Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 06/03/2017 – 14/03/2017
Medical Practitioner's name: Dr Vasudha MASHANKAR

GMC reference number: 7210631

Primary medical qualification: MBBS 1984 Nagpur University - Medical College Nagpur

Type of case
New - Misconduct

Outcome on impairment
Impaired

Summary of outcome
Erasure

Immediate order imposed

Tribunal:

Medical Tribunal Member (Chair)	Dr Helen McCormack
Lay Tribunal Member:	Mr Geoffrey Brighton
Medical Tribunal Member:	Dr Pamela Cowan

Legal Assessor:	Mr Charles Thomas
Tribunal Clerk:	Mrs Laura Piercy (6 March 2017) Miss Rosanna Sheerin (7- 14 March 2017)

Attendance and Representation:

Medical Practitioner:	Not present and not represented
GMC Representative:	Ms Chloe Hudson, Counsel

Allegation and Findings of Fact

That being registered under the Medical Act 1983 (as amended):

1. On 27 and 28 March 2015 you worked at North Tees Hospital as a Trust Grade Doctor (Registrar);
Found proved

~~3.~~ 2. ~~As an alternative to the charges referred to at Paragraph 2,~~ ~~on~~ On 28 March 2015 you: **Amended under Rule 17(6)**

a. failed to attend to Patient A around or between 01.00-01.30 hours, therefore you failed to:
Found proved

i. respond to the concerns of nursing staff about Patient A's presentation;
Found not proved

ii. obtain any medical history for Patient A;
Found not proved

iii. carry out any examination and assessment of Patient A;
Found proved

iv. adequately determine whether it was necessary to arrange further investigations;
Found proved

v. adequately diagnose Patient A in that you relied solely upon the previous diagnosis of viral gastritis;
Found proved

vi. develop and implement any treatment for Patient A;
Found not proved

vii. address Patient A's ongoing symptoms;
Found proved

viii. communicate with Patient A's mother.
Found proved

b. created false documents with Patient A's medical records in that you recorded:

i. obtaining a full history relating to Patient A at or around 01.00 on 28 March 2015;
Found proved

ii. examining Patient A between 01.00-01.30 on 28 March 2015;
Found proved

iii. discussing blood test results with Patient A's mother at or around 01.00 on 28 March 2015.
Found proved

~~2.~~ 3. As an alternative to the charges referred to at Paragraph 2, ~~On~~ on 28 March 2015 when providing care to Patient A (a child) around or between 01.00-01.30 hours you failed to: **Amended under Rule 17(6)**

a. carry out an adequate examination or assessment of Patient A because you did not:

i. complete a full neurological assessment;

ii. obtain blood pressure recordings;

iii. adequately assess if any other examinations or investigations were required.

b. commence regular formal neurological observations as part of the monitoring of Patient A in consideration of his on-going symptoms;
Not considered in light of the findings made at paragraph 2

4. On 28 March 2015 when providing care to Patient A at or around 03.30 hours you failed to:

a. obtain an adequate medical history for Patient A in that your observations were limited to Patient A being unsteady whilst going to the toilet; **Found not proved**

b. carry out an adequate examination of Patient A in that you did not:

i. wake Patient A for examination;
Found proved

ii. determine whether it was necessary to conduct further investigations.
Found proved

c. assess or challenge the diagnosis of viral gastritis provided on the evening of 27 March 2015;
Found not proved

d. create or implement any treatment plan for Patient A to include:

i. a full neurological examination;
Found proved

ii. on-going neurological observations;
Found proved

e. adequately communicate with Patient A's mother;
Found not proved

f. adequately record the communication with Patient A's mother.
Found proved

5. On 28 March 2015 when providing care to Patient A around 07.30 hours you failed to:

a. adequately communicate with Patient A's mother;
Found not proved

b. adequately record the communication with Patient A's mother.
Found not proved

6. Your actions at paragraph ~~3~~ 2,b, i-iii were:
Amended under Rule 17(6)

a. misleading; **Found proved**

b. dishonest. **Found proved**

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.

Attendance of Press / Public
The tribunal agreed, in accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004, that the press and public be excluded from those parts of the hearing where matters under consideration were deemed confidential.

Determination on Service and Proceeding and Facts - 10/03/2017

Ms Hudson:

Service and Proceeding in Absence- 6 March 2017

1. Dr Mashankar is neither present nor represented at these proceedings. The Tribunal has considered whether notice of this hearing has been properly served in accordance with Rules 15 and 40 of the General Medical Council (Fitness to Practise) Rules 2004 ("the Rules") and Schedule 4, Paragraph 8 of the Medical Act 1983 (as amended). In so doing, the Tribunal has taken into account all the information placed before it, together with your submissions on behalf of the General Medical Council (GMC) and the email correspondence from Dr Mashankar dated 13 and 28 February 2017.

2. The Tribunal observed that the Notice of Hearing was sent to Dr Mashankar's registered address in India on 17 January 2017 by DX Courier Service. The Tribunal noted that this document was also sent to Dr Mashankar via email.

3. The Tribunal also took account of the email correspondence between the GMC and Dr Mashankar relating to pre-hearing case management and preparations for this hearing, to which Dr Mashankar had responded on several occasions. The Tribunal was satisfied that Dr Mashankar was aware of this hearing taking place.

4. Accordingly, the Tribunal is satisfied that the Notice of Hearing was properly served upon Dr Mashankar in accordance with the Rules.

5. The Tribunal next considered whether to proceed with this hearing in Dr Mashankar's absence, in accordance with Rule 31.

6. The Tribunal noted that it has a discretion to continue a hearing in the practitioner's absence, but in doing so it should exercise the utmost care and caution. The Tribunal has balanced the interests of Dr Mashankar, including fairness to her, together with the overarching public interest.

7. The Tribunal noted that Dr Mashankar had not requested that the hearing be adjourned or indicated any particular circumstances which prevented her from attending. The Tribunal noted Dr Mashankar's email to the GMC dated 13 February 2017 stating "I do not intend to attend the hearing or make any written submissions for the Tribunal to consider". In a further email to the GMC dated 28 February 2017, Dr Mashankar stated "I

do not want to make any representations/submissions in respect of the Tribunal proceeding in my absence."

8. The Tribunal was satisfied that Dr Mashankar was aware that the Tribunal could proceed in her absence, and that she had voluntarily chosen not to attend or to instruct a legal representative to attend on her behalf. The Tribunal was also satisfied that Dr Mashankar was aware of the allegation and of the implications of her non-attendance, particularly as this is a case where dishonesty is alleged. The Tribunal noted that Dr Mashankar did not indicate whether she would be able to attend on another occasion, should the hearing be adjourned. The Tribunal was therefore of the view that an adjournment would serve no useful purpose and that it was in the public interest to proceed expeditiously with this matter.

Amendment to Allegation

9. The Tribunal, after hearing your submissions, determined under Rule 17(6) of the Rules to amend the Allegation as follows:

> ~~2.~~ 3. *As an alternative to the charges referred to at Paragraph 2, ~~On~~ on 28 March 2015 when providing care to Patient A (a child) around or between 01.00-01.30 hours you failed to:*
>
> And
>
> ~~"3.~~ 2. ~~*As an alternative to the charges referred to at Paragraph 2, on*~~ *On 28 March 2015 you:*

10. The Tribunal determined that the amendment would not alter the substance of the Allegation as it merely appeared to be a change in the numbering of the paragraphs of the Allegation and would cause no injustice to Dr Mashankar.

