ROYAL COLLEGE OF VETERINARY SURGEONS

INQUIRY RE:

RAHUL CHANDULAL SHAH MRCVS

DECISION ON FINDING OF FACTS

The Respondent, Rahul Chandulal Shah, MRCVS ("the Respondent)" appeared before the Disciplinary Committee to answer the following charges:

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

1. On 7 June 2018, in relation to surgery performed by you on that day to Paz, a kitten belonging to Ms P, such surgery having been arranged for the purposes of castration:

- *(a) anesthetised Paz, or allowed Paz to be anaesthetised, without having first undertaken a clinical examination of Paz and/or without ensuring that Paz had undergone a clinical examination by another veterinary surgeon;*
- *(b) having failed to locate a second testicle during the said surgery, failed to contact or attempt to contact Ms P to inform her of this failure and to discuss the treatment options arising as a result of the failure, before ending your attempts at the castration;*
- *(c) failed to devise an adequate plan for the completion of the castration;*
- *(d) failed to take adequate steps to ensure that Ms P was fully informed post-operatively of the details of the said surgery, more particularly:*
  - *(i) failed to adequately explain to Ms P the results of the surgery;*
  - *(ii) failed to provide or arrange for adequate scheduled time post-operatively to explain to Ms P the result of the surgery;*
  - *(iii) failed adequately to discuss with Ms P a plan for Paz's future treatment;*
  - *(iv) failed to ensure that a veterinary nurse and/or assistant provided such explanation and/or discussion*
  - *(v) gave Ms P inaccurate and/or incomplete information in relation to any plan for and/or likely cost of further castration surgery;*
- *(e) failed to make adequate clinical notes in relation to Paz, more particularly failed to record:*
  - *(i) the findings of your examination under anaesthesia;*

(ii) your surgical approach;
(iii) your post-operative communication with Ms P;
(iv) your plan for completion of the castration;

2. In relation to the conduct in 1 above, you failed to have adequate regard to previous advice and/or warnings from the Royal College of Veterinary Surgeons ("the College") about your conduct in relation to neutering surgery and related note-keeping and communication with clients, more particularly;

(a) a reprimand issued on 23 September 2016 by the College's Disciplinary Committee following its finding of disgraceful conduct with regards to your discharge of a dog castration surgery in 2014; and/or
(b) advise issued to you by letter of 21 March 2018 by the College's Preliminary Investigation Committee with regards to circumstances surrounding canine spay surgery performed by you in 2016

AND THAT in relation to the facts alleged you have been guilty of disgraceful conduct in a professional respect.

1. The charges relate to a number of aspects of the Respondent's care and management of surgery performed on Paz, a kitten belonging to Ms P, on 7 June 2018 whilst he was working at the Easipetcare practice in Luton. He had been contracted to work at the above practice as a locum for two weeks at the relevant time.

The College's case as to the facts

2. Ms P, who wishes to be identified by her initials "JP", initially made arrangements for her two litters of Russian Blue kittens consisting of 7 kittens (of which Paz was one) to be neutered by her preferred veterinary surgeon, Louise Marsh, MRCVS, ("LM") at Bagshot Vets4Pets on 7 June 2018.

3. This surgery was cancelled as LM was unavailable. JP wished to proceed with the neutering as the kittens were due to be delivered to their new owners. She did not contact another practice she had previously used (Easipetcare Reading) because she understood that LM was in dispute with this practice. JP therefore made arrangements for the kittens to be neutered at Easipetcare Luton.

4. The neutering surgery was booked over the telephone by Alexandra Calvert, SVN ("AC"). JP used an alias name when booking the appointment. She also said that the kittens were part of a single litter and that they were 'moggies', apparently because she was known as a breeder of Russian Blues and did not wish to be recognised.

5. When JP took the kittens to Easipetcare Luton on the morning of 7 June 2018, they were admitted by the veterinary nurse, Alexandra Taylor, RVN ("AT"), who checked their mucous membranes, heart rates and respiratory rates. There was a mixture of male and female kittens. When sexing the kittens, she could see, in the case of the male kittens, that their scrotums were small. She did not palpate them to check the presence of testicles. Consent forms were completed.

6. The Respondent was assisted in theatre by Melody Harding, Animal Nursing Assistant ("MH"). According to MH, the neutering of the 7 kittens was the only surgery performed by the Respondent on that day. MH states that the Respondent did not examine any of the kittens prior to beginning surgery. According to MH, when surgery began on Paz, the second male kitten, the Respondent was able to identify one of Paz's testicles and remove it without difficulty. MH stated that the Respondent continued to try to locate

the other testicle with forceps but not without making an additional incision to improve access.

7. According to MH, AT came into the theatre and both MH and AT said to the Respondent that he should move on to the third kitten. The third kitten was castrated without difficulty. The Respondent then returned to Paz and continued to use forceps and scalpel to attempt to locate the remaining testicle. MH states that AT returned and AT stated that the Respondent should stop and contact the owner to arrange to bring the kitten back when the remaining testicle had dropped. According to MH, the Respondent seemed reluctant to stop and continued to state that he could feel the testicle and thought that he could retrieve it.

8. AT states that she could see that the Respondent had made quite a large incision in the side of the scrotum and that she expressed concern about possible injury to the kitten. She further states that she told the Respondent that he should contact the breeder and explain the situation to her. She does not recall the Respondent's response but confirms that he stopped looking for the testicle and the kitten was taken to recovery.

9. MH further states that while the kittens were recovering she and AT told the Respondent that, as the surgeon who had carried out the procedure, it was important for him to telephone the owner and explain what had happened to Paz.

10. Ella-May Farr, SVN ("E-MF"), states that she was asked to discharge the kittens. She asserts that she was not told of any complications. Accordingly, when she returned the kittens to JP she told her that they had been neutered without any problems. She states that as JP was getting ready to take the kittens to her car, the Respondent was leaving the premises.

