PUBLIC RECORD

Dates: 06/04/2021 – 19/04/2021
12/08/2021 – 13/08/2021
31/08/2021 - 03/09/2021

Medical Practitioner's name:	Dr Daniel VEERAVALLI
GMC reference number:	5188929
Primary medical qualification:	MB BS 1982 Andhra

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Conditions, 12 months
Review hearing directed

Tribunal:

Legally Qualified Chair	Mr Julian Weinberg
Lay Tribunal Member:	Mr Keith Moore
Medical Tribunal Member:	Dr Laura Florence

Tribunal Clerk:	Mr John Poole 06/04/2021 - 19/04/2021 Ms Lauren Duffy 12/08/2021 - 13/08/2021 Ms Hollie Middleton 31/08/2021 - 03/09/2021

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Jonathan Holl-Allen, QC, instructed by DAC Beachcroft LLP
GMC Representative:	Ms Kathryn Johnson, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 31/08/2021

Background

1. Dr Veeravalli qualified in 1982 from the University of Andhra, India. He later completed a diploma and postgraduate doctorate in Obstetrics and Gynaecology in 1987 and 1988. He went on to work as an Assistant Professor of Obstetrics and Gynaecology in India from 1991 to 1999, during which time he also undertook private practice at Consultant level. Dr Veeravalli came to the UK in 1999 where he continued his training in Obstetrics and Gynaecology, obtaining his Certificate of Completion of Training in May 2009. He was made a Fellow of the Royal College of Obstetricians and Gynaecologists in 2013. At the time of the events which are the subject of this hearing, Dr Veeravalli was working as a Consultant in Obstetrics and Gynaecology at Tameside and Glossop Integrated Care NHS Foundation Trust ('the Trust'). He has worked at the Trust in this capacity since December 2010 and continues to be employed in this role.

2. The Allegation that has led to Dr Veeravalli's hearing relates to the clinical care he provided to Patient A whilst she was in labour with Patient B on 8 March 2017. Unfortunately, Patient B died during a difficult breech delivery. It was recorded at an inquest, which concluded in July 2018, that the cause of death was osteo-diastasis of the occipital bone on a background of hypoxia.

3. It is the GMC's case that Dr Veeravalli was the Consultant with overall responsibility of Patient A's care and that there were a number of failings on his part in relation to the care afforded to her following his decision that she be given the drug, syntocinon, a drug used to augment labour.

4. By way of background, Patient A was admitted to the Tameside General Hospital ('the Hospital') at approximately 06:50 on 8 March 2017 having started labour and experiencing strong and regular contractions. After counselling, she agreed to proceed with a vaginal

breech delivery. Progress in the second stage of labour was slow and syntocinon was commenced at 09:11. Progress remained slow before Patient B's left leg delivered spontaneously at 09:43. The remainder of the delivery was slow and complex until Patient B was delivered at 10:28. Patient B showed no signs of life and resuscitation was started at 10:29. Despite the efforts of the paediatric team, Patient B was pronounced dead 30 minutes later.

5. The GMC alleged a number of failings on the part of Dr Veeravalli in relation to the care provided to Patient A on 8 March 2017. It is alleged that at all material times he was the Consultant with overall responsibility for Patient A's labour and the safe delivery of Patient B. Further, that between the hours of 07:50 and 09:11, Dr Veeravalli recommended the commencement of syntocinon, without a direct clinical review of Patient A, and he failed to obtain her consent for its commencement. It is alleged that he did not record the reasons to justify his recommendation for the commencement of syntocinon nor did he formally prescribe it in the drug chart. In the alternative to the allegation that he failed to obtain consent for the commencement of syntocinon, it is alleged that, at or around 09:15, when he went to review Patient A, he failed to obtain consent for the continuation of syntocinon.

6. It is also alleged that at or around 09:15 when Dr Veeravalli went to review Patient A , he did not recognise high risk features, adequately interpret her cardiographic trace ('CTG') and follow NICE guidelines. It is further alleged that he failed to communicate his overall impression of the CTG to the delivery team, take appropriate action, stop the use of syntocinon and offer Patient A a caesarean section. Moreover, it is alleged that Dr Veeravalli failed to obtain consent for Patient A's management plan and vaginal examinations, and failed to maintain adequate records. In the alternative to the allegation that he failed to obtain consent for the commencement or continuation of syntocinon, it is alleged that he failed to record discussions that took place with Patient A regarding consent.

7. The matters came to the attention of the GMC following Dr Veeravalli's self-referral on 2 September 2018.

The Outcome of Applications Made during the Facts Stage

8. The Tribunal granted an application made by Ms Kathryn Johnson, Counsel, on behalf of the GMC, on 16 April 2021, for the Allegation to be amended pursuant to Rule 17(6) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). These amendments involved minor changes to the formatting of a number of sub-paragraphs of the Allegation and various wording to ensure clarity of the Allegation. The application was not opposed by Dr Veeravalli's representative, Mr Jon Holl-Allen, QC, and the Tribunal was satisfied that the amendments could be made without injustice to either party.

9. The Tribunal identified that there appeared to be a typographical error in paragraph 3aii2 of the Allegation in that the word 'simulation' should read 'stimulation'. Both Ms Johnson and Mr Holl-Allen agreed that it would be appropriate to amend the allegation to reflect the case against Dr Veeravalli. The Tribunal considered that no injustice or unfairness

would be caused by allowing the amendment to be made and therefore made the amendment pursuant to Rule 17(6) of the Rules.

The Allegation and the Doctor's Response

10. The Allegation (as amended) made against Dr Veeravalli is as follows:

1. At all material times you were the Consultant with overall responsibility for Patient A's labour of Patient B. To be determined

2. On 8 March 2017 between the hours of 07:50 and 09:11 you:

   a. recommended the commencement of syntocinon without direct clinical review of Patient A; To be determined

   b. failed to:

      i. obtain consent for the commencement of syntocinon, in that you did not:

         1. discuss your recommendation for the administration of syntocinon with Patient A;
            To be determined

         2. explain the:

            a. benefits of syntocinon; To be determined

            b. risks of syntocinon; To be determined

         3. take into account Patient A's views of syntocinon; To be determined

         4. obtain verbal consent from Patient A for the commencement of syntocinon;
            To be determined

      ii. maintain adequate records, in that you did not:

         1. record the reasons to justify your recommendation of the commencement of syntocinon as set out at paragraph 2. a.;
            To be determined

         2. formally prescribe syntocinon in the drug chart.
            To be determined

3. On 8 March 2017 at or around 09:15 you reviewed Patient A and you failed to:

a. in the alternative to paragraph 2. b. obtain consent for the continuation of syntocinon, in that you did not:

i. engage in a discussion with Patient A regarding the continuation of syntocinon; To be determined

ii. explain the:

1. benefits of syntocinon, including achieving adequate contractions with a view to aim for vaginal delivery of Patient B in breech presentation; To be determined

2. risks of syntocinon, including hyper stimulation of the uterus which could lead to fetal compromise; To be determined. Amended under Rule 17(6)

iii. ~~3.~~ take into account Patient A's views of syntocinon; To be determined
Amended under Rule 17(6)

iv. ~~4.~~ obtain verbal consent from Patient A for the continuation of syntocinon; To be determined
Amended under Rule 17(6)

b. recognise high risk features, including:

i. full cervical dilation since 07:25 with active pushing since 08:12; To be determined

ii. breech presentation; To be determined

iii. persistent fetal tachycardia for approximately one hour; To be determined

c. adequately interpret Patient A's cardiotocographic trace ('CTG'), in that you did not:

i. assess all features of the CTG; To be determined

ii. ~~regard~~ take into account the whole clinical picture and progress of labour, including the factors set out at paragraph 3. b.; To be determined

Amended under Rule 17(6)

d. follow NICE guidelines, in that you did not undertake a systematic assessment of Patients A and B; To be determined

e. communicate your overall impression of the CTG to the delivery team; To be determined

f. take appropriate action, including:

i. discussing the interpretation of the CTG findings with:

1. Patient A; To be determined

2. the midwifery team; To be determined

ii. undertaking a systematic assessment of Patient A by:

1. assessing:

a. the maternal early warning score; To be determined

b. maternal hydration; To be determined

~~c. excluding possible causes of tachycardia including sepsis; To be determined~~

2. excluding possible causes of tachycardia including sepsis; To be determined
Amended under Rule 17(6)

~~2~~ 3. investigating persistent fetal tachycardia by:

a. checking maternal observations; To be determined

b. recommending hydration; To be determined

~~3~~ 4. formulating a safe management plan in discussion with Patient A and her partner; To be determined

g. stop the use of syntocinon and offering a caesarean section, in light of:

i. a suspicious CTG; To be determined

ii. in-coordinate uterine contractions and slow descent; To be determined

iii. the factors as set out at paragraph 3. b.; To be determined

h. obtain consent for:

i. Patient A's management plan~~, and ensuring shared decision-making,~~ in that you did not discuss with Patient A the: Amended under Rule 17(6)

1. suspicious CTG; To be determined

2. factors as set out at paragraph:

a. 3. a. i; To be determined
b. 3. a. ii. 1. and 2.; To be determined

c. 3. b.; To be determined

ii. vaginal examinations; To be determined

i. maintain adequate records, in that you did not sign the CTG or ensure it was signed on your behalf. To be determined

4. In the alternative, you failed to record discussions that took place with Patient A with regards to consent as set out at paragraph:

a. 2. b.; To be determined

b. 3. a. To be determined

The Facts to be Determined

11. Dr Veeravalli made no admissions to the Allegation. Therefore, the Tribunal is required to determine the entirety of the Allegation.

12. The Tribunal received evidence on behalf of the GMC from the following witnesses by video link:

- Patient A.

- Dr C, Specialty Trainee in Gynae-oncology. At the time of the events Dr C was a Year 5 Specialty Trainee doctor in Obstetrics and Gynaecology at the Hospital and had been on the night shift on 7 March 2017 which ended at 09:00 on 8 March 2017.

- Dr D, Consultant in Obstetrics and Gynaecology at the Hospital since 2002. At the time of the events, in addition to his clinical role, he was also the rota master whereby he would devise weekly rotas for the Obstetrics and Gynaecology department.

- Dr E, Year 4 Specialty Trainee doctor in Obstetrics and Gynaecology.
At the time of the events, she was an ST1 trainee in Obstetrics and Gynaecology at the Hospital.

- Dr F, ST4 Trainee in Obstetrics and Gynaecology. At the time of the events, she was an ST1 Trainee in Obstetrics and Gynaecology at the Hospital.

- Miss G, Band 6 midwife on the labour ward at the Hospital since 2011.

- Ms H, Band 6 midwife since 2017. She has worked at the Hospital since 2002.