Facts

11. The Tribunal has considered each of the paragraphs of the Allegation separately. In doing so it has considered all of the evidence adduced in this case, both oral and documentary. It has taken account of your submissions on behalf of the GMC.

Background

12. The Tribunal deemed it necessary at the outset of its consideration to undertake a detailed examination of the events in question. It has taken this information from the documentation provided to the GMC by North Tees and Hartlepool NHS Foundation Trust (The Trust).

13. Patient A attended the Accident and Emergency department of North Tees and Hartlepool Trust on 27 March 2015 at 12.59 hours. The records document that he had been fine the night before but had complained of a headache that morning. It was documented that his mother gave him Calpol at around 08:30 hours. He became unwell on the school transport and returned home, following which he was reported to have vomited five times prior to arriving in the Emergency department. He complained that his neck hurt. Patient A's mother reported he had had a slight runny nose. He was also known to have a diagnosis of autism.

14. On examination Patient A was 'pale, quiet and wanting to sleep'. Cardiovascular, respiratory and ENT examinations were normal. There was no evidence of neck stiffness and he had normal pupillary responses. He was monitored for a short period in the Accident and Emergency department but due to further vomiting was referred to the paediatric day unit for on-going observation at around 14:33 hours.

15. The junior doctor on the paediatric day unit took a further history of the illness and repeated the examination. It was noted in the history that Patient A had asked his sister to turn off the lights and that he had coryzal symptoms for two days. Physical examination again recorded that he was lethargic and pale, and had limited communication. Neurologically he was documented to be moving all four limbs, his pupils were dilated with limited reaction to light, there was no neck stiffness or photophobia and there was no papilloedema.

16. At approximately, 18:30 hours on 27 March 2015, Patient A was seen by the Paediatric Consultant, Dr A. A junior doctor recorded some brief notes from this consultation subsequent to which Dr A added some retrospective comments on 01 April 2015 at around 15:15 hours. In this he concluded that the clinical impression was that Patient A had a diagnosis of viral gastritis and the management plan was for Patient A to be admitted to the children's ward for observation, blood tests and intravenous fluids.

17. At 19:15 hours on 27 March 2015 the notes record that Patient A was admitted to the children's ward from the day unit. He had intravenous fluids running and he appeared very lethargic and very pale.

18. The next entry in the medical notes is a retrospective record, timed at 05:10 hours on 28 March 2015 from the Nurse A, who was looking after Patient A overnight. She documented that Patient A had had his observations monitored and recorded that he had intravenous fluids running and he continued to appear pale and lethargic. She noted that Patient A had slept for most of the shift but had been rousable. He had continued to vomit, some of which contained blood, possibly due to retching and that the doctors had been informed. She documented that Patient A continued to complain of headaches and that the doctors had been asked to review him. She recorded the doctors had refused to see him as

his 'bloods were normal so not concerned'.

19. Nurse A recorded that Patient A had not passed any urine since passing a large volume in the day unit, prior to admission to the children's ward. She recorded that Patient A's mother had walked him around the ward at approximately 03:00 hours in an attempt to encourage him to pass urine, however, he became dizzy and shaky and had to be placed on the floor and subsequently helped back to bed. His observations were recorded and blood pressure noted to be stable. Dr Mashankar was asked to review Patient A immediately. Nurse A recorded that Dr Mashankar was not concerned about the lack of passing urine. She made a further note at 06.00hours in which she recorded Patient A's observations and stated that both Patient A and his mother were asleep.

20. The next entry in the medical records is by Dr Mashankar and is timed at 08.50 hours on 28 March 2015. Dr Mashankar was the on-call paediatric middle grade doctor (registrar) on the night of 27 March 2015. It is labelled as written in retrospect. In her retrospective note she summarises Patient A's presentation and that he had been vomiting persistently until 2am. She records that she had seen Patient A at around 1.00am when Nurse A had raised concerns about the persistent vomiting and headache. Dr Mashankar documents a discussion with Patient A's mother about his symptoms and a physical examination of Patient A. She documents a discussion with Patient A's mother about the blood test results and the plan to continue observations and intravenous fluids.

21. Dr Mashankar went on to record that she saw Patient A again at approximately 03.30am when she had been told that Patient A had become unsteady when going to the toilet. She recorded his 'vital parameters', but there is no record of further examination other than 'He appeared to be in deep sleep. His tone of the extremities was ok'.

22. Dr Mashankar continued to write retrospectively that she had been asked to see Patient A again at around 07.30am by Nurse A as she was concerned that Patient A's pupils were not responding. Dr Mashankar records that when she examined Patient A's right pupil it appeared to react briskly but the left pupil was sluggish. She noted that Patient A's arms had increased tone and were held close to his chest. She recorded that soon afterwards she noticed tonic posturing of Patient A's upper and lower limbs associated with arching of his back. His pupillary reactions were said to be fluctuating. He was not responding to voice but withdrawing to pain. Dr Mashankar recorded that she gave Patient A buccal midazolam five minutes after the tonic posturing had started to 'stop the convulsion'. She recorded that blood samples were collected and that her clinical impression was of encephalitis or meningoencephalitis. She documented giving intravenous cefotaxime (antibiotic) and intravenous acyclovir (antiviral) and speaking with the on-call consultant, Dr B.

23. Dr Mashankar documented the discussion including the necessity for CT scanning and anaesthetic input for airway maintenance. Dr Mashankar documented that Patient A was subsequently seen by the anaesthetic team, by which time Patient A had improved and intubation was deferred. She recorded that Patient A received intravenous lorazepam after Dr B had arrived and that a CT scan was subsequently arranged.

24. Dr C, neonatal specialist registrar, documented in the notes that he had been asked to assist by "Sister XXX" (the ward sister). The entry in the medical records is timed at 08:50 hours although it is clear these are written retrospectively. He noted that Patient A was only responding to painful stimuli, that his pupils were dilated 4-5 mm and not reactive to light and that he had increased tone in his legs and arms. He asked for anaesthetic support given Patient A's level of responsiveness. He documented that he was called away to a neonatal emergency but returned at about 08:30 hours by which time the anaesthetic team were present and Patient A was more responsive, his tone was improving and his pupils were responding to light. He documents that the Consultant, Dr B was then present.

25. Dr B wrote in the notes retrospectively at 10:15 hours on 28 March 2015. She documented a telephone discussion with the registrar at around 08:15 hours about Patient A, giving some advice and advising she would attend the ward. Dr B arrived at approximately 08:45 hours where she noted Patient A to have a GCS of 9-10/15, his pupils were fixed and the left optic disc margins appeared unclear. His limb tone was variable and both plantar reflexes were up-going. Her impression was that Patient A had on-going seizure activity and advised intravenous lorazepam, to which he seemed to respond with the tonic episodes ceasing.

26. Dr B documented on-going management thereafter which included intubation and ventilation of Patient A by the anaesthetic team, CT head scan, discussion with the Paediatric Intensive Care Unit (PICU) and neurosurgical teams in Newcastle. The CT head scan showed an intracranial bleed. Patient A was transferred to Newcastle PICU but died on 28 March 2015.