11. According to E-MF, as the Respondent was on his way out of the building he turned to speak to JP and told her that he had not been able to remove one of the testicles. He recommended JP to leave it a few months and then get the remaining testicle removed. E-MF states that JP was unhappy about paying for another procedure and generally unhappy at the situation. She said that the Respondent did not discuss costs with JP.

12. JP's account of the discharge is as follows. She describes a man, whom she subsequently learnt was the Respondent, leaving the practice by the front door at 3pm then turning back and coming to speak to her in reception. Without introduction the man asked, *"Are these your kittens?"* or words to that effect. She states that the man then went on to explain that he had been unable to extract one of the testicles, whereupon it dawned on her that this was the vet who had operated on her kittens. She further states that the man continued in a *"rambling manner"* to explain that he had made two scrotal incisions while looking for the second testicle. According to JP he then said that she could bring the kitten back to see any surgeon to have the testicle removed, adding: *"It should only cost you £5 or £10"* or words to that effect.

13. JP was shocked by what she was told and remembers saying, "*Why did nobody phone me to tell me that there was only one testicle? If they had done so, I would have pulled him out", o*r words to that effect.

14. JP states that it was her opinion that the Respondent was trying to justify having performed an operation that Easipetcare would not condone, because the widely accepted veterinary policy for early castrations is that unless both testicles are present the operation will be refused.

15. JP states that she was angry at the Respondent's lack of checks prior to incision.

16. JP states that on Friday 8 June 2018 Paz was really not well. Having spoken to LM by telephone, she took the kittens to Bagshot Vets4Pets where she saw a veterinary nurse, Tina Llewellyn, RVN ("TL"). TL confirmed that the back end of Paz was swollen. Paz's condition got worse and on 9 June 2018 JP took Paz to see Mr Darren Cawardine at Langford Vets in Bristol, upon referral by LM.

17. Mr Cawardine identified a urethral tear or rupture. He was not able to palpate and find the right testicle. Having discussed the surgical options with JP, with no guarantee of resolving the urethral tear, JP decided to stop treatment and consented to Paz being put to sleep. Mr Cawardine produced the records of his treatment of Paz at Langford Vets including a detailed post mortem report.

The evidence in support of the College's case

18. The Committee heard oral evidence from the following witnesses, all of whom verified their witness statements, and were cross-examined.

JP, the owner of Paz

19. JP was frank about the fact that she booked in her kittens to the Easipetcare, Luton practice using an alias name, and giving a false address. She also told the practice that the kittens were part of a single litter, and were "moggies", because she was known as a breeder of Russian Blues, and did not want to be recognised due to personal concerns. In cross-examination, she immediately stated that she regretted giving false details to the practice.

20. The Committee considered that JP was a clear and confident witness, who gave her evidence in a calm and objective way. When asked to explain or justify her evidence, she gave credible explanations. The Committee considered that JP was honest and open in her evidence, and when she did not know the answer to questions, she said that she did not know. The Committee considered that JP was a credible and reliable witness, who was trying to assist the Committee as far as she was able. There was one aspect of her evidence relating to the conversation with the Respondent during the discharge of Paz that the Committee was unsure about, which will be dealt with in the findings of fact below.

21. During the booking process and the admission of the kittens, JP does not recall being asked about the health status or vaccination status of the kittens. JP recalls the kittens being examined by the nurse during the 30-minute admission consultation. Although in her written statement JP refers to two male and five female kittens, it is not disputed that there were in fact three male and four female kittens.

22. JP recalled receiving two telephone calls from Easipetcare Luton on the day of the surgery, first to clarify the identity of two of the kittens early in the morning, and the second around 1pm to inform her that the surgeries had been completed and that she may collect the kittens at 3:30pm.

23. JP arrived early at Easipetcare Luton to collect the kittens around 3pm, rather than the agreed 3:30pm. JP was taken to the kennel area where the kittens were put in their carriers to take home and was returned to the waiting area to meet the discharging nurse. The nurse began to describe the discharge and aftercare in the waiting room

when a man, who was later identified as the Respondent, exited the practice past them. After having left the building, the Respondent returned to the waiting area and interrupted the discharging nurse to explain the complication that had arisen during the surgery. The Respondent did not introduce himself. He explained that Paz had one retained testicle and the reason he proceeded with the castration, despite Paz being cryptorchid, was that *"if a client brings an animal to me to be neutered, I will always do my best to achieve this".* It was only part way through the conversation, which JP described as "*repetitious ramblings and self justifications"*, that JP realised he was the operating surgeon.

24. The conversation with the Respondent lasted only a few minutes, and JP was dismissive and angry in her communication with the Respondent. In oral evidence she described being distressed, shocked and incensed at not having been contacted previously about the retained testicle and that the castration had been started without an examination. Had she been given the information that Paz had only one descended testicle prior to surgery she would have opted to wait until he was older. JP recognised this is a common event when electing for early neutering of young animals. JP informed the Respondent that she would certainly not be returning to that practice.

25. JP stated that she was further angered when the Respondent mentioned that the follow-up surgery was likely to cost £5-10, which she considered to be unrealistic and insulting. She was certain that the Respondent had said this, and on more than one occasion. Upon further questioning, JP confirmed that the Respondent quoted this amount: *"[he] absolutely most emphatically did [say this] and more than once. I remember it because I knew it was ludicrous and untrue."* She thought the Respondent's manner was very condescending.

26. JP gave further evidence regarding the aftercare of Paz, the subsequent conversations with her original vet LM and the outcome of the referral to Langford Vets. JP was certain that the cost of a second castration surgery was not a consideration in her reason for being angry, and she cited the cost of the referral treatment in support of this assertion.

Alexandra Taylor RVN (AT)

27. The Committee considered that AT was a straightforward witness, who knew what she was talking about. She readily stated that she did not remember, when she was asked about certain matters and also gave credible and coherent explanations for those aspects she could remember. AT admitted the kittens to the practice from JP and briefly observed the surgery on the males.

