PUBLIC RECORD

Dates: 07/09/2026 - 16/09/2026

Doctor:	Dr David ROSEWARNE
GMC reference number:	4607308
Primary medical qualification:	MB ChB 1999 University of Birmingham

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Not Impaired

Summary of outcome
Warning

Tribunal:

Lay Tribunal Member (Chair)	Mr Thomas Scapens
Lay Tribunal Member:	Ms Jo Palmiero
Registrant Tribunal Member:	Dr Carol Roberts

Tribunal Clerk:	Ms Keely Crabtree

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Ben Rich, Counsel, instructed by CMS Law
GMC Representative:	Mr Tom Orpin-Massey, 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.

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection 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 - 10/09/2026

1. This determination was handed down in public.

Background

2. Dr David Rosewarne qualified in 1999 with a Bachelor of Medicine, and Bachelor of Surgery (MB ChB) from the University of Birmingham. He attained Membership of the Royal Colleges of Physicians (MRCP) in 2003 and Fellowship of the Royal College of Radiologists (FRCR) in 2007.

3. Dr Rosewarne has worked as a Consultant Radiologist at New Cross Hospital, Wolverhampton, since 2009. In addition to his role as a Consultant Radiologist, Dr Rosewarne also undertook teaching roles at New Cross Hospital (Clinical Tutor for Radiology trainees 2014 to 2022) and the Royal College of Radiologists (FRCR Part 1 Physics Examiner for 2017 to 2022). These roles involved supervision and assessment of trainee radiologists within routine clinical practice.

4. The allegations that have led to Dr Rosewarne's hearing relate to his misconduct. It is alleged by the General Medical Council (GMC) that, on 1 July 2023, Dr Rosewarne reviewed Patient A's peripheral CT angiogram scan images at the request of a junior radiological trainee and failed to diagnose the presence of an aortic dissection.

5. The initial concerns were raised with the GMC by Ms C, Area Coroner for the Black Country.

Patient A

6. Patient A became unwell on the morning of the 1 July 2023 with right groin and back pain and numbness in his right leg. He had a background of poorly controlled hypertension and was prescribed regular medication.

7. Patient A was taken by ambulance to New Cross Hospital and seen in the Emergency Department (ED) at approximately 12 pm. Based on his presenting symptoms, he was diagnosed with an ischaemic right leg. This required input from the vascular team based at Russells Hall Hospital who requested further tests including a CT scan of the abdominal aorta and legs.

8. The radiology resident on-call, Dr B, identified a right common iliac artery occlusion, and asked Dr Rosewarne to review the scans and advise on any further critical input. Dr Rosewarne confirmed the right common iliac artery occlusion, which required urgent vascular treatment. Patient A was transferred to the specialist vascular hub at Russells Hall Hospital for further treatment. Dr Rosewarne did not identify an aortic dissection upon his review of the scans.

9. After his transfer, Patient A's scan was reviewed by a Vascular Radiologist at Russells Hall Hospital who suspected the aortic dissection. A further scan took place shortly afterwards which confirmed the aortic dissection and the location of the dissection (Type A), and Patient A was transferred back to New Cross Hospital for emergency high risk cardiothoracic surgery and vascular surgery to repair the aortic dissection.

10. Patient A developed multi organ failure and passed away at New Cross Hospital on the 2 July 2023.

The Allegation and the doctor's response:

11. The Allegation made against Dr Rosewarne is as follows:

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

1. On 01 July 2023 you:
2.

a. reviewed Patient A's peripheral CT angiogram scan images at the request of a junior radiological trainee Dr B;
Admitted and found proved

b. failed to diagnose the presence of an aortic dissection.
To be determined

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

The admitted facts

12. At the outset of these proceedings, through his Counsel, Mr Ben Rich, Dr Rosewarne made an admission to paragraph 1 of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced paragraph 1 of the Allegation as admitted and found proved. Dr Rosewarne also admitted the fact of not diagnosing the aortic dissection. However, he denied that he was under a duty to do so. The Tribunal is therefore required to determine whether Dr Rosewarne was under a duty to diagnose the presence of an aortic dissection in regard to paragraph 1(b) of the Allegation and if he was under such a duty whether he failed in that duty.

Witness evidence

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

- Dr B, Radiology resident at New Cross Hospital dated 14 April 2026;
- Dr D, Consultant Radiologist at New Cross Hospital dated 14 April 2026.

14. Dr Rosewarne provided his own witness statement dated 16 July 2026 and also gave oral evidence at the hearing.

Expert witness evidence

15. On behalf of the GMC, the Tribunal received an expert report prepared by Dr E dated 12 March 2025 and two supplemental expert reports dated 2 September 2025 and 10 July 2026. He also gave oral evidence to the Tribunal.

16. Dr E outlined his experience in the reporting of peripheral angiogram CT scans. He stated that he had over 37 years of experience in radiology and more than 20 years of experience as a clinical supervisor of junior and trainee radiologists.

17. Having heard his evidence, the Tribunal was of the view that Dr E was a credible and reliable witness, who gave a clear, balanced, consistent and unwavering view of the expectations of an on-call radiologist.

18. Dr E opined that the standard of care provided by Dr Rosewarne fell seriously below the standard of radiology reporting. He stated that the care which was seriously below the standard expected of a reasonably competent Consultant general radiologist was the failure to diagnose the presence of an aortic dissection. He opined that the reasons why Dr Rosewarne's failure was seriously below the standards expected of radiology reporting were:

> *'i. The dissection is effortlessly visible.*
> *ii. Aortic dissections are common time critical medical emergencies which, without timely treatment, may result in death.*
> *iii. Suspected aortic dissection is a common indication for an emergency CT scan during out of hours. Hence, it is imperative that consultant radiologists who participate in the diagnostic radiology out of hours on call rota, irrespective of whether they are general radiologists, or are from a subspecialty, are able to diagnose this disease.*
> *iv. I aver that a reasonable body of general consultant radiologists, exercising reasonable degree of skill and care, would have diagnosed this aortic dissection.'*

Documentary evidence

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

- GMC referral from Ms C, area Coroner for the black country (undated);

- Record of Inquest dated 5 December 2024;
- Statement from Dr Rosewarne regarding the incident (undated);
- Incident reports dated 3 July 2023 and 5 July 2023;
- A Root Cause Analysis (RCA) report dated 11 January 2024;
- Inquest transcript dated 28 November 2024;
- Medical records of Patient A (various dates);
- Computed tomography (CT) scan images dated 1 July 2023;
- Multi-Source Feedback (MSF) report dated 23 February 2026 to 14 May 2026;
- TLHC Performance Statement dated June 2026;
- Statement given by Dr Rosewarne to the Coroner dated 5 August 2024;
- Statement given by Dr F to the Coroner dated 14 August 2023;
- Statement given by Dr G to the Coroner dated 9 February 2024;
- Statement given by Dr H to the Coroner dated 25 April 2024,
- Statement given by Dr I to the Coroner dated 23 April 2024;
- Statement given by Dr J to the Coroner dated 3 May 2024;
- Statement given by Dr K to the Coroner dated 3 August 2023;
- Statement given by Dr L to the Coroner dated 2 August 2023.

