more particularly in that you:

a) On 30 January 2018, told TC words to the effect that:

(i) there was no such thing as "early stage" laryngeal paralysis;

(ii) that Harvey had right side laryngeal paralysis and that the left side could "*go at any time*" causing Harvey to die;

(iii) treatment by non-surgical means was not a realistic option and/or that tie-back surgery was the only option that would work;

(iv) laryngeal tie-back surgery would prevent breathing problems for Harvey;

(v) the surgery would be a simple operation and leave Harvey with a wound and nothing more;

b) On 1 February 2018, sent an email to TC in response to her query regarding how Harvey would be post-operatively, stating:

"*So it should just be a wound on his neck and nothing more*";

c) On 7 February 2018, sent an email to TC stating:

"*There is no other option for a laryngeal paralysis. The only option is surgery*";

d) On 20 February 2018, sent an email to TC stating that if the March 2018 surgery failed, Harvey would return to how he was before the operation;

e) On 21 February 2018, sent an email to TC stating that:

(i) there was not really an early or late stage of laryngeal paralysis; and

(ii) if the surgery failed then Harvey would just be back to the same condition he was pre-surgery;

f) On 29 March 2018, told TC and/or her husband words to the effect that:

(i) Harvey had to have the surgery if TC did not want him to die;

(ii) After the surgery Harvey would never have breathing problems;

(iii) Surgery was the only option;

4) After the surgery, failed to communicate adequately with TC more particularly in that you:

a) On 30 March 2018, told TC that:

(i) Harvey did not have aspiration pneumonia; and

(ii) you would not undertake post-operative radiographs, despite TC requesting these;

b) On 31 March 2018, told TC that Harvey had had a peaceful night and was on track for recovery, when this was not the case;

5) Between 1 April 2018 and 12 February 2021 made alterations to the clinical records for Harvey, by way of additions to the records for 31 March 2018;

6) Your conduct at 3 and/or 4 and/or 5 above was:

a) Dishonest; and/or

b) Misleading;

(B) In relation to oesophageal surgery performed by you on or around 6 October 2018 ("the October 2018 surgery") to Boss, a boxer dog belonging to HS, you:

1) Between 5 October 2018 and 6 October 2018, failed:

a) to obtain fully informed consent for the October 2018 surgery;

b) adequately to communicate the extent of risks and or complications of the October 2018 surgery;

c) adequately to communicate alternative options to the October 2018 surgery;

d) adequately to communicate the outcome of the October 2018 surgery and/or Boss' condition after the surgery;

2) In relation to a CT scan of Boss' oesophagus on 6 October 2018 before the October 2018 surgery:

a) failed to seek appropriately skilled assistance with regards to interpretation of the said scan;

b) told HS that you would seek appropriately skilled assistance with regards to interpretation of the said scan but failed to do so;

c) failed to identify oesophageal changes visible on the said scan;

d) failed to inform HS of the oesophageal changes visible on the said scan and/or inform HS of the increased risks associated with those changes if Boss were to have the October 2018 surgery;

3) On or around 5 and/or 6 October 2018, failed to provide appropriate and adequate care to Boss, more particularly in that you:

a) subjected Boss to an excessive period of anaesthesia;

b) having failed to retrieve by oesophagoscopy a foreign object in Boss' oesophagus, failed to give adequate consideration to and/or offer other treatment options and/or a referral for Boss prior to commencing the October 2018 surgery;

c) undertook the October 2018 surgery when it was outside your competence;

d) failed to place a thoracostomy tube and/or a gastrostomy following oesophagotomy;

4) Between 6 October 2018 and 31 October 2018, made clinical notes for Boss indicating that he had sustained an iatrogenic pneumothorax during the surgery and that he would be cared for by veterinary surgeons RD and AM on 6 October following the October 2018 surgery when:

a) you did not on 6 October 2018 inform either HS or RD (the veterinary surgeon taking over Boss's care from you) that Boss had sustained an iatrogenic pneumothorax, and you therefore:

(i) failed to communicate fully and openly with HS and/or RD;

(ii) failed to provide adequate and appropriate care to Boss by ensuring HS and RD were fully informed as to his condition;

or

b) you were not aware that Boss had sustained an iatrogenic pneumothorax at the point when care was handed over to RD, and your clinical notes were therefore

(i) misleading; and/or

(ii) dishonest;

5) Failed to make adequate clinical records for Boss;

6) Between 5 October 2018 and 31 October 2018, failed to provide a referral report and/or clinical records for Boss to Best Friends Holbeach veterinary practice following its referral of Boss to you on 5 October 2018, despite requests for the same;

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