28. AT admitted all seven kittens for neutering from JP. She examined each of them, identified them via a coloured collar and sexed them. Her examination was limited to checking the mucous membranes, heart rate and respiratory rate. She did not palpate the scrotums of the male kittens but noted they were very small.

29. During the consent process, AT recorded information on the consent form relating to Paz. This included a 'tick' next to the question "starved?" and a cross next to the question "descended testes?". All other answers to questions on the consent form were marked with a cross. AT explained that a cross next to the box regarding descended testes should indicate to the operating veterinary surgeon to check the scrotum. AT attached each consent form, with the corresponding anaesthetic sheet, to individual clipboards in preparation for surgery.

30. AT did not recall if she had asked JP for the previous history of the kittens nor if they had been vaccinated previously. She described that typically if an animal was new to the practice, or if the nurse was unsure if the testes has descended, then the nurse would identify the need for a "vet check" to be performed by writing this on the white board located in surgery. AT could not recall if this had been written up for Paz, nor if she specifically told the Respondent of Paz's status separate to the check box on the consent form.

31. At some point during surgery of Paz, AT went into theatre to observe and saw Paz's legs 'flinching'. AT immediately told the Respondent to stop and provide more pain relief. The Respondent agreed and AT exited theatre to prepare some local anaesthetic. Later on, after the local anaesthetic had been given the Respondent continued to look for the retained testicle. AT observed that the scrotal incision was quite large and that the Respondent was using large forceps. AT said to the Respondent *"if he carried on to explore further, he might damage the kitten and affect its ability to urinate*". AT also suggested that the Respondent telephoned JP to explain the situation to her.

32. AT had no further engagement with the surgery or in the recovery or discharge of Paz. However, AT further confirmed that typically in circumstances where there are complications, it would be expected that the veterinary surgeon would contact the owner or discharge the animal to the owner. AT also confirmed that at no point did the Respondent ask her to inform the owner of the complication. Under re-examination AT confirmed that it was the veterinary surgeon's responsibility to inform the client regarding any complications in surgery.

Melody Harding (MH)

33. The Committee considered that MH was a confident and reliable witness, who gave her answers clearly. MH was an animal care assistant and was involved with assisting the Respondent during surgery on the three male kittens. The Committee considered that she was a credible witness who attempted to assist the Committee fully and honestly.

34. MH recalls setting up the theatre in preparation for the surgery and preparing the animals by clipping and cleaning them following their pre-anaesthetic medications (which were administered by another member of the nursing staff). MH did not perform an examination on the kittens. That day, there were only the seven kittens to be neutered, no other surgeries occurred.

35. MH described the sequence of events as follows. The first male kitten was anaesthetised and castrated by the Respondent. Paz was the second kitten, who was then anaesthetised. The Respondent removed the first testicle but was unable to remove the second testicle. During this part of the surgery the Respondent told MH that the first testicle was quite small and difficult to locate. While the Respondent was looking for the remaining testicle Paz began to flinch and the anaesthetic gas was increased. The Respondent continued to look for the second testicle by increasing the incision and using forceps, at which point Paz began to move again and AT entered the theatre. Both AT and MH told the Respondent to stop operating on Paz and to move on to the third male while AT obtained some local anaesthetic.

36. While AT was out of theatre, the Respondent completed the castration on the third kitten before returning back to Paz. At this point, AT returned with the local anaesthetic. The Respondent continued to try and remove the remaining testicle but

without success. AT told the Respondent to stop, but he seemed reluctant to do so. AT repeated that he must stop which he then agreed to do.

37. All three male kittens recovered uneventfully. While they were recovering, MH, AT and AC spoke together to tell the Respondent that it was important for him, rather than for a nurse, to telephone the owner to explain what had happened with Paz. MH was not aware if the Respondent did telephone JP, but had no further involvement with the kittens.

38. Upon further questioning, MH confirmed that the consent forms and the anaesthetic charts for each kitten were placed on the kennel that the kittens were in prior to the procedures. The forms stayed with the individual kittens as they moved into the prep area prior to surgery. During surgery, the forms were placed on the operating table in the theatre for the Respondent to see. The forms and the charts remained with the kittens as they moved back to the recovery room.

Ella-May Farr SVN (E-MF)

39. The Committee considered that this witness, who gave her evidence via videolink, was truthful, as best as she remembered the relevant events. Her evidence was consistent with that of JP, except in regards to the discussion of the cost of follow up surgery. This will be dealt with in the findings of facts below.

40. E-MF was only involved in the discharge of the kittens, which occurred in the waiting room of the practice with the owner JP. It was normal practice for the registered or student veterinary nurses to discharge patients when they were not complicated surgeries, such as a routine neuter. E-MF had not previously been told of any complication regarding Paz's surgery and used the standard template of discharge to explain the aftercare to JP.

41. After E-MF had completed the discharge explanation she then witnessed the conversation between the Respondent and JP. E-MF recalled the Respondent explaining that Paz was cryptorchid and that JP should wait a few months before having the remaining testicle removed. E-MF recollected that JP was clearly unhappy about the costs of a second procedure, however E-MF did not recall that there was a discussion specifically regarding costs.

Alexandra Calvert RVN (AC)

42. AC, who was a student veterinary nurse at the time of Paz's castration, booked the appointment for the kittens to be neutered and was present within the waiting room during the discharge procedure following the surgery. The Committee considered AC to be an honest and straight-forward witness. She clearly recalled the events she was involved in and was honest about what she did not remember. The Committee considered her a credible witness. Her evidence was consistent with that of JP, except in regards to the discussion of the cost of follow up surgery. This will be dealt with in the findings of facts below.