- Dr I, Consultant in Obstetrics and Gynaecology. At the time of the incident, Dr I, although qualified as a Consultant, was for various reasons, undertaking ad-hoc locum shifts at the Hospital at a middle grade Registrar level.

13. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Dr J, ST3 GP trainee. At the time of the incident, he was an ST1 GP trainee doing a rotation in Obstetrics and Gynaecology at the Hospital.

- Dr K, FY2 doctor. At the time of the incident she was a fourth-year medical student on placement in Obstetrics and Gynaecology at the Hospital.

14. Dr Veeravalli provided his own witness statement, dated 5 February 2021, and gave oral evidence at the hearing.

Expert Witness Evidence

15. The Tribunal received evidence from two expert witnesses:

- Mr L, Consultant Obstetrician and Gynaecologist, instructed by the GMC. He provided an expert report dated 21 August 2019.

- Mr M, Consultant Obstetrician and Gynaecologist, instructed on behalf of Dr Veeravalli. He provided an expert report dated 28 January 2021.

16. In addition, Mr L and Mr M provided a joint expert report dated 22 February 2021 in which they outlined areas of agreement and disagreement. Both experts also gave oral evidence at the hearing.

Documentary Evidence

17. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:

- Witness statements from Patient A, Dr E, Miss G, Dr I, Ms H and Dr C, provided to the Coroner as part of the Inquest and transcripts of the evidence they gave.
- Record of Inquest, post-mortem and pathology reports.
- An email exchange between Dr D and Dr Veeravalli on 7 March 2017 regarding cover for the Consultant role and a subsequent email from Dr D containing the staff rota, in which Dr Veeravalli was marked down for the Consultant role.
- The Trust Incident Investigation Report, July 2016.
- Trust Guidelines 'Breech presentation and ECV (External Cephalic Version): management of Breech Presentation', July 2015.
- Royal College of Obstetricians and Gynaecologist Guidance (2006 and 2017 versions)
- Trust Guidelines for the use of oxytocin in labour, July 2016.
- Dr Veeravalli's Rule 4 response dated 8 May 2019.
- Dr Veeravalli's Rule 7 Response Letter, dated 11 November 2019.

The Legal Advice and the Tribunal's Approach

18. In reaching its decision on the facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Veeravalli does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

19. The legally qualified chair (LQC) referred the Tribunal to the case of *H (Minors) [1996] AC 563* and *Re B (Children) [2008] UKHL 35,* advising that, the more serious the allegation, the less probable it is to have occurred and, hence, the more cogent the evidence should be before the Tribunal can conclude that the allegation is proved on the balance of probabilities.

20. The LQC advised that the Tribunal should assess the evidence in its entirety. In terms of the extent to which it should consider the question of a witness's demeanour or credibility, he referred the Tribunal to the case of *Suddock v NMC [2015] EWHC 3612* which states that:

"Whilst demeanour is not an irrelevant factor for a court or tribunal to take into account, the way in which the witness's evidence fits with any non-contentious evidence or agreed facts, and with contemporaneous documents, and the inherent probabilities and improbabilities of his or her account of events, as well as consistencies and inconsistencies (both internally, and with the evidence of others) are likely to be far more reliable indicators of where the truth lies. The decision-maker should therefore test the evidence against those yardsticks so far as is possible, before adding demeanour into the equation."

21. The LQC noted that various paragraphs and sub-paragraphs of the Allegation refer to alleged failures on the part of Dr Veeravalli. He advised that in considering allegations of failure, the Tribunal must decide in the first instance whether, and on what basis, Dr Veeravalli was under a duty to do the things he was accused of failing to do. If the Tribunal determined that Dr Veeravalli was under a duty to do these things, it must then go on to decide whether he failed to discharge that duty in each instance.

The Tribunal's Analysis of the Evidence and Findings

22. The Tribunal considered each paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

Paragraph 1 of the Allegation

1. At all material times you were the Consultant with overall responsibility for Patient A's labour of Patient B. **Determined and found proved**

23. In order for Dr Veeravalli to have been the Consultant with overall responsibility for Patient A's labour of Patient B at all material times, he would have to have been the Consultant at the time of the commencement of syntocinon at 09:11. It is accepted that he was the on-call Consultant until 08:00 and that Dr I covered from 08:00 – 09:00. What is in dispute, and what the Tribunal must determine therefore, is at what point after 09:00, Dr Veeravalli became the Consultant again.

24. Dr Veeravalli had started a shift as on-call Consultant at 18:00 on Tuesday 7 March 2017 and this was due to finish at 08:00 on Wednesday 8 March 2017. The Tribunal heard that due to staffing issues at the time, on-call Consultant cover for Wednesday mornings was allocated by the rota master, Dr D on an ad-hoc basis. Email correspondence dated 7 March 2017 shows that Dr D contacted the Consultant obstetricians at the Hospital to ask for help in covering the labour ward for the day shift on 8 March 2021. The Tribunal noted that Dr Veeravalli responded: '*As agreed I am covering the CDU* [central delivery unit] *and will be on call for O & G* [Obstetrics and Gynaecology] *from 0800 hours to 1300 hours on 8th March 2017.'* In his evidence, Dr Veeravalli stated that this email was to confirm a conversation he had with Dr D and to ensure everyone knew that it was proposed that he would be the Consultant from 08:00 on 8 March 2017.

25. The Tribunal noted that following this, Dr D sent out an amended rota at 20:05 on 7 March 2017. Dr Veeravalli was marked on the rota on 8 March 2017 for the role of 'CON CDS' – Consultant on the central delivery suite.

26. In Dr D evidence he explained that there was some uncertainty with planning the shifts as there was a possibility that on 8 March 2017, the Obstetrics and Gynaecology Department would be short of one Consultant and possibly also one Registrar. He stated that he arrived at the hospital at around 07:30 to sort out the allocation of roles for that day. He stated that shortly after he arrived at the Hospital, he bumped into Dr C who told him about Patient A. In response, he stated that:

> *' I asked Dr C to let Dr Veeravalli know, as he was still the on-call night shift Consultant. I told Dr C that Dr I would most probably be covering as Consultant until 9am and I would provide a further update after that, once staffing levels were clearer. I informed her that Dr I was due to pop into my office soon so I could chat to him about cover today and would update her.'*

27. Dr D explained that Dr I's role would depend on whether other staff members arrived at work by 9am. He stated that he had a discussion with Dr I at around 7:50am:

> *'He [Dr I] stated that he was happy to cover both as Registrar and as Consultant depending on availability at 9am. There was an hour between the labour ward night shift Consultant leaving and Dr Veeravalli starting at 9am as agreed as Consultant (and on the daytime rota). Dr I said that he would cover as Consultant until 9am as he was on the premises and Dr Veeravalli was at home…'*

28. Dr D explained that, at around 09:00, the staffing levels had become clear and so he went to the labour ward doctors' handover to ensure that it was clear which doctor was undertaking which role. He stated:

> *'I told Dr Veeravalli that he was the designated Consultant that day and told Dr I that he was the designated Registrar and checked they were both happy with this arrangement. Of course, this would be the appropriate allocation of roles as Dr Veeravalli had agreed the night before to cover as Consultant and was the substantive senior Consultant at our Hospital and Dr I was the locum. I can't remember my exact wording, but I was very clear and both Dr I and Dr Veeravalli agreed and were happy to do their respective roles. …Dr Veeravalli was our established obstetric Consultant. It would therefore have been inappropriate for a locum Consultant to take be (sic) the substantive Consultant and Dr Veeravalli to be the middle grade.'*

29. Dr D's evidence was that he was at the handover for around five minutes. He stated that after ensuring both Dr Veeravalli and Dr I were clear about their respective roles and that there were no other rota gaps, he left, at around 09:10, as he had an outpatients' clinic starting around 09:15.

30. In Dr I's witness statement, he stated that at around 08:45 Dr D told him to step back down to Registrar as Dr Veeravalli had become available. He stated:

> *'Dr D told me that since Dr Veeravalli was senior to me and a substantive Consultant, and there was no other doctor available to cover the Registrar role, the sensible arrangement was for me to assume the role of the Registrar and Dr Veeravalli the Consultant.*
>
> *This conversation took place at the handover area. Dr D told me that he'd already told Dr Veeravalli that he would be Consultant. I think that this was announced in front of the rest of the team. I can't remember if Dr Veeravalli was present when Dr D told me this, but Dr Veeravalli knew that I was Registrar and he was Consultant. Dr Veeravalli then took over as Consultant and I saw no doubt from Dr Veeravalli as to whether he was Consultant.'*

31. The Tribunal also noted that in Dr C's witness statement, she stated she remembered:

> *'Dr D saying something along the lines that Dr I will be providing Registrar cover for the day shift, as Dr Veeravalli had emailed Dr D to say that he wanted to cover the Consultant shift as a locum Consultant. This was a conversation that Dr D and I had in the corridor. This conversation took place before departmental hand-over which was led by Dr Veeravalli…*
>
> *The first time that I saw Dr Veeravalli on 8 March 2017 was at the 9:00am handover, when my shift ended. Dr Veeravalli led the handover, which, again, suggested that he was the Consultant responsible for the shift…'*

32. The Tribunal also noted that Dr F stated that Dr Veeravalli was the Consultant leading the handover and that Dr I was present as Registrar:

> *'I was on a day shift (approximately 8:30am to 5pm) and Dr Veeravalli was the Consultant on call. In the morning, there was a handover from the night shift doctors to the oncoming day shift. Dr Veeravalli led the handover and Dr C provided details about the patient in question to Dr Veeravalli and the rest of the doctors who were incoming day staff. I remember Dr C confirming that the patient had arrived at the hospital in labour and that the baby was breech. Dr C confirmed that the patient had been counselled regarding the options of a breech vaginal delivery or a caesarean section. Dr I ('Dr I) was also present as Registrar'*

33. The Tribunal was satisfied that the overall impression of the other members of staff involved in the handover, was that Dr Veeravalli had become the Consultant at 09:00. Dr Veeravalli stated in his evidence that he was not told until the end of the handover that he would be the Consultant. He stated that he had spoken to Dr I about Patient A's case at 08:15, and that Dr I told him that he (Dr I) was the on-call Consultant for the day. In his witness statement, Dr Veeravalli stated:

'At the end of the handover at 09:15 hours, as we were all about to disperse, it was realised that the middle grade doctor (Registrar) who was supposed to cover the central delivery suite had still not arrived. I was asked therefore by Dr D whether I would be prepared to help Dr I from 09:15 hours until 13:00 hours. I agreed and so I assumed the role of on call Consultant from 0915 hours to 1300 hours and Dr I agreed to take up the role of on call Registrar/middle grade from 0915 hours, as clarified by the rota master.'

