BEFORE THE PROFESSIONAL CONDUCT COMMITTEE OF THE
ROYAL COLLEGE OF VETERINARY SURGEONS

RCVS

v

MS EMMA KATHLEEN BOWLER MRCVS (Respondent)

DECISION OF THE DISCIPLINARY COMMITTEE ON FINDING OF FACTS

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1. The Respondent came before the Disciplinary Committee facing the following four allegations in respect of 19[1] animals:

    1. *Between 1 August 2018 and 31 March 2022, you failed to provide adequate care to animals in relation to surgery undertaken by you, more particularly in relation to:*

    (a) Belle, a female Cockerpoo belonging to British Hardwood Tree Nursery Ltd, failed to ensure adequate pre-surgical and/or post-surgical radiographs were taken in relation to surgery in or around June 2019;

    (b) Benson Roebuck, a male Springer Spaniel failed to undertake surgery in or around August 2018 adequately and/or failed to undertake adequate post-operative assessment and/or failed to ensure adequate post-surgical radiographs were taken;

    (c) Dolly Blue Smart, a female French bulldog, failed to undertake surgery on 15 November 2019 adequately and/or failed to ensure adequate post-surgical radiographs were taken and/or failed to adequately interpret post-surgical radiographs and/or failed to undertake adequate post-operative investigation;

[1] Following amendment of the charges as set out below

(d) *Dolly Woodward, a female Shih Tsu cross, failed to ensure adequate pre-surgical and/or post-surgical radiographs were taken in relation to surgery on 29 March 2019 and/or failed to adequately[2] record surgical procedure relating to revision surgery and/or failed to record findings that led to the revision surgery on 23 April 2019;*

(e) *Harvey Jamieson-Bailey, a male Cocker Spaniel, failed to undertake surgery on 15 February 2019 adequately and/or failed to ensure adequate pre-surgical and/or post-surgical radiographs were taken; ~~and/or failed adequately to record surgical procedure~~[3]*

(f) *Izzy Neilan/Appiah, a female Doberman, failed to ensure adequate pre-surgical radiographs were taken in relation to surgery in May 2019;*

(g) *Daisy Juskeviciute, a female Chihuahua, failed to ensure adequate post-surgical radiographs were taken in relation to surgery on 6 December 2018 and/or revision surgery on 4 January 2019 and/or failed adequately to record the surgical procedure relating to revision surgery on 4 January 2019;*

~~(h) Jen Massey, a female Border Collie, failed to ensure adequate pre-surgical radiographs were taken in relation to surgery in January 2019~~[4]

~~(i) Maisie Buckby, a female Yorkshire Terrier, failed to ensure adequate pre-surgical and/or post-surgical radiographs were taken in relation to surgery in July 2019~~[5]

(j) *Otis Prescott, a male Labrador retriever, failed to ensure adequate pre-surgical and/or post-surgical radiographs were taken in relation to surgery on 8 December 2018;*

(k) *Ryobi Gilbert, a male Beagle, failed to undertake surgery on 1 April 2019 adequately and/or failed adequately to record the surgical procedure and/or*

[2] As amended upon application by the College
[3] Withdrawn by the College
[4] Withdrawn by the College
[5] Withdrawn by the College

failed to ensure adequate pre-surgical and/or post-surgical radiographs were taken and/or failed to provide adequate post-operative assessment and management;

(l) *Prince Witty, a male Pomeranian, failed to ensure adequate post-surgical radiographs were taken in relation to surgery on 17 May 2019;*

(m) *Willow Sharp, a female Pointer, failed to ensure adequate ~~pre-surgical and/or~~[6] post-surgical radiographs were taken in relation to surgery on 15 February 2019 and/or 8 April 2019;*

(n) *Tommy Hadden, a male domestic short-haired cat, failed to undertake surgery on 1 August 2019 adequately and/or failed to undertake adequate post-operative assessment and/or failed to ensure adequate ~~pre-surgical and/or~~[7] post-surgical radiographs were taken;*

(o) *Sky Oliver, a female Staffordshire Bull Terrier, failed to ensure adequate post-surgical radiographs were taken in relation to surgery on 7 January 2019 and/or failed adequately to record the surgical procedure;*

(p) *Sindy Burgin, a female Yorkshire Terrier, failed to ensure adequate ~~pre-surgical and/or~~[8] post-surgical radiographs were taken in relation to surgery in April 2019;*

(q) *Vera Hitchen, a female French Bulldog, failed to ensure adequate post-surgical radiographs were taken in relation to surgery in or around March 2022;*

(r) *Toby Teasdale, a male Springer Spaniel, failed to ensure that adequate pre-surgical radiographs were taken in relation to surgery on 24 September 2021 and/or failed to identify that a screw had been mal-positioned during surgery on 24 September 2021 and/or failed to take adequate steps to revise the surgery;*

[6] Withdrawn by the College
[7] Withdrawn by the College
[8] Withdrawn by the College

(s) Sissy Wilkinson, a British Bulldog, failed to ensure adequate post-surgical radiographs were taken in relation to surgery on 14 March 2022 and/or failed adequately to record the surgical procedure;

(t) Daisy Drew, a Jack Russell terrier cross, failed to ensure adequate post-surgical radiographs were taken in relation to surgery on 20 May 2021.

2. In relation to surgery performed by you on 24 January 2020 and/or 12 February 2020 to Bear, a German Shepherd Cross Belgian Malinois belonging to Elaine and Jason Sewell, you failed to provide adequate care to Bear, more particularly in that you:

(a) failed to offer and/or recommend a referral to another more experienced practitioner prior to the surgery on 24 January 2020 and/or 12 February 2020; and/or
(b) failed to obtain fully informed consent to the surgeries on 24 January 2020 and/or 12 February 2020; and/or
(c) failed to take adequate steps to ensure that you had sufficient skills, expertise and/or support from other veterinary surgeons before embarking on the surgery on 24 January 2020 and/or 12 February 2020; and/or failed to take adequate steps to seek assistance from another veterinary surgeon during the course of that surgery; and/or;
(d) failed to obtain adequate post-operative radiographs for the surgery on 24 January 2020 and/or 12 February 2020; and/or failed to provide adequate aftercare following the surgery on 24 January 2020 and/or 12 February 2020.

3. On 25 May 2021, when speaking to Ms S Drew about surgery you had performed on 20 May 2021 to Daisy, Ms Drew's Jack Russell terrier, you told Ms Drew that:

(a) everything that had been written in Daisy's clinical records up to the point of the surgery on 20 May 2021 referred to the right hind being the problem, when this was not the case; and/or
(b) the veterinary surgeon who had seen Ms Drew about the x-rays taken prior to the surgery on 20 May 2021 had not placed any notes on the file at the time Daisy came in for surgery, when this was not the case;

4. Your conduct at 3(a) and/or 3(b) above was:

(a) dishonest; and/or

(b) misleading

AND that in relation to the above, whether individually or in any combination, you are guilty of disgraceful conduct in a professional respect. [9]

2. The Respondent did not attend the hearing. She was legally represented by counsel, Ms Priya Malhotra and solicitors. A Respondent's Bundle was put before the Committee which contained a document titled 'Indication re charges', a medical report from the Respondent's GP with supporting documents, a signed statement from the Respondent, and testimonials and supporting documentation.

Application for parts of the hearing to be heard in private.

3. Ms Malhotra applied for parts of the hearing to be heard in private on the basis that she would be referring to the [redacted] health of the Respondent. She submitted that such matters were contained in a GP letter dated 18 October 2024 and in an email from her instructing solicitor dated 21 October 2024. She also said that the personal history of the Respondent [redacted] should also be heard in private because there was no public interest in those matters being heard in public.

