**ROYAL COLLEGE OF VETERINARY SURGEONS**

**INQUIRY RE:**

**DAVID EDWARD SMITH MRCVS**

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**DECISION ON FACTS**

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**Background**

1. At the time of the allegations Mr Smith was practising as a veterinary surgeon at the Lakeview Veterinary Centre, Crete Road West, Folkestone, Kent. The Practice operated from two surgeries, one based in Deal and the other in Hawkinge (Folkestone). The Allegations can be divided into two separate categories; Charges A to E relate to Mr Smith's management of 5 animals and Charge F concerns Mr Smith's conviction for a criminal offence.

2. Charge A relates to a Clydesdale mare called Grace who was 7 years old at the time. It is alleged that, Mr Smith failed to perform an adequate examination or undertake sufficient investigation into Grace's presentation. It is also alleged that, Mr Smith failed to respond adequately to telephone calls from Grace's owner describing Grace's deteriorating health and it is alleged that the clinical records for Grace were inadequate.

3. Charge B relates to Holly a Labradoodle dog and again the Charge relates to inadequate clinical records.

4. Charge C relates to Maisey a cat. It is alleged that, there was an inadequate examination and investigation of Maisey's health in a number of respects, and inadequate clinical records.

5. In relation to Mr Smith's communications to the RCVS (Royal College of Veterinary Surgeons) concerning Maisey it is alleged that he sought to misrepresent the fact that there

was another veterinary surgeon involved in the care of Maisey. That misrepresentation is said to be dishonest.

6. Charge D relates to Comet a cat and again the Charge relates to inadequate clinical records. It is further alleged that Mr Smith failed to respond appropriately to the concerns raised by Ms Ward about a veterinary surgeon at Mr Smith's practice and that he failed to provide Ms Ward with details about how to raise a concern or a complaint to the practice.

7. Charge E relates to the care of Poppy a Yorkshire terrier. Again, the Charge concerns inadequate communication and advice given to Poppy's owner by Mr Smith,

8. Charge F relates to Mr Smith's conviction on 13 June 2016, for a criminal offence. He was convicted at the Crown Court at Maidstone following a trial, of conspiracy to commit fraud. For this offence he received a sentence of 30 months imprisonment.

**Decision on Facts**

9. In coming to its decision on facts the Committee had regard to all the evidence both oral and documentary. It was reminded that it is for the College to prove its case and that there was no burden on Mr Smith to prove anything. The standard of proof applied when considering whether the allegations are made out is that the Committee must be sure.

10. The Committee took into account the submissions made by both parties and it accepted the advice of the Legal Assessor. In considering the allegation of dishonesty the Committee were referred to the recent case of Ivey v Genting Casinos (UK) [2017] UKSC 67.

11. The Committee heard from a number of witnesses of fact relating to Charges A-E called by the College. The College also called 2 expert witnesses: Mr Peck MRCVS who gave evidence relating to small animals and Mr Hepburn MRCVS who gave evidence regarding Grace.

12. Mr Smith attended on the first day of the hearing. He denied Charges A-E and he admitted the fact of Charge F, namely that he had the conviction set out. However, he expressed that he was innocent of the criminal charge, Charge F of which he had been found guilty. Following the Charges having been read out Mr Smith left the hearing and stated that he did not wish to hear or cross-examine any of the College's witnesses but that he would return to give his oral evidence. The Committee drew no adverse inference from Mr Smith's non-attendance. On day 6 of the hearing Mr Smith returned and gave evidence before the Committee. At times, the Committee found his evidence to be contradictory, inconsistent and lacking in credibility. Mr Smith made detailed oral submissions at the conclusion of the evidence. He stated that he did not wish to hear the submissions of Counsel for the College and he wished to make his submissions first. Mr Smith also left the Committee with a copy of his submissions in writing. The Committee took his evidence and oral submission into account when considering whether the College had made out its case. The Committee also took into account the evidence of Ms Kelly Simmons, Mr Smith's witness. Ms Simmons has

worked for over 20 years with Mr Smith and is described as his “Head Nurse” although she is not professionally qualified as a veterinary nurse.

13. There were a number of applications made during the course of the College’s case. For ease of reference the Committee sets out those applications here.

**Application to proceed in Mr Smith’s absence**

14. Mr Smith attended on the first day of the hearing and responded to the Charges. He denied all matters save for the fact of the conviction. He then informed the Committee that he did not wish to stay to hear or cross examine the College’s witnesses. He stated that he would return when the College’s case was concluded to give evidence.

15. The Committee had regard to The Veterinary Surgeons and Veterinary Practitioners (Disciplinary Committee) (Procedure and Evidence) Rules 2004; Rule10.4;

> *If the respondent does not appear, the Committee may decide to proceed in the respondent’s absence if it is satisfied that the notice of inquiry was properly served and that it is in the interests of justice to do so*.

16. The Committee therefore had to consider whether to continue with the case in the absence of Mr Smith. The Committee concluded that it was appropriate to continue to hear the evidence. It noted that Mr Smith was aware that witnesses were in attendance and he had chosen to voluntarily absent himself from those parts of the hearing where the College presents its case. The Committee was satisfied that the notice of the Inquiry was properly served and that it was in the interests of justice to proceed.

**Further Applications**

17. In respect of the applications to adduce evidence the Committee had regard to The Veterinary Surgeons and Veterinary Practitioners (Disciplinary Committee) (Procedure and Evidence) Rules 2004; Rule 23.1

> *The Committee may receive oral evidence whether or not under oath, documentary evidence, or other evidence of any fact which appears to it relevant to the inquiry into the case before it. Subject to any other provision of these Rules, the Committee may receive evidential material prior to the hearing of an inquiry.*

**Application to hear the evidence of Ms Ward and Ms Blumenthal by Skype**

18. The Committee heard that Ms Ward and Ms Blumenthal could not attend the hearing in London due to personal reasons that were explained to the Committee.

19. The Committee noted that Mr Smith was written to regarding the applications to hear evidence by Skype and he had not responded. Counsel for the College told the Committee

that prior to the hearing starting, he had told Mr Smith that he would be making the applications for the evidence of these witnesses to be given by Skype.