Further retrospective notes

27. Nurse A made further retrospective entries in Patient A's notes at 05.00am on 29 March 2015. This was presumably on her next night shift, as the notes had been unavailable to her earlier when Patient A had been taken for a CT scan and theatre for ventilation. The written entries were mainly about the events from 07.30am onwards on 28 March 2015. She documented that Patient A had not passed urine all night and had informed the doctors of this 'numerous times'. At 07.30am, when she went to read his drip, Patient A was sleeping. Nurse A encouraged his mother to wake him to see if he needed to pass urine. Subsequently his mother came to the desk saying she could not wake him and that he was unresponsive.

28. Nurse A assessed Patient A's pupils and noted these to be fixed and of unequal size. Nurse A immediately called for assistance from Dr Mashankar and Nurse B. Patient A did not respond to pain and his arms went very stiff and his fists clenched. He continued to have what Nurse A described as a seizure for six minutes. Nurse A asked Dr Mashankar if they should give midazolam, antibiotics and/or antivirals but recorded that Dr Mashankar stated that she was just repeating his bloods and that she was not sure that Patient A was having a seizure and she would wait to speak with Dr B. Nurse A says she was unhappy with this decision and sought advice from Sister A. On Sister A's intervention Dr Mashankar decided to give Patient A buccal midazolam and to commence intravenous antibiotics and antiviral medications. Nurse A documented that Patient A was moved to the high dependency bay and assistance was sought from the neonatal registrar and subsequently the anaesthetic team. Nurse A documented that Patient A "stopped seizing", started to respond to voices and his pupils started to react to light again.

Witnesses and Evidence

29. The Tribunal was provided with documentary evidence that included copies of medical notes from North Tees and Hartlepool NHS Foundation Trust and a number of statements made for their own investigation including 3 undated statements from Dr Mashankar, Trust Investigation Report dated 19 November 2015, response by Dr Mashankar to GMC dated 1 September 2015.

30. The Tribunal heard oral evidence from the following witnesses on behalf of the GMC:

- Patient A's mother
- Mrs A, Staff Nurse, The Trust,
- Dr B, Consultant Paediatrician, The Trust,
- Miss B, Staff Nurse, The Trust,
- XXX (Nee XXX), Sister A, The Trust,
- Dr D, GMC Expert witness

31. In addition to the background that has already been set out each of the witnesses confirmed that the ward was particularly busy during that shift.

32. The Tribunal has determined that the oral evidence provided by all the witnesses was credible, consistent and cogent. It was satisfied that their testimony was truthful and reflected accurately their recollection of events in question. In assessing and evaluating the oral evidence, the Tribunal has borne in mind that there has been no cross-examination. Nevertheless, the Tribunal tested and assessed the evidence in framing its own questions. In order to ensure the fairness of the proceedings, in the absence of Dr Mashankar, the Tribunal has been careful to consider evidence that might support Dr Mashankar's case.

33. The Tribunal has also received hearsay evidence in the form of statements in the absence of oral evidence. It acknowledges that the value of such evidence is limited because it has not had the opportunity to observe these witnesses giving their evidence and the evidence has not been tested under cross-examination. The Tribunal has therefore approached such evidence with caution and has only attached such weight to this evidence as deemed appropriate in each case.

Tribunal approach

34. The Tribunal has considered each paragraph of the Allegation separately and has made the following findings:

Paragraph 1:
"On 27 and 28 March 2015 you worked at North Tees Hospital as a Trust Grade Doctor (Registrar)"
Found proved

35. The Tribunal has accepted the letter dated 7 September 2015 from Mr A, Medical Director, North Tees and Hartlepool NHS Foundation Trust to the GMC in which he states:

> *"I am able to confirm that Dr Mashankar was employed in our trust as a trust grade doctor in paediatrics from August 2014 until July 2015"*

36. Accordingly the Tribunal has found this paragraph proved.

Stem of Paragraph 2:
"On 28 March 2015 you:

Paragraph 2a:
"failed to attend to Patient A around or between 01.00-01.30 hours"
Found proved

37. The Tribunal has determined that oral evidence provided by Patient A's mother and Nurse A was credible, consistent and cogent. The Tribunal has considered the notes of the Trust meetings which took place with Patient A's mother on 1 May and 26 June 2015. At these meetings Patient A's mother confirmed that between 01.00-01.30 hours Dr Mashankar did not see Patient A at all. The Tribunal notes that the evidence of Patient A's mother has been consistent in this regard throughout.

38. The Tribunal has also considered the evidence of Nurse A in relation to this matter. In her Trust statement dated 6 April 2015 Nurse A referred to Dr Mashankar as Dr Vasudha and states:

> *"…At approximately midnight mum advised that the patient was continuing to wake complaining of headaches despite having IV paracetamol, however stated that she was unsure if he really had a headache as the patient had sensory problems due to his autism. I advised that I would inform the doctors and would ask them to review the patient. This was the second time I raised a concern. I advised Doctor Vasudha that the patient continued to complain of headache despite receiving IV paracetamol and that he appeared really pale and I felt he needed assessing. Doctor Vasudha advised that she was really busy with ward demands and asked if his current observations were within normal limits, I reassure her that they were. At 01.00am approximately I went to read the patient's drip and mum advised that he was still waking up vomiting and complaining of a frontal headache. She also advised that he had began to complain about his neck hurting. I asked mum if the patient had been reviewed by a doctor and she advised that a doctor had not been to see him overnight… I advised mum again that I would ask the doctor to review this patient. This was the third time that I raised a concern with doctor Vasudha…At this point doctor Vasudha looked at the patients blood results which were all unremarkable. She advised that she was busy with ward demands and that she was not concerned about the patient as his observations and blood results were normal…"*

39. The Tribunal is aware that Nurse A made a retrospective note of events at 05.10hours on 28 March 2015 which was before Patient A's condition deteriorated. In that note she states that Dr Mashankar refused to see Patient A. It is clear that it was her understanding at 05.10 hours that Dr Mashankar had not examined Patient A as requested at about 1.00am. The Tribunal accepts the view of Dr D that it is highly unlikely that Dr Mashankar would have examined Patient A at that time without giving at least some brief verbal feedback to the nurse in charge of his care.

40. Dr Mashankar asserts in her statements to the Trust that she did examine Patient A at that time. However, her first assertion that she did so was only made in her retrospective note at 8.50am by which time Patient A was seriously unwell. The Tribunal notes that there is no new information in that note about Patient A.

41. Accordingly the Tribunal accepts the evidence of Patient A's mother and Nurse A and has found this paragraph proved.

Paragraph 2ai:

"therefore you failed to respond to the concerns of nursing staff about Patient A's presentation"

Found not proved

42. In her Trust statement dated 6 April 2015 Nurse A states:

> *"…I advised her that Patient A still appeared pale, he was still vomiting and complaining of headaches and he had began to complain of his neck hurting. I also advised that despite been on full maintenance fluids for over 6 hours the patient had still not passed urine, however mum reassured me that the patient was waking regularly and that he was speaking in coherent sentences and that he knew where he was, I also advised that I had checked the patients eyes and they were equal and reacting and there was no evidence of photophobia. At this point doctor Vasudha looked at the patients blood results which were all unremarkable. She advised that she was busy with ward demands and that she was not concerned about the patient as his observations and blood results were normal…"*

43. The Tribunal has previously accepted the evidence of Nurse A and it notes that Dr Mashankar did provide Nurse A with a limited response to the concerns raised about Patient A's presentation.