4. Mr Mant on behalf of the College did not oppose the application.

5. The Committee took into account that the principle of open justice required its proceedings to be heard in public but that Rule 21.2 of the Veterinary Surgeons and Veterinary Practitioners (Disciplinary Committee) (Procedure and Evidence) Rules Order of Council 2004 (the DC Procedure Rules) provides for an exception where it would be in the interests of justice.

6. The Committee decided that those parts of the hearing and its decision that referred to the health of the Respondent should be heard in private and redacted in its decision in the interests of justice. It did not find that it was in the public interest that those

[9] As amended upon application by the College

matters needed to be heard in disciplinary proceedings in public. It decided that the private interests of the Respondent and her right to a private life and to privacy of her personal health outweighed the public interest that proceedings should be heard in public. It therefore determined that any parts in its decision or the hearing that referred to the Respondent's health would be redacted.

Proceeding in Absence.

7. The DC Procedure Rule 10.4 allows for proceedings to take place in the absence of the Respondent if she has been properly served with the Notice of Inquiry and if it was in the interests of justice.

8. Ms Malhotra asked the Committee not to adjourn the hearing but for the hearing to proceed in the Respondent's absence. She indicated that she was instructed on behalf of the Respondent. She submitted that the Respondent was not attending the hearing due to her ill-health and that it was unknown whether her health would improve even if the Committee adjourned.

9. Mr Mant also invited the Committee to proceed in the absence of the Respondent. He submitted that the Notice of Inquiry had been properly served on the Respondent. He confirmed that the College had considered the RCVS Health Protocol. Mr Mant further submitted that it was in the interests of all parties that the hearing proceed in the Respondent's absence. He further submitted that the Committee could be satisfied that the Respondent had the capacity to instruct counsel and that there was no medical evidence that she was unfit to attend the hearing but that she had chosen not to attend the hearing.

10. The Committee considered the Notice of Inquiry, the evidence contained in the GP letter dated 18 October 2024 and the email from the Respondent's instructing solicitor dated 21 October 2024. [redacted] It further noted that it was being invited by Ms Malhotra and Mr Mant to proceed in the Respondent's absence.

11. The Committee was satisfied that the Respondent had been properly served with the Notice of Inquiry. It noted it had a discretion to proceed in the absence of the Respondent and that it should exercise its discretion with the utmost care and caution

particularly if it was to find that the Respondent was unwell and that was the reason she was not attending the hearing.

12. The Committee concluded on the evidence before it that the Respondent had chosen not to attend the hearing due to her background of [redacted] ill-health. However it did not find that she was medically unfit to attend on the basis of the medical evidence before it.

13. The Committee further decided that adjourning the hearing would not guarantee the Respondent attending the hearing at a later date in the light of her medical history and the submissions made by her counsel. The Committee therefore decided to exercise its discretion to proceed in the Respondent's absence on the basis that she was legally represented and she was through her counsel, inviting the Committee to proceed in her absence.

14. The Committee concluded that it was in the public interest and interests of the Respondent to proceed in her absence so that the hearing could be concluded expeditiously. The Committee noted that these charges dated back to between 2018 and 2022.

Amendments or Withdrawal of parts of the charges

15. At the outset of the hearing, Mr Mant applied for Charge 1(o) to be amended in respect of the date from 10 January 2019 to 7 January 2019.

16. Ms Malhotra did not object to the application.

17. The Committee decided that it was just to allow the amendment and that no prejudice was caused to the Respondent by allowing it.

18. During the College's case, Mr Mant applied to withdraw parts of the charges at Charge 1(e), 1(h), 1(i), 1(m), 1(n), and 1(p).

19. There was no objection from Ms Malhotra.

20. The Committee allowed for those parts to be withdrawn as the Respondent was not disadvantaged by doing so.

21. During the College's case, Mr Mant applied to amend Charge 1(d) to insert the word '*adequately*' between '*failed to*' and '*record surgical procedures*' following his review of the Respondent's written statement, made available to the College and the Committee for the first time immediately before the start of the hearing. Mr Mant submitted that it was fair to make the amendment after the College had been able to consider the representations made by the Respondent in her statement about this charge. Ms Malhotra objected to that amendment being made because the evidence relied on had been known to the College and because of the timing of the application; it being a late proposed amendment.

22. The Committee decided to allow that amendment on the basis that was not the fault of the College that the Respondent's most recent statement in response to the charges was first delivered and able to be considered on the morning of the hearing. This was despite directions having been made at Case Management Conferences on 7 October 2024 and 16 October 2024, for the Respondent to disclose her response in advance of the disciplinary hearing.

23. Further, the Committee decided that although the proposed amendment was late, it was in the public interest and the interest of animal welfare to allow the amendment. It decided that although late, there was no injustice to the Respondent in allowing it at this stage of the proceedings. It therefore allowed the amendment to be made.

Admissions

24. At the outset of the hearing, Ms Malhotra made the following admissions on behalf of the Respondent:

    Charge 1(a)
    Charge 1(b)
    Charge 3(a)
    Charge 3(b)
    Charge 4(b)

25. The Committee found those charges proved on the basis of the admissions made.

26. Ms Malhotra also made some partial admissions in relation to the following charges: Charge 1(c), 1(d), 1(e), 1(g) 1(l), 1(m), 1(n), 1(q), 1(r), 1(s), 2(c) qualifying those admissions in the 'Indication re Charges' document.

Background

27. The Respondent qualified as a veterinary surgeon in 2012. She started working for Rase Vets, as Head of Small Animal Veterinary Surgery, in 2017.

28. The charges related to alleged concerns about the Respondent's practice in respect of:

    i) the adequacy of care provided to 17 animals between 1 August 2018 and 31 March 2022. The concerns related to the adequacy of orthopaedic surgery, and in particular repeated failure to take adequate pre-and/or post operative radiographs, among other matters;

    ii) the adequacy of care provided to Bear Sewell in relation to a total hip replacement (THR) procedure undertaken on 24 January 2020 and revision surgery undertaken on 12 February 2020; and

    iii) false statements made to Stephanie Drew, the owner of Daisy Drew, in a telephone conversation on 25 May 2021 which the College alleged were misleading and/or dishonest.

The Hearing

29. The Committee received both written and oral evidence from the College and written evidence from the Respondent.

30. It heard oral evidence in relation to Bear. It heard evidence from Bear's owners, from Chloe Panton, at that time, a receptionist who worked at the Lincoln branch of Rase Vets and Hannah Miles, another veterinary surgeon working at Rase at the time. It also heard from Professor Gareth Arthurs, a specialist to whom Bear was referred after the unsuccessful THR revision surgery.

31. The Committee heard oral evidence in relation to Daisy. It heard evidence from Mrs Drew, one of Daisy's owners. The Committee also had written statements from Devon Michael MRCVS and Hannah Davis RVN, both of whom had also dealt with Daisy at the relevant time.

32. The Committee also heard evidence from an expert witness, as part of the College's case, Dr Mark Bush MRCVS, about the care and treatment the Respondent provided to 19 animals.

33. The Committee read the Respondent's bundle. It considered carefully all that the Respondent had written about the charges including in her three earlier written responses supplied to the College in 2020 and 2021, responding to the concerns raised. It heard and read evidence about the Respondent's previous good character from veterinary surgeons and a veterinary nurse. It also noted the matters set out in her witness statement about the difficulties she faced in her personal life and the difficulties she said she experienced with her workload at the practice.

34. The Committee also received all relevant evidence relating from Rase Vets regarding the 19 animals it was considering.

35. The Committee received and took into consideration the oral and written closing submissions from both Ms Malhotra and Mr Mant. These submissions have not been summarised in this document, but they were read carefully by the Committee.

36. In the Respondent's absence the Committee took into account her written statement**.** Although the Committee was not able to ask the Respondent any questions, it did not hold her absence against her when deciding on any of the charges.