The Tribunal's approach

20. In reaching its decision on the facts, the Tribunal will apply the civil standard of proof. This means that the Tribunal must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged. The burden of proof rests with the GMC and it is for the GMC to prove the case that it is presenting against the doctor. There is no burden on the doctor to prove or disprove anything.

21. The Tribunal will approach fact finding by firstly identifying agreed facts and evidence. To reach a decision on the disputed facts, the Tribunal will assess the evidence in the round. It will consider what conclusions and inferences can be drawn from the documentary evidence. The Tribunal will then consider the available oral evidence and subject that evidence to critical scrutiny against the agreed facts and documentary evidence to consider a witness' reliability and credibility. The Tribunal should not decide reliability and credibility based on the demeanour of a witness alone.

22. The LQC reminded the Tribunal that Dr Rosewrne was not obliged to participate in this hearing, much less to give evidence and, thereby, expose himself to cross-examination. That he has done so was to his credit. Having heard his evidence, the Tribunal will form its

own views on the accuracy and veracity of that evidence, just as it will with the evidence of the other witness, Dr E, expert witness for the GMC who appeared before it.

23. In considering the oral evidence that the Tribunal has heard from the witnesses, the LQC reminded the Tribunal that any attempt to assess a witness's credibility largely, if not exclusively, on that witness's demeanour when giving evidence was described by the High Court, in the case of *Dutta v The General Medical Council* [2020] EWCA 1974 (Admin), as a 'discredited method of judicial decision-making'. In *Dutta,* Mr. Justice Warby referred to earlier caselaw which had distilled (what he described as) '*lessons of experience and of science in relation to the judicial determination of facts'*. Among the lessons to which he referred are:

> *'…*
>
> • *The best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable facts. "This does not mean that oral testimony serves no useful purpose... But its value lies largely... in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth…'*

24. The Legally Qualified Chair (LQC) reminded the Tribunal that the evidence of Dr B and Dr D was agreed. In addition, the content of the GMC bundle was agreed between the parties.

25. The LQC referred the Tribunal to the case of *Re B children* [2008] UKHL 35 ('Re B') Lord Hoffman said,

> *'There is only one rule of law, namely that the occurrence of the fact in issue must be proved to have been more probable than not. Common sense, not law, requires that in deciding this question, regard should be had, to whatever extent appropriate, to inherent probabilities.'*

26. The Tribunal is entitled to draw inferences, that is to say, they are entitled to come to common sense conclusions based on the evidence which they accept, but they must not speculate about what other evidence might have been adduced or what other witnesses might have been called. When drawing inferences, the Tribunal must be able to safely exclude, as less than probable, any other explanation.

27. This is a case in which the Tribunal has received both live evidence and documentary evidence. Through the live evidence the Tribunal has been able to see and hear the evidence tested by cross-examination and, indeed, the Tribunal itself has been able to put its own questions to witnesses.

28. The Tribunal was advised that its approach to fact-finding was governed by the MPTS Guidance (the 'MPTS Guidance') which came into effect on 24 November 2025. The Tribunal was further reminded that its decisions must also satisfy the overarching objective.

29. The Tribunal will also have regard to the written and oral submissions of each party on the issues they wish us to consider in reaching a determination of the facts; this will include reference to any case law or principles contained therein.

30. The Tribunal has heard that Dr Rosewarne is of good character. However, good character, cannot by itself, provide a defence to an allegation but, when deciding whether the GMC has proved the allegations against him on the balance of probabilities, the Tribunal should take it into account in his favour in the following ways: in the first place, Dr Rosewarne gave evidence. As with any person of good character, it supports his credibility. This means that it is a factor which the Tribunal should take into account when deciding whether it believes his evidence. In the second place, the fact that he is of good character may mean that he is less than otherwise likely to commit that which is alleged now.

The Tribunal's analysis of the evidence and findings

Paragraph 1(b) of the Allegation

31. The Tribunal considered the outstanding paragraph of the Allegation and evaluated the evidence to make its findings on the facts.

32. It is the GMC'S case that Dr Rosewarne could (competent) and should (duty) have diagnosed Patient A's aortic dissection.

33. It is the position of Dr Rosewarne that, whilst he did not diagnose the presence of an aortic dissection, he had not been under a duty to undertake a full review of Patient A's CT peripheral angiogram of the lower abdomen and legs. It is the position of Dr Rosewarne that he was acting in a triage capacity only when reviewing Patient A's scans. It is also his position that a reasonable and correct decision had already been made to send Patient A to the vascular department at Russells Hall Hospital.

34. The Tribunal noted the circumstances in which Dr Rosewarne was asked to look at Patient A's peripheral CT angiogram scan images on 1 July 2023. It had regard to Dr B's witness statement dated 14 April 2026 which was agreed by both parties as follows:

> *'I was the radiology registrar on-call on the 1st of July, 2023. In the afternoon at approximately 13:12 hrs, I received a phone call from the emergency department asking for a lower limb computed tomography angiogram as [Patent A] had an acutely painful, cold right leg with absent pulses. The suspected diagnosis was a blocked artery in the right leg, this is evidenced on our system 'Soliton.' There was no mention, by the clinical team, of a suspicion of an aortic dissection. I promptly accepted the request for the scan at 13:14 hrs and informed the radiographer to do the scan as an emergency. We performed the necessary routine protocol needed for a lower limb angiogram in a suspected blocked vessel in the leg. This involves imaging the vessels from just below the diaphragm until the feet of both legs.*
>
> *The scan was then completed at 13:37 hrs and the radiographer notified me that the scan was completed, and also, that [Patient A] was being transferred to Russell Hall hospital for emergency vascular surgery input. Upon immediate review of the images I noticed there was a blocked vessel in the right leg and due to the critical nature of this finding and me being a junior radiology trainee, I immediately escalated the scan to be reviewed by the on-call radiology consultant Dr Rosewarne to confirm this diagnosis and for any further critical input. He reviewed the images and said that there was an occluded vessel in his right leg and this needs to be escalated to the vascular team including the vascular radiologist to have a look, as this was under their specialty. In this conversation, there had been no mention or concern for an aortic dissection. Immediately after, the emergency department called me to inform me that the patient is being transferred to Russell Hall Hospital and I informed them that this was a vascular emergency due to the occluded vessel in the right leg, which required the vascular team input including the vascular radiologist on-call. The clinical team had*

not mentioned any concern for an aortic dissection at this point either. I do not recall the exact time, but I believe all this was done within the hour of the scan being performed (by 15:00hrs).'

35. The Tribunal noted that Dr Rosewarne was the on-call out of hours Consultant Radiologist for the ED at New Cross Hospital on 1 July 2023 and Dr B was a second-year radiology registrar. The Tribunal concluded that Dr Rosewarne was the more senior practitioner within the department that day in that he was the on-call radiologist and that Dr B could and should have contacted him for advice, secondary opinions or further critical input given that she was a second-year radiology registrar. It was noted that upon review of the CT images of Patient A, Dr B had asked Dr Rosewarne to confirm Patient A's '*diagnosis and for any further critical input'*.