20. Mr Smith was not present to cross-examine the witnesses and the Committee came to the view that it would not be disadvantaged in assessing the witnesses' evidence and demeanour via Skype. The Committee acceded to both applications.

**Application to adduce into evidence the blood test results of Maisey produced by Mr Barnes MRCVS**

21. During the course of Mr Barnes' evidence, he produced the blood test results for Maisey that had not previously been before the Committee. Further, those results would not have been seen by Mr Smith. Counsel for the College submitted that the blood test data were referred to in the clinical notes and whilst Mr Smith would not have seen them, there would be no injustice to him as they simply confirm what is on the clinical records.

22. The Committee determined to admit the blood tests data as they were relevant to the case. It noted that these simply confirm the accuracy of what was recorded on the clinical notes and therefore there was no injustice to Mr Smith in him not having seen them.

**Application to admit the written statement of Mr Vines into evidence**

23. Counsel for the College applied to have the written statement of Mr Vines admitted into evidence. The Committee noted that his statement simply corroborated the evidence of Mrs Vines and was not the sole or decisive evidence to a particular issue in the case. The Committee therefore determined to admit the statement into evidence. It determined that at the conclusion of the case it would consider what if any weight could be attached to it bearing in mind the truth or accuracy of its contents could not be tested.

**Application by Mr Smith to admit documentary evidence**

24. When Mr Smith attended on day 6 of the hearing, he applied to have a number of documents admitted into evidence. Those documents related to the conviction only. Mr Smith passionately believes in his innocence of the crime he was convicted of, and he has thus far appealed to the Court of Appeal, unsuccessfully, and he has asked that his case is reviewed by the CCRC (Criminal Cases Review Commission). He is awaiting its decision to see if they will refer the case back to court. The documents he wishes to rely upon were described by Counsel for the College as statements which support Mr Smith's view that he is innocent of the crime he has been convicted of. He wished them to be put before the Committee "to prove that he is innocent". Counsel for the College objected to those documents going in. He stated it was not for the Committee to go behind the fact of the conviction but of course Mr Smith could give evidence as to the nature and circumstances of the conviction. Mr Smith did not disagree with the College's description of the documents. After receiving legal advice the Committee retired to consider its decision and it determined to reject the application of Mr Smith. The reasons were announced at the hearing.

**Charge A**

**Charge A reads as follows:-**

> ***In relation to a Clydesdale Mare named Beyonce (stable name Grace) belonging to Ms Sharon Mancini:***
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> ***A.1 on 14th August 2014, having attended Grace at the request of Ms Mancini, you failed to perform an adequate examination of Grace and/or undertake sufficient investigation into her presentation and/or history; and/or***
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> ***A.2 on 14th August 2014, after your initial visit to Grace on that day, you failed to respond adequately to Ms Mancini's telephone report/s that Grace had deteriorated and/or failed to improve; and/or***
>
> ***A.3 between 14th October 2013 and 15th August 2014, you failed to make any or any adequate clinical records for Grace.***

25. The Committee took into account the evidence of Mr Hammant and Mrs Hammant (formerly Ms Mancini). It also had regard to the expert evidence from Mr Hepburn. Mr Smith gave his evidence in relation to Grace.

26. The Committee found Mrs Hammant to be a convincing and reliable witness. Her evidence was supported by that of Mr Hammant and the Committee found no reason to disbelieve them. By contrast the Committee found Mr Smith's evidence to be inconsistent and lacking credibility.

**Charge A.1**

27. On 14 August 2014 Mrs Hammant's Clydesdale mare Grace was 7 years old. When Mrs Hammant took Grace her breakfast that morning Grace was lethargic and unresponsive.

28. Mr Smith attended Grace. Mrs Hammant stated that she was told by Mr Smith that Grace was suffering from a 'tummy ache'. Mr Hammant stated that Mr Smith expressed the view that Grace had 'mild colic' from a distance, while walking up the drive. The only examination of Grace by Mr Smith according to Mrs Hammant was that he took her temperature but undertook no other examination. She stated that he asked no questions to establish the history of Grace's illness. He proceeded to give Grace medication by injection, which Mr Smith states in correspondence was Finadyne intravenously and Buscopan intramuscularly. Mr Smith then left, telling Mrs Hammant to contact him if she had any worries.

29. In oral evidence Mr Smith said Grace was not in pain but, in his correspondence to the College on 14 April 2016, he stated that Grace "had acute abdominal pain". In oral evidence he said, for the first time, that he was able to undertake a rectal examination without Grace being held or tethered. He also stated that Grace did not move when this examination was being undertaken. In his written submissions which were put before the Committee commenting on the College's witness statements he stated that he considered that Grace's condition was terminal. However, when he was asked questions by the Committee when describing his examination of Grace, he related findings of a horse that were normal except for the colour of her mucous membranes for which he could not identify a cause. He suspected "foul play".

30. The Committee also took account of the fact that the medicine Mr Smith gave Grace, was consistent with colic and supports the evidence of Mrs Hammant, that Mr Smith told her that Grace had mild colic.

31. Mr Smith has also suggested that Grace may have been poisoned. Mrs Hammant denies that she was ever told of this possibility when Mr Smith came to examine Grace. The Committee also concluded that if this had really been Mr Smith's suspicion then even on his own account his examination of Grace was inadequate.

32. The Committee had regard to the evidence of the expert Mr Hepburn, as to what a reasonably competent veterinary surgeon would do if they suspected poisoning in a horse. He stated that if poisoning was suspected an examination should have included a basic investigation of the nervous system, the cardiovascular system, the respiratory system, ocular and visual examinations, observation for spontaneous muscle fasciculation or altered muscle function and a urine sample. Mr Smith should also have taken a history to identify potential intoxicants. Treatment would have been required, by way of the nasogastric evacuation of stomach contents followed by the administration of binding agents or demulcents and intravenous fluids and electrolytes and potentially a referral. Mr Hepburn stated in his report and in oral evidence that it would not have been appropriate to administer Finadyne and/or Buscopan. He stated that Finadyne was contraindicated in cases of renal compromise which might well be a consequence of poisoning. These were the drugs Mr Smith accepts he gave to Grace.