37. The Committee also took into account the RCVS Supporting Guidance (relevant at the time of Charge 2 in respect of 'Informed Consent' and the RCVS Code of Practice (the Code).[10]

The Committee's decisions and reasons

[10] the version of the Code relevant at the time of the charges it was considering

38. The Committee accepted the evidence given by the Respondent in her most recent statement, supported by Hannah Miles and Chloe Panton, that she had a very busy workload. She also experienced significant personal pressures. However, it did not find that that these were justifiable reasons for any of the failures alleged in the charges although it accepted that these matters could later amount to mitigating factors in Stage 2 and/or Stage 3.

Charge 2

2. In relation to surgery performed by you on 24 January 2020 and/or 12 February 2020 to Bear, a German Shepherd Cross Belgian Malinois belonging to Elaine and Jason Sewell, you failed to provide adequate care to Bear, more particularly in that you:

Background

39. This charge related to a dog called Bear on whom the Respondent performed two hip surgeries in January and February 2020.

40. The Respondent stated that Bear was the first THR that she had performed on a live animal.

41. There was a dispute as to what was said to the owners before and after the surgery. In summary, in issue between the College's evidence and the written evidence from the Respondent was what the Respondent had told Bear's owners about her level of experience with respect to THR surgery and whether Bear's owners were offered a referral to a veterinary specialist.

42. In addition, the Respondent disputed, as she did with several other charges, the College's case regarding the adequacy of post-operative radiographs that were taken. In particular she disputed that a magnification marker was always necessary where there was a left or right marker used instead.

43. On 24 January 2020, the Respondent unsuccessfully attempted the THR procedure on Bear's left hind leg, without support or supervision from any other veterinary surgeon. The Respondent did not speak to Bear's owners before the surgery.

Afterwards, she telephoned the owners and told them that the procedure had not been successful. There is no record of any post-operative radiographs being taken.

44. On 12 February 2020, the Respondent performed revision surgery, again without support or supervision from any other veterinary surgeon. The Respondent spoke to Bear's owners following the surgery. The records indicate that a single lateral radiograph was taken post-operatively.

45. On 17 February 2020 the owners felt a "*pop*" when applying an ice pack to Bear's hip. They called the surgery and spoke to a nurse, who sought advice from the Respondent, who recommended that the owners keep icing the area.

46. The owners stated that Bear was lethargic and not able to manage four, ten minute walks as had been advised. On 28 February 2020 the Respondent phoned Bear's owners and left a voicemail message. The Respondent advised the owners to scale down Bear's exercise. No radiographs were taken.

47. On 25 March 2020 (two days after the start of the first national lockdown for Covid-19 (the Pandemic)) the owners reported that Bear was having serious difficulties walking and could not rest in a sitting position at all. They submitted videos which the Respondent viewed on 26 March 2020. The notes record "*no obvious dislocation of the hip (on video)*" and state that ideally Bear would be doing hydrotherapy, but this had been put on hold due to the Pandemic. The owners were advised to continue as before until restrictions were lifted. The Respondent did not make any arrangements for Bear to be seen, or for radiographs to be taken, on an urgent basis or at all.

48. The Respondent was furloughed around April 2020 and she then took a period of maternity leave, returning to work in July 2020 having taken eight weeks maternity leave.

49. On 9 June 2020 radiographs were taken which showed the revision surgery had failed.

50. The owners subsequently requested a referral to Dick White Referrals where Bear was seen and treated by Professor Arthurs.

Charge 2(a)

(a) failed to offer and/or recommend a referral to another more experienced practitioner prior to the surgery on 24 January 2020 and/or 12 February 2020;

51. The Committee found that the owners had not heard the term 'referral' until after they were advised by another veterinary surgeon in the practice, following discussion with the Respondent, on 9 June 2020, that the best option for Bear was to euthanise him after the failure of the revision surgery. The Committee noted that in Bear's clinical records there was no reference to Bear's owners being informed about the option of a referral prior to either the first surgery on 24 January 2020 or the revision surgery on 12 February 2020.

52. The Committee noted that the Respondent's responses to this charge had been inconsistent. In her response to the College in November 2020, she said that there was frequent communication and that she and other colleagues had offered referral to Bear's owners. However, in her response to the College in August 2023 and in her statement in response to the Charges dated 23 October 2024, she stated that it was her '*usual practice*' to offer referral.

53. The Committee further noted that in response to the Sewells' letter of complaint dated 22 June 2020, the Respondent's written response, signed by her and dated 30 June 2020, stated "…*I am sorry that referral wasn't offered, it was my understanding that this had been offered and discussed at your branch practice..."*

54. The Committee could not question the Respondent about the inconsistencies in her responses to this charge. The Committee concluded that since this letter by her was written closer to the time of the events, its contents were likely to be more accurate than her subsequent conflicting accounts in her subsequent statements.

55. However, the Committee also noted that, in the Respondent's most recent statement, she said that another veterinary surgeon had offered the Sewells a referral. The Committee found that there was no supporting evidence from that veterinary surgeon and no note in the medical records to support that assertion.

56. Hannah Miles said she was told by the Sewells that they were fully insured and could have afforded a referral to a specialist.

57. Based on the evidence of Mr and Mrs Sewell, the Committee was satisfied that they were not offered a referral before either surgery despite the Respondent's assertion that it was her '*usual practice*' to do so. Further it noted that there was no note in the records to suggest that they had been offered a referral before either surgery.

58. The Committee therefore found this charge proved.

Charge 2(b)

(b) failed to obtain fully informed consent to the surgeries on 24 January 2020 and/or 12 February 2020; and/or

59. The Committee considered carefully whether Mr and Mrs Sewell gave informed consent to the surgeries. It concluded on the face of all of the evidence before it that for both surgeries there were consent forms in existence. However, it noted that these were in a standard form and referred specifically to '*routine*' surgery and were therefore not specific to a THR surgery.

60. The Committee noted that none of the consent forms seen by the Committee made reference to the estimated fees to be charged for the surgeries as required by the Code 11.2(d). Furthermore, there was no written contemporaneous evidence in the clinical record that the Respondent discussed the complex procedure of a THR with the owners prior to surgery. Mr and Mrs Sewell both said that the Respondent did not discuss with them the potential risks of surgery or the expected outcomes. Mr and Mrs Sewell both stated that they were unaware that this was the first time the Respondent was performing a THR on a live animal. They said that they became aware of this only during a mediation process following their complaint. Dr Bush stated that this is part of informed consent and that "*it would be reasonable for an owner to assume their surgeon had reasonable proficiency with the technique or would be operating under the guidance of a surgeon with experience and proficiency with the technique unless told otherwise. To have not advised them of this denies them the opportunity to make an informed decision about whether to proceed with this surgeon or to look elsewhere".*

61. The Committee found no supporting evidence in the clinical record to indicate that Mr and Mrs Sewell were informed and understood the risks of either surgery. The Committee found that the consent forms produced to the Committee were of a

generalised nature for a routine surgical procedure and not specific to a complex surgery such as a THR.

62. The Committee referred to the Code and noted that it said:

2.3 Veterinary surgeons must provide appropriate information to clients about the practice, including the costs of services and medicines.
2.4 Veterinary surgeons must communicate effectively with clients, including in written and spoken English, and ensure informed consent is obtained before treatments or procedures are carried out.
2.5 Veterinary surgeons must keep clear, accurate and detailed clinical and client records.