36. The Tribunal had regard to the oral evidence of the GMC expert witness Dr E who said that '*because this condition [aortic dissection] is a life-threatening emergency, it is considered by the Royal College of Radiologists to be part of the core capabilities or skills of a person who is designated as a consultant radiologist. So, any person who has that title, consultant radiologist, irrespective of experience, is expected to identify an aortic dissection*'.

37. The Tribunal accepted Dr E's evidence that an out of hours ED radiologist must have sufficient competency across the board to be able to interpret a scan of this nature. The Tribunal also concluded that this had been an emergency situation in regard to Patient A's care.

38. The Tribunal had regard to Dr E's expert report dated 12 March 2025, in which he stated that *'The dissection is effortlessly visible'*. During his oral evidence, Dr E showed the Tribunal Patient A's peripheral angiogram CT scan images, and highlighted the indicators of an aortic dissection.

39. The Tribunal then considered whether or not Dr Rosewarne was competent enough to have diagnosed the presence of an aortic dissection.

40. The Tribunal noted Dr Rosewarne's contradictory evidence in regard to whether or not he could diagnose an aortic dissection. In parts, his evidence was that the diagnosis of an aortic dissection was not within the realm of his expertise. Latterly, he said he was capable of making the diagnostic assessment of an aortic dissection and this had been the subject of a published paper he did with colleagues 11 years or so ago. However, Dr Rosewarne told the

Tribunal that he had only reported a CT angiogram six times during his time as a Consultant Radiologist and this was outside his expertise.

41. The Tribunal noted Dr Rosewarne's evidence that had he been the primary reporter of this imaging, in retrospect he would have been likely to have reported an aortic dissection.

42. The Tribunal also noted that Dr Roswarne had co-authored with Dr D the primary and only report on the peripheral CT angiogram scan images following their discussion. The report is dated 1 July 2023.

43. The Tribunal concluded that Dr Rosewarne had the sufficient skill and competence to view the peripheral CT angiogram scan images as he had viewed such scans before and had reported on them. The Tribunal also concluded that Dr Rosewarne should not have co-authored the report of peripheral CT angiogram scan images of this type if he did not have the requisite amount of skill and training to do so. The Tribunal found this to be evidence of his role being one of a primary reporter and not simply undertaking a triage.

44. It was Dr Rosewarne's evidence that he did not look at Patient A's CT angiogram scan images fully.

45. The Tribunal had regard to Dr E's oral evidence: he told the Tribunal that in the Royal College of Radiologists guidelines, there was a duty for reporting radiologists to *'look at all images that have been acquired and include all four corners, and all four margins of that frame*.' He said that, '*if you do not do this key thing, things can be missed, which in Patient A's case they were*.' Dr E said that a reporting radiologist would look at all the images to find out whether there are any other significant findings.

46. The Tribunal accepted the evidence of Dr E. The Tribunal concluded that Dr Rosewarne should have looked at Patient A's CT angiogram scan images fully especially in such an emergency and time critical situation and had been asked by Dr B for a diagnosis and any further critical input. The Tribunal also concluded that Dr Rosewarne had an overall duty to consider the totality of these scans, over and above what he had been told by Dr B and accepted that duty by agreeing to review the images and provide further critical input.

47. Whilst Dr Rosewarne admitted that he did not look at all the images, he told the Tribunal that he had looked at Patient A's kidneys as this was his normal scope of practise.

48. During his oral evidence, Dr E showed the Tribunal Patient A's kidneys on the scan. He highlighted that the kidneys were asymmetric and showed a lack of perfusion. Dr E said that a general radiologist, which is how Dr Rosewarne described himself, should have picked up that particular abnormality, as the kidneys were not being normally perfused with blood. He said that in itself was a red flag. Dr E said that if the abnormality in the kidneys had been identified, it should have led Dr Rosewarne to consider a possible aortic dissection given that this is the number one cause of this abnormality.

49. Dr E said that in radiology, as per the Royal College's guideline, there was a staged reporting process. He said that you would first note the clinical information provided and then describe the type of study requested. In this case, it was a contrast enhanced CT angiogram of the lower limbs. Then you would move on to describe the findings, starting with the positive findings (the abnormalities). Next, any unexpected significant positive findings were described. Then move on to describe if there were significant negative findings. Dr E said that Dr Rosewarne's attention should have alighted on the appearance of the kidneys which were poorly perfused and '*grossly abnormal*'. He said that the right iliac artery occlusion and the abnormal renal appearances should have triggered Dr Rosewarne's enquiry into whether this may be an aortic dissection, as both can be symptoms of the same.

50. The Tribunal considered the appearance of Patient A's kidneys. The Tribunal acknowledged that in his evidence Dr Rosewarne accepted that scans of the body were within his realm of expertise which included scans of the kidneys.

51. The Tribunal acknowledged that Dr Rosewarne had diagnosed Patient A's right iliac artery occlusion which would explain the lack of blood supply to the leg. However, the Tribunal accepted Dr E's evidence that this artery was located below Patent A's kidneys and would not explain the abnormal appearance of the kidneys.

52. During his oral evidence, Dr Rosewarne conceded that Patient A's kidneys were clearly abnormal on the scan but could not provide an explanation for why he did not notice the abnormality.

53. The Tribunal concluded that the abnormal appearance of Patient A's kidneys should have indicated to Dr Rosewarne that the images required further investigation into whether this could be an aortic dissection.

54. In relation to his involvement with Patient A, it is Dr Rosewarne's position that he was only conducting a triage.

55. It was also the evidence of Dr Rosewarne that it was unusual for him to perform a simple triage and that he had only done so a handful of times in his career. When asked why he says he was triaging Patient A as opposed to undertaking a primary report on his scans, Dr Rosewarne said that he was acutely aware of the urgency of the situation, that undertaking a primary report would have taken him 30-40 minutes which would have delayed Patient A's transportation to Russells Hall Hospital, and that the vascular radiology team was already engaged. In cross-examination, Dr Rosewarne conceded that his undertaking of a primary report would not have delayed Patient A's transport to Russells Hall Hospital, given that the timeline set out in the RCA indicates that Patient A was already in transit.

56. The Tribunal concluded that Dr Rosewarne should have fully reviewed these scans irrespective of whether the scans were in the possession of and to be reviewed later by the vascular hub. The Tribunal accepts the evidence that the prescribed pathway meant that Patient A should have been directed straight to the vascular hub at Russells Hall. However, the Tribunal concluded that Dr Rosewarne assumed a clinical responsibility by accepting the request to review the scans, confirm any diagnosis and provide further critical input if applicable.

57. The Tribunal concludes that it was not appropriate for Dr Rosewarne to undertake a simple triage and that in fact was not what he had been asked to do. The Tribunal concludes that Dr Rosewarne should have undertaken a full and detailed examination of the scans presented to him. This was an emergency situation, a junior registrar had deferred to him for assistance with confirming a diagnosis and seeking further critical input.