33. The Committee accepts Mr Hepworth's evidence that the medicines Mr Smith administered, Finadyne and Buscopan, indicate that his analysis was just as Mrs and Mr Hammant describe. The Committee accepts Mr Hepworth's evidence that using those medications without a full examination is not acceptable, because the administration of Finadyne is common for the initial alleviation of pain in horses with colic, however, it has the potential to mask the cardiovascular signs of deterioration in cases of colic and a thorough colic examination is therefore required. The Committee also accepted Mr Hepburn's evidence that Buscopan is commonly used as a spasmolytic in cases of spasmodic equine colic but is contraindicated in the presence of ileus (reduced intestinal motility) and so confirmation of the presence of a spasmodic colic is required. The administration of Buscopan by the intramuscular route, is not licenced in a horse. However, Mr Smith stated that this was the practice 40 years ago and that this is how he continues to practise.

34. The Committee had no hesitation in accepting the evidence of Mrs and Mr Hammant. The Committee rejects Mr Smith's varying explanations as to what he had found on seeing Grace. The Committee further concluded that the only examination Mr Smith did undertake was Grace's temperature as described by Mrs Hammant.

35. The Committee is sure that this Charge is proved.

**Charge A.2**

36. The Committee accepted the evidence of Mrs Hammant as to the number of calls she made to Mr Smith. Ms Hammant telephoned Mr Smith, on four occasions over a period of five/six

hours, during the late morning and afternoon of 14 August 2014 to tell him about Grace's behaviour. She told the Committee, that on each occasion she called, she reported that Grace had further deteriorated since his visit and was continuing to deteriorate. By the time of the first call she was reporting that Grace was breathing erratically, sweating and behaving strangely (running up against a fence). In the second call she reported that Grace was moaning and groaning, flinging herself against the stable wall and trying to lie down. In the third call she told Mr Smith that Grace was not getting any better. In the fourth call she said that Grace was now not staying on her feet. Mrs Hammant stated that on each of these occasions Mr Smith's reaction was to advise her to stop panicking, that the problem would resolve, and that Mrs Hammant should leave Grace alone to sort herself out and that Grace would be fine. Mrs Hammant told the Committee that after speaking to Mr Smith she thought she was just "fussing". There was a fifth call, when Mrs Hammant rang Mr Smith to tell him that Grace had collapsed and died.

37. Mr Smith did not deny he received the calls. He stated to the Committee: "What could I do there was nothing I could do". He made no suggestion that she call another veterinary surgeon. He had an equine vet working for him at that time, and he could have notified her of the fact that the horse may have to be attended to and put down. According to Mr Hepburn the clear description that Mrs Hammant was giving Mr Smith of Grace's symptoms, was of terminal abdominal colic. In Mr Hepburn's opinion, Mr Smith failed to acknowledge a clear escalation of symptoms. Even on Mr Smith's evidence he said the horse was in a terminal emergency state. The Committee finds that he gave totally inappropriate advice to the owner of a dying horse. He failed to advise or arrange for a means by which euthanisa could have been given to Grace. Mr Hepburn described in graphic detail the pain that Grace would have been in during the last hours of her life.

38. The Committee found this charge proved so that it was sure that Mr Smith failed to respond adequately to telephone calls that Grace had deteriorated and failed to improve.

**Charge A.3**

39. There were some clinical records presented to the Committee regarding Grace. What was presented made no reference to the call out to see Grace on 14 August 2014. There was no entry as to any examination or treatment given on that day. Mr Smith in evidence to the Committee stated; he is "a very busy man". In respect of why he did not write up any notes after Grace had died he stated; "Yes, I didn't make any notes the horse died", "the animal was dead and I forgot and I was very busy, I was very sorry for Ms Mancini (Mrs Hammant)". Mr Smith went on to accept that he was at fault but followed that statement up with the words "I live in the real world I have to get on with things".

40. In respect of the notes that he produced for Grace at the hearing, he denied having made a home visit on 30 October 2013. He said if he had visited Grace at home it would have been recorded in the notes. He disputed Mrs Hammant's evidence that he had visited on that day. In oral evidence Mr Smith stated that he had prescribed antibiotics for Grace without examination. He stated that he was of the view that this was acceptable and done all the time. Mr Smith stated that this is his standard treatment for a coughing horse and he does not see the need to see every single one.

41. With regard to whether there was a home visit on 30 October 2013, the Committee note the clinical records refer to a re-examination by another veterinary surgeon on 18 November 2013. There is no intervening treatment of Grace and so this supports Mrs Hammant's evidence.

42. Mr Hepburn, with reference to the Code of Professional Conduct for Veterinary Surgeons, identified the need for all veterinary surgeons to keep clear and accurate records.

43. The Committee found this charge proved so that it was sure that Mr Smith failed to make any or any adequate clinical records for Grace.

**Charge B**

**Charge B reads as follows:-**

***In relation to Holly, a Labradoodle belonging to Ms Mancini:***

***B.1 between 29th September 2014 and 31st January 2015, you failed to keep adequate records for Holly.***

44. Holly was one of three Labradoodles owned by Mrs Hammant, who breeds Labradoodles. Holly was born in November 2006 and she was under the care of Mr Smith from birth. On 15 January 2015 Mr Smith performed a surgical procedure upon her and he saw Holly again on 16 January 2015. On the evening of 20 January 2015 Mrs Hammant was concerned about the wound and took Holly to another practice, the Barrow Hill Practice in Ashford, where Holly was seen by veterinary surgeon Alex McInroy. That consultation resulted in both Mrs Hammant and the Barrow Hill Practice making requests for Holly's clinical records from the Lakeview Practice on 21 January 2015. When Mrs Hammant chased the records a few days later she was told by a receptionist at the Lakeview Practice that as she paid cash there were no records. Eventually some records were provided to the Barrow Hill Practice. They arrived on 13 February 2015. On the Vaccination Record Holly's date of birth is 24 November 2006 and her colour as cream. However, there are two separate client records for Holly, which give different dates of birth for Holly: 24 November 2005 and 22 November 2006; different colours for Holly: fawn red and cream; different registration dates: 5 November 2005 and 15 February 2007 and in one of the records details of interventions which predate the date of birth and the date of registration. There is limited information for an operation performed in 2013. Further, there are different dates for the same procedure that was undertaken. In one set of records the procedure is said to have been undertaken in December 2014 and on the other set of records it is January 2015. There is little detail of the procedure. There is reference to the removal of a lump but no description as to what the lump was or where it was.