34. The Tribunal noted Dr Veeravalli's evidence is inconsistent with that of Dr D who suggests that it was made clear to Dr Veeravalli towards the start of the handover, that he would be the on-call Consultant. Moreover, Dr D stated he had left the handover at around 09:15 due to having his own patient clinic, and so it is unlikely that he would have stayed until the end of the handover. Indeed, Dr D said the staffing levels had become clear by 09:00. The Tribunal also considered it to be logical for Dr Veeravalli to assume the Consultant role and Dr I the Registrar role at the start of the handover. Furthermore, Dr Veeravalli was expecting to be the Consultant having agreed to it the night before.

35. The Tribunal concluded that it was more likely than not that Dr Veeravalli became the Consultant towards start of handover and therefore before 09:11. The Tribunal considered that it was logical that Dr D would have resolved the rota issues towards the beginning of the handover, as soon as staffing levels had become clear. Indeed, he had come in early to anticipate and sort out rota issues. Moreover, he had his own clinic to prepare for 09:15. The fact that Dr D has no recollection of discussions about Patient A at the handover also lends support to the fact he left the handover towards its start. The Tribunal also noted that other staff members at the handover were under the impression that Dr Veeravalli, and not Dr I, was the Consultant for that shift.

36. The Tribunal was satisfied on the balance of probabilities, that Dr Veeravalli assumed the role of Consultant towards the start of the handover and before 09:11. He was, therefore, the Consultant at all material times with overall responsibility for the care of Patient A's labour of Patient B.

37. Accordingly, the Tribunal found paragraph 1 proved.

Paragraph 2a of the Allegation

2. On 8 March 2017 between the hours of 07:50 and 09:11 you:

   a. recommended the commencement of syntocinon without direct clinical review of Patient A; **Found proved**

38. The Tribunal read this paragraph of the Allegation to be that Dr Veeravalli recommended the commencement of synotcinon and had done so without having made a direct clinical review of Patient A; rather than that his recommendation was to start the

syntocinon and to do so without directly clinically reviewing Patient A.

39. The Tribunal had regard to the evidence received in relation to the recommendation to start syntconion.

40. Dr C was unequivocal that the recommendation to commence syntocinon did not come from her. In her evidence, she stated that at some time before 09:00, she had a conversation with Ms H who advised that Patient A's contractions had slowed down. She stated that Ms H asked her about augmenting the contractions with syntocinon. She stated that she advised Ms H that she would not use syntocinon to augment a fully dilated vaginal breech delivery and said that Ms H accepted this and went back to her managerial duties.

41. Dr C stated that at the 09:00 handover she spoke to Dr Veeravalli about Patient A, and informed him that she was the patient they had discussed on the phone earlier and who wanted to try for a vaginal breech birth. Dr C stated:

> *'… Dr Veeravalli requested that the patient by given Syntocinon (Oxytocin)… I said words to the effect of ''are you sure about that?'' (i.e because of everything that I had just discussed at the handover) and he replied ''yes''….*
>
> *…After the handover, I left my shift. At around 09:08am I saw Ms H in the treatment room, and I stated that Dr Veeravalli wanted the Syntocinon (Oxytocin) to be commenced as per his decision at departmental handover. I told Ms H this, in light of our previous conversation where I advised that I would not recommend the use of Syntocinon (Oxytocin) in the augmentation of vaginal breech deliveries. Ms H stated that she was already preparing the Syntocinon (Oxytocin) as per Dr Veeravalli's request…*
>
> *…to my knowledge, Dr Veeravalli was not on the labour ward until the 09:00am handover and had not physically reviewed the patient prior to the handover. As far as I'm aware, Dr Veeravalli's decision to prescribe Syntocinon (Oxytocin) was made before physically seeing the patient…''*

42. The Tribunal noted that Dr C's evidence is supported by that of Dr E. In her statement, Dr E stated that the decision to commence syntocinon was made by Dr Veeravalli:

> *'…I do recall that Dr Veervalli requested that a syntocinon infusion be commenced, and Ms H left to prepare the infusion.*
>
> *... I can't recall there being any concern expressed about the commencement of syntocinon, I just recall it being discussed generally.*
>
> *Although it is difficult to recall now, at the time I wrote the coroner's statement, I remember being very sure that Dr Veeravalli requested the syntocinon infusion and I remember Ms H leaving to prepare the infusion…'*

43. Dr I was also adamant that he did not recommend the commencement of syntocinon. In his witness statement he stated that:

> *''…At around 8:45am, Ms H asked me words to the effect of ''what do you think about giving syntocinon to this patient?''. I said that I would not, as the baby was breech… I was not asked to prescribe syntocinon at any point and did not do so either verbally or by way of written prescription. I have been trained not to use syntocinon on breech babies, therefore would not do so…*
>
> *…Shortly after Dr Veeravalli took over the role of Consultant, he was asked by Midwife Ms H the same question, whether the patient should be given syntocinon to enhance her contractions. From my recollection, Dr Veeravalli said words to the effect of ''yes''. This conversation took place in the handover area, around 9am…''*

44. In Ms H's evidence she stated that she went to speak to Dr Veeravalli regarding Patient A. She stated that she thought the handover had finished at this point and she told Dr Veeravalli that Patient A's contractions had reduced in strength and that Patient A was fully dilated. She stated:

> *''Dr Veeravalli said words to the effect of "lets start oxytocin". I responded with words to the effect of "do you really want to give syntocinon on a breech where she's only had premature twins at 27 weeks?". He said words to the effect of "yes…that's the only way we're going to get contractions".*
>
> *…*
> *Dr Veeravalli gave the instruction to commence syntocinon without physically seeing or examining the patient. I will never forgive myself for not telling Dr Veeravalli to come in and see/examine the patient. He should have done a vaginal examination then decided for himself. This is what would usually be done for a breech delivery. It is not every day you have a vaginal breech delivery and they are more risky than regular births.*
>
> *I also heard Dr C also challenge Dr Veeravalli with words to the effect of "really, are you sure you want to start syntocinon?". This was said in front of me. I think again, this was after the formal handover had finished and it was an informal discussion about this particular patient.*
>
> *After challenging Dr Veeravalli and him maintaining his instruction, I went to prepare the bag of syntocinon and brought it into the delivery room. I commenced the oxytocin drip at 9:11am…''*

45. The Tribunal then considered Dr Veeravalli's evidence. He stated that during the handover there was a discussion about Patient A, and senior midwife Ms H:

''came to the handover with a bag of infusion in her hands and asked whether she could give a "trickle" of syntocinon to get the baby delivered. A discussion ensued between the team members about whether syntocinon could be given. The only options the team felt they had in view of the patient's expressed desire to achieve a vaginal delivery were either to await events, or to give oxytocin [syntocinon] to see whether it would make the labour progress resulting in vaginal delivery. I participated in the discussion and gave my opinion. Which was that I felt that oxytocin could be given in those circumstances with caution and under Consultant supervision. It was my understanding that that was consistent with Trust guidelines at the time...'

46. The Tribunal also had regard to Dr Veeravalli's email to the GMC on 2 September 2018. This was a response to the GMC's request during the provisional inquiry stage, prior to the commencement of the GMC investigation. Dr Veeravalli stated that on 8 March 2017:

'At around 0900 hours during the handover at the delivery suite, there was an informal discussion, and the information presented was that Patient A would still like to have a vaginal delivery, the contractions slowed down or almost stopped and the Labour ward Coordinator wants to start syntocinon. During the discussion, I informed that as per the trust guidelines syntocinon could be used in Breech presentation after an assessment and discussion with the patient regarding the other options available by a Consultant, the other options being, allowing to deliver spontaneously or doing a Caesarean section. Following further discussion with the team, it was decided, to augment the labour with syntocinon. At the time of discussion, I am not on call but attended the hand over to know if any patients were admitted under me, as I was on call the previous night from 1800 hours on 7th March to 0800 hours on 8th March 2017.'

47. In Dr Veeravalli's witness statement, in response to this specific paragraph of the Allegation, he stated that did not accept he recommended the commencement of syntocinon but merely gave his view as the senior Consultant. This view was that syntocinon could be administered under close supervision and with caution. Indeed, the Tribunal noted the agreed expert opinion regarding two common principles in the use of syntocinon:

' 1. Syntocinon is not universally recommended but that it can be used in specific circumstances with the agreement of a Consultant Obstetrician and the consent of the mother.
2. Syntocinon augmentation is widely performed, the literature showing a range of use from 10.7 to 74% of breech labours.'

48. The experts also agreed that:

'The Unit's guideline of July 2015 stated 'Syntocinon augmentation-may be used with caution but only after discussion with the on-call Consultant'.'

49. The Tribunal considered the consistent evidence of Dr C, Dr I, Dr E and Ms H suggests that Dr Veeravalli did request the commencement of syntocinon. It considered that it was unlikely that Dr C or Dr I made the recommendation. The Tribunal noted that Dr Veeravalli accepted that he advised that syntocinon could be given in the circumstances and under Consultant supervision as per his understanding of the Trust's guidelines. The Tribunal considered this to amount to a recommendation which perhaps was made in the context of answering a question raised by Ms H at the handover (the evidence suggests she had previously asked both Dr C and Dr I for their opinions regarding syntocinon).

50. While the Tribunal considered that Dr Veeravalli assented to and effectively recommended that syntocinon could be used, it concluded that it was likely his recommendation was effectively a decision in principle, not a decision that it should be commenced without reviewing Patient A or obtaining proper consent. It accepted that he would have reviewed the patient as was his practice.

51. Nevertheless, the Tribunal determined that, as a matter of fact, he did recommend the commencement of syntocinon, and he did so at a time when there had not been a direct clinical review of Patient A.

52. Accordingly, the Tribunal found paragraph 2a proved.

Paragraph 2b of the Allegation

2. On 8 March 2017 between the hours of 07:50 and 09:11 you:

b. failed to:

i. obtain consent for the commencement of syntocinon, in that you did not:

1. discuss your recommendation for the administration of syntocinon with Patient A; **Not proved**

2. explain the:

a. benefits of syntocinon; **Not proved**

b. risks of syntocinon; **Not proved**

3. take into account Patient A's views of syntocinon; **Not proved**

4. obtain verbal consent from Patient A for the commencement of syntocinon; **Not proved**

ii. maintain adequate records, in that you did not:

1. record the reasons to justify your recommendation of the commencement of syntocinon as set out at paragraph 2.a.; Not proved

2. formally prescribe syntocinon in the drug chart. Not proved

53. The Tribunal first considered paragraph 2bi of the Allegation, that is whether Dr Veeravalli had a duty to obtain consent for the commencement of syntocinon. It was satisfied that for proper consent to be obtained, it would be necessary for there to be a discussion with Patient A about the recommendation of syntocinon and an explanation of its benefits and risks. It would also require Patient A's views being considered and her giving verbal consent for the commencement of syntocinon.

54. The Tribunal noted that Mr L considered that it was necessary for Dr Veeravalli to obtain Patient A's consent to the use of syntocinon given that Dr Veeravalli was the most experienced and senior obstetrician.