Louise Marsh MRCVS (LM) and Darren Cawardine MRCVS (DC)

43. In addition to the oral evidence of the College's witnesses, the evidence set out in the witness statements of Louise Marsh MRCVS, JP's normal veterinary surgeon, and

Darren Cawardine MRCVS, of Langford Vets in Bristol, as summarised above, was agreed and read into the record.

44. LM was not involved in the treatment of Paz prior to his surgery. However, she does recall exchanging a series of text messages with JP the day after his surgery. One of those messages asked if Easipetcare Luton had telephoned JP when they had been unable to remove the retained testicle, to which JP replied that they had not. Another of the messages from JP relayed the information regarding the costs of a second surgery in which JP said the Respondent used words to the effect of *"By the way, I only removed one testicle for the one boy because I couldn't reach the other. It will cost you £5-£10 to get the other removed by another vet later"*

45. DC was not involved in the care of Paz until two days after the discharge had occurred to JP.

The expert evidence of Ms Burrow MRCVS (RB)

46. The Committee took into account the evidence of an expert witness called by the College Ms Rachel Burrow MRCVS. RB is an RCVS and European Recognised Specialist in Soft Tissue Surgery. RB has not undertaken general practice work for several years, but is responsible for teaching Day One Competencies to undergraduate veterinary students, training for veterinary interns and residents in surgery and also providing CPD to general practitioners.

47. RB was critical *inter alia* of the lack of review of any records and the lack of clinical examination prior to surgery. She opined that the Respondent's conduct fell far below the standard expected of a reasonably competent veterinary surgeon, if he knowingly anaesthetised a kitten without having examined the kitten himself or without any record of the kitten having been reported as healthy, following examination by a veterinary surgeon.

48. RB stated that it was a fair assumption that kittens presented anaesthetised to an operating veterinary surgeon in theatre had previously undergone a clinical examination by a veterinary surgeon. She explained that the basis of this assumption was founded in the expectation that anesthetised animals must first have been examined by a veterinary surgeon. However, she further explained that she always teaches to undergraduates and post-graduate veterinary surgeons to undertake their own clinical examination of animals prior to surgery, and that she herself would always examine animals prior to operating on them.

49. RB was not critical of the manner in which surgery was performed which led to the complication of a urethral tear nor was she critical of the timing of the discharge of Paz in that Paz was believed to be in a fit state to be discharged. However, she opined that the manner of the discharge was inadequate. She further opined that, if the Respondent had properly handed over Paz's details for discharge to a Registered Veterinary Nurse, this would be acceptable, but not ideal. However, if the Respondent did not know the veterinary team he was working with, as was the case, it was unacceptable for anyone other than a veterinary surgeon, or a Registered Veterinary Nurse given full instructions, to manage the discharge of this case.

50. She was critical of the decision to continue with surgery without seeking to update JP. On failing to locate the testicle, the Respondent should have contacted JP to discuss the options and devise a plan. There would have been no increased risk to Paz to

remain anaesthetised while the Respondent called the owner. Had the Respondent not called the owner during surgery, he should have done so as soon as possible after surgery. The post-operative communication was inadequate, and the Respondent should have scheduled an appointment for a veterinary surgeon (preferably himself) to meet the client so that the circumstances could be explained with a plan made for completion of the castration in the future.

51. RB described the Respondent's discussion with the owner at discharge as unplanned and circumstantial. He appeared to be leaving the practice at the end of his shift, and it was coincidental that JP was there because she had arrived 30 minutes earlier she had previously planned. To undertake a discharge consultation in a public area was unprofessional. Furthermore, If the Respondent did state that the castration could be completed in several months' time by any veterinary surgeon for £5-10, this would be unrealistic, unprofessional and far below the accepted standard.

52. RB further states that the computer records are inadequate in that they are too brief and undetailed. The note relating to Paz's surgery read *"right testicle inginul, unabl to remove, left ok".* In RB's opinion this was at best ambiguous and had such a record been sent to her as a referral surgeon, she would have telephoned the Respondent to seek clarification over the ambiguity. Although the Respondent states he had intended to add additional notes to describe the surgery, he did not intend to add further notes on the discussion he had with JP.

The evidence of the Respondent

53. Mr Shah was a locum veterinary surgeon who had been appointed to Easipetcare Luton for a period of two weeks to cover another veterinary surgeon on maternity leave. His record of employment indicates that he was due to work from 9am to 3pm each day.

54. The Respondent's preliminary observations to the College in advance of the hearing, and his witness statement, are as follows. He stated that he assumed that the nurse had checked the position of the testicles during admission and that he was not informed of any concerns with Paz. He says that he examined the cat after it was anaesthetised and prepared for surgery and detected that one testicle had descended but the other had not but was present nearby. The Respondent described the sequence of events as starting his incision to first locate and remove the undescended testicle, but when he was unsuccessful in removing it he stopped and then removed the descended testicle.

55. Any cutting of the urethra, which he was unaware of, was accidental. He further stated that *" I relayed all information to the nurse that I was unsuccessful and that the cat will require another anaesthetic to remove retained one if/when it descends."*

56. The Respondent also stated that as he was leaving the building he happened to see the owner just outside the practice. He states, as follows: *"I informed the owner about all in this case of this cat. She seems happy that I had tried to castrate this cat."*

57. In relation to the clinical notes, the Respondent stated: *"In my opinion, I wrote sufficient information in notes as I recall only looking but unsuccessful and not cutting anything besides skin. But you think I need to write more, I will."* The Respondent states that he remembers writing more notes but is unsure why this was not saved onto the computer. He also sets out what he states he recalls having noted as *"Right testicle descended and routine excision. Left testicle not descended but a small swelling noted*

over sac area, could not feel testicle but suspected is nearby. I made an incision over sac and looked for the testicle, some soft tissue found where sac should have been, cut and removed to increase exposure, still no luck so stopped and closed up area with skin glue".

58. In his comments on the witness statements dated 18 June 2019, the Respondent stated *inter alia* that he assumed that AT checked the testicles. He further stated that he expected the nurse on discharge to mention to the owner that he was only able to remove one testicle.