45. Mr Smith from his evidence did not see the need for records as an account of what has happened to the animal. He seemed to see the notes as a memory jogger to himself. He referred to himself as having a good memory and he said it was the responsibility of staff to write up the notes. If the notes were inaccurate it was their fault and not his responsibility. In the notes that were presented to the Committee, there was no pain scoring in the clinical

records, no description of the type or quantity of anaesthetic agents used. There was no record of the type of material used for sutures.

46. Sufficiently detailed records are required for animal welfare. As confirmed by the expert Mr Peck, without sufficiently detailed records, other veterinary surgeons who become involved in an animal's care will be reliant upon the owner's recollection of the history, which is unlikely to be comprehensive and may or may not be accurate and could compromise the animal's effective treatment.

47. The Committee was satisfied so that it was sure that Mr Smith did not keep adequate clinical records.

**Charge C**

**Charge C reads as follows:-**

***In relation to Maisey, a cat belonging to Nicola and Mark Beck:***

***C.1 Between 30th October 2014 and 11th November 2014 you failed:***

***(a) adequately to examine Maisey; and/or***

***(b) adequately to investigate Maisey's history and/or signs; and/or***

***(c) to identify and/or note and/or adequately investigate significant r radiographic changes, namely loss of serosal detail consistent with the presence of free peritoneal fluid; and/or***

***(d) to identify and/or recognise and/or take action with regards to the fact that Maisey was in a seriously ill condition;***

***C.2 On 6 November 2014:***

***(a) you made a diagnosis of diabetes mellitus without having first undertaken the minimum investigation required to achieve such a diagnosis, namely a blood/glucose test; and/or***

***(b) you gave Mrs Beck insulin to administer to Maisey when:-***

***(i) you had not, before you gave the insulin to Mrs Beck, undertaken blood tests to obtain a baseline glucose concentration to confirm the diagnosis of diabetes for Maisey; and/or***

***(ii) you had been told by Mrs Beck that Maisey was inappetent; and/or***

***(iii) you did not give Mrs Beck adequate instructions as to the dose of insulin to be given; and/or***

***(iv) you did not alert Mrs Beck to the signs of hypoglycaemia and/or the circumstances in which to administer glucose;***

***C.3 Between 30th October 2014 and 11th November 2014, you failed to keep adequate clinical records for Maisey;***

***C.4 In a letter to the RCVS dated 19th December 2014:-***

**(a)** ***you informed the RCVS that when Maisey had attended for a consultation at the practice on 6th November 2014 she had been examined by another veterinary surgeon, AP, and that AP had asked you to 'look in on the case';***

**(b)** ***the statement referred to in C4(a) above was not correct, as you had been the only veterinary surgeon who had seen Maisey at the consultation on the 6th November 2014;***

**(c)** ***your conduct in C4(a) and C4(b) was misleading; and/or***

**(d)** ***your conduct in C4(a) and C4(b) was dishonest, in that you knew that the indication you had given in this regard was not correct.***

48. The Committee had regard to the evidence of Mr and Mrs Beck, the other veterinary surgeons who subsequently cared for Maisey (Mr Barnes MRCVS, Ms Sadykova MRCVS), Ms Posadas MRCVS who saw Maisey before Mr Smith and the expert evidence of Mr Peck. The Committee also had regard to the evidence of Mr Smith. Again, the Committee found Mr Smith's evidence to be self-contradictory, inconsistent and lacking credibility or reliability.

49. The Committee also had regard to the evidence of Ms Kelly Simmons, Mr Smith's witness. The Committee considered that her evidence was not entirely satisfactory or reliable in a number of respects. Ms Simmons could not explain why the mistakes in her statement were identical to the errors contained in Mr Smith's written submissions to the Committee.

50. The Committee found Mr Smith to be an inherently unreliable witness and the Committee preferred the evidence presented by the College.

51. Mr Smith first saw Mr and Mrs Beck's cat Maisey, on 31 October 2014. By that time, Maisey had already been seen another veterinary surgeon at the Practice, Ms Ana Posadas, on 23 October 2014. Maisey had gradually been going off her food and eating less and on 22 October 2014 had urinated inside the house. Ms Posadas had found no explanation on examination for these presenting signs. She decided to treat Maisey symptomatically and advised Mrs Beck to return in 48 hours if no improvement. There was an initial degree of recovery but it was not sustained and Maisey began howling when urinating.

**Charges C1 (a) and (b)(c) and (d)**

52. Between the 30 October 2014 and 11 November 2014 Mr Smith saw Maisey on 3 occasions. On each of those occasions there was a description by the owners of the examination. There was no assessment of the mucous membranes, no auscultation, no temperature taken. There was no blood screening and no ultrasound examination was carried out although Mr Smith stated that it was available in his practice. Mr Smith on the 6 November undertook a urine test which showed glucose and did not confirm the results with a blood glucose level test before instituting Caninsulin.

53. On 31 October 2014, after being told the history and examining Maisey, Mr Smith told Mr Beck that Maisey had cystitis. Mr Smith stated that he diagnosed cystitis because that was

what Ana Posadas had diagnosed and he did not wish to depart from her diagnosis. There was no record that she had diagnosed cystitis.

54. Mr Smith said he did not believe the cat had cystitis but he could give no reason to the Committee as to why he would persist with and treat for a diagnosis he did not believe to be accurate.

55. Mr Smith gave Maisey an antibiotic injection and Mr Beck was given some antibiotic tablets for the cystitis and he was told to return Maisey in a few days or a week. Maisey deteriorated further and on 6 November 2015 Mrs Beck took her back to the veterinary surgery.
56. Mr Smith said to the Committee that he was not the veterinary surgeon conducting the consultation but that it was Ana Posadas. Mrs Beck stated that the only veterinary surgeon she saw on that day was Mr Smith and he alone conducted the consultation. Mr Smith stated that the consultation was Ana Posadas' consultation, and that he was simply asked to have a look at the cat. Ms Simmons stated that it was she who asked Mr Smith to have a look at the cat. Irrespective of Ms Simmon's evidence, the Committee is satisfied so that it is sure that Mr Smith was the veterinary surgeon conducting the consultation.