44. Accordingly the Tribunal has found this paragraph not proved.

Paragraph 2aii:
"therefore you failed to obtain any medical history for Patient A"
Found not proved

45. In her Trust statement dated 6 April 2015 Nurse A states:

> *"…I advised her that Patient A still appeared pale, he was still vomiting and complaining of headaches and he had began to complain of his neck hurting. I also advised that despite been on full maintenance fluids for over 6 hours the patient had still not passed urine, however mum reassured me that the patient was waking regularly and that he was speaking in coherent sentences and that he knew where he was, I also advised that I had checked the patients eyes and they were equal and reacting and there was no evidence of photophobia. At this point doctor Vasudha looked at the patients blood results which were all unremarkable. She advised that she was busy with ward demands and that she was not concerned about the patient as his observations and blood results were normal…"*

46. During the conversations Nurse A had with Dr Mashankar over the course of the night and as recorded in paragraph 38, Dr Mashankar was advised about Patient A's presenting symptoms. Dr Mashankar also viewed Patient A's blood results. As a result Dr Mashankar did have some knowledge of Patient A's medical history.

47. Accordingly the Tribunal has found this paragraph not proved.

Paragraph 2aiii:
"therefore you failed to carry out any examination and assessment of Patient A"
Found proved

48. The Tribunal has previously determined that Dr Mashankar failed to attend to Patient A around or between 01.00-01.30 hours and therefore she could not have examined or assessed Patient A at that time.

49. Accordingly the Tribunal has found this paragraph proved.

Paragraph 2aiv:
"therefore you failed to adequately determine whether it was necessary to arrange further investigations"
Found proved

50. The Tribunal has previously determined that Dr Mashankar did provide Nurse A with a response to the concerns raised about Patient A's condition but it was merely limited to a review of Patient A's blood results and observations. It also notes that Dr Mashankar had not taken account of new symptoms reported by Nurse A. It has also determined that she did not attend Patient A between 01.00-01.30 hours.

51. Dr D in his report dated 9 November 2015 states:

"…While it may not have been necessary to organise further investigations at this point, consideration of alternative diagnoses… based on the persistence of, or change in symptoms and further assessment on examination may have indicated the need for further investigations and/or treatment..."

52. The Tribunal has accepted the evidence of Dr D in relation to this matter.

53. Accordingly the Tribunal has found this paragraph proved.

Paragraph 2av:
"therefore you failed to adequately diagnose Patient A in that you relied solely upon the previous diagnosis of viral gastritis"
Found proved

54. In his report Dr D states:

"Dr Mashankar's retrospective notes made no reference to confirming the original diagnosis or considering alternative diagnoses. On the basis of on-going symptoms of headache and vomiting there should have at least been confirmation that the initial diagnosis remained likely and that other diagnoses had been considered. This was, therefore, inadequate.

However, it is disputed that Dr Mashankar assessed Patient A at this time, and if the Complainant's version was accepted, then Dr Mashankar's assessment was based on previous diagnosis of viral gastritis without clinically examining Patient A, which was inadequate."

55. The Tribunal notes that there is no mention in any of the notes made by Dr Mashankar to a differential diagnosis.

56. Dr D also stated in his oral evidence to the Tribunal in order to evaluate a patient you need to see the patient awake, review the symptoms and carry out an examination.

57. The Tribunal has previously determined that Dr Mashankar failed to attend to Patient A around or between 01.00-01.30 hours and therefore she did not examine or assess Patient A at that time.

58. Accordingly the Tribunal has found this paragraph proved.

Paragraph 2avi:
"therefore you failed to develop and implement any treatment for Patient A"
Found not proved

59. In her Trust statement dated 6 April 2015 Nurse A states:

"…I advised her that Patient A still appeared pale, he was still vomiting and complaining of headaches and he had began to complain of his neck hurting. I also advised that despite been on full maintenance fluids for over 6 hours the patient had still not passed urine, however mum reassured me that the patient was waking regularly and that he was speaking in coherent sentences and that he knew where he was, I also advised that I had checked the patients eyes and they were equal and reacting and there was no evidence of photophobia. At this point doctor Vasudha looked at the patients blood results which were all unremarkable. She advised that she was busy with ward demands and that she was not concerned about the patient as his observations and blood results were normal…"

60. The Tribunal has considered that Nurse A noted that Patient A's observations were normal at that time. The Tribunal has determined that even though Dr Mashankar did not attend Patient A at that time this does not necessarily mean that there was a failure to develop and implement any treatment for Patient A. Even if Dr Mashankar did attend Patient A there may not have been an indication to develop and implement any treatment but merely to maintain the treatment plan.

61. Accordingly the Tribunal has found this paragraph not proved.

Paragraph 2avii:
"therefore you failed to address Patient A's ongoing symptoms"
Found proved

62. In her Trust statement dated 6 April 2015 Nurse A states:

> *"…I advised her that Patient A still appeared pale, he was still vomiting and complaining of headaches and he had began to complain of his neck hurting. I also advised that despite been on full maintenance fluids for over 6 hours the patient had still not passed urine, however mum reassured me that the patient was waking regularly and that he was speaking in coherent sentences and that he knew where he was, I also advised that I had checked the patients eyes and they were equal and reacting and there was no evidence of photophobia. At this point doctor Vasudha looked at the patients blood results which were all unremarkable. She advised that she was busy with ward demands and that she was not concerned about the patient as his observations and blood results were normal…"*

63. The Tribunal notes that Nurse A did inform Dr Mashankar of Patient A's ongoing symptoms at that time. Dr Mashankar failed to carry out a further assessment, including an examination of Patient A, and therefore did not put herself in a position to address those ongoing symptoms.

64. Accordingly the Tribunal has found this paragraph proved.

Paragraph 2aviii:
"therefore you failed to communicate with Patient A's mother"
Found proved

65. The Tribunal has previously determined that Dr Mashankar failed to attend to Patient A around or between 01.00-01.30 hours and therefore she could not have spoken to Patient A's mother at that time. The Tribunal has previously accepted the evidence of Patient A's mother in relation to this matter.

66. Accordingly the Tribunal has found this paragraph proved.

Paragraph 2b:
"created false documents with Patient A's medical records in that you recorded"

Paragraph 2bi:
"obtaining a full history relating to Patient A at or around 01.00 on 28 March 2015"

Paragraph 2bii:
"examining Patient A between 01.00-01.30 on 28 March 2015"

Paragraph 2biii:
"discussing blood test results with Patient A's mother at or around 01.00 on 28 March 2015"
Have been found proved

67. The Tribunal considered the retrospective note made by Dr Mashankar in Patient A's notes which states:

> *"I had seen him around 1am when SN A raised concerns re him due to persistent vomiting and headaches. I spoke to Mum and gathered history re his illness"*

68. The Tribunal noted that in her undated Trust witness statements and her response to the GMC, Dr Mashankar continues to assert that she had seen Patient A between 00.30 and 01.30 hours.