59. The Respondent gave further evidence through a written statement and orally to the Committee. The written statement detailed that he had not been given an induction when he first started at Easipetcare Luton and was reliant on other members of staff to explain to him how 'things were done'. He was aware that Easipetcare Luton was a budget practice with a business model that maximised the use of veterinary nurses. Although he had not seen any written protocols to this effect, he did not feel, that as a locum, he could change the operating model. At the time of the surgery on Paz, the Respondent was the most senior veterinary surgeon in the practice.

60. The Respondent assumed that when the kittens were admitted they had undergone a clinical examination by a nurse and that he would have expected an experienced nurse, such as AT, to have checked for the presence of both testicles prior to anaesthesia. One of the nurses had stated the cats had been vaccinated, and this re-inforced the Respondents assumption that they had been previously checked by a veterinary surgeon.

61. Regarding the consent form for Paz, the Respondent submitted that the first time he saw the consent form was when he reviewed the Inquiry Bundle for this hearing in late December 2019. He had not seen it on the day of the surgery, and did not know what the 'X' next to the question "descended testes?" meant. The admitting nurse did not make him aware of any complications before he began the surgery.

62. The Respondent's written account of the surgery matches his previous description except that he does not recall Paz flinching during the procedure nor does he recall AT requesting that he stopped the procedure in case he caused damage to Paz. He conceded that it would have been *"preferable"* to have contacted the owner to discuss her options when it became evident that he was unable to locate the second testicle. The Respondent instigated a conversation with the nursing staff to inform them of his findings during surgery so that this could be conveyed to the owner at discharge. He denies that the nurses told him to contact the owner and relay the information about the complication and the plan.

63. Having confirmed that Paz was fit to be discharged in the afternoon, the Respondent did not speak to the nurses any further and *"expected the discharge nurse [to] check the clinical records and ask me for clarification if they had any queries"*. He was not aware of the discharge appointment with JP at 3:30pm. When he left the practice at the end of his shift at 3pm he passed the owner and having assumed that the discharge nurse had explained what had occurred during surgery he *"thought it was sensible … to discuss my findings and to offer reassurance."* According to the Respondent, JP did not appear to be surprised by the explanation.

64. In oral evidence, the Respondent confirmed that the kittens were new to the practice and that he did not examine them prior to surgery. He confirmed that he assumed that the nurse had undertaken a clinical examination because one nurse actively told him

that they were fit and healthy. He asserted that *"The onus is on her [the nurse] to do all of these checks. My job was just to go in and operate"*.

65. When questioned about the consent form, the Respondent confirmed he did not look at the consent form prior to surgery, nor did he check the computer records until after the surgery had been completed.

66. The Respondent described the sequence of events during the castration of Paz as starting with the undescended testicle, and when that was not successful, he went on to the descended testicle and removed it normally. While Paz remained anaesthetised, he castrated the third male, before returning to Paz to try again to find the retained testicle. He recalled telling the nursing staff to telephone the client while he was castrating Paz to take further instructions from the owner, and he did not get a response from the nurses and said words to the effect of *"I have not heard anything back from you guys, let's wake him up".* This evidence did not appear in the Respondent's previous comments on the complaint, in his comments on the witness statements, or in his own witness statement. It emerged for the first time in his oral evidence.

67. Following the surgery, while the nurses were clearing up, the Respondent then asked one of them, possibly MH, to make the telephone call to JP. He also told MH the information that needed to be relayed to the owner when Paz was to be discharged and assumed this would be passed on to the discharging nurse E-MF. The Respondent asserted that this was a sufficient mechanism to relay the information because this is a common outcome of early neutering. During the remaining afternoon between 1:30pm and 3pm the Respondent remained on the premises although did not have any further surgeries or consultations. When asked why he did not relay the complication about Paz directly to the discharging nurse during the afternoon, the Respondent replied to the effect of *"Nobody came to ask me if the procedures were ok and routine. They had two hours to come and ask me if anything went wrong, nobody came to ask me before the discharge. Had they have come to ask me I would have told them that it had gone wrong. This is the fault of the nurses, it is their responsibility."*

68. In regards to the chance meeting with JP at the point of discharge, the Respondent admitted that he did not introduce himself. His purpose of the meeting was to reassure JP that he had tried to remove the testicle. He did not recall the owner saying anything at all to him, but was quite certain that he did not mention a value of £5-10 for a follow up surgery. As a locum veterinary surgeon who was new at the practice, he did not know the pricing scheme well enough to quote a value. He did not relay to JP the consequences of having a cryptorchid kitten that had one testicle removed.

The Committee's assessments of the Respondent as a witness

69. The Committee found the Respondent's approach while giving evidence to be defensive and garrulous. He did not always consider his answers before he gave them, and he seemed to develop his answers in their complexity while he was responding to questions. He appeared to embellish the written statements and other information he had previously provided, even when that embellishment conflicted with the previous evidence he had already given. He also provided entirely new accounts of events which did not appear in previous statement. At times, there was confusion between the evidence of factual events that the Respondent witnessed and what he had assumed had happened. The Committee noted that the evidence that he gave about instructing MH during his attempted castration of Paz to call JP to tell her what had happened, and to ask JP whether she wanted him to stop, or continue to try and find the undescended testicle, emerged for the first time in his oral evidence. On this

point, it appeared to the Committee that the Respondent was making his account up as he went along. The Respondent's general manner with the Committee was informal, dismissive and almost jovial at times. The Committee found the Respondent to be a very poor witness, whose recollection of events was unreliable.