58. In his evidence, Dr Rosewarne conceded that the official responsibility for the reporting of the scans rested with New Cross Hospital.

59. When asked by the Tribunal how Dr Rosewarne made it clear to his colleagues that he was simply triaging as opposed to undertaking a primary report, he was unable to satisfactorily explain this position.

60. The Tribunal concluded that Dr Rosewarne had a duty to fully review the scans as he was the on-call consultant.

61. The Tribunal concluded that Dr Rosewarne did not investigate the abnormal appearance of the kidneys or diagnose the aortic dissection when he initially viewed the scans at the request of Dr B. The Tribunal concluded that later in the day on 1 July 2023, Dr Rosewarne had co-authored a final report in regard to Patient A with Dr D. This final report did contain the diagnosis of an aortic dissection. This report was completed after Dr Rosewarne had discussed the case of Patient A and the presence of an aortic dissection was brought to his attention by Dr D.

62. Dr Rosewarne confirmed in his evidence that it was unusual for him to provide a joint report. The Tribunal concluded that Dr Rosewarne did not provide an explanation as to why he co-authored the report if he was simply triaging the scans.

63. The Tribunal acknowledged that Dr Rosewarne did not have primary responsibility for Patient A's clinical management. However, it concluded that Dr Rosewarne did have a responsibility to Patient A in his role as the on-call radiologist of the ED. It also concluded that Dr Rosewarne had a duty to fully examine the CT angiogram scan images.

64. The Tribunal noted the RCA report dated 11 January 2024, as follows:

> *'Identifying the Root cause*
>
> *The diagnosis of acute aortic dissection was not considered in ED.*
>
> *The interpretation of the angiogram at New Cross Hospital and the initial interpretation at Russells Hall Hospital did not recognize the presence of a dissection of the aorta.*
>
> *The possibility of an aortic dissection had not been considered prior to the angiogram being interpreted by a vascular radiologist. Human error.*
>
> *The diagnosis was not made clinically in ED or by the vascular specialists at Russells Hall Hospital before it was detected at 1539 from the angiogram done at 1337.*
>
> *The interpretation of the angiogram at New Cross Hospital and the initial interpretation at Russells Hall Hospital did not recognize the presence of a dissection of the aorta.*

The presence of an acute aortic dissection was not detected by the on-call radiologists at New Cross Hospital or at Russells Hall Hospital before the patient transfer had started.'

65. The Tribunal acknowledged that the aortic dissection was not diagnosed in the ED by anyone else, although the vascular registrar at Russells Hall Hospital did note the renal abnormalities. The Tribunal notes that within the sections entitled 'Root Causes' in the RCA Report dated 11 January 2024, it is stated that the failures to identify the aortic dissection occurred both at New Cross Hospital and Russells Hall Hospital.

66. In his oral evidence, Dr Rosewarne said that in the 24-hour period (at the time of the index events) he was on call and had been involved and had authorised in 66 CT scans. This was a figure that he had obtained from the Radiology Information System (RIS).

67. In all the circumstance, the Tribunal concluded that Dr Rosewarne could and should have diagnosed Patient A's aortic dissection because it was his duty to do so. Accordingly, the Tribunal found paragraph 1(b) of the Allegation determined and found proved.

The Tribunal's overall determination on the facts

68. The Tribunal has determined the facts as follows:

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

1. On 01 July 2023 you:

   a. reviewed Patient A's peripheral CT angiogram scan images at the request of a junior radiological trainee Dr B;
   Admitted and found proved

   b. failed to diagnose the presence of an aortic dissection.
   Determined and found proved

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

Determination on Impairment - 16/09/2026

69. This determination was handed down in public.

70. 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 Rosewarne's fitness to practise is impaired by reason of misconduct.

The evidence

71. The Tribunal has reviewed its findings of fact. The Tribunal received a stage two bundle from Dr Rosewarne which included a witness statement from Dr M, Dr Rosewarne's Responsible officer (RO) dated 20 June 2026 and Dr Rosewarne's Continuous Professional Development (CPD) portfolio. Within the stage two bundle the Tribunal also received a number of testimonials in support of Dr Rosewarne, all of which it has read.

Submissions on behalf of the GMC

72. On behalf of the GMC, Mr Orpin-Massey, Counsel, referred the Tribunal to Good Medical Practice (GMP), and the Guidance for MPTS Tribunals (the guidance). He also referred the Tribunal to the cases *John Roylance Appellant v General Medical Council Respondent (No. 2)* [2000] 1 A.C. 311 and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

73. Mr Orpin-Massey submitted that Dr Rosewarne's failure to diagnose an aortic dissection in Patient A met the threshold for and amounted to misconduct for the following reasons:

- Dr Rosewarne was asked by a junior colleague to look at the scan and help her with its interpretation;
- He agreed to do so;
- At the time he was the on-call consultant radiologist
- He was expected to be able to interpret scans of this nature as the oncall radiologist;
- Indeed he could interpret scans of this nature, had done so in the past, albeit it wasn't his speciality;
- Dr E was clear that once you agree to review a scan you must do so properly i.e. all four corners and margins, citing guidance on radiology;

- Dr Rosewarne accepted that he did not do this, saying his job was to triage only;
- Dr B did not come to him for a triage, nor was it appropriate to attempt some sort of triage;
- Patient A was acutely unwell and needed proper care and attention from Dr Rosewarne at the time he reviewed the scan;
- The aortic dissection was in the words of Dr E "*effortlessly visible*", and indeed Dr Rosewarne accepted in evidence (after some back and forth) that he would have "*likely*" seen it had he reviewed that part of the scan;
- Missing the aortic dissection put Patient A at significant risk of further injury and death (NB: we do not say the omission can be linked to the death);
- It caused delay in a time critical emergency;
- There were warning signs of aortic dissection present from the parts of the scan Dr Rosewarne did look at – the blocked artery and the poor kidney perfusion;
- Dr Rosewarne went on to co-author the report of the scan, indicating he was competent to view it, and provide a joint expert opinion, albeit hours after the scan had taken place.

74. Mr Orpin-Massey submitted that the following paragraphs of GMP were engaged:

'1. You must be competent in all aspects of your work

6. You must provide a good standard of practice and care.

7. In providing clinical care you must: a)adequately assess a patient's condition(s) c) promptly provide (or arrange) suitable advice, investigation or treatment where necessary e) propose, provide or prescribe effective treatment based on the best available evidence) consult colleagues or seek advice from your supervising clinician, where appropriate.'

75. Mr Orpin-Massey submitted that Dr Rosewarne's failure to diagnose the aortic dissection and the circumstances surrounding this failure amounted to misconduct.

76. Mr Orpin-Massey submitted that Dr Rosewarne's failure sat in the middle of the spectrum of seriousness. Mr Orpin-Massey submitted that this is where the misconduct lies as what started off as an isolated failing, albeit with high-risk, faces uplift when one considers the doctor's response to the allegation, namely maintaining that the scan and the patient were not his responsibility, and the limited insight and remediation since.