55. Mr M however, stated that it was not necessary for Dr Veeravalli to obtain consent personally as this was not stated in the Unit's own guideline which permits that consent could be taken by anyone with the relevant knowledge and experience.

56. Dr Veeravalli accepted that he did not obtain consent but disputed that this was a culpable failure on his part as he had not recommended the commencement of syntocinon and considered that Dr I had assumed responsibility for Patient A. However, the Tribunal has already determined that Dr Veeravalli did make the recommendation to commence its administration, albeit only in principle.

57. The Tribunal considered that as the recommendation to commence syntocinon came from Dr Veeravalli, and that he was the most experienced and senior obstetrician dealing with Patient A, there was an obligation on him to obtain consent from Patient A, or to at least ensure that another suitably qualified clinician obtained the consent. However, the Tribunal accepted that this obligation could only exist in circumstances where Dr Veeravalli had the opportunity to consent Patient A (or ensure that somebody with the relevant knowledge and experience) had the opportunity, prior to the syntocinon being commenced.

58. The Tribunal considered that Dr Veeravalli's recommendation to commence syntocinon was not a recommendation that it be commenced without direct clinical review of Patient A and without her providing verbal consent to it. Seemingly, however, his recommendation was taken to be an instruction and syntocinon was commenced prior to Patient A being review and her consent obtained.

59. The Tribunal noted that in Ms H's evidence she stated:

'Dr Veeravalli gave the instruction to commence syntocinon without physically seeing or examining the patient. I will never forgive myself for not telling Dr Veeravalli to come in and see/examine the patient…

I also heard Dr C also challenge Dr Veeravalli with words to the effect of ''really, are you sure you want to start syntocinon?''…

After challenging Dr Veeravalli and him maintaining his instruction, I went to prepare the bag of syntocinon and brought it into the delivery room. I commenced the oxytocin drip at 9:11am…'

60. In Dr Veeravalli's statement, he stated:

'It was my expectation that having decided to administer syntocinon, those directly caring for patient A would have discussed that with her and commenced the infusion. I have to say when I saw Patient A with Dr I at 09:15 I was surprised to see the infusion had already been started and assumed therefore there must have been a discussion with patient A about this prior to the handover meeting. I accept of course that prior to commencing the infusion this should have been discussed fully with patient A and that discussion documented.'

61. The Tribunal accepted that Dr Veeravalli was surprised to see the syntocinon had already been started when he went to see Patient A. The Tribunal had no reason to consider that Dr Veeravalli would not have sought consent before commencing syntocinon. It concluded that the syntocinon was, for whatever reason, mistakenly commenced by Ms H.

62. In the circumstances, the Tribunal considered that there was not a failure on Dr Veeravalli's part to obtain consent for the commencement of syntocinon on the basis that there was no opportunity for him to do so because of the premature administering of syntocinon.

63. Accordingly, the Tribunal found paragraph 2bi not proved.

64. The Tribunal then considered paragraph 2bii of the Allegation which alleges that Dr Veeravalli failed to maintain adequate records in that he did not record the reasons to justify his recommendation of the commencement of syntocinon, and he did not formally prescribe it in the drug chart.

65. The Tribunal noted the expert evidence that Dr Veeravalli could have made the entries retrospectively and that, in any event, it could have been done by any member of the team. It therefore did not consider there was an obligation on his part, between the hours of 07:50 and 09:11 on 8 March 2017 as prescribed by the wording of the Allegation, to record the reasons to justify his recommendation of syntocinon. The Tribunal also considered that there was not an obligation on him to formally prescribe syntocinon in the drug chart at that time, and it would have been reasonable to expect this to be done by Dr I.

66. Accordingly, the Tribunal found paragraph 2bii not proved.

67. In summary, the Tribunal found the entirety of paragraph 2b of the Allegation, not proved.

Paragraph 3a of the Allegation

3. On 8 March 2017 at or around 09:15 you reviewed Patient A and you failed to:

a. in the alternative to paragraph 2. b. obtain consent for the continuation of syntocinon, in that you did not:

i. engage in a discussion with Patient A regarding the continuation of syntocinon; **Determined and found proved**

ii. explain the:

1. benefits of syntocinon, including achieving adequate contractions with a view to aim for vaginal delivery of Patient B in breech presentation; **Determined and found proved**

2. risks of syntocinon, including hyper stimulation of the uterus which could lead to fetal compromise; **Determined and found proved. Amended under Rule 17(6)**

ii. ~~3.~~ take into account Patient A's views of syntocinon; **Determined and found proved**
Amended under Rule 17(6)

iii. ~~4.~~ obtain verbal consent from Patient A for the continuation of syntocinon; **Determined and found proved**
Amended under Rule 17(6)

68. Having determined that Dr Veeravalli did not fail to obtain consent for the commencement of syntocinon between 07:50 and 09:11, the Tribunal considered the alternative allegation, which is whether Dr Veeravalli failed to obtain consent for the continuation of syntocinon when he reviewed Patient A at or around 09:15 on 8 March 2017.

69. The Tribunal accepted that to obtain consent for the continuation of syntocinon, this would have entailed a discussion with Patient A regarding the continuation of syntocinon, an

explanation of the benefits and risks of syntocinon to her, and the taking into account of her views of syntocinon and the obtaining of her verbal consent for its continuation.

70. Mr L was of the opinion that, if at 09:15, it was decided that it was appropriate to continue the infusion of syntocinon, Dr Veeravalli should have discussed this decision with Patient A and obtained her consent. In contrast, Mr M considered that there would be no need to discuss the continuation of syntocinon if it was appropriate for it to have been commenced in the first place, and so there would be no need to discuss the benefits and risks at 09:15, as these should already have been discussed prior to its commencement.

71. The Tribunal noted that when Dr Veeravalli went to see Patient A, he had been *'slightly surprised to see that oxytocin was already up and running'*. The Tribunal considered that it was not a reasonable assumption on his part that the syntocinon must have been prescribed by Dr I prior to the handover meeting. This seems illogical given Dr Veeravalli's recollection of the discussion at the handover meeting which was in relation to whether syntocinon could be given, suggesting that a decision had not yet been made. The Tribunal did not consider it likely that Dr Veeravalli did not realise that Patient A had not been counselled prior to the commencement of syntocinon. Indeed, the mere fact that Dr Veeravalli was surprised to see the syntocinon had commenced, should have prompted him to consider the matter more carefully and realise that Dr I could not possibly have spoken to Patient A and obtained her consent. Accordingly, the Tribunal considered that at this point in time, there was a duty on Dr Veeravalli to engage in a discussion with Patient A regarding syntocinon and for him to obtain Patient A's verbal consent for its continuation. Unlike with the commencement of the syntocinon, Dr Veeravalli had an opportunity on this occasion, to engage with discussion with Patient A and obtain her consent but he did not do so.

72. Accordingly, the Tribunal found paragraph 3a proved in its entirety.

<u>Paragraph 3b of the Allegation</u>

b. recognise high risk features, including:

i. full cervical dilation since 07:25 with active pushing since 08:12; **Not proved**

ii. breech presentation; **Not proved**

iii. persistent fetal tachycardia for approximately one hour; **Not proved**

73. The Tribunal considered whether Dr Veeravalli reviewed Patient A and failed to recognise the high risk features outlined above.

74. The GMC contended that Dr Veeravalli did not recognise these high risk features based on his subsequent actions. However, the Tribunal considered it unlikely that Dr Veeravalli would not have been aware that Patient A had full cervical dilation since 07:25 with active

pushing since 08:12, and that she was a breech presentation. Dr C had previously relayed relevant clinical information regarding Patient A to him by phone and at the handover, and the fact she was the first patient to be seen by him after the handover, suggests she was a priority.

75. In Dr Veeravalli's evidence, he stated that he was aware of these matters but he did not accept that the CTG tracing at 09:15 could be described as showing a tachycardia which had been persistent for an hour. The Tribunal noted that, while it is accepted that at 09:15 there was fetal tachycardia, the experts did not agree as to whether it had been persistent for one hour. Having regard to the expert evidence of Mr M that there is no definition of a 'persistent fetal tachycardia', the Tribunal could not be satisfied on the balance of probabilities that there was a persistent fetal tachycardia for approximately one hour and so it did not conclude that there was a failure on Dr Veeravalli's part to recognise this.

76. Accordingly, the Tribunal found paragraphs 3bi-iii not proved.

Paragraph 3c of the Allegation

3. On 8 March 2017 at or around 09:15 you reviewed Patient A and you failed to:

c. adequately interpret Patient A's cardiotocographic trace ('CTG'), in that you did not:

i. assess all features of the CTG; **Determined and found proved**

ii. ~~regard~~ take into account the whole clinical picture and progress of labour, including the factors set out at paragraph 3. b.; **Determined and found proved**

Amended under Rule 17(6)

77. The Tribunal considered whether Dr Veeravalli failed to adequately interpret Patient A's CTG by not assessing all the features of the CTG and taking into account the whole clinical picture and progress of labour including the high risk features set out at paragraph 3b.

78. The Tribunal noted that the experts identified the core features of a CTG which form part of a systematic review are the fetal heart rate, beat-to-beat variability, decelerations and acceleration. Having had regard to Dr Veeravalli's entry in Patient A's medical records in relation to his attendance at 09:15, the Tribunal noted that he identified just three of these features but mis-recorded the base rate. On this basis, the Tribunal was not satisfied he assessed all the features of the CTG.

79. Accordingly, the Tribunal found paragraph 3ci proved.

80. The Tribunal then considered paragraph 3cii. Given its determination in relation to paragraph 3b of the Allegation, it did not find this matter proved on the basis of those features set out at paragraph 3b of the Allegation. However, this paragraph of the Allegation refers to taking into account the whole clinical picture and the Tribunal has noted that Dr Veeravalli's notes record that at 09:15, the CTG shows a baseline of 160, there being no concerns identified. However, the Tribunal had regard to the expert evidence in this case which showed that the baseline at 09:15 was 170 and not 160 and hence was suspicious. By failing to identify this error, the Tribunal found that Dr Veeravalli failed to take into account the whole clinical picture and, as such, the Tribunal found the factual Allegation proved albeit not in relation to the factors set out at paragraph 3b.

81. Accordingly, the Tribunal found paragraph 3cii proved.

Paragraph 3d of the Allegation

3. On 8 March 2017 at or around 09:15 you reviewed Patient A and you failed to:

d. follow NICE guidelines, in that you did not undertake a systematic assessment of Patients A and B; **Not proved**

82. The Tribunal took into account the contents of the joint experts' report which made reference to an extract from the NICE guidelines. Those guidelines included a requirement *to 'make a documented systematic assessment of the condition of the woman and unborn baby (including cardiotocography [CTG] findings) every hour, or more frequently if there are concerns'* in addition to a number of other requirements. The Tribunal noted that the NICE guidelines do not particularise what constitutes a *'systematic assessment'*. The GMC has not specifically identified those areas of a systematic assessment which it alleged that Dr Veeravalli failed to carry out. In the circumstances, the GMC has not discharged the burden of proof and therefore, the Tribunal found this paragraph of the Allegation not proved.