57. The Committee accepted the evidence of Mr and Mrs Beck. Mrs Beck stated that Mr Smith examined Maisey by feeling her stomach and said he wished to perform some X-rays. During that day Mr Smith told Mrs Beck over the telephone that all he had found on the X-ray was that Maisey was full of faeces. When Mrs Beck said Maisey had not been eating, Mr Smith told her she was wrong and that Maisey must have been obtaining food elsewhere. He also told Mrs Beck over the telephone that he had taken a urine sample which showed that Maisey was diabetic, that this was the issue and that once her insulin had been sorted out she would start to pick up. Mr Smith prescribed and dispensed insulin (in the form of Caninsulin) for Maisey, and he provided Mrs Beck with the medication and told her how to administer it. When Mrs Beck specifically asked if that was appropriate when Maisey was not eating Mr Smith said her eating would right itself. He advised Mr Beck (who had also gone to collect Maisey) and Mrs Beck to bring Maisey back to him in two weeks to see if her glucose level had improved. Mr Smith in oral evidence stated that there was no risk from the insulin as it does not work that fast and it takes 2 weeks to have effect.

58. Mr Smith gave differing accounts of what happened. He states that he knew at once that Maisey's condition was terminal and that he was just treating Maisey with Caninsulin to give her time so that Mrs Beck could speak to her husband regarding euthanasia. He denied he told the owners that the cat had diabetes. He also said there was a clear lump which he could palpate and had shown it to Mrs Beck. Mrs Beck was never shown any lump according to her evidence. Mr Smith said the X-rays that he viewed were better than the copies presented to the Committee and he could see a lump. Later in evidence he accepted that he would not have seen a lump on an X-ray and in his written statement to the College on 19/12/2014 he stated "I was still sure Maisey had a tumour… but could not at that stage visualise it on X-ray or feel it by palpation".

59. The Committee had regard to the expert evidence of Mr Peck and it is clear to the Committee, as it was to Mr Peck, that the X-ray image provided by Mr Smith to the College

was of sufficient diagnostic quality. It is also clear from the evidence of Mr Peck that if Mr Smith had undertaken a blood test or ultrasound that he should not have followed a pathway for treating for cystitis as he did on 31 October 2014.

60. Having regard to the clinical records and the evidence of Mr Peck; Mr Smith failed to identify, note or adequately investigate significant radiographical changes such as loss of serosal detail consistent with the presence of free peritoneal fluid. The Committee also found that Mr Smith did not identify or recognise and did not take action when it should have been clear to him that Maisey was in a seriously ill condition.

61. Maisey's deteriorating condition led Mrs Beck to return her to the Practice on Monday 10 November 2014, when Mr Smith advised a further X-ray. Over the telephone he advised that he suspected that a shadow on the X-ray was a tumour and that Maisey should be put to sleep. Mr and Mrs Beck decided to take Maisey to the Manor Veterinary Clinic for a second opinion. There she was examined by Mr Anthony Barnes MRCVS, who was of the opinion that Maisey did not present with symptoms which necessarily meant she was diabetic, in particular she was not eating and drinking a lot. Mr Barnes took Maisey's temperature and found that it was raised, indicating the presence of infection. This was supported by a blood test, that showed a raised white blood cell count. The blood glucose level was normal and did not support the diagnosis of diabetes. Mr Barnes reviewed X-rays he arranged for and those from Mr Smith's Practice, and he formed a tentative diagnosis of peritonitis. He arranged for Maisey to undergo laparotomy, with a guarded prognosis. The laparotomy was performed that same day by Inga Sadykova MRCVS. She found a lot of malodorous fluid in Maisey's abdomen; adhesed, inflamed intestine; a hole in the intestine approximately 4 to 5 cm in length with necrotic edges and a constriction in the small intestine, preventing the passage of ingesta. She accorded a differential diagnosis (it was never tested) of lymphoma. The diseased tissues were removed but despite the efforts of those treating her at the Manor Veterinary Clinic, Maisey did not recover from this surgery and was put to sleep.

62. The Committee was concerned that while Mr Smith had recognised the fact that Maisey was seriously ill and he did not undertake the appropriate investigations or supportive care in the 2 weeks until the 11 November 2014.

63. Mr Smith's investigations into Maisey's deteriorating ill health were inadequate, with the consequence that he failed to understand the seriousness of Maisey's illness early enough.

64. The Committee concluded based on the evidence before it, that Mr Smith failed to read the X-rays properly. The x-rays both clearly show loss of serosal detail consistent with the presence of free peritoneal fluid on 6 November 2014 and on the 10 November 2014. As Mr Peck stated, such a sign requires the inclusion of peritonitis in the differential diagnosis. The Committee also took account of the fact that Mr Barnes saw the same feature on the X-rays taken at the Manor Veterinary Clinic on the same day as the second of Mr Smith's X-rays was taken, and Mr Barnes made that (provisional) diagnosis of peritonitis.

65. The Committee is satisfied so that it is sure on the evidence presented to it by the College that Charges C.1 a, b, c, and d are proved.

**Charge C.2 (a) and (b)**

66. The Committee had regard to the expert evidence of Mr Peck. It took into account his written report. Mr Peck gave oral evidence to the Committee in a careful, detailed and considered manner. The Committee accepts Mr Peck's expert evidence. The Committee also accepted the evidence of Mrs Beck as to what she had told Mr Smith at the consultation on the 6 November 2014.

67. Mr Smith made a diagnosis of diabetes on the basis of a urine sample. Mr Peck in his expert evidence stated that the minimum that would be required for such a diagnosis is a blood test. Mr Peck stated that this was particularly so when Mr Smith had himself administered a medication (Depo-Medrone V) on 31 October 2014. This medication can result in the presence of glucose in the urine of cats. He also stated that stress in an animal can also raise the glucose level. Blood tests are the minimum requirement for such a diagnosis.

68. The Committee was satisfied so that it was sure that Charge C.2 (a) was proved.

69. It is not in dispute that Mr Smith gave Mrs Beck insulin to administer to Maisey. It is also not in dispute that blood tests were not undertaken before it was given to confirm the diagnosis of diabetes.