69. The Tribunal has also considered the Trust Investigation Report under Incidental Findings which states:

> *"There were entries in the health care records which cannot be corroborated"*

70. The Tribunal has previously found that Dr Mashankar did not attend Patient A between 01.00-01.30 hours; therefore an examination did not occur nor did a discussion in relation to blood test results with Patient A's mother. The Tribunal has therefore determined that Dr Mashankar's retrospective entry in this regard was false.

71. Accordingly the Tribunal has found these paragraphs proved.

Paragraph 3:
"As an alternative to the charges referred to at Paragraph 2, On 28 March 2015 when providing care to Patient A (a child) around or between 01.00-01.30 hours you failed to"

a. carry out an adequate examination or assessment of Patient A because you did not:

i. complete a full neurological assessment;

ii. obtain blood pressure recordings;

iii. adequately assess if any other examinations or investigations were required.

b. commence regular formal neurological observations as part of the monitoring of Patient A in consideration of his on-going symptoms;

Not considered in light of the findings made at paragraph 2

Paragraph 4:

"On 28 March 2015 when providing care to Patient A at or around 03.30 hours you failed to"

Paragraph 4a:

"obtain an adequate medical history for Patient A in that your observations were limited to Patient A being unsteady whilst going to the toilet"

Found not proved

72. The Tribunal has considered the retrospective entry made by Dr Mashankar in relation to the care she provided to Patient A at 03.30 hours. Dr Mashankar retrospectively recorded the reason she assessed Patient A at 03.30 hours being that he had become 'unsteady while going to the toilet'. Dr Mashankar recorded his 'vital parameters', to be normal and she stated that 'he appeared to be in deep sleep'.

73. In her statement to the GMC Patient A's mother states:

"We did not see Dr Mashankar until after 3.30am. Nurse A was in and out in the intervening period and she was asking Dr Mashankar to come in and see Patient A but she never did. Patient A collapsed around 3.00am. The nurse asked me to get him up and take him to the toilet if he hadn't passed any urine but he collapsed and Nurse A came to help me. I could not hold onto him. I was helped back to the room and the nurse did observations, then Dr Mashankar came in.

I told Dr Mashankar that I was concerned. However, she told me that she was not concerned and Patient A just had a virus. She did not examine him at all. Dr Mashankar came in the room on her own so there was just Dr Mashankar, Patient A and I present, she did not have a nurse with her at that stage. I recall that we did have a conversation about Patient A's autism and Dr Mashankar claims that I asked her whether Patient A could feel pain… She was only in the room a few minutes and did not seem interested. She did apologise to me saying that she had been busy…"

74. The Tribunal is aware that no notes or details about what exactly was discussed between Patient A's mother and Dr Mashankar have been provided. The

Tribunal is aware that Dr Mashankar had seen Patient A's blood results but no other details are known.

75. In her statement Nurse A said that she had updated Dr Mashankar as to the patient's observations and symptoms but the information recorded in the notes is not sufficient to determine the extent of the medical history that was taken. The Tribunal concludes that Dr Mashankar had more information than the report of unsteadiness alone.

76. The Tribunal has not been provided with sufficient evidence and therefore has found this paragraph not proved.

Paragraph 4b:
"carry out an adequate examination of Patient A in that you did not"
Paragraph 4bi:
"wake Patient A for examination"

Paragraph 4bii:
"determine whether it was necessary to conduct further investigations"
Have been found proved

77. Patient A's mother confirmed in her oral evidence that when Dr Mashankar came into the room she did not touch Patient A. The Tribunal also notes that Dr Mashankar recorded in her retrospective note that Patient A's 'vital parameters', were normal and that 'he appeared to be in deep sleep'.

78. In his oral evidence Dr D stated that it is necessary to wake a patient for a proper examination to be carried out. He stated that in order to "assess alertness and responsiveness" the patient needs to be woken and that if a child collapses then "you have to evaluate the cause". He also stated that Dr Mashankar "should have tried to rouse him". He stated that in the light of a changing clinical picture a full examination would be necessary to determine the need for further investigations.

79. Dr Mashankar recorded that Patient A was asleep and that the "tone of the extremities was ok". Patient A's mother states that Patient A was neither woken nor touched by Dr Mashankar. The Tribunal has accepted the evidence of both Patient A's mother and Dr D.

80. Accordingly the Tribunal has found this paragraph proved.

Paragraph 4c:
"assess or challenge the diagnosis of viral gastritis provided on the evening of 27 March 2015"
Found Not Proved

81. The Tribunal has previously determined that no notes or details about what exactly was discussed between Patient A's mother and Dr Mashankar have been provided. The Tribunal is aware that Dr Mashankar had seen Patient A's blood results but no other details are known. The Tribunal was aware that Dr Mashankar was at Patient A's bedside for a few minutes and that there was a dialogue between her and Patient A's mother. Without a full record of that assessment or the opportunity to question Dr Mashankar in the hearing, the Tribunal had insufficient evidence upon which to evaluate the quality of that assessment.

82. The Tribunal has not been provided with sufficient evidence and therefore has found this paragraph not proved.

Paragraph 4d:
"create or implement any treatment plan for Patient A to include"

Paragraph 4di:
"a full neurological examination"

Paragraph 4dii:
"on-going neurological observations"
Have been found proved

83. In her Trust statement dated 6 April 2015 Nurse A states:

> *"…At this point I raised my voice and told doctor Vasudha that I was concerned about this patient and I was not happy that I had raised various concerns with her overnight and that she had not listened to them. I also told her I was not happy that she had not been to review the patient overnight and felt that she needed to review him immediately. It was at this point only that doctor Vasudha went to review the patient. She advised that she was not concerned about the patient; she felt he had viral gastroenteritis and stated that she wanted me to continue with his IVT despite me raising my concerns again about him not passing urine…"*

84. The Tribunal has considered Dr Mashankar's retrospective note: no mention is made of a full neurological examination or on-going neurological observations being required.

85. Dr D in his oral evidence stated that Patient A's developing symptoms, including collapse, indicated that a full neurological examination and neurological observations were required.

86. The Tribunal has accepted the evidence of both Nurse A and Dr D.

87. Accordingly the Tribunal has found this paragraph proved.

Paragraph 4e:
"adequately communicate with Patient A's mother"
Found Not Proved

88. In her statement to the GMC Patient A's mother states:

> *"I told Dr Mashankar that I was concerned. However, she told me that she was not concerned and Patient A just had a virus. She did not examine him at all. Dr Mashankar came in the room on her own so there was just Dr Mashankar, Patient A and I present, she did not have a nurse with her at that stage. I recall that we did have a conversation about Patient A's autism…"*

89. The statement of Nurse A confirms that after seeing Patient A at 3.30am Dr Mashankar confirmed that the patient had viral gastroenteritis. This was consistent with what she had communicated to Patient A's mother.

90. Accordingly the Tribunal has found this paragraph not proved.

Paragraph 4f:
"adequately record the communication with Patient A's mother"
Found Proved

91. The Tribunal has considered Dr Mashankar's retrospective note. No mention is made of her providing a diagnosis of gastroenteritis to Patient A's mother at that time. However, Patient A's mother has confirmed this in both her oral evidence and statements. The Tribunal has accepted the evidence of Patient A's mother.