Paragraph 3e of the Allegation

3. On 8 March 2017 at or around 09:15 you reviewed Patient A and you failed to:

e. communicate your overall impression of the CTG to the delivery team; **Not proved**

83. The Tribunal considered whether Dr Veeravalli failed to communicate his overall impression of the CTG to the delivery team. In so doing, it had regard to the evidence of the midwives.

84. The Tribunal had regard to Miss G's statement to the Coroner:

'Dr I and Dr Veeravalli came to review Patient A at 09:15hrs. Fetal tachycardia was seen on the CTG but this was uncomplicated with all other features remaining reassuring. The doctors advised they would return to review in 15 minutes…'

85. The Tribunal also noted the transcript of Miss G evidence at the Inquest, including the following exchange with the Coroner as record in the transcripts:

'Q. What discussions did they have with you about and what was happening?
A. There wasn't much discussion with myself other than they were just asking, you know, how I felt the CTG was or how I felt was coping, but in terms of management and plans, there wasn't any real discussion with myself.'

86. In Ms H's witness statement, she stated:

'At around 9:15am, Dr Veeravalli and Dr I came back from the handover into the room where the patient was. At this point, the oxytocin had already been commenced. Dr Veeravalli did not do an internal examination, which he should have done. I think he probably asked about the cardiotocograph (CTG). I think that I pointed out that Miss G and I had just classified the CTG as suspicious as the baseline rate of the foetus was up to 180bpm, but the variability was okay. I don't think that Dr Veeravalli gave any comments on the CTG or I would have written these down. I cannot recall how long Dr Veeravalli stayed in the room for. I do not recall any exchange between Dr Veeravalli and the patient, I don't even think that he said hello to the patient.'

87. Dr Veeravalli denied this allegation and stated that Dr I was present with him when they reviewed the CTG trace as were the members of the midwifery team.

88. The Tribunal determined that Dr Veeravalli did, on the balance of probabilities, communicate his overall impression of the CTG to the delivery team. The Tribunal was satisfied that there was a discussion about the CTG and plan put in place to review Patient A in 15 minutes.

89. Accordingly, the Tribunal found paragraph 3e of the Allegation not proved.

<u>Paragraph 3f of the Allegation</u>

3. On 8 March 2017 at or around 09:15 you reviewed Patient A and you failed to:

f. take appropriate action, including:

i. discussing the interpretation of the CTG findings with:

1. Patient A; **Not proved**

2. the midwifery team; **Not proved**

ii. undertaking a systematic assessment of Patient A by:

1. assessing:

a. the maternal early warning score; **Not proved**

b. maternal hydration; **Not proved**

~~c. excluding possible causes of tachycardia including sepsis; **To be determined**~~

2. excluding possible causes of tachycardia including sepsis; **Not proved**
Amended under Rule 17(6)

~~3~~ 3. investigating persistent fetal tachycardia by:

a. checking maternal observations; **Not proved**

b. recommending hydration; **Not proved**

~~3~~ 4. formulating a safe management plan in discussion with Patient A and her partner; **Determined and found proved**

90. The Tribunal considered whether Dr Veeravalli failed to take appropriate action including discussing the interpretation of the CTG findings with Patient A and the midwifery team, and undertaking a systematic assessment of Patient A.

91. The Tribunal considered whether Dr Veeravalli was under a duty to discuss his interpretation of the CTG findings with Patient A. It noted that according to Patient A, there was no discussion about the CTG with her. In her evidence she stated that:

> *'At no point during my labour did anyone discuss using syntocinon with me. I didn't even know what syntocinon was at that time. I can't remember who administered it, possibly Ms H or Miss G. I wasn't told why I was being given syntocinon; Miss G or Ms H just put it into my hand. I don't recall exactly when this was as I didn't know what it was at the time, I thought I was being given an antibiotic'*

92. The Tribunal had regard to the joint expert evidence on this point:

'Was it necessary at 0915 for Dr Veeravalli (a) to communicate his overall impression of the CTG to the delivery team and/or (b) to discussion his interpretation of the CTG findings with (i) Patient A and/or (ii) the delivery team?
We agree: To some degree this is a matter of factual evidence. There were sufficient members of 'the team' present at 0915 during the CTG discussions and planning by Dr Veeravalli and Dr I, thus suggesting some degree of communication between the members of the team. The case records suggest that some discussion of the CTG involved at least Dr I and Patient A. This seems appropriate.'

93. The Tribunal was not satisfied that there was an obligation on Dr Veeravalli at this point to discuss the interpretation of the CTG findings with Patient A.

94. The Tribunal therefore found paragraph 3fi1 not proved.

95. The Tribunal then considered if Dr Veeravalli failed to discuss the interpretation of the CTG findings with the midwifery team. The Tribunal considered this allegation to be a duplication of the paragraph 3e of the Allegation.

96. The Tribunal therefore found paragraph 3fi2 of Allegation not proved, for the reasons given in relation to paragraph 3e.

97. The Tribunal then considered paragraph 3fii of the Allegation, that is whether Dr Veeravalli failed to undertake a systematic assessment of Patient A.

98. Mr M was of the opinion, and the Tribunal accepted, that there was no obligation on Dr Veeravalli to assess the maternal early warning score and both experts agreed that:

'Should the MEOWS have been indicated, the responsibility to obtain the clinical information lies with the midwifery (or nursing) staff and the interpretation lies with the medical staff.'

99. The Tribunal was not satisfied that there was an obligation on Dr Veeravalli to assess the maternal early warning score. It therefore found paragraph 3fii1a not proved.

100. The Tribunal then considered if Dr Veeravalli failed to assess the maternal hydration. The Tribunal accepted that there was no evidence of dehydration at that point, nor is there any evidence that there was not a fluid balance chart for which the midwifery team would have been responsible. The Tribunal was not satisfied that Dr Veeravalli failed to take appropriate action as alleged. It therefore found paragraph 3fii1b not proved.

101. The Tribunal then considered paragraph 3fii2 of the Allegation, that is whether Dr Veeravalli failed to exclude possible causes of tachycardia including sepsis.

102. The Tribunal had regard to the expert evidence:

'Should sepsis have been excluded as a possible cause of the fetal tachycardia at 0915 and if so by whom and by what means?

We agree: Yes, but rather more because of the maternal tachycardia that [sic] *the fetal. It was important to consider sepsis as a differential diagnosis investigate the cause of rising baseline fetal heart and maternal tachycardia. The RCOG Green Top Guideline 64 a (2012) states that clinical signs suggestive of sepsis include one or more of the following: pyrexia, hypothermia, tachycardia, tachypnoea, hypoxia, hypotension, oliguria, impaired consciousness, and failure to respond to treatment. One should take the maternal temperature in the first instance. The midwife should do this automatically, but the doctor should request it had she not checked.*
If afebrile then no further investigation for infection would be needed at that point unless the liquor was green or offensive (which it was not) or other if features as above were present (which they were not).'

103. The Tribunal accepted Mr M's evidence that Dr Veeravalli only had to enquire about Patient A's temperature in order to exclude sepsis. Moreover, such observation should have been made and recorded by the midwifery team. Given that Patient A did not go on to develop sepsis and that there was going to be a further review in 15 minutes, the Tribunal found paragraph 3fii2 of the Allegation not proved.

104. The Tribunal then considered paragraph 3fii3 of the Allegation, that is whether Dr Veeravalli failed to investigate persistent fetal tachycardia which would have involved, a - checking maternal observations and, b- recommending hydration.

105. The Tribunal had regard to the expert evidence on this point:

'There was a need to take the maternal pulse rate and temperature.
These observations should have been made and recorded by midwifery staff and reviewed by the medical team led by the Consultant.'

106. Given that it is accepted that Dr Veeravalli looked at the CTG on which the maternal pulse rate is shown and the readings led him to take no further action other than to review in another 15 minutes, the Tribunal was satisfied he did check the maternal observations. It therefore found paragraph 3fii3a not proved.

107. The Tribunal then considered whether Dr Veeravalli had a duty to recommend hydration.

108. The Tribunal had regard to the expert evidence on this point:

'Was it necessary at 0915 to recommend hydration of Patient A?
We agree: Patient A already had a clear fluid intravenous infusion (but we do not know the rate of infusion). There was no need to recommend further hydration unless

there was either a concern about dry mouth or urine output (as recorded on the fluid input-output chart).'

109. The Tribunal was satisfied that there no need to recommend further hydration at this point. It therefore found paragraph 3fii3b not proved.

110. The Tribunal then considered paragraph 3fii4 of the Allegation, that is whether Dr Veeravalli failed to formulate a safe management plan in discussion with Patient A and her partner.

111. The Tribunal had regard to the expert evidence:

'Was there a failure at 0915 to formulate a safe management plan?
'Mr M: No. The plan was a reasonable one, in keeping with responsible clinical opinion and evidence-based medicine. Tragically, there will never be a zero perinatal mortality associated with vaginal breech delivery but rather a balance of risks and opinions between selective vaginal breech delivery and universal Caesarean section for breech presentation.
Mr L: Yes, it is my opinion that the overall standard of care provided by Dr Veeravalli at 0915 and communication with patient […] and her partner was seriously below that reasonably expected of a Consultant in obstetrics and gynaecology due to lack of systematic and thorough clinical assessment. This opinion is based upon issues related to Dr Veeravalli's failure to consider emerging risk factors outlined above and formulating a safe management plan in discussion with Patient […] and obtaining her informed consent for the final choice.'

112. The Tribunal noted that both experts described the baseline at 09:15 as being 170 and suspicious. Given it was suspicious, the Tribunal considered that there was a duty on Dr Veeravalli to talk with Patient A but he did not do so.

113. Accordingly, the Tribunal found paragraph 3fii4 of the Allegation proved.

Paragraph 3g of the Allegation

3. On 8 March 2017 at or around 09:15 you reviewed Patient A and you failed to:

g. stop the use of syntocinon and offering a caesarean section, in light of:

i. a suspicious CTG; **Not proved**

ii. in-coordinate uterine contractions and slow descent; **Not proved**

iii. the factors as set out at paragraph 3. b.; **Not proved**

114. The Tribunal considered whether Dr Veeravalli failed to stop the use of syntocinon and should have offered a caesarean section in light of a suspicious CTG, in-coordinate uterine contractions and slow descent, and the high risk factors set out in paragraph 3b.