70. The Committee accepted that Mr Smith had been told by Mrs Beck that Maisey was inappetent. The Committee also concluded that Mr Smith did not give Mrs Beck adequate instructions as to the dose or frequency of insulin to be given. Mrs Beck said that Mr Smith told her to give insulin once per day. In the clinical notes from the Manor Veterinary Practice the dose was recorded as "[? 4units insulin]". In Mr Smith's clinical records the note says "use as directed by veterinary surgeon". There is no mention of the dose or frequency. Mr Smith stated that the label was probably on the box that the bottle of medicine came in, rather than the bottle itself. According to the clinical record and Mr Smith's evidence, the insulin was to be given once per day. This is contraindicated by the Caninsulin sheet which states that in cats it should be given twice a day. Mr Smith in evidence stated that he prescribed Caninsulin just to make Maisey feel better not because he thought she had diabetes. The Committee accepts Mr Peck's evidence that if Mr Smith held the opinion that Maisey did not have diabetes, it was wholly inappropriate to prescribe insulin.

71. Mr Peck explained that if too much insulin is given there is the risk of collapse and death. There is no evidence before the Committee that Mr Smith told Mrs Beck about the signs of hypoglycaemia.

72. The Committee is satisfied so that it is sure that Charges C.2 (b) (i)(ii)(iii) and (iv) are proved.

**Charge C.3**

73. The Committee had regard to the clinical records provided for Maisey. It considered that the records were inadequate in a number of respects namely; the X-rays provided to the Manor Veterinary Clinic were unlabelled with either name or date and Maisey's notes contained no record of Mr Smith's interpretation of them. The history is not properly recorded on any of the occasions upon which Mr Smith saw Maisey. No findings are recorded in respect of his examinations. The dose of Caninsulin prescribed was not recorded; there is no treatment plan; and results of the urine test of 6 November 2014 were not recorded.

74. Mr Smith in evidence to the Committee stated that he thought the notes were adequate and he said; "they were adequate for me". The Committee does not agree with Mr Smith.

75. The Committee is satisfied so that it is sure Mr Smith failed to keep adequate clinical records for Maisey between 30 October 2014 and 11 November 2014.

**Charge C.4**

**Charge C.4(a)**

76. It is a matter of fact that Mr Smith wrote a letter to the RCVS dated 19 December 2014. In that letter Mr Smith states " Maisey was re-examined on the 6/11/14 and this time Ana asked if I would look in on the case".

77. Mr Smith does not deny that he wrote this letter. The Committee therefore finds this charge proved.

**Charge C.4 (b)**

78. In evidence before this Committee, Mr Smith stated that when he wrote that letter he was at home and that the clinical notes for Maisy were at the surgery so he was writing the letter from his recollection. Under cross-examination he stated that he was wrong about the date and that he was referring to the 31 October 2014. Mr Smith in the letter stated that Ms Posadas had undertaken the X-rays of Maisey. Mrs Beck was clear in evidence that the only veterinary surgeon that she saw in consultation on 6 November 2014 was Mr Smith. Further the evidence of Ms Simmons supports the evidence of Mrs Beck, that Mr Smith was the only veterinary surgeon that saw Maisey in consultation on that day.

79. The Committee is satisfied so that it is sure that this Charge is proved.

**Charge C.4 (c)**

80. The Committee concluded based on all the evidence and having regard to Mr Smith's oral evidence that the date in the letter namely the 6/11/2014 was incorrect and therefore was misleading. Mr Smith accepted in evidence that as the date was wrong, it was misleading.

81. The Committee is satisfied so that it is sure that this Charge is proved.

**Charge C.4(d)**

82. Having found as a fact that the letter sent to the College by Mr Smith was misleading the Committee went on to consider whether Mr Smith was being dishonest in that he knew that

the information that he had given was not correct; namely that another veterinary surgeon was involved in the care of Maisey on 6/11/14. The Committee considered Mr Smith's evidence. It was only under cross-examination that he suggested that the date given in the letter was incorrect and that he must have been referring to the consultation on 31 October 2014. Even in oral evidence he continued to distance himself from the care of Maisey on the 6 November 2014, saying that Maisey was X-rayed by Ms Ana Posadas. He denied that he was seeking to mislead the College. The Committee found Mr Smith to be a thoroughly unconvincing and misleading witness. Throughout all his evidence to the Committee he sought to deflect blame from himself by blaming others, clients and his own staff for whom he was responsible as the practice principal. The Committee considered that Mr Smith deliberately sought to mislead the College as to who the veterinary surgeon was who conducted the consultation. The letter is written in a way that suggests that Ms Posadas was involved in that consultation. Ms Simmons who came to give evidence on Mr Smith's behalf confirmed that Mr Smith was the veterinary surgeon who saw Maisey on 6 November 2014.

83. The Committee concluded that at the time Mr Smith wrote the letter that he knew that he was misleading the College and that by doing so he was being dishonest as to the true state of the facts. Mr Smith stated in oral evidence that he wrote the letter from home without regard to the clinical records because he liked to reply promptly to the College. The Committee rejects Mr Smith's evidence that he was not deliberately intending to mislead the College as being implausible.

84. The Committee is satisfied so that it is sure that Mr Smith was dishonest when he wrote the letter on the 19 December 2014 and that he knew he was the veterinary surgeon who had seen Maisey in consultation on 6 November 2014.

85. The Committee is satisfied so that it is sure that this Charge is proved.

**Charge D**

**Charge D reads as follows:-**

***In relation to Comet, a cat belonging to Rachel Ward:***

***D.1 between 1st April 2015 and 17th April 2015 you failed to keep adequate clinical records for Comet;***

***D.2 between 1st April 2015 and 17th April 2015 you failed to respond adequately and appropriately to concerns raised by Ms Ward about a veterinary surgeon at your practice, more particularly in that you failed to provide Ms Ward with any details about how to raise concerns with or make a complaint about the practice.***

86. Comet was born in June 2014 and along with a second kitten owned by Ms Rachel Ward was spayed by a veterinary surgeon at the Lakeview Veterinary Practice in Deal on 22 December 2014. However, by April 2015 Comet was showing signs of being in season and Ms Ward made an appointment for her to be seen at the Practice. The appointment took place on 4 April 2015 and the veterinary surgeon was Mr Smith. Mr Smith advised a second procedure to investigate and remove any remaining tissue. Mr Smith performed that

procedure himself on 11 April 2015. On collecting Comet at the end of the day Ms Ward made an appointment for Comet to be seen on 17 April 2015 and requested that a copy of Comet's clinical records be available for her to collect at that appointment. Ms Ward reminded the Practice of this request when she rang on 16 April 2015 to confirm the appointment.