77. In regard to impairment, Mr Orpin-Massey submitted that Dr Rosewarne's fitness to practise is impaired on all three grounds. He referred the Tribunal the cases of *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *The General Medical Council v Professor Sir Roy Meadow v Her Majesty's Attorney General* 2006 EWCA Civ 1390.

78. In regard to Dr Rosewarne's insight, Mr Orpin-Massey submitted that he had given confusing evidence as to whether he should have seen the aortic dissection (duty), and whether he would have been able to see it had he looked at the appropriate part of the scan (competence). He submitted that Dr Rosewarne did not accept the GMC's case that he should have conducted a thorough review of the scan in its entirety, given his role as the on-call consultant in a time critical emergency. Mr Orpin-Massey said that Dr Rosewarne's case at this hearing was that he was acting in a triage role, despite there being no evidence that triage was an option open to him in his role. Furthermore, it was effectively Dr Rosewarne's position that the scan and the patient were not his responsibility.

79. Mr Orpin-Massey also submitted that there was no evidence before the Tribunal of proper remediation such that Dr Rosewarne could be trusted to review a scan of this nature in the future if required to do so as the on-call radiology consultant in a time critical emergency. Mr Orpin-Massey said that this concern was particularly acute at Dr Rosewarne's Trust setting where there appeared to be separation of functions and that there must therefore be a risk of repetition should Dr Rosewarne be asked to review a scan of this nature in the future.

80. Mr Orpin-Massey submitted that a clear message should be sent that this kind of misconduct was not acceptable. He submitted that a finding of impairment should be made in the public interest, given the severity of the failing, and the lack of insight and remediation following the incident.

Submissions on behalf of Dr Rosewarne

81. On behalf of Dr Rosewarne, Mr Rich, Counsel, referred the Tribunal to the relevant cases of *Roylance v GMC* [1999] Lloyd's Rep Med 139, *Silver v General Medical Council* (14 April 2003), *Nandi v The GMC* [2004] EWHC 2317 (Admin) [at 31] and *R (Calhaem) v. General Medical Council* [2007] EWHC 2606.

82. Mr Rich submitted that Dr Rosewarne's failure to diagnose an aortic dissection in Patient A did not amount to serious misconduct. He submitted that Dr Rosewarne's decision not to do a full review of the scans was a decision made in good faith and was consistent with what he understood to be his duty at the time and was what he judged to be in the patient's best interests. Mr Rich reminded the Tribunal of its finding that "the prescribed pathway meant that Patient A should have been directed straight to the vascular hub at Russells Hall" but went on to find that once Dr Rosewarne had agreed to review the scan, he had assumed responsibility for doing a full and complete review. Mr Rich submitted that because the prescribed pathway meant Patient A should be directed straight to the vascular hub at Russells Hall, Dr Rosewarne understood his duty to be to make sure the patient was on his way to the vascular specialists who could best assess and treat him and therefore he did not appreciate that he needed to fully review the scans at that time. Mr Rich submitted that this reduces the culpability of the failing.

83. Mr Rich invited the Tribunal to consider the case of *Nandi* which was relevant. He said that in order for misconduct to be considered sufficiently *'serious*,' conduct must '*be regarded as deplorable by fellow practitioners.'* Mr Rich submitted that '*deplorable*' carries a level of blameworthiness which would be attached to a doctor whose negligence occurred whilst acting recklessly or in bad faith; therefore, the Tribunal could not determine that Dr Rosewarne's misconduct was '*deplorable'* as he was acting in good faith.

84. Mr Rich stated that the caution in *Calhaem* about a single negligent act or omission constituting misconduct reflects the fact that it is not the purpose of the fitness to practise regime to attach, to any doctor who makes a single mistake (even if significant), the opprobrium that comes with a finding of misconduct.

85. Mr Rich submitted that this was a single clinical omission, relating to a short period of time and a single patient. It was not a failure to do something that it was clear to Dr Rosewarne he should do, but a failure to recognise in the moment what it was he was required to do.

86. Mr Rich referred the Tribunal to the Guidance (table on page 22), which states that misconduct *"… includes single clinical acts or omissions that are serious …"*. He submitted this omits the notion that single act would have to be "*particularly grave"* to amount to misconduct [Calhaem]. Insofar as they differ, the Tribunal should imply *"particularly grave*" into the guidance and apply the case law.

87. Mr Rich referred the Tribunal to the Guidance at paragraph 28 which includes among allegations that fall at the lower end of the spectrum of seriousness *"clinical failings; …"*. At paragraph 31 allegations usually falling at the higher end of the spectrum of seriousness include *"clinical failings that are not considered easily remediable, including those amounting to gross negligence or recklessness about a risk of serious harm to patients"*.

88. Mr Rich submitted that Dr Rosewarne's omission to do a full review falls into the lower category; it is of a type that is easily remediable and did not amount to *"gross negligence of recklessness about a risk of serious harm to patients"*. He submitted that none of the factors increasing seriousness set out in the table (page 28 of the Guidance) apply to Dr Rosewarne or this incident. He submitted that the proper application of the Guidance would put this misconduct at the lower end of the spectrum of seriousness.

89. Mr Rich submitted that the character of Dr Rosewarne's omission was a failing due to uncertainty about how to operate when the designated hospital system did not follow the path it was supposed to. He submitted that this was not the sort of action that was intended to be met with the stigma of a finding of misconduct.

90. Mr Rich acknowledged that a finding of serious misconduct was a basis for finding impairment.

91. In regard to impairment, Mr Rich said that if the Tribunal determined that the omission did amount to misconduct then he submitted that Dr Rosewarne is not currently impaired.

92. Mr Rich submitted that Dr Rosewarne was a dedicated and effective radiologist of some 30 years standing in medicine, and nearly 20 years as a Fellow of the Royal College of Radiologists. He reminded the Tribunal that Dr Rosewarne had no fitness to practise history. Furthermore, Dr Rosewarne has retained the full support of his colleagues and his employing hospital because, as is shown by his testimonials, he is a highly valued member of the hospital team, who practises, teaches and undertakes clinical management tasks alongside the clinical team. Mr Rich said that the breadth of his work and the reliance his colleagues place upon him was apparent from the material that the Tribunal has been provided with. Mr Rich submitted that Dr Rosewarne's reputation was as a clinician who had made great contributions to improving services for his patients and was a dedicated NHS consultant.

93. Mr Rich submitted that Dr Rosewarne's denial of the paragraph 1(b) of the allegation was not a denial of a plain fact that was not found proved, but presented his perspective on '*an evaluative issue relating to the extent of his duties on 1 July 2023 with which the Tribunal disagreed.'* Mr Rich therefore submitted that Dr Rosewarne's response to the allegations was not indicative of a lack of insight.

94. Mr Rich said that in his oral evidence Dr Rosewarne stated that such an error as this would never recur if he were faced with the same situation, and he would do a full report. Mr Rich submitted that Dr Rosewarne would never '*operate in the 'triage' fashion again.'*

95. Mr Rich submitted that Dr Rosewarne's co-operation with all the investigations into the incident, his commitment to personal change, and the work he had done to improve the hospital's systems would allow the Tribunal to assess his insight. Furthermore, the effect of finding out about the undiagnosed aortic dissection, and the subsequent reflection and analysis, do act as guarantees that the error will not recur.