115. The Tribunal noted that syntocinon could have been used in the circumstances. It considered whether there was a duty on Dr Veeravalli to stop the syntocinon at around 09:15, taking into account that it had only been commenced at 09:11. The Tribunal was persuaded by Mr M's evidence that as the original reason to start the syntocinon was not inappropriate, it would not be unreasonable to let the infusion run and review the position in 15 minutes. The Tribunal therefore concluded that the facts alleged did not amount to a failure on Dr Veeravalli's part.

116. Accordingly, the Tribunal found paragraph 3g of the Allegation not proved.

Paragraph 3h of the Allegation

3. On 8 March 2017 at or around 09:15 you reviewed Patient A and you failed to:

h. obtain consent for:

i. Patient A's management plan~~, and ensuring shared decision- making,~~ in that you did not discuss with Patient A the: **Amended under Rule 17(6)**

1. suspicious CTG; **Determined and found proved**

2. factors as set out at paragraph:

a. 3. a. i; **Determined and found proved**
b. 3. a. ii. 1. and 2.; **Determined and found proved**
c. 3. b.; **Determined and found proved in relation to 3bi and 3bii but not proved in relation to 3biii**

ii. vaginal examinations; **Not proved**

117. The Tribunal considered paragraph 3hi1-2 of the Allegation, that is whether Dr Veeravalli failed to obtain consent for Patient A's management plan in that he did not discuss with Patient A the suspicious CTG and other factors.

118. It was accepted by Mr M that consent was required at 09:15 for the management plan which related to the continuation of the syntocinon together with a further review 15 minutes later. Such consent, the Tribunal concluded, should be based on the patient's

understanding of all relevant facts. The Tribunal accepted the evidence of Patient A that at or around 09:15, the suspicious CTG was not discussed with her. In those circumstances, the Tribunal concluded that informed consent for the management plan had not been given. As a matter of fact, the Tribunal therefore found paragraph 3hi1 of the Allegation proved.

119. In relation to paragraph 3hi2a, the Tribunal has already determined that Dr Veeravalli was required to but failed to obtain consent for Patient A's management plan. It has also found the facts of paragraph 3ai of the Allegation proved. It therefore found paragraph 3hi2a of the Allegation proved.

120. In relation to paragraph 3hi2b, the Tribunal has already determined that Dr Veeravalli was required to but failed to obtain consent for Patient A's management plan. It has also found the facts of paragraph 3aii 1&2 of the Allegation proved. It therefore found paragraph 3hi2b of the Allegation proved.

121. In relation to paragraph 3hi2c, the Tribunal has already determined that at or around 9:15 Dr Veeravalli failed to obtain consent for Patient A's management plan. The Tribunal has also found in relation to paragraph 3bi and 3bii that Dr Veeravalli recognised these high risk features. However, the Tribunal accepted the evidence of Patient A regarding the lack of Dr Veeravalli communication with her and therefore the Tribunal accepted that these high risk factors were not discussed with her either within the context of her management plan, or at all. In the circumstances, the Tribunal found paragraph 3hi2b proved in relation to paragraph 3bi and 3bii of the Allegation.

122. In relation to the facts set out at paragraph 3biii, the Tribunal has determined that there is insufficient evidence to establish a persistent fetal tachycardia for approximately one hour. In those circumstances, Dr Veeravalli would not have been under an obligation to discuss a persistent fetal tachycardia with Patient A. In the circumstances, the Tribunal found the facts of this sub paragraph of the Allegation not proved in relation to the high risk feature particularised at paragraph 3biii of the Allegation.

123. The Tribunal then considered paragraph 3hii of the Allegation, namely whether Dr Veeravalli failed to obtain consent for Patient A's management plan in that he did not discuss vaginal examinations with her. The Tribunal noted that there is no evidence that Dr Veeravalli did perform a vaginal examination at 09:15. It therefore considered that there was no duty on him to obtain consent where a vaginal examination did not take place.

124. Accordingly, it found paragraph 3hii not proved.

<u>Paragraph 3i of the Allegation</u>

3. On 8 March 2017 at or around 09:15 you reviewed Patient A and you failed to:

i. maintain adequate records, in that you did not sign the CTG or ensure it was

signed on your behalf. **Not proved**

125. The Tribunal considered whether Dr Veeravalli failed to maintain adequate records in that he did not sign the CTG or ensure it was signed on his behalf.

126. The Tribunal noted that while Mr L stated Dr Veeravalli should have signed the CTG, Mr M stated that it was not necessary. The Tribunal considered that it was necessary that one of the team did it, however, it was not satisfised on the balance of probabilities that this obligation was on Dr Veeravalli.

127. Accordingly, the Tribunal found paragraph 3i of the Allegation, not proved.

Paragraph 4 of the Allegation

4. In the alternative, you failed to record discussions that took place with Patient A with regards to consent as set out at paragraph:

   a. **2. b.; Not proved**

   b. **3. a. Not proved**

128. Having found paragraph 2b not proved, it follows that Dr Veeravalli could not have failed to record discussions with Patient A with regards to consent to commence syntocinon, as these discussions did not take place.

129. Accordingly, the Tribunal found paragraph 4a not proved.

130. Similarly, the Tribunal found that Dr Veeravalli did not have the discussion with regard to consent as outlined at pagraph 3a. The Tribunal considered that he could not be under an obligation to record a discussion he did not have.

131. Accordingly, the Tribunal found paragraph 4b not proved.

The Tribunal's Overall Determination on the Facts

132. The Tribunal has determined the facts as follows:

1. At all material times you were the Consultant with overall responsibility for Patient A's labour of Patient B. **Determined and found proved**

2. On 8 March 2017 between the hours of 07:50 and 09:11 you:

   a. recommended the commencement of syntocinon without direct clinical review of Patient A; **Determined and found proved**

b. failed to:

i. obtain consent for the commencement of syntocinon, in that you did not:

1. discuss your recommendation for the administration of syntocinon with Patient A; **Not proved**

2. explain the:

a. benefits of syntocinon; **Not proved**

b. risks of syntocinon; **Not proved**

3. take into account Patient A's views of syntocinon; **Not proved**

4. obtain verbal consent from Patient A for the commencement of syntocinon; **Not proved**

ii. maintain adequate records, in that you did not:

1. record the reasons to justify your recommendation of the commencement of syntocinon as set out at paragraph 2. a.; **Not proved**

2. formally prescribe syntocinon in the drug chart. **Not proved**

3. On 8 March 2017 at or around 09:15 you reviewed Patient A and you failed to:

a. in the alternative to paragraph 2. b. obtain consent for the continuation of syntocinon, in that you did not:

i. engage in a discussion with Patient A regarding the continuation of syntocinon; **Determined and found proved**

ii. explain the:

1. benefits of syntocinon, including achieving adequate contractions with a view to aim for vaginal delivery of Patient B in breech presentation; **Determined and found proved**

2. risks of syntocinon, including hyper stimulation of the uterus which could lead to fetal compromise; **Determined and found proved. Amended under Rule 17(6)**

iii. ~~3.~~ take into account Patient A's views of syntocinon; **Determined and found proved**
Amended under Rule 17(6)

iv. ~~4.~~ obtain verbal consent from Patient A for the continuation of syntocinon; **Determined and found proved Amended under Rule 17(6)**

b. recognise high risk features, including:

i. full cervical dilation since 07:25 with active pushing since 08:12; **Not proved**

ii. breech presentation; **Not proved**

iii. persistent fetal tachycardia for approximately one hour; **Not proved**

c. adequately interpret Patient A's cardiotocographic trace ('CTG'), in that you did not:

i. assess all features of the CTG; **Determined and found proved**

ii. ~~regard~~ take into account the whole clinical picture and progress of labour, including the factors set out at paragraph 3. b.; **Determined and found proved**

Amended under Rule 17(6)

d. follow NICE guidelines, in that you did not undertake a systematic assessment of Patients A and B; **Not proved**

e. communicate your overall impression of the CTG to the delivery team; **Not proved**

f. take appropriate action, including:

i. discussing the interpretation of the CTG findings with:

1. Patient A; **Not proved**

2. the midwifery team; **Not proved**

ii. undertaking a systematic assessment of Patient A by:

1. assessing:

   a. the maternal early warning score; Not proved

   b. maternal hydration; Not proved

   ~~c. excluding possible causes of tachycardia including sepsis; To be determined~~

2. excluding possible causes of tachycardia including sepsis; Not proved
   Amended under Rule 17(6)

~~4~~ 3. investigating persistent fetal tachycardia by:

   a. checking maternal observations; Not proved

   b. recommending hydration; Not proved

~~3~~ 4. formulating a safe management plan in discussion with Patient A and her partner; Determined and found proved

g. stop the use of syntocinon and offering a caesarean section, in light of:

   i. a suspicious CTG; Not proved

   ii. in-coordinate uterine contractions and slow descent; Not proved

   iii. the factors as set out at paragraph 3. b.; Not proved

h. obtain consent for:

   i. Patient A's management plan~~, and ensuring shared decision-making,~~ in that you did not discuss with Patient A the: Amended under Rule 17(6)

      1. suspicious CTG; Determined and found proved

      2. factors as set out at paragraph:

         a. 3. a. i; Determined and found proved
         b. 3. a. ii. 1. and 2.; Determined and found proved

c. 3. b.; Determined and found proved in relation to 3bi and 3bii but not proved in relation to 3biii

ii. vaginal examinations; Not proved

i. maintain adequate records, in that you did not sign the CTG or ensure it was signed on your behalf. Not proved

4. In the alternative, you failed to record discussions that took place with Patient A with regards to consent as set out at paragraph:

a. 2. b.; Not proved

b. 3. a. Not proved

Determination on Impairment - 02/09/2021

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Veeravalli's fitness to practise is impaired by reason of misconduct.

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received the following further evidence.

3. The Tribunal received evidence from Dr Veeravalli's colleague, Dr O, Locum Consultant in Obstetrics & Gynaecology at Tameside and Glossop Integrated Care NHS Foundation Trust.

4. The Tribunal also received in support of Dr Veeravalli, five testimonials from colleagues, all of which it has read.

5. The Tribunal also received a further bundle of documentary evidence provided by Dr Veeravalli which included a statement of his reflections and actions letter with enclosures, dated 7 February 2019 and Dr Veeravalli's reflections and remediation undertaken since 20 January 2019 to date, dated 5 February 2021.

Submissions

6. On behalf of the GMC, Ms Johnson submitted that Dr Veeravalli's actions constituted misconduct and that his fitness to practise is impaired. She reminded the Tribunal of the facts found proved in that Dr Veeravalli had not provided a good standard of care to Patient A and

had failed to appreciate that his recommendation of the use of syntocinon would be acted on by Ms H. She also drew the Tribunal's attention to the evidence of Mr L in that Dr Veeravalli's failings were seriously below the standard expected of him. She submitted that the Tribunal's findings in this case amounted to serious misconduct.