87. At the end of the appointment on 17 April 2015, Ms Ward was given an envelope and was told that Comet's notes were not in the envelope but that if she waited the vet was just writing them up. The receptionist made a telephone call, left reception and a few minutes later came back with a copy of the notes.

88. The Committee considered the clinical records for Comet. There is no entry in relation to the consultation Mr Smith held with Ms Ward on 4 April 2015, at which he advised the second procedure. Although Mr Smith denied that there was a separate meeting on the 4 April, he accepts that he had a conversation with Mrs Ward on the day of the procedure. Unfortunately for Mr Smith his evidence is not backed up by any records. The Committee accepts the evidence of Ms Ward. There is no entry for the 11 April 2015, when that second procedure was carried out. That procedure is described, but against the wrong date, the 16 April 2015, which is the day before that upon which Ms Ward attended with Comet and collected the notes. These notes do not fully document the procedure or anaesthetic or other medications administered during the procedure. The name against which those notes are entered is not Mr Smith's but 'Carmel'. Carmel is the receptionist whose correct name is Carmen. The Committee also considered the letter which Mr Smith wrote to the College on 20th December 2015. It included the sentence: 'The clinical records look fine to me … .' In another letter from Mr Smith to the College dated 24 January 2016, it includes the sentences: 'All I was asked to do was operate on the cat. I did not write up the clinical notes nor did I take out the stitches.'

89. The Committee considered the clinical records and it had regard to the expert opinion of Mr Peck as to the need to keep accurate clinical records. It concluded that the records kept for Comet were wholly inadequate.

90. This Committee is satisfied so that it is sure that this Charge is proved.

**Charge D.2**

91. In a conversation between Ms Ward and Mr Smith at the appointment on 4 April 2015, Ms Ward asked Mr Smith what had gone wrong with the original spay. Ms Ward recounts that Mr Smith said he could not answer that question, that the surgeon who carried out the spay had left the Practice and that if Ms Ward was concerned about how the spay had been done she should raise her concerns with the VDS (Veterinary Defence Society). In her letter to the VDS, Ms Ward makes a number of complaints about the treatment her kitten had received and Mr Smith's approach to what she saw as an error by the veterinary surgeon. The VDS referred Ms Ward to the RCVS.

92. Mr Smith stated that he had referred Ms Ward to the VDS as he had thought she wanted financial compensation and so referred her to his insurers, the VDS. The Committee accepts

that Mr Smith may have understood her complaint to relate to financial recompense however, it was also clear she was concerned about quality of care. This is not a matter that Mr Smith addressed, and it appears from his evidence and that of Ms Simmons that there is no formal complaint process at the practice.

93. To this extent the Committee finds this Charge proved so that it is sure that Mr Smith failed to respond adequately and appropriately to Ms Ward's concerns raised about Mr Smith's Practice.

**Charge E**

**Charge E reads as follows:-**

***With regards to Poppy, a Yorkshire Terrier Belonging to Nicola Vines, in relation to which on 1st October 2012 the Practice made a diagnosis of diabetes mellitus:***

***E.1 on Saturday 4th April 2015, Ms Vines made an out of hours telephone to you informing you that Poppy had collapsed, was shaking and appeared distressed and:***

***(a) During that telephone call you failed to recommend and/or advise that Poppy should undergo examination by a veterinary surgeon;***

***(b) Between 4th April 2015 and 1st July 2015 you failed to make a record of that telephone call in Poppy's clinical records;***

***E.2 On Monday 6th April 2015 (a Bank Holiday) Ms Vines made an hour of hours telephone call to you, informing you that Poppy was still unwell and had been sick on more than one occasion and:***

***(a) during that telephone call you failed to recommend and/or advise that Poppy should undergo examination by a veterinary surgeon;***

***(b) Between 6 April 2015 and 1st July 2015 you failed to make a record of that telephone call in Poppy's clinical records;***

***E.3 On 7th April 2015 Ms Vines attended the Practice, during which time:***

***(a) Ms Vines asked if you had been on duty during the Bank Holiday weekend, 4th, 5th and 6th April 2015;***

***(b) you confirmed to Ms Vines that you had been on duty at that time;***

***(c ) when you were then informed by a member of the Practice staff, in Ms Vines' presence, that Poppy had died, you stated 'It was L … (naming another veterinary surgeon at the Practice) and you then left without saying anything further to Ms Vines;***

***E.4 your conduct at E.3 (a) to (c) above was such that you failed to communicate effectively and/or adequately with Ms Vines.***

94. Ms Vines' Yorkshire Terrier Poppy was diagnosed with diabetes mellitus, and prescribed insulin (Caninsulin) in October 2012 when she was approximately 12 years old. On 2 April 2015 Ms Vines saw that Poppy had become ravenously hungry and whilst begging for food had some sort of collapse. She described Poppy as having a head that was shaking, she

moved back and then fell over. After this happened a second time Ms Vines' father Mr Derek Vines took Poppy to the Lakeview Veterinary Practice where he was given a glucose drink to add to Poppy's water bowl. That evening Ms Vines rang the Practice for further advice, and was told (by way of advice from the duty veterinary surgeon relayed by whoever it was who answered the telephone) to give Poppy her food but not her insulin. Ms Vines cancelled an appointment made for Poppy for 4 April 2015 in light of a slight improvement. Unfortunately, Poppy deteriorated and Ms Vines made a telephone call to the out of hours number on Saturday 4 April 2015 just after 5 pm after Poppy had another shaking episode and she had fallen over. Mrs Vines spoke to Mr Smith. Mr Smith accepted he took the call. He said he may have been a bit "grumpy", as he had a number of calls in quick succession and he was in his garden at the time. It is not in dispute that Mr Smith did not recommend or advise that Poppy should be seen by a veterinary surgeon.