63. The Committee also noted that the Guidance to the Code on Informed Consent says at 11.2 '*that the following matters should be considered during the discussion with the client to ensure informed consent:*

a) the nature and purpose and benefits of any treatment or procedures;
b) the likely outcomes of any treatment or procedures with a clear indication of both common and serious risks presented in a way that the client understands (e.g. explain any clinical terms);
c) the veterinary surgeon should avoid making assumptions, for example about a client's financial constraints of a client's understanding of the possible side effects, complications or the failure to achieve the desired outcome with the agreed treatment;
d) financial estimates, and an agreement on any financial limits. This should also be documented on the consent form, or on an attached detailed estimate;
e) ..
f) checking with the client whether they have any questions or concerns regarding the diagnosis, treatment and costs;
g) informing the client (where appropriate) that other treatment is available that may have greater potential benefit than those available at the practice (see Chapter 1 Referrals and second opinions);
h) ensuring, where possible that consent can be obtained from the client for any deviations from the treatment plan (including costs), therefore where possible ensuring that the practice has the client's emergency contact details and that these are up to date.'

64. The evidence of Ms Panton and reference to the Respondent being a 'spinal specialist' did not persuade the Committee that Mr and Mrs Sewell had provided informed consent. On the contrary this illustrated the lack of information that they were supplied with about the Respondent's actual level of experience. The Committee were persuaded by the uncontested evidence from Dr Bush that Mr and Mrs Sewell had not, according to the notes, "*been offered an adequate range of options as alternatives to the surgeries including referral to another practitioner".* There was no contemporaneous paperwork that supported the Respondent's case that she believed Mr and Mrs Sewell were aware of her level of experience.

65. The Committee concluded that Mr and Mrs Sewell had not been given the opportunity to speak to the Respondent and ask her any questions about the first surgery, before it took place, according to their evidence and with reference to clinical records, despite the Respondent's assertion in her most recent statement that she had phoned them before the surgery.

66. The Committee accepted the evidence of Mrs Sewell that she did not know who would be performing the first surgery. Although Mrs Sewell met the Respondent after the second surgery, it was agreed evidence (and not challenged by the Respondent's counsel) that the owners of Bear had not been contacted during the surgery when there was a deviation from the treatment plan and when a femoral head and neck revision was to be performed by the Respondent instead of the planned THR. The Committee noted that paragraph 11.2 (h) of the Code referred to "*ensuring, where possible, that consent can be obtained from the client for any deviations from the treatment plan (including costs)..".*

67. The Committee was therefore satisfied on the evidence before it that Mr and Mrs Sewell did not provide informed consent for either surgery.

Charge 2(c)

(c) failed to take adequate steps to ensure that you had sufficient skills, expertise and/or support from other veterinary surgeons before embarking on the surgery on 24 January 2020 and/or 12 February 2020; and/or failed to take adequate steps to seek assistance from another veterinary surgeon during the course of that surgery;

68. The Committee noted from the Respondent's CPD record that she had completed an accredited course in THR in December 2018 in respect of which she recorded 14 hours for CPD. The THR surgery on Bear on 24 January 2020 was the Respondent's first such surgery on a live animal. There was no evidence indicating that she had carried out work on a cadaver, or performed THR surgery with a more experienced colleague, either in preparation for the surgery on Bear, or at any time since December 2018. There was no evidence indicating that the Respondent had refreshed her knowledge and practical skills before Bear's surgery.

69. The Respondent, in her response to the charges, stated that she "*accepts it would have been better if she had performed the surgery with someone who was already experienced in the procedure".* The Committee took this partial admission into account when deciding on this charge.

70. Further Dr Bush stated that "at *no point is it recorded that she had sought assistance during the surgery despite the complications encountered"* and he also stated *"in a situation where the surgery undertaken is very challenging in nature, the pre-operative imaging is inadequate, the pre-surgical planning is inadequate, the surgeon's surgical experience is inadequate, the intra-operative surgical assistance is inadequate, the post operative imaging is inadequate and the outcome of the surgery is very poor, one cannot expect the surgery to have been undertaken adequately. Furthermore, there is an expectation of a significantly increased level of difficulty in the performance of a revision surgery of a failed hip replacement, and the issues regarding the absence of more qualified and capable supervision applies to an even greater extent here".*

71. The Committee decided that the implant fitted in the first surgery was the wrong size because of the poor pre-operative radiographs that were taken. The Committee decided, on the basis of Dr Bush's opinion, that these were poor positionally and because they lacked a magnification marker. The Committee also agreed with Dr Bush's opinion that the second surgery was particularly complicated because it was a revision and, knowing that the first surgery had failed, the Respondent should either have sought the assistance of a more experienced veterinary surgeon, or urged referral to an experienced orthopaedic specialist veterinary surgeon.

72. The Committee was therefore satisfied for these reasons that this charge was proved.

Charge 2(d)

(d) failed to obtain adequate post-operative radiographs for the surgery on 24 January 2020 and/or 12 February 2020; and/or failed to provide adequate aftercare following the surgery on 24 January 2020 and/or 12 February 2020.

73. The Respondent denied that she had failed to obtain adequate post-operative radiographs.

74. The Committee was provided with a number of radiographs, but there was no evidence of any post-operative radiographs following the first surgery and there was a single lateral view image taken after the second surgery. Although there was some suggestion by Ms Malhotra that radiographs may have been lost or not provided to the College, the Committee was not persuaded that this was the case.

75. The Committee was satisfied that the single lateral radiograph taken after the revision surgery was wholly inadequate. It did not find any evidence that there had been more radiographs taken and it was not persuaded by the Respondent's explanations that taking post-operative radiographs was difficult due to the location of the x-ray room within the practice and the difficulty in maintaining the animal's anaesthesia once in the x-ray room. The Committee did not consider these explanations justified not taking the necessary radiographs. The Respondent also stated that, due to being pregnant at the time, she was unable to take the radiographs herself, although accepted that she was ultimately responsible for their adequacy.

76. Furthermore, the Committee accepted the evidence from Dr Bush that the surgeon undertaking the operation is responsible for ensuring that appropriate post-operative images are taken, irrespective of whether they personally take the images or delegate the task to others. It also accepted Dr Bush's opinion when he stated "*it is inconceivable that a competent surgeon would not take post-operative views following a failed implantation of a total hip replacement where there is a view to revise the surgery at a future date as was the case here. There is no justifiable reason for failing to take adequate immediate post-operative radiographs following a total hip replacement."*

77. The Committee noted that Bear was discharged from the second surgery on 14 February 2020. At the post-operative check on the 25 February 2020, Bear was scuffing his nails (to the point of bleeding) and was lethargic. By 28 February 2020,

Bear was unable to cope with walks of 10 minutes' duration. By 25 March 2020, there were concerns that Bear was struggling to stand, not fully loading the operated limb and placing excessive load on his right hind limb.

78. Although Bear was seen post-operatively by another veterinary surgeon, the Committee decided that it was the Respondent's responsibility to liaise with her colleagues and ensure that Bear had post-operative radiographs by no later than 6-8 weeks after the revision surgery.

79. Furthermore, the Committee was satisfied that, even during the Pandemic and when measures were introduced for Covid, it was still necessary for post-operative radiographs to be taken 6-8 weeks after THR surgery, particularly given the failure of the first surgery, the complexity of the procedure and that recovery was not straightforward. The Committee agreed with the opinion of Dr Bush that such radiographs should have been taken.

80. The Committee further noted that the owners had to request radiographs on 30 May 2020, despite an earlier report on 20 May 2020, when Bear was reported to be '*really suffering now'* post revision surgery, but no assessment, physical examination or radiographs were done. The Committee found that it took until 9 June 2020 for a radiograph to be taken and in its view there was no justifiable reason for such a delay bearing in mind the apparent failure of the revision surgery. Even with the Respondent having been furloughed by April 2020, there should have been a plan put in place by the Respondent for Bear to have post-operative imaging 6-8 weeks after the revision surgery.