96. In regard to relevant context, Mr Rich submitted that the complex system for dealing with vascular scans and the way in which the hospitals operated were significant for characterising Dr Rosewarne's failure to diagnose the aortic dissection.

97. Mr Rich submitted that public confidence would not be negatively impacted by a finding of no impairment. He submitted that an informed member of the public would recognise the unusual way in which the incident occurred and that the likelihood of repetition was extremely low.

98. Mr Rich suggested that the Tribunal follow the case law of *Cohen v GMC* [2008] EWHC 581 (Admin):

> *"63. I must stress that the fact that the stage 2 is separate from stage 1 shows that it was not intended that every case of misconduct found at stage 1 must automatically mean that the practitioner's fitness to practice is impaired. …*
>
> *64. There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is iso remote that his or her fitness to practice has not been impaired.'*

99. Mr Rich submitted that, in the event that the Tribunal found misconduct, this was an isolated error and the chance of it being repeated was so remote that there was no risk to public protection. He therefore submitted that Dr Rosewarne's fitness to practise is not impaired.

The relevant legal principles

100. There is no burden or standard of proof at this stage of the proceedings and the decision of impairment is a matter for the Tribunal's judgment alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

101. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious and then whether the finding of that misconduct which was serious poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

102. To assess whether Dr Rosewarne poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal will consider:

- where on the spectrum of seriousness the allegation lies, based on the facts found proved,
- the impact of any relevant context known about Dr Rosewarne and/or their working environment; and
- how Dr Rosewarne has responded to the allegation.

The Tribunal's determination on impairment

Misconduct

103. In determining whether the facts found proved amounted to misconduct which was serious, the Tribunal considered its findings of fact in relation to Patient A. The Tribunal reminded itself that Dr Rosewarne was the on-call out of hours Consultant Radiologist for the

ED at New Cross Hospital on 1 July 2023. He was asked by a second-year junior colleague to review Patient A's CT angiogram scan images to confirm diagnosis and for any further critical input if there was any to give. Dr Rosewarne agreed to review these scans on those terms.

104. In agreeing to review the scans, Dr Rosewarne imposed an overall duty upon himself to consider the totality of these scans, irrespective of the hospitals prescribed protocols. The Tribunal concluded that Dr Rosewarne could and should have diagnosed Patient A's aortic dissection because it was his duty to do so.

105. Dr Rosewarne accepted that he did not look at all of the scan images and gave evidence that this was one of the most '*hyperacute cases that had come into the ED for a very long time*.' The Tribunal concluded that this should have served to further underline the need for Dr Rosewarne to fully look at all of the scans in the method described by Dr E in his evidence.

106. The Tribunal concluded that Dr Rosewarne's failures were two-fold.

107. First, Dr Rosewarne failed to review Patient A's scans in their entirety as he was duty bound to do.

108. Second, Dr Rosewarne failed to identify the abnormalities on the parts of the scan that he did review.

109. The consequence of these two failures led to the failure to diagnose the aortic dissection.

110. The Tribunal noted the above failures formed part of a singular event. The Tribunal reminded itself that misconduct can be found where there has been a single clinical act or omission which is serious. The Tribunal concluded that the single clinical act or omission by Dr Rosewarne was in fact serious.

111. Having considered all of the evidence before it, the Tribunal concluded that Dr Rosewarne's failures fell so far short of the standards of conduct reasonably to be expected of a doctor that they amount to misconduct.

<u>Is there a legal basis for considering impairment?</u>

112. Having concluded that the facts found proved amount to misconduct, the Tribunal went on to consider whether there was a legal basis upon which they could proceed to consider if Dr Rosewarne is impaired.

113. The Tribunal had regard to paragraph 6 of the MPTS guidance which states;
"6. An MPT can only assess whether a doctor is fit to practise where there is a legal basis for doing so. There are six legal bases which are known as the grounds for impairment. These are:

- *misconduct*
- *deficient professional performance*
- *a conviction or caution*
- *adverse physical or mental health*
- *not having the necessary knowledge of English and*
- *a determination."*

114. The Tribunal was satisfied that having found Dr Rosewarne's actions amounted to misconduct, there was a legal basis for them to proceed to consider if Dr Rosewarne is impaired.

115. The Tribunal noted that Mr Rich, on behalf of Dr Rosewarne, acknowledged that a finding of misconduct was a legal basis for finding impairment.

116. The Tribunal considered each of the three steps set out in Steps 2(b) - 2(d) of the Guidance in turn.

Where on the spectrum of seriousness does the allegation lie?

117. The Tribunal reminded itself that a finding of impairment requires a finding that Dr Rosewarne poses a current ongoing risk to public protection. In order to assess this, the Tribunal first considered where on the spectrum of seriousness the allegation lies. In doing so it had regard to its findings as set out above, and any features of the Allegation that increase seriousness.

118. The Tribunal considered paragraphs 28 to 33 of the Guidance which provides examples of Allegations that would fall at the lower end, mid-range and higher end of the spectrum of seriousness. The Tribunal noted that this is not a definitive list.

119. The Tribunal considered the nature of the Allegation by looking at the individual circumstances of the case in order to determine seriousness. The Tribunal concluded that whilst this was a serious clinical failing with a risk of serious harm, it was a singular, isolated clinical failing which was easily remediable.

120. The Tribunal concluded that factors described as falling in the mid-range and high range of seriousness were not applicable in this case. The Tribunal therefore concluded that the starting point for assessing seriousness in this case was low.

121. The Tribunal noted Mr Orpin-Massey's submission that the spectrum of seriousness in this case faced uplift when Dr Rosewenes's response to the Allegation was considered, namely his maintaining that the scan and the patient were not his responsibility, and the limited insight and remediation since.

122. However, the Tribunal did not agree with this submission. The Tribunal noted that Dr Rosewarne had made a positive decision not to review all of Patient A's scans, however, he contextualised this by saying that he believed Patient A to be on the right pathway to the vascular hub at Russells Hall Hospital where someone with expertise in vascular radiology would in any case be reviewing these scans.

123. The Tribunal was therefore of the view that Dr Rosewarne's actions were not a reckless disregard of professional standards but rather as a result of an incorrect decision made in the context of the prevailing circumstances as they presented at that time.

124. The Tribunal noted that the GMC did not invite it to consider that there was a reckless disregard for patient safety or professional standards as a factor that would increase the seriousness of the allegation.

125. The Tribunal concluded that none of the factors increasing seriousness as set out in the table at pages 34 to 41 of the Guidance were applicable in this case.

126. In the absence of any features identified which may increase seriousness, the Tribunal concluded that the Allegation remained at the lower end on the spectrum of seriousness.

What is the impact of any relevant context known about Dr Rosewarne and/or their working environment?

127. The Tribunal considered whether there was any relevant context that impacted on Dr Rosewarne's behaviour. In doing so it had regard to paragraph 45 of the Guidance. There are three types of relevant context: working environment context, role and experience, and personal context.