70. Throughout the Respondent's evidence, he repeatedly abdicated responsibility of his actions onto the nursing staff around him, despite their level of qualification and accountability. He expected staff to present to him with the information that he was required to obtain, and claimed to be without fault if that information was not provided. His refusal to accept responsibility was pervasive in his general attitude. For example when considering his orientation at the practice he said *"I didn't ask for a manual, I just assumed that the practice manager would give me an induction".* When considering the time before discharge of Paz, the Respondent replied *"They [the nurses] had two hours to come and ask me if anything went wrong, nobody came to ask me before the discharge. Had they have come to ask me I would have told them that it had gone wrong. This is the fault of the nurses, it is their responsibility."*

71. For the avoidance of doubt where there is a conflict of evidence between the accounts of the nursing staff and the accounts of the Respondent, the Committee accepts the evidence of the nursing staff in preference to the Respondent.

Expert evidence of Mr Chitty

72. The Committee heard evidence from an expert witness Mr Chitty MRCVS (JC), who was called by the Respondent. JC is an RCVS Advanced Practitioner in Zoological Medicine.

73. The Committee found the evidence of JC to be, at times, limited in its use of all available factual information when formulating conclusions. Some of the conclusions reached appeared to have no factual basis to them but were found to be in support of the Respondent. For example, JC concluded that *"it is not unreasonable [for the Respondent] to have decided to discuss this [follow up surgery] with the owner at discharge",* however there is no reference to the Respondent having made that decision and, in fact, the Respondent did not intend to discuss follow up surgery with the owner at discharge.

74. The Committee agrees with the College's submission that of particular concern was an apparent reluctance on JC's part, in giving evidence, and in forming his conclusions on the evidence, to take any or sufficient account of any evidence that contradicted the account provided by the Respondent. A striking example was in relation to the discharge arrangements. Both in his report and evidence he failed to have any regard to the fact that it was the nurses' account that they told the Respondent he should speak directly to the owner and not the other way round. Similarly, in relation to the notes, Bluebell's notes are described in JC's report, without qualification, as "holding notes", which appear to corroborate the Respondent's account rather than taking an objective view of the evidence. Furthermore, JC demonstrated some inflexibility where the account provided by the Respondent in evidence shifted fundamentally from his previous written accounts-for example in relation to his oral assertion that he instructed a nurse to call JP during the procedure in order to discuss options for treatment.

75. JC explained that he had been time limited when producing the report, which was to be completed over the Christmas period while still working in general practice. However, the Committee is mindful that his duty was to the Committee and to be

impartial, and JC failed to modify his stance when evidence became available during the hearing. JC apologised if he had given the impression of not being impartial, and the Committee accepted that apology.

Previous Reprimand and Advice

76. The experts were not asked to comment on Charge 2, which related to a previous Reprimand and Advice given to the Respondent. The Committee notes that on 22 September 2016 a previous Committee found disgraceful conduct and reprimanded the Respondent in relation to his discharge of a dog, Shadow, following a castration operation. The decision states:

"In imposing the sanction of Reprimand, the Committee urges the Respondent in the strongest possible terms to ensure that his future conduct by way of training and support systems within his practice are such at to avoid any possibility of a future incident such as this occurring in order to ensure animal welfare and public confidence in the veterinary profession. The committee notes that in her evidence EM said that the working practices at the surgery have changed and the committee expects that all animals kept in the care of the Respondent are fully monitored, examined and assessed in relation to their condition before being discharged."

77. Furthermore, in March 2018 the Respondent received formal Advice from the Preliminary Investigation Committee of the College relating to the circumstances surrounding canine spay surgery in 2016. The formal advice was as follows:

(i) In relation to paragraph 1.3 of the Code of Professional Conduct, which states that:

"Veterinary surgeons must provide care that is appropriate and adequate."

(ii) In relation to paragraph 2.5 of the Code of Professional Conduct, which states that:

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

78. Charge 2 alleges that, in relation to the conduct complained of in Charge 1, as set out above, the Respondent failed to have adequate regard to the previous advice and/or warnings from the College about his conduct in relation to neutering surgery and related note-keeping and communication with clients.

Findings of the Committee as to the facts

79. The Respondent denied all of the charges. In reaching its decision on the facts, the Committee considered all of the written and oral evidence, the submissions of the parties, and the advice of the Legal Assessor which the Committee accepted.

Charge 1(a)

80. The Respondent admits that he did not undertake a clinical examination on Paz prior to him being anaesthetised and therefore does not dispute the first part of this charge. The second part of this charge is disputed by the Respondent. He asserts that he

assumed that Paz had undergone an examination by a veterinary surgeon because Paz had been previously vaccinated. The Respondent clearly remembers being told that the kittens had been vaccinated although the nursing witnesses could not be certain that this conversation had occurred.

81. When considering this charge, the Committee was mindful of the specific words of the charge and, in particular, that it required the Respondent to have 'ensured' Paz had been examined by a veterinary surgeon prior to anaesthesia. The Committee considered the evidence of both expert witnesses.

82. Mr Chitty informed the Committee of the rationale behind the importance of the veterinary examination, rather than a nursing examination, prior to surgery. This is due to the requirement in the Code of Professional Conduct which stipulates that a veterinary examination is required prior to the administration of POM-V drugs such as would happen during anaesthesia. Mr Chitty further opined that because Paz was admitted by an RVN and that because the RVN did not raise concerns directly to the Respondent he was entitled to believe that Paz had been examined by a veterinary surgeon. If the RVN did not check the 'Vet Check box' on the white board and the nursing staff did not specifically book the kittens into the veterinary surgeon's consultation list, then the Respondent was not unreasonable in assuming that a clinical examination had been performed.