81. As to aftercare, the Committee did not accept the Respondent's case that she had acted appropriately in circumstances which were radically different after the first 'lockdown' following the Pandemic in March 2020. It agreed with the submissions made by Mr Mant on behalf of the College that '*the aftercare following the revision surgery was unacceptable and fell far below expected standards*' due to the failure to obtain follow up radiographs and to undertake urgent investigations following concerns being raised and videos being submitted on 25 March 2020.

82. The Committee accepted the uncontested opinion of Dr Bush that, if the Respondent was relying on the Pandemic as being the reason why she did not assess Bear face to face, then she should have made a note in the clinical record to that effect and

recorded her serious concerns and 'that the practice was not permitting face to face assessments'. She did not do so and therefore the Committee found this was not the reason for her failure to provide such aftercare.

83. The Committee viewed the videos submitted by Bear's owners and accepted Dr Bush's opinion that they indicated an urgent examination was required, particularly in the context of revision surgery having been conducted, complications having arisen and repeated concerns being raised by Bear's owners. The Respondent said in her statement that she was furloughed around April 2020 so in the Committee's view, Bear's aftercare before that date, particularly on 25 March 2020, would still have been the responsibility of the Respondent.

84. The Committee noted that although the recommendation for euthanasia was made by another veterinary surgeon in the practice in June 2020, the clinical records show that that he discussed the case with the Respondent, then on maternity leave.

85. The Committee considered carefully the Respondent's reasons as to why she believed she had provided appropriate aftercare. It did not find that the Respondent's actions were sufficient as she asserted.

86. The Committee accepted the opinion of Dr Bush when he said that when the failure of the revision surgery was identified "*a recommendation of amputation or euthanasia is made. This is not appropriate as it is accepted that dog's hind limb may function adequately following a correctly performed THR explantation. It should also be noted that at no point did EKB seek the advice of a vet experienced in this technique to discuss the plan for surgery, the complications encountered or the progress of the case."* The Committee therefore accepted the conclusion of Dr Bush on aftercare when he said "*Bear's aftercare was wholly inadequate, and Bear will have suffered unnecessarily as a consequence of this. EKB falls far below the standards expected of a reasonably competent veterinary surgeon."*

87. The Committee therefore found this charge proved.

Charges 3 and 4

3. On 25 May 2021, when speaking to Ms S Drew about surgery you had performed on 20 May 2021 to Daisy, Ms Drew's Jack Russell terrier, you told Ms Drew that:

(a) everything that had been written in Daisy's clinical records up to the point of the surgery on 20 May 2021 referred to the right hind being the problem, when this was not the case; and/or

(b) the veterinary surgeon who had seen Ms Drew about the x-rays taken prior to the surgery on 20 May 2021 had not placed any notes on the file at the time Daisy came in for surgery, when this was not the case;

4. Your conduct at 3(a) and/or 3(b) above was:

(a) dishonest; and/or

(b) misleading

Background

88. These charges relate to a dog called Daisy.

89. On 4 May 2021 Daisy was assessed by Dr Devon Michael. Radiographs were taken. Dr Michael told Mrs Drew that Daisy's left cruciate ligament had ruptured. Corrective surgery was discussed.

90. On 14 May 2021 Dr Michael retrospectively made a note in Daisy's records of the assessment and discussion that took place on 4 May 2021.

91. On 20 May 2021, Mr Drew took Daisy to the Newark Road branch of Rase Vets for surgery on her left knee. He signed a consent form without reading it. The consent form referred to "MMP on right hind leg". The surgery was undertaken on the right hind leg by the Respondent at the Market Rasen branch.

92. On 21 May 2021, after Daisy was discharged, the owners complained that the surgery had been undertaken on the wrong leg.

93. On 25 May 2021, Mrs Drew recorded a telephone conversation with the Respondent in which she stated (among other things) that

"I checked her x-rays beforehand and checked her over. Now in the notes, everything that was written at the time before her surgery said her right hind was the problem…"

"unfortunately the vet you saw… hadn't actually placed any notes on the file at the time of when she came in for her surgery…"

"everything on the, on the notes that I had available… at the time to me said the right hind…"

94. The College alleges that these statements were untrue, misleading and dishonest.

95. The Respondent admitted Charge 3(a), Charge 3(b) and Charge 4(b) in that her conduct in relation to Charges 3(a) and 3(b) was misleading, albeit not intentionally so. She did not accept that her conduct was dishonest.

96. In determining whether the Respondent's conduct was dishonest, the Committee considered firstly the Respondent's state of knowledge or belief as to the facts; and secondly, whether her conduct was dishonest by the standards of ordinary decent people. (Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67).

97. The Committee noted that the Respondent had given inconsistent accounts as to whether she had seen the clinical record of 14 May 2021 prior to her conversation with Mrs Drew on 25 May 2021. However, it decided that those inconsistencies alone did not prove that the Respondent had acted dishonestly to the required standard of proof (so that it was sure).

98. The Committee noted that the Respondent spoke to Daisy's owner in May 2021 after the radiographs were taken but before the surgery. The notes of Devon Michael were on the clinical record on the 14 May 2021. It accepted that until 14 May 2021, there was no reference in the notes to Daisy's left hind leg.
99. The Committee noted that there was no suggestion by the College that the Respondent had performed surgery on the wrong leg and therefore she had no reason to cover up or lie about what she had read in the notes when speaking to Daisy's owners.

100. The Committee also decided that it would not have been difficult for the Respondent to justify her actions and why she had operated on the right hind leg, rather than the left hind leg when speaking to Daisy's owners even if she had seen Devon Michael's notes. It also noted that the consent form referred to the right hind leg and that the initial presentation was for right hind lameness. The Committee accepted the Respondent examined the dog pre-operatively and established that the cruciate ligament of the right hind limb was ruptured.

101. The Committee therefore found the Respondent's knowledge or belief could have been genuine, (despite the inconsistent accounts which she had given) when she was seeking to reassure Mrs Drew. It also noted her previous good character and it therefore found it was possible that the Respondent had been misleading only, and not intentionally so.

102. The Committee noted that the Respondent now agreed that the notes of Devon Michael were present when she spoke to Daisy's owners on 25 May 2021 and that she had been wrong about them not being on the clinical record at that time. The Committee decided in the absence of the Respondent and without being able to question her further, it did not find the College had proved its case on dishonesty.

103. The Committee decided that without being able to ask questions of the Respondent, it could not be sure what her state of mind was. It took into account the submissions made by Mr Mant regarding dishonesty but it found those submissions were speculative regarding the Respondent's state of mind and it was not persuaded by Mr Mant's submissions that the Respondent had acted dishonestly. It therefore was not satisfied that she had been dishonest.

104. The Committee therefore found Charge 4(a) not proved.

Charge 1(t)

Daisy Drew, a Jack Russell terrier cross, failed to ensure adequate post-surgical radiographs were taken in relation to surgery on 20 May 2021.

105. This charge also related to Daisy Drew and a failure to take adequate post-surgical radiographs. The Committee noted that the clinical record showed that '*x-rays'* (in the plural) had been taken but that the owners had been billed for one '*x-ray'* only.

106. The Committee accepted that in this case only some radiographs may have been misplaced or not saved by the practice and therefore unavailable when submitting the paperwork to the College. It noted that the clinical record said on 20 May 2021 that the '*post op x-rays showed a good position'*. It therefore was not satisfied in this case that the post-operative radiographs were inadequate in either number taken or in their ability to assess the adequacy of the surgery undertaken.

107. The Committee therefore gave the benefit of the doubt to the Respondent and found this charge not proved.

Charge 1

Between 1 August 2018 and 31 March 2022, you failed to provide adequate care to animals in relation to surgery undertaken by you, more particularly in relation to:

General points in relation to the charges under Charge 1[11]

108. The Committee found in favour of the Respondent on any charge that related only to the quality of the radiograph. It was not persuaded that without looking at the DICOM images it could be satisfied to the required standard about the quality of radiographs taken. The Committee accepted that DICOM images would have been better quality images and it took that into account in the Respondent's favour when assessing all of the images before it for every charge.