128. The Tribunal found that at the time of the Allegation Dr Rosewarne was providing clinical support to a busy and demanding ED department as an on-call Consultant Radiologist and was covering the entire hospital over a weekend period. The Tribunal accepted Dr Rosewarne's evidence that weekends could be busier than usual. The Tribunal accepted that at the time of the Allegation he was on call for a 24-hour period during which time he had authorised 66 CT studies. The Tribunal acknowledged Dr E's evidence that reporting this number of CT scans in a 24-hour period was on the '*high side of normal*.'

129. The Tribunal had regard to Dr Rosewarne's RO witness statement dated 20 June 2026, and in particular to his evidence about the model of working practices at the New Cross Hospital. The Tribunal noted the following:

> *'I am reassured that Dr Rosewarne has learned a lot from this unfortunate episode and I have had several individual conversations with him about this case…*
> *As stated in the RCA there were a number of complex clinical and systemic factors involved in this case and the sad demise of the patient was not solely due to the radiology report…*
> *I would also like to ensure the model of vascular services in the Black Country is clear to the panel. For over 10 years the region has worked as a "hub and spoke" vascular service. The main vascular hub is based at Russell's Hall Hospital (Dudley Group Foundation Trust) whilst the tertiary cardio-thoracic service is based at The Royal Wolverhampton NHS Trust. To complicate matters further some complex aneurysms are referred to University Hospital Birmingham. It is therefore evident that the provision of vascular services in the Black Country is a complex arrangement. There is therefore a dedicated on call vascular team (including an on call vascular interventional radiologist). This arrangement requires frequent movement of patients, patient related information (e.g. scans) between organisations. I think it is important that the panel recognise the complexity of this clinical service and the suboptimal arrangements of having different aspects of the service delivered in different organisations. In the case in question, Dr Rosewarne was the "general" on call radiologist for The Royal Wolverhampton NHS Trust. Dr Rosewarne is not a vascular radiologist and has never been part of the specialist vascular team. Given the specialist*

vascular service it is unusual for general radiologists to report on peripheral CT angiograms…'

130. The Tribunal noted that in its report dated 11 January 2024, the RCA had identified issues with the model of the vascular care pathway at New Cross Hospital at the time of the index events and that this had since been changed. It also stated that *'Vascular radiology has almost become a distinct specialty with consequent deskilling of non-vascular radiologists'*.

131. The Tribunal noted that Patient A's CT angiogram should not have been carried out at New Cross Hospital and should not have come to Dr Rosewarne. Dr Rosewarne was aware that Patient A was on his way to the vascular specialists at Russells Hall Hospital who he believed could best assess and treat him.

132. The Tribunal noted that in its report dated 11 January 2024, the RCA had identified issues with the model of the vascular care pathway at New Cross Hospital at the time of the Allegation and that this had since been changed.

133. The Tribunal noted that the newly imposed vascular pathway at New Cross Hospital has resulted in the fact that scans of the kind being considered in this case would no longer ever be presented to a general Consultant Radiologist such as Dr Rosewarne.

134. The RCA also stated that *'Vascular radiology has almost become a distinct specialty with consequent deskilling of non-vascular radiologists'*.

135. The Tribunal accepted Dr Rosewarne's evidence in his witness statement dated 16 July 2026, as follows:

'My subspecialty interests are thoracic imaging, head and neck radiology, and cardiac CT. Vascular radiology — and peripheral CT angiography in particular — is not within my subspecialty area. Since my appointment as a Consultant Radiologist at New Cross Hospital in October 2009 and up to 1 July 2023, I have reported six CT lower leg angiograms at consultant level. This figure is not a reflection of any gap in my training or competence. It is the direct and predictable consequence of the Black Country Vascular Network's hub-and-spoke model, which concentrates vascular imaging at the hub site at Russells Hall Hospital, performed and reported by the on-call Vascular Radiologist. The Root Cause Analysis into this case explicitly identified the deskilling of

general radiologists at spoke sites as a documented and foreseeable consequence of that network design'.

136. The Tribunal noted that whilst Dr Rosewarne wrote to Dr I, clinical director of vascular surgery in June 2026 requesting clarification about the vascular pathway, this was three years after the incident. Dr Rosewarne had not raised concerns about Patient A's safety at the time. Dr Rosewarne gave evidence that, as far as he was concerned, everything had already been done correctly, and he genuinely believed that Patient A was being transported to specialists at Russells Hall Hospital.

137. The Tribunal considered Dr Rosewarne's role and expertise. It noted that in Dr E's evidence, he opined that Dr Rosewarne's conduct fell far below the standards expected of an on-call consultant radiologist. However, the Tribunal was mindful that this was an isolated incident and balanced this against the failures in this particular case. The Tribunal found that the risk of seriousness had not changed.

138. The Tribunal considered paragraph 63 of the Guidance and the fact that at the time of the Allegation Dr Rosewarne held a leadership role given that junior colleagues were under his supervision. The Tribunal considered whether his misconduct had caused any additional or wider impact. The Tribunal concluded that Dr Rosewarne's misconduct had not had a negative impact on Dr B. The Tribunal also concluded that Dr Rosewarne's misconduct did not have a negative impact on the workplace culture at New Cross Hospital as it was a one-off incident.

139. The Tribunal took into account the numerous testimonials it received on behalf of Dr Rosewarne. The testimonials attest to Dr Rosewarne showing '*diligence to thorough clinical assessment.'* and that he was '*widely regarded as a supportive colleague and an effective mentor, consistently contributing to the development of others within the team.'.* His colleagues describe Dr Rosewarne as '*approachable'* and *'reliable*' and also *'generous with his time and knowledge, particularly in education.'*

140. The Tribunal noted that Dr Rosewarne had remained in a leadership role supervising resident doctors as a Consultant Radiologist since the index event, and that there had been no further incident or criticism of his performance since.

141. The Tribunal therefore concluded that there was no relevant contextual factor which increased the level of seriousness and risk.

How has Dr Rosewarne responded to the allegation?

Insight

142. The Tribunal was mindful that as per paragraph 89 of the Guidance, Dr Rosewarne had the right to advance a defence in regard to paragraph 1(b) of the Allegation. Whilst the Tribunal had found paragraph 1(b) of the allegation proved, it accepted Mr Rich's submission that Dr Rosewarne was not denying a plain fact, but was simply contending that, due to New Cross Hospital's pathways, he had no duty to review the CT scans. The Tribunal acknowledged Dr Rosewarne's evidence that in hindsight he should have checked the entirety of the scans and would do so were he presented with this situation again.

143. In assessing Dr Rosewarne's insight, the Tribunal was satisfied that Dr Rosewarne had considered the Allegation and understood what went wrong. It had regard to his oral evidence in which he stated '*In retrospect, there was an opportunity to diagnose the aortic dissection at New Cross. I have reflected an awful lot since. One never wants to be associated to a case with a fatal outcome and which was suboptimal both professionally and clinically.'*

144. The Tribunal concluded that Dr Rosewarne had not fully accepted that he should have acted differently and considered his evidence on this issue at times conflicting. However, the Tribunal accepted Mr Rich's submission that Dr Rosewarne had taken steps to identify how he would act differently in the future.