83. Ms Burrow identified that the Respondent had not reviewed the patient records, nor confirmed the health status or the presence of normal genital anatomy prior to anaesthesia. Although the RVN had reported them to be 'fit and healthy', Ms Burrow reports that 'good health' is not an indicator of absent congenital disease which could adversely affect anaesthetic safety. Ms Burrow considered the Respondent's assumption that the kittens had been previously examined by a veterinary surgeon to be a fair assumption as explained above in that because they had been anaesthetised, they ought to have previously been examined by a veterinary surgeon. However, Ms Burrow also informed the Committee that it is standard teaching to all undergraduate and post graduate veterinary surgeons to always undertake a clinical examination prior to anaesthesia, and personally she would never make assumptions that another veterinary surgeon had done this. The Committee does not agree that the Respondent had any reasonable basis to assume that the kittens had been examined previously, and does not agree that he assumed they had been recently examined at a vaccination clinic. The Respondent said that when he examined the clinical records after the three castrations, he realised that there was no record of an examination and then undertook one on the female kittens. Such actions are not consistent with the considered belief that they did not require an examination.

84. The Committee was mindful that due to the false information provided by the owner at time of admission, it would have been impossible to obtain the previous clinical records to confirm an examination had been performed. However, the Respondent made no attempts to view the patient records, determine the health status of the patient with the nurse or view the consent form prior to surgery. The Respondent said that if the admitting RVN detected a retained testicle she ought not to have admitted the kitten for castration. Had the Respondent seen the consent form he would have noticed the cross in response to the question "descended testes?" on the consent form, which the experts agree is, at best, ambiguous as to its meaning. The Committee agrees with this view regarding the ambiguity of the cross in the box, and this should have prompted the operating veterinary surgeon to examine the kitten.

85. The combination of the factors listed above do not, in the opinion of the Committee, amount to 'ensuring' that an examination had been performed by another veterinary

surgeon prior to surgery. The Respondent did not do any of the things that he could have done to ensure that Paz had been examined. He did not ask if they had been examined, he did not look at the medical records and he did not look at the consent form.

86. Accordingly the committee find Charge 1(a) proved in relation to both limbs, to the requisite standard of proof.

Charge 1(b)

87. It is not disputed that the Respondent did not telephone JP during surgery regarding the failure to complete the castration and to take further instruction regarding treatment options. The question for the Committee is whether the Respondent instructed the veterinary nurses to telephone the client, or if they instructed him. The Committee considers the evidence provided by the nursing staff to be consistent in their view that the onus was on the Respondent to call the owner during or immediately after surgery. In oral evidence, the Respondent further asserted that he directed MH, who was monitoring the anaesthesia, to telephone the owner during the procedure. However he got no response from MH who did not leave the room nor use the telephone in the operating theatre. This account is inconsistent with the evidence from MH and did not appear in the Respondent's own witness statement. The Committee considers that this was an example of the Respondent embellishing his account of events as he gave his oral evidence.

88. Both expert witnesses agree that the Respondent should have telephoned the owner, or have arranged for the owner to have been telephoned either during or as soon as possible after surgery to relay the information on the failure to complete the castration. Mr Chitty opined that a telephone call to the owner during surgery could have increased the anaesthetic risk for a young kitten. Ms Burrow disputed that such a telephone call could have adversely affected the risks already present during anaesthesia. Both agreed that it would have been ideal for the operating surgeon to have made that telephone call as he would have been most familiar with the situation

89. The Committee is certain, given the factual evidence, that the Respondent did not make the telephone call to JP before ending his attempts of castration. The Committee also finds that he did not arrange for someone else to call. However, when the Committee considered the wording of the charge that to not have made the telephone call during surgery was a failure, it must have been certain that there was a duty to have made this call or arranged to make this call before the end of surgery. However, the wording of the charge indicates that the 'failure' or duty was to make the call during surgery and the Committee is not persuaded that there is such a duty.

90. Accordingly the Committee find this charge not proved.

Charge 1(c)

91. The College submitted that Charge 1(c) is linked to Charge 1(b) insofar that it relates to the period of time before the Respondent had completed his attempts at castration.

92. The Respondent's plan to complete the castration of Paz at a later date involved allowing Paz to recover from anaesthesia and waiting for Paz to mature for one or two months in the hope that the undescended testicle would descend naturally.

93. RB expressed the view that a plan to delay castration for several weeks to allow the undescended testicle time to descend was an adequate plan for the completion of the

castration at a later date. However, this assumes that the Respondent contacted JP during, or immediately after, surgery to explain what had occurred.

94. The Committee is unable to be satisfied so that it is sure that this charge has been proved to requisite standard for the period during the attempts at castration.

Charge 1(d)(i)-(v)

95. The Committee accepts the College's submission that there is some overlap between the sub-paragraphs under this head. As the operating surgeon, the Respondent was responsible for ensuring that adequate discharge arrangements were in place. In view of his previous involvement with the Royal College in 2016 the Respondent should have been particularly aware of the importance of making satisfactory discharge arrangements in this case. As RB stated, it was entirely predictable that the owner would be unhappy in this situation. The Committee agrees.

96. The Committee agrees that whilst discharge can be delegated to a veterinary nurse, here there is no evidence of satisfactory delegation. There is a dispute of fact as to whether the Respondent asked one of the animal care assistants, MH, to speak to the owner. MH's evidence is that she and the other nursing staff told the Respondent that he should speak to the owner himself. AT also confirms that she told the Respondent that he should do this. The Committee accepts the consistent account of the nurses in this regard.

97. JC conceded that, if the nurses' accounts were accepted, to the effect that it was they who told the Respondent that he should contact the owner and not the other way round, the Respondent's conduct fell far below an acceptable standard.

98. The Respondent's evidence suggests that he attached little weight to the complication during surgery. This is consistent with the College's case to the effect that he failed to take adequate steps to ensure that JP was fully informed post-operatively of the details of the surgery or make adequate notes. The Committee agrees.

99. It is not in dispute that E-MF who discharged the patient was unaware of any complication. The Committee accepts the College's submission that the Respondent had wrongly sought to shift the blame for the discharge responsibilities to the nurses.