109. Dr Bush stated the following specifically about the lack of a magnification marker:

"A magnification marker is essential in the assessment of radiographs and their use in planning procedures in veterinary orthopaedics. A magnification marker must be present because when X-rays are generated, they are formed at a point in the X-ray

[11] Except Charge 1(t)

machine, and then spread out from that point in a diverging cone shape before striking the x-ray plate and creating an image. The x-rays produced at the machine will continue to diverge after passing through the object before striking the plate. This means if the object is closer to the machine and far from the plate, it will appear larger on the radiograph than if the same object is placed closer to the plate and further from the machine. This is the same principle as making the shadow of your hand appear larger on a wall by moving your hand closer to the light. Because of the divergent beam, a magnification marker must be used to take account of this and scale the images correctly, otherwise there would be no way of knowing how far from the plate the object was positioned when the image was obtained. Typically, the marker is a metal sphere of known diameter, and this is placed adjacent to the object, crucially at the same distance from the xray plate as the object. Many radiographs are taken without magnification markers where a simple diagnosis is needed, for example, is the bone broken or not? Or is there swelling within the joint. However, if any subsequent surgical planning is needed, a magnification marker is mandatory. It is not possible to accurately plan an orthopaedic surgery without one, and throughout the cases below, the absence of a marker falls far below the standards expected of a reasonably competent veterinary surgeon undertaking orthopaedic surgery. Orthogonal views are essential for accurately assessing cases, both before and after surgery. Where orthogonal views have not been taken there is a very high risk of missing important information concerning planning for the surgery that is to be undertaken or assessing the quality of the surgery that has taken place. To not obtain orthogonal views falls far below the standards expected of a reasonably competent veterinary surgeon undertaking orthopaedic surgery."

110. The Respondent disputed this and she stated that it was possible in the absence of such a magnification marker to know the measurements due to the uniformity of the 'L' (left) and 'R' (right) markers on the radiograph instead. She also submitted that radiographs which were DICOM images were better quality than the images provided to the Committee.

111. The Committee accepted the explanation given by Dr Bush about a magnification marker and rejected the explanation given by the Respondent that they were not necessary. It also found that use of a left and right marker was not an adequate substitute for a radiographic marker. It concluded that in orthopaedic surgery, it was standard practice to use a magnification marker to plan properly for the

surgery and that without such a marker there was the potential for a wrongly sized implant to be obtained with knock-on consequences for animal welfare.

112. The Committee heard evidence that sometimes images which were of poor quality were deleted or other images were sometimes saved in a different file or accidentally not saved. Where the clinical records suggested that other images may have been taken but not supplied, the Committee gave the Respondent the benefit of that doubt. However, in the absence of any other evidence, the Committee rejected the explanation that there may have been images not recorded in the clinical notes or not supplied to the College.

Charge 1(c)

Dolly Blue Smart, a female French bulldog, failed to undertake surgery on 15 November 2019 adequately and/or failed to ensure adequate post-surgical radiographs were taken and/or failed to adequately interpret post-surgical radiographs and/or failed to undertake adequate post-operative investigation

113. This charge related to a dog called Dolly Blue Smart.

114. The Respondent accepted this charge in part, accepting that the surgery was not adequate and that she did not ensure adequate post-surgical radiographs were obtained. The Respondent stated that she accepts that an orthogonal view radiograph should have been taken post-operatively. The Respondent did not accept that she failed to interpret the post-operative radiographs or that she failed to undertake post-operative investigations.

115. The Committee noted that Dr Bush was critical of the Respondent's interpretation of post-operative radiographs, in particular the screw '*having migrated from the bone and plate'.* He did not accept the Respondent's comment in the clinical record stating that "*one screw possibly loosening a bit"* could be accurate*.* The Committee noted that Dr Bush stated it was not possible to evaluate the extent of bone healing from the one image supplied.

116. Dr Bush also criticised the signing off of the case without further investigation. The Committee agreed with the analysis of Dr Bush that the radiographs showed an obviously loose screw even without an orthogonal image. Further, it accepted the

uncontested evidence of Dr Bush that the post-operative investigation was inadequate in that there was unnecessary delay in instigating further investigation when the dog remained non-weight bearing and lame.

117. The Committee agreed with the opinion of Dr Bush when he stated "*Overall, the surgery and treatment for this case was poorly planned, poorly executed and the follow up was lacking and inappropriate. The dog will have suffered unnecessarily as a consequence of the treatment administered. The intra-operative errors were perhaps due to inexperience and lack of ability but several opportunities to identify and resolve the problems were missed due to poor practice. In conclusion the conduct of EKB falls far below the standards expected of a reasonably competent veterinary surgeon."*

118. For these reasons the Committee found this charge proved.

Charge 1(d)

Dolly Woodward, a female Shih Tsu cross, failed to ensure adequate pre-surgical and/or post-surgical radiographs were taken in relation to surgery on 29 March 2019 and/or failed to adequately record surgical procedure relating to revision surgery and/or failed to record findings that led to the revision surgery on 23 April 2019

119. This charge related to a dog called Dolly Woodward.

120. The Respondent accepted this charge in part, stating that she accepted the surgery was not adequate and that she did not ensure adequate pre and post-surgical radiographs were obtained but she did not accept failing to adequately record the surgical procedure. She also accepted in her witness statement the substance of the amended allegation and that she failed to record the findings that led to the revision surgery.

121. Dr Bush stated in his report, that although orthogonal views were obtained in this case, pre-operatively, the images lacked a radiographic marker making it impossible to accurately size the implants required. Dr Bush also stated that "*had adequate post-operative images been acquired, any inadequacies of the repair would have been noted, allowing for an immediate revision, thus avoiding the failure of repair*

seen on 16/4." He also stated that there was no immediate post-operative craniocaudal image.

122. Dr Bush also explained in his report the lack of an appropriate radiographic magnification marker in pre-operative images means that the surgeon is unable to determine an accurate scale of the images and implant selection becomes guesswork, with the potential for a catastrophic surgical outcome.

123. The Committee considered carefully the clinical record in this case and it was satisfied that it did not adequately recorded the surgical procedure in relation to the revision surgery.

124. The Committee therefore found all parts of this allegation proved.

Charge 1(e)

Harvey Jamieson-Bailey, a male Cocker Spaniel, failed to undertake surgery on 15 February 2019 adequately and/or failed to ensure adequate pre-surgical and/or post-surgical radiographs were taken

125. This charge related to a dog called Harvey Jamieson-Bailey.

126. The Respondent accepted that the surgery was not adequate and she did not ensure that adequate pre-surgical or post-surgical radiographs were obtained.

127. Following amendment of this charge, the Committee found this charge proved on the Respondent's admissions.

Charge 1(f)

Izzy Neilan/Appiah, a female Doberman, failed to ensure adequate pre-surgical radiographs were taken in relation to surgery in May 2019

128. This charge related to a dog called Izzy Neilan-Appiah.

129. The Respondent submitted that in the circumstances of this matter it was reasonable not to take pre-surgical radiographs. The Respondent stated she had also taken into consideration the client's ability to pay.

130. The Committee did not accept that it was acceptable to diagnose and treat such an injury without pre-surgical radiographs, even in circumstances where the injury is clear and the need for surgery is obvious. It noted that, without such radiographs, the surgery cannot be properly planned and measurements obtained for implants and neither can all injuries be ascertained.

131. The Committee considered the owner's ability to pay is a factor in decision making, but the decision to proceed to surgery without radiography would need to be carefully and fully explained to the owner and recorded in the clinical record. It did not accept that the client's possible inability to pay for such radiographs in this case should have influenced whether they were taken, as was suggested by the Respondent.