95. Ms Vines stated that Mr Smith told her to give Poppy sugar or anything that was sweet, sugar or honey. Mr Smith denied that he said this. He said that he was of the impression that Mrs Vines understood a lot about diabetes because Poppy had been a diabetic for 3 years. Mr Smith also stated that if Ms Vines had asked to see Poppy he would have seen her. He said, she never asked.

96. Ms Vines' telephone records show that this telephone conversation lasted 1 minute and 36 seconds. Ms Vines stated that she had the impression that Mr Smith was disinterested, and she was made to feel as if she was being a nuisance.

97. The Committee also had regard to the expert evidence of Mr Peck. He said that any reasonably competent veterinary surgeon would have been concerned about a long term diabetic patient who might be demonstrating signs of hypoglycaemia or ketoacidosis, such as Poppy was doing when she was collapsing. As a minimum they should have recognised the need for the patient's blood glucose level to be investigated and would have given a firm recommendation that the animal be reassessed in clinic by a veterinary surgeon as soon as possible to account for the possibility of serious diabetic complications. Such criticisms related to Mr Smith's responses to Ms Vines' telephone calls on both 4 April 2015 and 6 April 2015. Mr Smith in evidence stated that he did not make records of telephone calls particularly when out of hours. He reiterated that he was a very busy man and on numerous occasions throughout his evidence expressed exasperation at the need to keep detailed notes stating that the College was obsessed with record keeping. Mr Smith also stated that he saw no point in writing the notes up after Poppy had died.

98. The Committee had no hesitation in finding Charges E.1 (a) and (b) proved to the required standard.

**Charge E.2**

99. Over the Easter weekend Poppy was sick on a number of occasions. By the morning of Easter Monday, 6 April 2015, she was immediately bringing up any water she had drunk. At about 9 am Ms Vines therefore rang the Practice and was once again referred to a mobile telephone number which resulted in her speaking for a second time to Mr Smith. Ms Vines'

telephone records show that this telephone conversation lasted 1 minute and 15 seconds. Once again Ms Vines felt that Mr Smith was totally disinterested in her call. The Committee accepted the evidence of Ms Vines. Mr Smith in evidence did not suggest that he had advised Ms Vines to have Poppy seen by a veterinary surgeon. Mr Smith believed that he was not on duty on the morning of the Bank holiday Monday. However, the Committee accepted the evidence of Ms Vines that she recognised the voice of Mr Smith and she knew who he was from attending that surgery. The Committee also heard from Mr Lukasz Rybczynski MRCVS who explained the rota system at the surgery.

100. In the evening of that Easter Monday Ms Vines had further communication with the Lakeview Practice, first on Facebook and then over the telephone but with a different veterinary surgeon, Lukasz Rybczynski. During those calls Mr Rybczynski said that Ms Vines could take Poppy to the Practice and when Ms Vines expressed concern about the effect of a 30 minute car journey on Poppy, he gave advice to her as to establishing Poppy's glucose level at home. Ms Vines was not able to obtain a blood glucose level but determined using a urine dipstick that the level was high in glucose and ketones. Mr Rybczynski explained that Poppy had ketoacidosis, said again he would see Poppy and advised that Poppy required insulin not sugar and that if something was not done it would be too late. The Committee had a copy of the detailed notes of Mr Rybczynski's telephone discussions with Ms Vines.

101. Ms Vines understood that the Lakeview Practice would not have someone on site throughout the night. She therefore took Poppy to a closer Practice, Anna House, which did have overnight cover. Poppy was admitted at 11.45 pm and received treatment under the care of Carol Blumenthal MRCVS. In the event Poppy died in the early hours of the following morning from what appeared to be the complications of hyperglycaemia.

102. The Committee finds charge E.2 (a) proved so that it is sure.

**Charge E.2 (b)**

103. By the time of the second of the two telephone calls from Ms Vines on 6 April 2015, Poppy was immediately vomiting any glucose water she had managed to drink. The Committee had regard to the evidence of Mr Peck that at that point any competent veterinary surgeon would have appreciated that Poppy's condition had significantly deteriorated and would make the strongest possible recommendation that the dog be brought into the clinic to be seen. For these reasons and as has been set out in E.1(b) the Committee finds proved that Mr Smith failed to make a record of the telephone call he had on 6 April 2015.

104. The Committee is satisfied so that it is sure that this Charge is proved.

**Charge E.3 (a)**

105. It is not in dispute that on 7 April 2015 Ms Vines visited the Lakeview Practice. Ms Vines gave evidence that she spoke to Lorraine the receptionist and Ms Simmons. Ms Vines explained she had asked if Mr Smith was on duty during the bank holiday weekend.

106. The Committee finds this fact proved on the basis of Ms Vine's evidence that she spoke to Lorraine and Ms Simmons.

**Charge E.3 (b) and (c)**

107. The Committee took into account Mr Smith's evidence. He denied that he would have behaved in the manner alleged. He stated that he did not recall ever seeing Ms Vines or having a conversation with her about Poppy. Ms Simmons explained that she may have been there, but any conversation would have been in passing. She said she believed Mr Smith would have been in the Practice, but she did not have a recollection of him at that conversation. Ms Simmons explained that the surgery is a very busy place and that lots of conversations happen all the time.

108. The Committee determined, based on the evidence presented to it that it was not satisfied so that it was sure that the Charges b and c are made out to the required standard.

109. Charges E.3 (b) and (c) are found not proved.

**Charge E.4**

110. The Committee found that E.3(a) was proved to the extent that Ms Vines had a discussion with Lorraine and Ms Simmons as to whether Mr Smith was on duty. Given that the Committee found E.3 (b) and (c) not proved, it therefore concluded that it had no evidence upon which this Charge could be proved.

111. Charge E.4 is found not proved.

**Charge F- The Conviction**

112. Mr Smith admitted at the outset of this hearing that he had been convicted as set out in the certificate on conviction.

113. The Committee also had regard to the certificate of conviction which states; on 13 June 2016, Mr Smith was convicted at the Crown Court at Maidstone following a trial, of conspiracy to commit fraud, for which offence he received a sentence of 30 months imprisonment on 11 July 2016.

114. This Charge is proved.