7. In relation to impairment, Ms Johnson submitted that Dr Veeravalli has not demonstrated full insight as he has not taken full responsibility for his actions and has sought to shift the blame on to others. She accepted that Dr Veeravalli has provided evidence of having attended courses to demonstrate his attempts at remediation and has expressed remorse for what happened. However, she invited the Tribunal to consider that he has failed to accept responsibility for the decision to commence Patient A on syntocinon. She submitted that Dr Veeravalli's remediation has not been directed to the specific findings of the Tribunal and that his denial of those matters demonstrate that he cannot have insight into those failings. She further submitted that given the serious nature of the Tribunal's findings, a finding of impairment was necessary in order to fulfil the overarching objective.

8. On behalf of Dr Veeravalli, Mr Holl-Allen submitted that the Tribunal's findings were not sufficient to justify a finding of impairment in that Dr Veeravalli's actions did not amount to misconduct. He submitted that in the event the Tribunal found that Dr Veeravalli's actions do amount to misconduct, his fitness to practise is no longer impaired by reason of that misconduct. He submitted that in *'ordinary circumstances*', Dr Veeravalli would have personally reviewed and consented Patient A for commencement of syntocinon and the reasons why he did not related to the consultant cover taking place on the 8 March 2017. He submitted that Dr Veeravalli was in a '*slightly unusual role'* in that he reviewed Patient A with Dr I who was a senior and experienced clinician.

9. Mr Holl-Allen reminded the Tribunal that its findings related to the substandard management of a single patient and at a single point in time of the management of that patient. He invited the Tribunal to consider that it had only found a small proportion of the Allegation proved. He referred to Dr O's evidence in which she testified to Dr Veeravalli's experience and skills, stating that he is *'a generous colleague, always willing to offer advice and support and to help out in difficult circumstances'.* He drew the Tribunal's attention to the courses and other forms of continued professional development that Dr Veeravalli has undertaken including those relating to team working and leadership which he submitted directly address some of the issues in this case. He submitted that Dr Veeravalli has taken a reflective approach to what has been a *'terrible personal tragedy'* for Patient A and a single clinical incident in his career.

The Relevant Legal Principles

10. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof to be applied and the decision of impairment is a matter for the Tribunal's judgement alone.

11. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: firstly whether the facts as found proved were serious and amounted to misconduct and then whether the finding of that misconduct could lead to a finding of impairment.

12. The Tribunal must determine whether Dr Veeravalli's fitness to practise is impaired today, taking into account Dr Veeravalli's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

The Tribunal's Determination on Impairment

Misconduct

13. In determining whether Dr Veeravalli's fitness to practise is currently impaired by reason of misconduct, the Tribunal first considered whether the facts found proved amount to misconduct.

14. The Tribunal reminded itself of the evidence given during the hearing so far and its findings that Dr Veeravalli recommended the commencement of syntocinon, albeit in principle, without direct clinical review of Patient A and his failure to obtain informed consent from Patient A for the continued used of syntocinon. Dr Veeravalli also failed to engage in a discussion with Patient A and explain the risks and benefits of the use of syntocinon. Dr Veeravalli failed to adequately interpret Patient A's cardiotocographic 'CTG' and formulate a safe management plan in discussion with Patient A and her partner. Furthermore, Dr Veeravalli failed to obtain consent from Patient A for her management plan.

15. The Tribunal had regard to Mr L's report which stated:

> *'the standard of care provided by Dr Veeravalli in regard to obtaining informed verbal consent, documentation of the consent and discussion in the context of shared decision making was seriously below the standard expected of a reasonably competent consultant in obstetrics and gynaecology.'*

16. The Tribunal had regard to the *GMC Consent: patients and doctors making decisions together (2008) ('GMC Consent Guidance')* which was in force at the time of the incident in question which sets out the significance and importance of consent in patient care. It considered the following paragraphs to be relevant:

> *'3 For a relationship between doctor and patient to be effective, it should be a partnership based on openness, trust and good communication. Each person has a role to play in making decisions about treatment or care.*
>
> *5 If patients have capacity to make decisions for themselves, a basic model applies:*

a…

b The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.

c The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one. They also have the right to accept or refuse an option for a reason that may seem irrational to the doctor, or for no reason at all.

d…

7 The exchange of information between doctor and patient is central to good decision-making. How much information you share with patients will vary, depending on their individual circumstances. You should tailor your approach to discussions with patients according to:

a their needs, wishes and priorities

b their level of knowledge about, and understanding of, their condition, prognosis and the treatment options

c the nature of their condition

d the complexity of the treatment, and

e the nature and level of risk associated with the investigation or treatment.'

17. Where there have been serious departures from expected standards of conduct and behaviour, this can constitute misconduct as identified by reference to *Good Medical Practice (2013 Edition) ('GMP')*. The Tribunal considered the following paragraphs to be most relevant:

'15 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…

c…

17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.

31 You must listen to patients, take account of their views, and respond honestly to their questions.

32 You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.*

49 You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:

a their condition, its likely progression and the options for treatment, including associated risks and uncertainties

b the progress of their care, and your role and responsibilities in the team

c…

d…'

18. The Tribunal considered that Dr Veeravalli's failure to question why Patient A was being administered syntocinon was significant as he was the Consultant in charge at the relevant time. It noted that the handover took place at approximately 09:00 and that Dr Veeravalli prioritised Patient A's review, attending with Dr I. The Tribunal did not accept Mr Holl-Allen's submission that the circumstances in which Dr Veeravalli found himself were particularly unusual or out of the ordinary.

19. The Tribunal considered that Dr Veeravalli failed to exchange the appropriate information with Patient A for her to make decisions about her care. It considered that it was not acceptable for Dr Veeravalli to acknowledge that syntocinon had been administered and continue administering it without consulting with Patient A. The Tribunal took the view that obtaining consent was particularly important in the management of Patient A given the options available to her and the risks involved by the use of syntocinon in a breach birth. In failing to adequately interpret Patient A's CTG, Dr Veeravalli did not take into account the full clinical picture in order to obtain informed consent from Patient A and to discuss her management plan with her.

20. The Tribunal was of the view that Dr Veeravalli's actions in failing to obtain consent from Patient A constituted a serious departure from the paragraphs of GMP and the GMC Consent Guidance as identified. It concluded that Dr Veeravalli's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct. It considered that the culmination of Dr Veeravalli's actions regarding the overall management of Patient A amounted to a serious failure. The Tribunal was therefore satisfied that the facts found proved amounted to misconduct.

Impairment

21. The Tribunal having found that the facts found proved amounted to misconduct went on to consider whether, as a result of that misconduct, Dr Veeravalli's fitness to practise is currently impaired.

22. In determining whether Dr Veeravalli's fitness to practise is currently impaired, the Tribunal considered whether there was any evidence of insight and remediation on the part of Dr Veeravalli and whether there was a likelihood of him repeating his misconduct in future.

23. The Tribunal was mindful that a denial of the factual allegations does not preclude a doctor from being able to demonstrate his developed insight. However, the Tribunal has considered whether Dr Veeravalli has demonstrated that he has accepted responsibility for his conduct and whether he had taken steps to ensure that there would be no repetition of it.

24. The Tribunal considered the contents of Dr Veeravalli's written reflections, dated 5 February 2021 in which he stated:

> *'After reflecting on this incident for the last 4 years and doing and taking several remedial actions, I realise that in this tragic incident factors like, the staff shortages, miscommunication, rota changes and confusion among the junior medical and nursing staff and other human factors played a major role.*
>
> *I take the full responsibility as the named consultant on-call from 09.15 hours until after delivery. All my team on that day worked very hard and well, and wanted to do their best to patient A.*
>
> *There was no disagreement among the team members in the management of the patient as clearly brought out by the Trust internal investigation.*
>
> *After doing various modules on the leadership, team work, effective communication, situational awareness and other relevant courses now I can clearly see the misperception amongst the team members and the way different team members had seen and received the information at the time of the discussions during the hand over. This was in-turn due to last minute changes in the Consultant rota twice that day, once at 0800 hours and again at 0915 hours and that these changes were not being communicated to all the team members.*

I think all the staff including myself, became task oriented and got fixated on the idea of giving patient A vaginal delivery, and lost the situational awareness. I also think that the counselling regarding the risk of C section at full dilatation, did not help and go well with the couple as they were under the impression that believed that C Section is more dangerous, than the vaginal delivery as expressed by both the Patient A and her partner in their statements.'

25. The Tribunal also had regard to the positive testimonials from fellow professionals that Dr Veeravalli had provided who spoke positively about his competence and professionalism.

26. With regard to Dr Veeravalli's insight into his actions, the Tribunal took into account that four years have passed since the events that concerned an isolated incident and there was no evidence before it of a repetition of the shortcomings that have brought him before this Tribunal. However, it noted that although Dr Veeravalli had taken overall responsibility as the consultant in charge of the team, it had not been provided with sufficient meaningful evidence that he has accepted any personal responsibility for his actions and the impact that his failings have had on Patient A. It therefore considered that Dr Veeravalli has demonstrated little insight in relation to his personal failings as opposed to his generic responsibility as the Consultant in charge.

27. With regard to Dr Veeravalli's remediation, the Tribunal acknowledged that Dr Veeravalli had provided evidence of completing a *'Decision making and consent: new guidance from the GMC'* webinar on 21 January 2021. However, the Tribunal noted that Dr Veeravalli had not acknowledged the importance of taking consent within his reflections dated 5 February 2021. The Tribunal was mindful that Dr Veeravalli had not repeated his conduct since the events in question and noted that Dr Veeravalli's Responsible Officer, Mr N, who provided a statement that Dr Veeravalli had reflected on the case. It nevertheless concluded that on the basis that Dr Veeravalli had not demonstrated recognition and acceptance of his personal shortcomings but had instead reflected on the failings of the system and of others, it could not be satisfied that it was highly unlikely that his failings would be repeated.

28. The Tribunal therefore determined that the need to protect, promote and maintain the health, safety and well-being of the public; promote and maintain proper professional standards and conduct for members of the medical profession; and to promote and maintain public confidence, would be undermined if a finding of impairment were not made in this case.

29. The Tribunal has therefore determined that Dr Veeravalli's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 03/09/2021

1. Having determined that Dr Veeravalli's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

2. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

Submissions

3. On behalf of the GMC, Ms Johnson submitted that the appropriate sanction in this case was one of suspension. She reminded the Tribunal that it had found serious departures from *Good Medical Practice (2013 Edition) ('GMP')* and expressed concern about Dr Veeravalli's insight in that he had not taken personal responsibility for his failings. However, she drew the Tribunal's attention to the fact that Dr Veeravalli has no history of previous disciplinary proceedings in the context of a long career and that it was clear from the testimonial evidence that he was held in high regard by a number of his colleagues.