132. It therefore found this charge proved.

Charge 1(g)

Daisy Juskeviciute, a female Chihuahua, failed to ensure adequate post-surgical radiographs were taken in relation to surgery on 6 December 2018 and/or revision surgery on 4 January 2019 and/or failed adequately to record the surgical procedure relating to revision surgery on 4 January 2019;

133. This charge related to a dog called Daisy Juskeviciute.

134. The Respondent submitted that orthogonal radiographic views were not essential to manage radius and ulnar fractures. She also submitted that her surgical notes should have been more detailed but that the overwhelming workload and lack of time available affected the quality of her notes, although she accepted that she should have taken steps to ensure this was not the case. She also submitted that there were both radiographic images on file pre- and post-surgery which demonstrated the mode of failure of the original fracture, as well as following the revision surgery.

135. The Committee did not accept the Respondent's submission that post-operative orthogonal views were not necessary in this case. It noted that the

Respondent accepted her record-keeping should have been more comprehensive, but it did not find that the images taken were a substitute for adequate record keeping as she suggested.

136. Dr Bush stated that in this case without an orthogonal view post-operatively, the surgeon falls far below the standard to be reasonably expected of a competent veterinary surgeon. He also said it was not clear why details of the revision surgery on 4 January 2019 were not recorded. The Committee accepted his opinion.

137. The Committee therefore found this charge proved.

Charge 1(j)

Otis Prescott, a male Labrador retriever, failed to ensure adequate pre-surgical and/or post-surgical radiographs were taken in relation to surgery on 8 December 2018

138. This charge related to a dog called Otis Prescott.

139. The Respondent stated she could not recall whether or not pre- and post-operative orthogonal radiographs were taken. She submitted that they were not essential in the management of this fracture, although she appreciated that only taking a single lateral view could increase the likelihood of fissures or other bone fragments being missed.

140. Dr Bush stated it is possible that an orthogonal post operative image was obtained but not supplied. However, he also stated that, if no orthogonal view was taken, this falls far below the standards expected of a reasonably competent veterinary surgeon.

141. The Committee noted there was nothing in the clinical record at the time of the surgery to indicate that there had been such images taken. The record showed orthogonal views were taken on 28 January 2019, 49 days after surgery. The Committee considered the radiographs available to it and noted that the pre-operative radiographs did not show a magnification marker. In addition there was only one post-operative radiograph taken on the day of the surgery and the lack of an orthogonal view meant the adequacy of the surgery was unable to be determined.

142. The Committee noted from the numbers on the images provided that it was possible other pre-operative images had been taken (images 1, 2 and 5 were not provided). However, there was nothing in the clinical record to suggest that more images were taken and in Hannah Miles's evidence she said it was possible for images to have been taken and allocated a number but deleted if they were non-diagnostic.

143. The Committee concluded that since Dr Bush stated that there may be images missing post-operatively and because post-operative radiographs taken on 28 January 2019 were not provided to it, it could not be sure that the charge in relation to post-operative imaging was proved.

144. The Committee therefore found this charge proved in part – proved regarding pre-operative images, not proved in relation to post-operative images.

Charge 1(k)

Ryobi Gilbert, a male Beagle, failed to undertake surgery on 1 April 2019 adequately and/or failed adequately to record the surgical procedure and/or failed to ensure adequate pre-surgical and/or post-surgical radiographs were taken and/or failed to provide adequate post-operative assessment and management

145. This charge related to a dog called Ryobi Gilbert.

146. The Respondent accepted that post-surgical radiographs should have been taken, including an orthogonal view and that her notes ought to have been more comprehensive. She disagreed that pre-surgical radiographs were inadequate on the basis of a lack of a magnification marker. She further stated that her plate choice and application for this surgery were adequate, but she did not explain her decision or provide any supporting evidence. She accepted that post-operatively she should have been more proactive due to the fact that Ryobi did not progress as well as she had hoped. Orthogonal images were taken on 20 September 2019. She did not comment on the images because DICOM images were not available to her for comment.

147. Dr Bush stated that applying a pan tarsal arthrodesis plate (PTA) laterally without a good, documented reason suggests an error and incompetence. He

concluded that the surgery was poorly executed with the plate positioned incorrectly and likely incorrect screw size used. He stated the fact that the dog was lame 2-3 weeks post-surgery was a concern that '*may warrant further investigation*'. He stated that four weeks post-operatively the fact that the dog was only occasionally using the limb meant further investigation should have been advised. He stated because the surgery had several possible complications that could have led to non-weight bearing, this should have been investigated. He said that, at ten weeks post-surgery, with a dog weight bearing 50% of the time and with clinical concerns, there had still been no follow up radiography. He also said that by the time \ a single lateral image is taken (over 4 months after surgery), this was insufficient for assessment of arthrodesis, possible implant loosening, breakage or migration. He stated that the image he had seen supported the suggestion that the plate is incorrectly positioned. He stated, in his opinion, the cause for the '*limp*' was not adequately investigated and no (fluid) aspirates were taken to exclude infection.

148. The Committee agreed with Dr Bush's opinion that the surgery was poorly executed with the plate positioned incorrectly and likely an incorrect screw size having been used.

149. Dr Bush also stated that aftercare was very poor and that several opportunities to intervene and manage this case appropriately were missed, and that when radiography was undertaken, the surgical errors were not identified or acknowledged. He said the conduct falls far below the standards expected of a reasonably competent veterinary surgeon.

150. The Committee noted that Dr Bush stated that this was missed due to incompetence or wilful dishonesty. The Committee decided this was due to incompetence, but there was insufficient evidence to support his opinion that it may have been due to dishonesty.

151. The Committee accepted Dr Bush's opinion of the Respondent's post-surgical assessment. This was particularly since Dr Bush was the only expert called before the Committee and, in the absence of any other evidence, the Committee had no reason to doubt his opinion. It noted the Respondent's admissions and explanations, but the Committee did not find there was any reason to doubt Dr Bush's opinion where the Respondent had not provided an acceptable alternative explanation.

152. The Committee therefore found this charge proved.

Charge 1(l)

Prince Witty, a male Pomeranian, failed to ensure adequate post-surgical radiographs were taken in relation to surgery on 17 May 2019

153. This charge related to a dog called Prince Witty.

154. The Respondent refuted Dr Bush's opinion on the necessity for magnification markers and stated that the radiographs taken were adequate. She agreed that it would have been best practice to take an orthogonal view post-operatively.

155. The Committee had already accepted that Dr Bush's opinion was accurate on why orthogonal views post-surgery were necessary. The Committee rejected the explanation given by the Respondent as to why orthogonal views would only '*have been best practice*'.

156. It therefore found this charge proved.

Charge 1(m)

Willow Sharp, a female Pointer, failed to ensure adequate post-surgical radiographs were taken in relation to surgery on 15 February 2019 and/or 8 April 2019

157. This charge related to a dog called Willow Sharp.

158. The Respondent disagreed with Dr Bush's opinion regarding the need for a magnification marker. She stated the radiographs taken were adequate, but that it would have been best practice to take an orthogonal view post-operatively.

159. The Committee had already accepted that Dr Bush's opinion that orthogonal views were necessary after surgery. The Committee rejected the explanation given by the Respondent as to why orthogonal views would only have been '*best practice*'.

160. It therefore found this charge proved.

Charge 1(n)

Tommy Hadden, a male domestic short-haired cat, failed to undertake surgery on 1 August 2019 adequately and/or failed to undertake adequate post-operative assessment and/or failed to ensure adequate post-surgical radiographs were taken

161. This charge related to a cat called Tommy Hadden.

162. The Respondent said she found the fractures in this cat very difficult to reduce as there was already some fibrous tissue forming. She accepted that there were limitations in the reduction of the bone fragments and the plate should have extended more proximally. She disputed the post-surgery radiograph was inadequate due to a lack of a magnification marker. She stated that she would not have been involved in the aftercare as this would have been transferred back to the branch to which the owner ordinarily went. She agreed that an orthogonal view should have been taken and stated that post-operative radiographs may have been taken by the veterinary surgeon at the branch and then not uploaded to the central computer system.