92. Accordingly the Tribunal has found this paragraph proved.

Stem of paragraph 5:
"On 28 March 2015 when providing care to Patient A around 07.30 hours you failed to"

Paragraph 5a:
"adequately communicate with Patient A's mother"

Paragraph 5b:
"adequately record the communication with Patient A's mother"
Have been found not proved

93. The Tribunal is aware that at 07.30 hours Patient A was very unwell and that the priority at that time would have been to attend to Patient A's clinical needs.

Dr Mashankar's responsibility at that time would have been to assist in stabilising Patient A and speak to other medical professionals as to the clinical priorities. In her retrospective record Dr Mashankar notes that she was administering medication and subsequently calling the on call consultant.

94. In her oral evidence Sister A confirmed to the Tribunal that the nurses who were present at the time were explaining to Patient A's mother the nature of the events which were occurring.

95. The Tribunal has determined that at 07.30 hours Dr Mashankar's priority was the care of Patient A and it was the nursing staff who were communicating with Patient A's mother. As a result, there would have been no record of Dr Mashankar communicating with Patient A's mother and the responsibility to record the nature of the communication lay with the nursing staff. Dr D provided evidence that it was the responsibility of those providing the communication to ensure an accurate record was made.

96. Accordingly, the Tribunal has found these paragraphs not proved.

Stem of paragraph 6:
"Your actions at paragraph 2b, i-iii were"

Paragraph 6a:
"misleading"
Found proved

97. The Tribunal has previously determined that Dr Mashankar did not attend Patient A around or between 01.00-01.30 hours on 28 March 2015 and that her retrospective entry regarding this time period is false. The Tribunal has determined that as Dr Mashankar recorded that she had examined Patient A, obtained a full history and discussed blood test results with Patient A's mother this would lead another health professional to deduce that these events had taken place at that time which was incorrect. This would therefore mislead any person who subsequently read Patient A's medical records.

98. Accordingly the Tribunal has found paragraph 6a in relation to paragraphs 2bi-iii proved.

Paragraph 6b:
"dishonest"
Found proved

99. The Tribunal has already previously determined that Dr Mashankar did not attend Patient A around or between 01.00-01.30 hours on 28 March 2015 and that her

retrospective entry regarding this examination is false. The Tribunal also notes that this retrospective entry was made after the events which occurred at 07.30 hours.

100. The Tribunal was satisfied that Dr Mashankar must have known this entry was false and deliberately misleading. The Tribunal considered that the deliberate making of a false entry in the medical notes, which she continued to adopt in her subsequent statements, was dishonest. The Tribunal considered that Dr Mashankar would have read the earlier critical entry made in the notes by Nurse A and may have been seeking to avoid criticism of her actions during that period of time. Accordingly, the Tribunal found that Dr Mashankar acted dishonestly.

101. Accordingly the Tribunal has found paragraph 6b in relation to paragraphs 2bi-iii proved.

Determination on Impairment - 13/03/2017

Ms Hudson:

1. The Tribunal has considered under Rule 17(2)(k) of the General Medical Council (GMC) (Fitness to Practise) Rules Order of Council 2004 whether, on the basis of the facts found proved, Dr Mashankar's fitness to practise is impaired by reason of her misconduct. It has taken into account your submissions on behalf of the GMC and all the evidence it has been provided during the course of these proceedings.

Submissions

2. You submitted that the facts found proved amount to misconduct and that Dr Mashankar's fitness to practise is impaired as a result. You submitted that Dr Mashankar's misconduct falls into two areas; her treatment provided to Patient A and her dishonesty. You submitted that in both regards these failings fell seriously below the standard expected of a reasonably competent Trust Grade Doctor/Registrar.

3. You drew the Tribunal's attention to the relevant paragraphs of Good Medical Practice (GMP)(2013 edition) which included paragraphs 1, 15, 31, 65, 66, 68, 71 and 72. You also drew the Tribunal's attention to the relevant case law including; Roylance [2001] 1 AC 311, Calhaem [2007] EWHC 2606 (Admin) and Grant [2011] EWHC 927 (Admin).

4. You submitted that there are multiple instances where Dr Mashankar has failed to act within the provisions of GMP. You stated that there is no evidence of any insight on Dr Mashankar's part, or any evidence of remediation. You submitted that Dr Mashankar's dishonest actions bring the medical profession into disrepute

and that a finding of impairment is required to maintain public confidence in the profession.

5. The Legal Assessor advised the Tribunal that the question of current impairment was a matter for its judgment and did not depend upon a burden or standard of proof. The Tribunal has accepted the advice of the Legal Assessor that in considering Dr Mashankar's impairment, the Tribunal should apply a two-stage process. First, the Tribunal should consider whether the facts found proved amount to serious misconduct. If it should find serious misconduct then the Tribunal should go on to consider, whether, on the basis of its findings, Dr Mashankar's fitness to practise is impaired.

6. Throughout its deliberations, the Tribunal has borne in mind its responsibility to protect the public interest. The public interest includes not only the protection of patients but also the maintenance of public confidence in the profession, and the declaring and upholding of proper standards of conduct and behaviour.

7. The Tribunal has given a detailed determination in relation to the facts of Dr Mashankar's case. It has taken those matters into account in its deliberations.

Misconduct

8. The Tribunal first considered whether the facts found proved in Dr Mashankar's case amounted to misconduct.

9. The Tribunal had regard to the decision of Jackson J in *Calhaem v GMC* [2007] EWHC 2606 (Admin), and his exposition of the term 'misconduct' in the context of section 35C (2) of the Medical Act 1983, as set out in paragraph 39 of the judgment. Jackson J said this:

> *"(1) Mere negligence does not constitute "misconduct" within the meaning of section 35C(2)(a) of the Medical Act 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to "misconduct".*
>
> *(2) A single negligent act or omission is less likely to cross the threshold of "misconduct" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as "misconduct".″*

Treatment of Patient A

10. In considering Dr Mashankar's treatment of Patient A the Tribunal noted the standards in GMP (2013 edition). The Tribunal has considered paragraph 15 in particular which states:

> *"You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> > *a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
> >
> > *b. promptly provide or arrange suitable advice, investigations or treatment where necessary…"*

11. The Tribunal has found proved that on 28 March 2015 Dr Mashankar failed to attend Patient A at around or between 01.00-01.30 hours and as a result failed to carry out any examination and assessment on Patient A; therefore Dr Mashankar failed to adequately determine whether it was necessary to arrange further investigations. She failed to adequately diagnose Patient A in that she relied solely upon the previous diagnosis of viral gastritis. She also failed to address Patient A's ongoing symptoms.

12. The Tribunal has also found proved that on 28 March 2015 when providing care to Patient A at or around 03.30 hours Dr Mashankar failed to carry out an adequate examination of Patient A as she did not wake him for examination nor determine whether it was necessary to conduct further investigations. Dr Mashankar also failed to create or implement any treatment plan for Patient A to include a full neurological examination and a full neurological examination.