100. Ms Burrow stated that the incidental meeting between the Respondent and JP in the waiting room was the only place where the results of the surgery and the plan to complete the castration were relayed. This meeting was circumstantial, coincidental and unplanned. JP was not due to arrive at the practice until 30 minutes later, and had she arrived at the agreed time, the Respondent would not have seen JP to relay this plan. Had this fortuitous meeting not occurred, JP would have left the practice unaware that one of the kittens was cryptorchid and with no knowledge of any plan to complete the castration. On any view, the Committee is satisfied so that it is sure that the Respondent failed to provide or arrange adequate scheduled time post-operatively to explain to JP the results of the surgery. JP described being shocked into silence by what she was being told by the Respondent who, at this stage, had not introduced himself and JP did not know who he was.

101. As stated in its earlier decision, the Committee considers that the information conveyed to JP was given to her in a chance meeting for which she was unprepared was inadequate. The Committee considers that the complication that had arisen during the surgery demanded a careful explanation in a location where JP would be able to

consider and digest what had been explained to her. This would have enabled JP to raise any considered queries that she may have had in the light of this explanation.

102. The Committee considers that Charge 1(d)(iii) alleges that the Respondent failed adequately to discuss with JP a plan for Paz's future treatment. In the view of the Committee a proper discussion with JP was required, and any plan for Paz's future treatment should have included possible outcomes as a result of the failure to achieve the castration of the undescended testicle, and included the option to complete the castration in the immediate future.

103. As to Charge 1(d)(iv) the Respondent has, at every stage, sought to pass the responsibility of explaining to JP the outcome and consequences of the surgery to the qualified and unqualified nursing staff within the practice. It is disputed whether the Respondent instructed the animal care assistant MH to pass on the relevant information to the discharging nurse and then to JP. The discharging nurse in this case was a student. If this did occur, in the view of the Committee, it would have been an unacceptable chain of communication for information of this magnitude. The Committee has no doubt, on the facts of this case, that the Respondent should have taken it upon himself to contact JP directly prior to discharge and explain what had happened.

104. Whilst the Committee has no doubt that by the end of the discharge meeting the owner was aware of the fact that only one testicle was removed, it is the Committee's view that the context and manner in which the discussion took place was inadequate and 'unprofessional', as stated by AC and RB. The Committee notes that AC described the Respondent's tone with JP as 'light-hearted', the Committee finds this attitude to have been inappropriate.

105. Accordingly the Committee finds charges 1(d)(i)-(iv) proved to the required standard.

106. As to Charge 1(d)(v), the Committee construes this charge to relate to the allegation that the Respondent told JP that the likely cost of further castration surgery would be £5-10. There is a conflict of evidence on this point between the evidence on the one hand of JP and LM that JP had been told this by the Respondent and that she had no doubt about it. However, on the other hand, the evidence of E-MF and AC is that they were unable to recall a discussion on the costs, and the Respondent insists that he never mentioned this. Having considered the evidence with care, the Committee considers that JP's account is probably correct. However, having regard to the fact that the Committee must be satisfied so that it is sure in relation to this allegation, the Committee is unable to be so satisfied. Accordingly this allegation is dismissed.

Charge 1(e)(iii) and (iv)

107. The Respondent admits that he did not make any clinical notes in relation to Paz regarding his post-operative communication with JP, or his plan for completion of the castration. At no stage has the Respondent argued that he did make notes in relation to these matters, as required by the Code of Professional Conduct.

108. Therefore, the Committee finds the heads of charge 1(e)(iii) and (iv) proved.

Charge 1(e)(i) and (ii)

109. It is common ground that the notes entered and saved by the respondent on the practice computer on the day of the surgery were brief and did not satisfy the

requirements of the Code of Professional Conduct. It is the view of the Committee that these entries were incomplete and ambiguous, particularly in relation to the entry *"left ok"*.

110. The Respondent contends that he made further notes, which he intended to save on the practice computer but that these did not in fact save. He claims that he only realised this some two months later when asked by the College about the completeness of his notes. In an email to the College dated 10 August 2018, the Respondent purported to reconstruct from memory alone some more detailed clinical notes as set out above (see paragraph 57 of this Decision). The Committee has already found that after his discharge conversation with JP in the waiting room, he should have returned to the practice and recorded details of that conversation including the matters referred to in Charges 1(e)(iii) and (iv). The Committee is of the view that the Respondent, on the day of the surgery, when he says he made his more substantive notes, should have checked that they had been uploaded and saved onto the computer. Even if he had not done that, he should have returned to the practice to make notes about his discharge conversation with JP, at which point he would have realised that these notes had not been saved.

111. In any event, it was the Respondent's responsibility to make comprehensive clinical notes following this incident, as soon as he became aware that JP had said that she did not propose to return to the practice for further treatment for Paz. In these circumstances, it should have been obvious to the Respondent that another veterinary surgeon would be likely to be treating Paz and therefore require full and comprehensible notes from the Easipetcare Luton practice.

112. Accordingly the Committee finds Charges 1(e)(i) and (ii) proved to the requisite standard.

Charge 2(a) and (b)

113. The Respondent accepted the factual background under Charges 2(a) and (b), in which he was reprimanded, and given advice, as to his future conduct on two separate occasions in 2016 and 2018 as set out in the charges.

114. The Reprimand in 2016 by the College's Disciplinary Committee followed its finding of disgraceful conduct with regard to the discharge of a dog after castration surgery. The Disciplinary Committee on that occasion found that the Respondent had been guilty of being grossly negligent in permitting the dog to be discharged into the care of the owner when it was not in a fit state to be discharged.

115. When asked about this finding when giving oral evidence, the Respondent replied *"I should have taken more effort to make sure that the nursing staff did the monitoring. They didn't do that. I assumed they would have done that, but they didn't. I should have made sure the nurses did this."* This was an example of the Respondent abdicating responsibility and seeking to place blame on the nursing staff as has been found in this case.

116. Accordingly, the Committee find Charge 2(a) and (b) proved in relation to the heads of charge have been found proved as set out above.