4. Ms Johnson told the Tribunal that, with the absence of any exceptional circumstances in the case, it would be entirely inappropriate for the Tribunal to take no action. She submitted that conditions were only appropriate in cases where a doctor has demonstrated insight and she reminded the Tribunal of the misconduct it has found in this case. She stated that Dr Veeravalli's conduct was not fundamentally incompatible with continued registration and that suspension was therefore the appropriate and proportionate outcome in order to mark the seriousness of Dr Veeravalli's failings, protect the public and maintain public confidence in the profession.

5. On behalf of Dr Veeravalli, Mr Holl-Allen submitted the appropriate sanction in this case was one of no action. He reminded the Tribunal that this case relates to Dr Veeravalli's management of a single patient at a single point in time and that this should be viewed in the context of Dr Veeravalli's lengthy and *'unblemished'* career. He stated that Dr Veeravalli takes his professional role seriously and is committed to providing a good standard of care. He submitted that Dr Veeravalli has actively engaged in the training and education of others which he has demonstrated through updating systems for safe provision of care within the Trust.

6. Mr Holl-Allen acknowledged that the Tribunal may consider that the circumstances of this case are not sufficiently exceptional to justify taking no action on Dr Veeravalli's registration and invited the Tribunal to consider conditions in the event that it concluded that some restriction on Dr Veeravalli's registration was required. He submitted that a period of conditions would be sufficient and proportionate in that Dr Veeravalli would be capable of

using the framework of conditions to remedy the deficiencies that the Tribunal has found proved. He acknowledged the distinction that the Tribunal has made in relation to Dr Veeravalli's insight into the broader and generic failings as opposed to Dr Veeravalli's acceptance for his personal failings. He also reminded the Tribunal of its finding that Dr Veeravalli has attempted to remediate his failings. He submitted that conditions could be workable in that they could be formulated to address the consent issues the Tribunal has found within the framework of a Personal Development Plan. He further submitted that if the Tribunal imposed a period of suspension then that may adversely impact on Dr Veeravalli's employment within the Trust.

The Relevant Legal Principles

7. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own independent judgment. In reaching its decision, the Tribunal has taken account of the Sanctions Guidance (November 2020) ('the SG'). It has borne in mind that the purpose of sanctions is not to be punitive, but to protect patients and the wider public interest, although it may have a punitive effect.

8. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Veeravalli's interests with the public interest. The public interest includes, amongst other things, the protection of patients, the promotion of public confidence in the profession, and the declaring and upholding of proper standards of conduct and behaviour.

The Tribunal's Determination on Sanction

9. The Tribunal has already given a detailed determination on facts and impairment and it has taken those matters into account during its deliberations on sanction.

10. The Tribunal considered the aggravating and mitigating factors in this case and carefully balanced them, applying the principle of proportionality and the overarching objective.

Aggravating Factors

11. The Tribunal considered Dr Veeravalli's lack of recognition of his personal responsibility, some four years after the events in question despite having completed an updated course on consent, was a significant aggravating feature in this case.

Mitigating Factors

12. The Tribunal considered that Dr Veeravalli did not deliberately disregard Patient A's care.

13. The Tribunal has already acknowledged that the events in question related to an isolated incident concerning a single patient over a short timeframe. It considered this in the context of an otherwise lengthy and unblemished career.

14. The Tribunal has also taken into account the testimonial evidence which attests to Dr Veeravalli being held in high regard by his colleagues and the breadth of his contribution to the Trust.

15. The Tribunal considered that Dr Veeravalli has taken some steps to address his failings such as completing relevant courses, has developed some insight as to the broader failings during the events in question and had expressed regret for those failings.

No action

16. In coming to its decision as to the appropriate sanction, if any, to impose, the Tribunal first considered whether to conclude the case by taking no action.

17. The Tribunal considered that, although Dr Veeravalli's actions did not reflect a deliberate failure on his part and arose from the particular circumstances at the time in question, those circumstances were not particularly unusual or out of the ordinary. The Tribunal therefore found that there were no exceptional circumstances capable of justifying taking no action against Dr Veeravalli's registration.

18. The Tribunal further determined that, in view of the serious nature of the Tribunal's findings on impairment, it would neither be sufficient, proportionate nor in the public interest to conclude this case by taking no action.

Conditions

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

20. The Tribunal carefully considered the background findings in this case, its previous determinations on the facts and on impairment, and the submissions advanced by the parties. The Tribunal balanced the public interest with Dr Veeravalli's interests.

21. The Tribunal had regard to paragraph 81 of the SG applied which states that conditions '*might be most appropriate'* in cases involving concerns *'where there is evidence of shortcomings in a specific area or areas of the doctor's practice'*.

22. The Tribunal identified the following factors as set out in paragraph 82 of the SG as relevant in Dr Veeravalli's case, indicating that conditions are likely to be workable where:

'*a the doctor has insight*

b a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings

c the tribunal is satisfied the doctor will comply with them

d the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.'

23. The Tribunal has already identified the shortcomings in Dr Veeravalli's management of Patient A. He failed to obtain consent and adequately interpret the CTG. The Tribunal had further concerns with regard to Dr Veeravalli's limited insight into his personal responsibility for his actions. The Tribunal also took into account the testimonials and other evidence before it that Dr Veeravalli is a committed doctor and noted his active role in education and updating Trust guidelines. Further, the Tribunal accepts that Dr Veeravalli has taken some steps to remediate his failings. Taking all of the evidence into consideration, notwithstanding Dr Veeravalli's limited insight into his personal responsibility for his failings, the Tribunal concluded that Dr Veeravalli would respond positively to further remediation and it was satisfied that he would comply with any conditions imposed on his registration.

24. The Tribunal went on to consider the GMC's submission that a period of suspension would be the appropriate and proportionate sanction in this case. It had regard to the mitigating features of this case in that Dr Veeravalli's failings reflected an isolated incident over a short period of time and did not represent a deliberate disregard for Patient A's care. It therefore considered that Dr Veeravalli's actions were not demonstrative of more general concerns in relation to his practice and that they did not reflect wider underlying behavioural concerns. It further acknowledged that Dr Veeravalli has been practising without restriction and without incident for over four years since the events in question. It therefore determined that suspension would be a disproportionate outcome in this case.

25. The Tribunal therefore determined to impose an order of conditions on Dr Veeravalli's registration.

26. The following conditions will be published:

'1 He must personally ensure the GMC is notified of the following information within seven calendar days of the date these conditions become effective:

a the details of his current post, including:

i his job title

ii his job location

iii his responsible officer (or their nominated deputy)

b the contact details of his employer and any contracting body, including his direct line manager

c any organisation where he has practising privileges and/or admitting rights

d any training programmes he is in

2 He must personally ensure the GMC is notified:

a of any post he accepts, before starting it

b that all relevant people have been notified of his conditions, in accordance with condition 5

c if any formal disciplinary proceedings against him are started by his employer and/or contracting body, within seven calendar days of being formally notified of such proceedings

d if any of his posts, practising privileges, or admitting rights have been suspended or terminated by his employer before the agreed date within seven calendar days of being notified of the termination

e if he applies for a post outside the UK.

3 He must allow the GMC to exchange information with any person involved in monitoring his compliance with his conditions.

4 a He must have a workplace reporter appointed by his responsible officer (or their nominated deputy).

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his workplace reporter

ii he has personally ensured that the GMC has been notified of the name and contact details of his workplace reporter.

5 a He must design a Personal Development Plan (PDP), with specific aims to address the deficiencies in the following areas of his practice:

- Communicating with patients

- Obtaining informed consent through the recognition of and taking into account patients' views
- Updating his skills in Cardiotocography 'CTG' interpretation

b His PDP must be approved by his responsible officer (or their nominated deputy).

c He must give the GMC a copy of his approved PDP within three months of these substantive conditions becoming effective.

d He must meet with his responsible officer (or their nominated deputy), as required, to discuss his achievements against the aims of his PDP.

6 a He must have an educational supervisor appointed by his responsible officer (or their nominated deputy)

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his educational supervisor

ii he has personally ensured that the GMC has been notified of the name and contact details of his educational supervisor.

7 He must get the approval of the GMC before working in a non-NHS post or setting.'

8 He must personally ensure the following persons are notified of the conditions listed at 1 to 7:

a his responsible officer (or their nominated deputy)

b the responsible officer of the following organisations:

i his place(s) of work, and any prospective place of work (at the time of application)

ii all of his contracting bodies and any prospective contracting body (prior to entering a contract)

iii any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application)

iv any locum agency or out of hours service he is registered with

v if any of the organisations listed at (i to iv) does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within that organisation. If he is unable to identify that person, he must contact the GMC for advice before working for that organisation.

Duration of Conditions

27. The Tribunal went on to consider the length of the period of conditions. The Tribunal was mindful that it needed to impose an order of conditions for a period of time that was sufficient to meet the overarching objective and would allow Dr Veeravalli time to demonstrate developing insight and further remediation. The Tribunal concluded that a period of 12 months would allow Dr Veeravalli time to demonstrate the appropriate evidence to a future reviewing Tribunal.

28. In considering the length of conditions to impose, the Tribunal bore in mind the aggravating and mitigating factors it had identified. Given that Dr Veeravalli has already developed some insight as to the broader failings and in all the circumstances of the case, the Tribunal could see no value in imposing a period in excess of 12 months.

Review Hearing

29. The Tribunal determined to direct a review of Dr Veeravalli's case. A review hearing will convene shortly before the end of the period of conditional registration, unless an early review is sought. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Veeravalli to demonstrate how he has remediated his failings and developed insight. It therefore may assist the reviewing tribunal if Dr Veeravalli provides:

- A report from his Responsible Officer;
- Evidence of continued professional development;
- Evidence of compliance with conditions including the PDP and evidence of progress towards the objectives; and
- Any other information that he considers will assist a reviewing tribunal.

Determination on Immediate Order - 03/09/2021

1. Having determined to impose a period of conditions on Dr Veeravalli's registration, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Veeravalli's registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Ms Johnson made no application for an immediate order.

3. On behalf of Dr Veeravalli, Mr Holl-Allen submitted that an immediate order is not necessary.

The Tribunal's Determination

4. The Tribunal had regard to the Sanctions Guidance (November 2020) ('the SG', and in particular the following paragraphs:

> *'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.'*

5. The Tribunal determined that none of the factors pointing to the need for an immediate order in paragraphs 172 or 173 of the SG apply. The Tribunal determined that in all the circumstances an immediate order is not required in this case.

6. This means that Dr Veeravalli's registration will be made subject to conditions 28 days from when notice of this decision is deemed to have been served upon him unless he lodges an appeal. If Dr Veeravalli does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

7. There is no interim order to revoke.

8. That concludes this case.

Confirmed
Date 03 September 2021 Mr Julian Weinberg, Chair