13. The Tribunal has determined that this was not purely one single incident but two incidents in a single night when Dr Mashankar was called upon to assess and examine Patient A. It has determined that Dr Mashankar's failure on both occasions to carry out an adequate assessment and assess changing clinical symptoms brought to her attention by nursing staff were serious failings. The Tribunal again considered the note made by Nurse A at 05.10 hours in which she stated that Dr Mashankar refused to see Patient A. It is clear that, even at that time, Nurse A was concerned that Dr Mashankar had not shown sufficient concern for Patient A's ongoing and changing symptoms. Whilst it accepts that there were many other calls on Dr Mashankar's time that night the Tribunal considered that Dr Mashankar's actions were a serious departure from GMP and agreed with Dr D's conclusion that Dr Mashankar's conduct fell seriously below the standard expected of a reasonably competent Trust Grade Doctor/Registrar.

14. In the circumstances the Tribunal has determined that Dr Mashankar's actions in relation to her treatment of Patient A constitute serious misconduct.

Dishonesty

15. Considering Dr Mashankar's dishonesty the Tribunal noted the standards in GMP and particularly paragraphs 55, 65, 68 and 71 which relate to probity.

> *"55. You must be open and honest with patients if things go wrong…*
>
> *65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
>
> *68. You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.*
>
> *71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.*
>
> *a. You must take reasonable steps to check the information is correct.*
>
> *b. You must not deliberately leave out relevant information."*

16. Doctors occupy a position of privilege and trust in society and are expected to uphold proper standards of conduct. Members of the public are entitled to place complete reliance upon doctors to be honest. The relationship between the profession and the public is based on the expectation that medical practitioners will act at all times with absolute integrity. Dishonesty in any form is serious because it can undermine the trust the public place in the medical profession.

17. The Tribunal is mindful of its responsibility to protect the public interest, particularly with reference to the protection of patients, the maintenance of public confidence in the profession, and the declaring and upholding of proper standards of conduct and behaviour.

18. The Tribunal has determined that Dr Mashankar breached the principles of probity contained within Good Medical Practice. Having considered all the evidence placed before it, the Tribunal has concluded that her action in making her retrospective entry regarding an examination of Patient A at around or between 01.00-01.30 hours on 28 March 2015 was dishonest. It has concluded that her behaviour fell seriously short of the standards of conduct that the public and patients are entitled to expect from all registered medical practitioners. The making of a false entry in a patient's notes is potentially misleading and has implications for patient safety. The Tribunal is satisfied such behaviour would be viewed by fellow practitioners, the public and patients as wholly unacceptable.

19. The Tribunal views Dr Mashankar's dishonest act as falling seriously below the standards of conduct that the public and patients are entitled to expect from a Trust Grade Doctor/Registrar, and that this amounts to serious misconduct.

Impairment

20. Whilst the Tribunal has considered your submissions the matter of impairment is one for it to determine, exercising its own professional judgement.

21. In considering the matter of impairment, the Tribunal has noted the case of Cohen v GMC [2008] EWHC 581 (Admin) in which Silber J stated, at paragraph 65:

> *"…It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."*

22. It also noted Dame Janet Smith's criteria for impairment set out in her fifth Shipman report and cited in CHRE v NMC and Grant [2011] EWHC 927 (Admin):

> *"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future."*

23. The Tribunal has concluded that there were serious clinical failings by Dr Mashankar in the treatment she provided to Patient A. The Tribunal has seen very little evidence of reflection on the clinical failings and no evidence of continuing professional development which would be relevant to the matter of remediation and likelihood of repetition.

24. The Tribunal notes that dishonest behaviour is by its very nature hard to remediate. There is no evidence of remediation in this case. Dr Mashankar failed in subsequent documents to acknowledge or address her false entry in Patient A's notes.

25. The Tribunal is aware that Dr Mashankar has not been present at these proceedings and has therefore not provided evidence in person or under oath. It notes that Dr Mashankar could have, but did not, provide a written statement. No evidence of continuing professional development or any evidence to address the risk of repetition has been provided. However, the Tribunal does note that Dr Mashankar did provide a response to the GMC in September 2015 which included her CV. In her response Dr Mashankar states:

> *" I have been extremely distressed by the incident and I am extremely sorry for what has happened. I am anguished by the irreparable loss to the family especially the parents. I have reflected on the unfortunate incident. It was an extremely busy night on 27th March when I started my shift and I had to look after the patients who had not been seen earlier. Though it is not a common practice to take routine ward round of the ward patients, I have learnt not to take the findings and diagnosis of patients at face value even when they are seen by a consultant. I have learnt that it is better practice to go through the history and examine the patients myself without any presumptions based on prior diagnosis by other clinicians"*

The Tribunal notes that Dr Mashankar does offer an apology to Patient A's family but she still fails to address the false entry made in Patient A's records. The Tribunal considers this shows very limited insight into her dishonest actions. The Tribunal considers that Dr Mashankar's insight on the clinical failings is limited to her reflection as above. Furthermore there has not been any evidence of remediation or reflection since.

26. There is no evidence before the Tribunal of the doctor showing any insight into her dishonesty. The only evidence the Tribunal has is Dr Mashankar's statements to the Trust and her response to the GMC. In all of these she maintained her false account of examining Patient A at about 01.00 hours.

27. The Tribunal has concluded that Dr Mashankar's actions have brought the profession into disrepute, that she has acted dishonestly and thus breached a fundamental tenet of the medical profession. All four criteria outlined by Dame Janet Smith for a finding of impairment are therefore satisfied.

28. The Tribunal has concluded that Dr Mashankar's actions have fallen seriously below the standards and conduct expected of a doctor and that this would undermine the confidence of the public in the medical profession.

29. In all these circumstances, the Tribunal concluded that Dr Mashankar's fitness to practise is currently impaired by reason of her misconduct.

Determination on Sanction - 14/03/2017

Ms Hudson:

1. Having determined that Dr Mashankar's fitness to practise is impaired by reason of her misconduct, the Tribunal has now considered what action, if any, it should take with regard to her registration, in accordance with Rule 17(2)(n) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules').

Submissions

2. You submitted that the appropriate sanction in Dr Mashankar's case was one of erasure. You submitted that this was as a result of the Tribunal findings of serious misconduct and due to Dr Mashankar's lack of insight, the risk of repetition cannot be disregarded. You drew the Tribunal's attention to the appropriate paragraphs of Sanctions Guidance (July 2016) ('the SG') which included paragraphs: 1, 14, 16, 21, 25, 41, 42, 46, 51, 60, 62, 71, 85, 91, 114-120 and 123-126.

3. You also drew the attention of the Tribunal to the options available to it. These were: to take no action, impose conditions on Dr Mashankar's registration, suspend her registration or erase Dr Mashankar's name from the medical register.

4. With regard to taking no action, you submitted that this was clearly not appropriate given the seriousness of Dr Mashankar's case. You stated that there had been no 'exceptional circumstances' in line with paragraph 53 of the SG.

5. You submitted that an order of conditions could possibly be appropriate to address Dr Mashankar's clinical failings but that evidence from Dr Mashankar would be required to address this issue. In relation to Dr Mashankar's dishonesty you submitted that conditions would not be appropriate, workable or sufficient, to remedy the serious misconduct as found proved by the Tribunal, or to uphold public confidence in the medical profession.

6. With regard to suspension, you stated that this has a deterrent effect and could be used to send out a signal regarding behaviour which is unbefitting of a doctor. You submitted that Dr Mashankar demonstrated a lack of insight. This was evidenced by her continued assertion both in her statements to the Trust and her response to the GMC, that on 28 March 2015 she attended Patient A at around or between 01.00-01.30 hours. Accordingly, it would be inappropriate and insufficient to suspend her registration.