163. Dr Bush stated that the single radiographic image post-surgery showed that the fracture had not been even close to appropriately stabilised, with the bone plate failing to bridge the fracture. He described it as a "*a case of genuinely appalling surgery"* because if the bone plate does not span the fracture it cannot hope to provide any stability. He could not understand how the cat was allowed to be recovered from anaesthesia and allowed to be discharged from the practice and said it was likely that an orthogonal view would have made the repair look even worse. He went on to say that the Respondent fell far below the standards to be expected of a reasonably competent veterinary surgeon and that "*this displays a complete absence of any understanding of veterinary orthopaedics".*

164. The Committee accepted the opinion of Dr Bush and did not accept the limited explanations given by the Respondent. It found that the surgical repair of the fracture was '*appalling*' as described by Dr Bush and that the fracture was not reduced, nor was the plate in the right place to stabilise the fracture. It therefore found this part proved.

165. The Committee noted that the Respondent had not adequately interpreted the one post-operative radiograph that had been provided, because had she done so she should have realised that the fracture had not been adequately stabilised. The Committee accepted that an orthogonal view should have been taken as this would have confirmed the inadequate repair. The Committee accepted Dr Bush's opinion that had an orthogonal view been taken this would in all likelihood have shown the image of the surgical repair to be worse than that shown on the lateral image. It therefore, for these reasons, found this part proved and rejected the Respondent's assertion that such an image may have been taken but not saved.

166. The Committee found that there was evidence of some post-operative assessment of this patient by other members of the practice team, firstly on the day immediately following surgery, prior to discharge (3 August 2019) and secondly ten days post operatively (12 August 2019) when the clinical record refers only to '*good healing*' which at this length of time post-operatively can only refer to superficial healing of the skin at the operated site. The owner was advised to return for further post-operative care but there was no evidence in the clinical notes that this occurred. The case may have been 'lost to follow-up'. The Committee therefore found the charge relating to post-operative assessment not proved.

167. Accordingly the Committee found parts of this charge proved (failure to undertake surgery adequately and taking adequate post-surgical radiographs) and the part relating to post-operative assessment not proved.

Charge 1(o)

Sky Oliver, a female Staffordshire Bull Terrier, failed to ensure adequate post-surgical radiographs were taken in relation to surgery on 7 January 2019 and/or failed adequately to record the surgical procedure

168. This charge related to a dog called Sky Oliver.

169. The Respondent admitted that her notes did not adequately record the surgical procedure. She did not provide a response to the charge in respect of the post-surgical radiographs.

170. The Committee noted there was no evidence of post-surgery radiographs at the time of the fracture repair and that the only post-surgical radiograph was taken nine months after the surgery was undertaken and it showed a pin within the stifle joint. There was no orthogonal radiographic image. Dr Bush stated that technically an orthogonal view would need to be taken to confirm the exact location of the pin, noting that it was bent at a point consistent with forces applied by its presumed location between the femur and tibia. The Committee accepted the opinion of Dr Bush that post-surgical radiographs should have been taken.

171. The Committee was satisfied on the Respondent's admission that there was a failure to adequately record the surgical procedure. It was further satisfied on the chronology that there was a failure to take immediate post-surgical radiographs and that there was no orthogonal view when radiography was undertaken nine months post-surgery. It therefore found proved the failure to take adequate post-surgical radiographs.

Charge 1(p)

Sindy Burgin, a female Yorkshire Terrier, failed to ensure adequate post-surgical radiographs were taken in relation to surgery in April 2019;

172. This charge related to a dog called Sindy Burgin.

173. The Respondent admitted that orthogonal views post-operatively should have been taken.

174. The Committee noted Dr Bush's opinion that the clinical record showed a failure of fixation on a single lateral radiograph taken two weeks post-operatively. Further he stated as there was only a single lateral image taken post-operatively, it was not possible to fully assess the case.

175. The Committee accepted the opinion of Dr Bush and on the Respondent's admission it therefore found this charge proved.

Charge 1(q)

Vera Hitchen, a female French Bulldog, failed to ensure adequate post-surgical radiographs were taken in relation to surgery in or around March 2022

176. This charge related to a dog called Vera Hitchen. There were two fractures repaired surgically.

177. The Respondent admitted that orthogonal post-operative radiographs should have been taken although she stated that she did not believe it was essential in this case, as an orthogonal view would not have given her any significant additional information.

178. Dr Bush stated that only a single radiograph was recorded in the clinical notes and that a minimum of one further orthogonal view was needed to assess the surgery, given the uncertainty of the location of the distal plate screw and the K wires and to assess whether the fracture sites had been adequately reduced. Dr Bush said these views were necessary to see if the fractures had been managed appropriately and because orthogonal views had not been taken, that fell far below the standard to be expected of a reasonably competent veterinary surgeon.

179. The Committee agreed with the expert opinion of Dr Bush which confirmed its own view that orthogonal views were necessary post-surgery to assess the adequacy of the repair of both fractures. In particular it also noted that the distal screw in the scapular fracture repair looked to be within the shoulder joint and needed further assessment with an orthogonal radiograph. It therefore rejected the explanations provided by the Respondent.

180. The Committee therefore found this charge proved.

Charge 1(r)

Toby Teasdale, a male Springer Spaniel, failed to ensure that adequate pre-surgical radiographs were taken in relation to surgery on 24 September 2021 and/or failed to identify that a screw had been mal-positioned during surgery on 24 September 2021 and/or failed to take adequate steps to revise the surgery

181. This charge related to a dog called Toby Teasdale.

182. The Respondent stated that she disagreed with the need for magnification markers on pre-surgical radiographs. She agreed that the transcondylar screw was too proximal and that she should have revised the surgery at the time by re-positioning the screw.

183. Dr Bush stated the failure to use a magnification marker on the pre-operative radiographs fell far below the standard to be expected of a reasonably competent veterinary surgeon. The Committee agreed with his opinion and rejected the Respondent's view on this point. It therefore found the failure to ensure adequate pre-surgical radiographs were taken proved.

184. On the Respondent's admission which was confirmed by Dr Bush, the Committee found that the Respondent had failed to identify that a screw had been mal-positioned during surgery. It therefore found that part of the charge proved.

185. On the Respondent's admission, confirmed by Dr Bush, the Committee also found the Respondent failed to take adequate steps to revise the surgery.

186. The Committee therefore found this charge proved.

Charge 1(s)

Sissy Wilkinson, a British Bulldog, failed to ensure adequate post-surgical radiographs were taken in relation to surgery on 14 March 2022 and/or failed adequately to record the surgical procedure;

187. This charge related to a dog called Sissy Wilkinson.

188. The Respondent admitted that an orthogonal post-surgical radiograph should have been taken. She referred to the fact that the owners had a payment plan in place due to limited funds available. She also stated that she should have inserted a detailed note regarding the surgery and how it went.

189. Dr Bush stated that there were many complications with the surgery conducted which could have been identified in an orthogonal view and that the failure to obtain an orthogonal view falls far below the standard to be expected of a reasonably competent veterinary surgeon. He also stated that it was not clear what implants were

used and that these could not be measured from the image taken as no radiographic marker was present.

190. The Committee was satisfied on the basis of the Respondent's admissions and Dr Bush's opinion that this charge was proved.

191. In summary the Committee therefore found all charges proved except for Charge 4(a) and Charge 1(t) and parts of Charge 1(j) and 1(n).

Disciplinary Committee
18 November 2024