7. You submitted that the sanction of erasure is necessary in the public interest. You drew the Tribunal's attention to paragraph 122 of the SG, which makes it clear that in cases involving persistent dishonesty, erasure may well be the appropriate sanction.

Tribunal's decision

8. The decision as to the appropriate sanction, if any, to impose in this case is a matter for the Tribunal alone, exercising its own judgement. In so doing, it has given consideration to its findings of misconduct and impaired fitness to practise, the submissions made by you on behalf of the GMC, and all the evidence the Tribunal has been provided with during course of these proceedings. The Tribunal also heard and accepted the advice of the legal assessor. The legal assessor's advice is a matter of record and the Tribunal has not rehearsed it in detail in this determination.

9. Throughout its deliberations the Tribunal has borne in mind that the purpose of sanctions is not to be punitive, but to protect the public interest. The public interest includes protecting and promoting the health, safety and wellbeing of the public, promoting and maintaining public confidence in the profession, and promoting and maintaining professional standards and conduct.

10. In reaching its decision, the Tribunal also had regard to the principle of proportionality, and it weighed Dr Mashankar's interests with those of the public. It also considered and balanced the mitigating and aggravating factors in this case.

11. Given its findings, throughout its deliberations the Tribunal also had regard to the following paragraphs of the SG, relating to the dishonesty.

> *"114. Good medical practice states that registered doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession."*
>
> *"119. Examples of dishonesty in professional practice could include:*
>
> *…*
> *b falsifying or improperly amending patient records*
> *…*
> *e failing to take reasonable steps to make sure that statements made in formal documents are accurate."*

12. In deciding what sanction, if any, to impose the Tribunal considered each of the sanctions available, starting with the least restrictive, to establish which was appropriate and proportionate in this case.

No Action

13. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Mashankar's case, the Tribunal first considered whether to conclude the case by taking no action.

14. The Tribunal determined that in view of the serious nature of its findings in relation to Dr Mashankar's dishonesty at the impairment stage, it would not be sufficient, proportionate, nor in the public interest, to conclude this case by taking no action.

Conditions

15. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Mashankar's registration. It bore in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

16. The Tribunal was mindful that the doctor had no previous proceedings before the MPTS and that she was undoubtedly under a lot of pressure on the night in question and having to prioritise between patients. The Tribunal noted that if the findings it made were in relation to Dr Mashankar's clinical failings alone then it may have been possible to formulate conditions that were appropriate.

17. However, the Tribunal did not consider that suitable conditions could be devised to remediate Dr Mashankar's dishonesty. It determined that an order of conditions would not be sufficient to uphold public confidence in the medical profession given the serious findings made in relation to Dr Mashankar's dishonest behaviour. Therefore, the Tribunal determined that it was not sufficient to direct the imposition of conditions on her registration.

Suspension

18. The Tribunal then considered whether to suspend Dr Mashankar's registration would be appropriate and proportionate. The SG at paragraphs 86 and 87 state:

> *"86. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention."*
>
> *"87. Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–45)."*

19. In relation to dishonesty, the Tribunal took account of paragraph 122 of SG which states:

> *"122. Dishonesty, if persistent and/or covered up, is likely to result in erasure (see further guidance at paragraph 114–122)."*

20. The Tribunal is of the view that Dr Mashankar's actions amounted to a serious departure from the principles of *Good Medical Practice* and represented a breach of the trust placed in doctors. Although each case must be dealt with on its own facts, findings of dishonesty are always regarded seriously in cases of misconduct. As part of its duty to protect the public interest, the Tribunal must declare and uphold proper standards of conduct and behaviour. The Tribunal is aware that the SG makes it clear that misconduct involving dishonesty may lead to erasure.

21. The Tribunal considers that Dr Mashankar has breached one of the basic tenets of the medical profession in that her dishonest actions were persistent in nature as she continued to maintain her false account of examining Patient A at about 01.00 hours both in her statements to the Trust, and in her response to the GMC. The Tribunal has borne in mind its findings at the impairment stage, that Dr Mashankar has not shown any insight into her dishonest behaviour and that there has been a lack of evidence of any remediation. The Tribunal is unable to satisfy itself that her behaviour is unlikely to be repeated. For these reasons, the Tribunal determined that a period of suspension would not be an appropriate or proportionate sanction, nor would such a sanction satisfy the public interest.

Erasure

22. The Tribunal then took account of the relevant paragraphs of the SG, in particular the following paragraphs:

> *"102. Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor."*
>
> *"103. Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.*
> *...*

> *h Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 114–122).*
>
> *…*
>
> *j Persistent lack of insight into the seriousness of their actions or the consequences"*

23. The Tribunal determined that the above factors are relevant and applicable to Dr Mashankar's dishonest conduct and behaviour.

24. The Tribunal has determined that Dr Mashankar's initial dishonest behaviour stemmed from one instance initially and on its own would not have been incompatible with continued registration as a medical practitioner. However, she continued to maintain the false account of examining Patient A at about 01.00 hours over an extended period of time. She had a number of opportunities to address these matters in subsequent documents but failed to do so. The Tribunal determined that this constituted persistent dishonesty.

25. The Tribunal has determined that Dr Mashankar's dishonest behaviour, which she failed to address over a prolonged period of time is fundamentally incompatible with continued registration as a medical practitioner. The Tribunal has therefore determined that her name be erased from the medical register. In all the circumstances of this case the Tribunal considers that erasure is the only appropriate sanction to maintain public confidence in the profession.

Determination on Immediate Order - 14/03/2017

Ms Hudson:

1. Having determined to erase Dr Mashankar's name from the medical register, the Tribunal has now considered, in accordance with Section 38 of the Medical Act 1983, as amended, whether to impose an immediate order of suspension on her registration.

2. In reaching its decision the Tribunal considered the relevant paragraphs of the Sanctions Guidance (July 2016) ('the SG'), which includes paragraphs 166, 167 and 172. It exercised its own judgement and had regard to the principle of proportionality.

3. The Tribunal also took into account the submissions made by you, on behalf of the General Medical Council (GMC).

4. You submitted that the findings made by the Tribunal in relation to Dr Mashankar's clinical failings, and dishonesty were sufficient to warrant an order for immediate suspension. You submitted that it would not be appropriate to allow Dr Mashankar to resume unrestricted practice given the findings made in this case.

You drew the Tribunal's attention to paragraphs 104 and 166- 172 of the SG. You submitted that an immediate order is required to protect patients and in the public interest.

5. The Tribunal has determined that, given the serious nature of its findings particularly in relation to Dr Mashankar's serious persistent dishonesty, she presents a risk to patients. Therefore, it is both necessary for the protection of members of the public and in the public interest, to make an order suspending Dr Mashankar's registration immediately.

6. The order of immediate suspension will take effect when notice is deemed to have been served upon Dr Mashankar. If she lodges an appeal, the immediate order for suspension will remain in force until the appeal is determined.

7. The interim order currently imposed on Dr Mashankar's registration will be revoked when notice is deemed to have been served upon her.

8. That concludes this case.

Confirmed
Date 14 March 2017 Dr Helen McCormack, Chair