145. The Tribunal noted Dr M's witness statement in which he stated that *'Dr Rosewarne extends his deepest sympathy to the family.'* However, the Tribunal noted that it had not been presented with any evidence of an apology from Dr Rosewarne in either his written or oral evidence.

146. The Tribunal was mindful that Dr Rosewarne had fully engaged with all investigations and enquiries into this case, namely the RCA process, the coroners' inquiry and the GMC's investigation and resulting Allegation, albeit the Tribunal also noted that he did not self-refer to the GMC.

147. The Tribunal acknowledged that Dr Rosewarne, through his explanation that he was triaging, may have attempted to minimise his role and culpability in the failure to diagnose

the aortic dissection. However, the Tribunal was satisfied that Dr Rosewarne is now acutely aware of his professional responsibilities and was assured that he will never unilaterally impose a 'triage' role upon himself again.

148. The Tribunal concluded that Dr Rosewarne's level of insight could, in parts, have been further developed but ultimately concluded that his level of insight is sufficient.

Remediation

149. The Tribunal concluded that Dr Rosewarne's misconduct was easily remediable. It was satisfied that the learning Dr Rosewarne had undertaken since the Allegation and the changes to the pathways at New Cross Hospital were such that the risk of repetition could be stated as very low.

150. The Tribunal acknowledged that Dr Rosewarne had maintained his CPD obligation and was satisfied that he had kept his knowledge and skills up to date. The Tribunal also acknowledged that Dr Rosewarne had continued to practise unrestricted for a three-year period since the date of this Allegation and that no issues or concerns about his practice, professionalism and capabilities had been reported.

Tribunal's decision as to whether Dr Rosewarne poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

151. The Tribunal next had to consider, overall, whether Dr Rosewarne poses any current and ongoing risk to public protection which may require restrictive action on his registration and make its decision on impairment.

152. The Tribunal determined that the misconduct falls at the lower end of the spectrum of seriousness and that there were no working environment, role and experience, or personal factors present which may have increased the risk. It further noted that there was evidence of insight and remediation. The Tribunal was satisfied that there was no real risk of repetition and if any existed it would be very low indeed.

153. The Tribunal reviewed its conclusions at Steps 2(a) to (d) above. Having regard to its findings of fact, the Tribunal determined that Dr Rosewarne posed no current and ongoing risk to public protection as this was an isolated incident which was remediable. The Tribunal concluded that Dr Rosewarne's actions amounted to misconduct but does not consider him

currently impaired. The Tribunal do not conclude that a finding of impairment is necessary to maintain public confidence in the profession. The Tribunal also determined that the need to uphold proper professional standards would not be undermined if a finding of impairment were not made.

154. The Tribunal has therefore determined that Dr Rosewarne's fitness to practise is not currently impaired by reason of his misconduct.

Determination on Warning - 16/09/2026

155. This determination was handed down in public.

156. As the Tribunal determined that Dr Rosewarne's fitness to practise was not impaired it considered whether a warning was required. It did so in accordance with Section 3, *'Part D: the Warnings section of the Guidance for MPTS Tribunals'*.

Submissions

157. On behalf of the GMC, Mr Orpin-Massey, Counsel, submitted that a warning is necessary in this case. He referred the Tribunal to part D of the Guidance.

158. Mr Orpin-Massey submitted that one of the duties of the MPT is to ensure the protection of the public. In order to do this the three aspects identified in the overarching objective should be considered.

159. Mr Orpin-Massey referred to the Guidance where it states that warnings are issued in the interest of maintaining public confidence in the profession, upholding professional standards and to highlight to the wider profession and public that certain behaviour or poor performance is not acceptable.

160. Mr Orpin-Massey reminded the Tribunal of its findings at the facts and impairment stages of this hearing. He submitted that the Tribunal found that there were failings in this case. The failings in question are that Dr Rosewarne had a duty to review the entirety of Patient A's scans and did not do so and also that he failed to identify the abnormalities on the parts of the scan that he did review.

161. Mr Orpin-Massey reiterated that that this was a '*hyperacute*' case which was serious in nature; something that Dr Rosewarne himself acknowledged.

162. Mr Orpin-Massey reminded the Tribunal that they had determined that Dr Rosewarne's actions amounted to misconduct and that he had breached tenets of GMP.

163. Mr Orpin-Massey referred the Tribunal to page 79 of the Guidance which states that warnings are appropriate for allegations that amount to a significant departure from professional standards and fall just short of a finding that a doctor's fitness to practise is impaired.

164. Mr Orpin-Massey identified that one of the questions posed is whether there had been a clear and specific departure from professional standards? He submitted that the answer to this question must be yes.

165. Mr Orpin-Massey invited the Tribunal to consider the totality of the evidence given by Dr E but specifically his evidence in relation to where there had been specific departures from professional standards. Mr Orpin-Massey submitted that Dr E's evidence had been firm on these points.

166. Mr Orpin-Massey reminded the Tribunal that the failings were disputed by Dr Rosewarne which were relevant to the issue of his insight and remediation.

167. Mr Orpin-Massey identified that another question posed in the Guidance was, did the Allegation about the doctor's behaviour or poor performance just fall short of a finding that the fitness to practise was impaired? He stated that this was a matter for the Tribunal to decide.

168. Mr Orpin-Massey reminded the Tribunal that it had raised queries about Dr Rosewarne's responsibility for the failing, his remorse, his insight and his remediation. Mr Orpin-Massey said the Tribunal *"had given Dr Rosewarne the benefit of any doubt."*

169. Mr Orpin-Massey submitted that within the impairment determination, the Tribunal had concerns that fell just short of impaired fitness to practice.

170. Mr Orpin-Massey submitted that if the behaviour or poor performance were to be repeated then almost undoubtedly any future Tribunal would have no hesitation in finding Dr Rosewarne impaired.

171. On behalf of Dr Rosewarne, Mr Rich, Counsel, submitted that there was no need for a warning in this case. He reminded the Tribunal that a warning was a serious regulatory response and had to be 'necessary'.

172. Mr Rich reminded the Tribunal of its finding that Dr Rosewarne is not currently impaired.

173. Mr Rich submitted that it was not necessary to *"send a signal"* to Dr Rosewarne that any repeat of similar behaviour or poor performance was likely to result in impairment. Mr Rich said that the process had taken place over a lengthy period of time and involved the hospital investigation, the coroner investigation, the GMC investigation and the findings of the Tribunal. He submitted that this had served to strongly bring it home to Dr Rosewarne what the likely outcome of repeating similar behaviour or poor performance would be.

174. Mr Rich reminded the Tribunal that it had found that the overall seriousness was low and that the mid or high range factors were not present. He said that the context had mitigated the seriousness of it, in the sense that it was not a decision taken recklessly or with a reckless disregard for patients but was a misjudgement.

175. Mr Rich submitted that the context of what happened on the day of the Allegation provides something of an explanation about how this completely isolated failing in Dr Rosewarne's professional standards came about and that furthermore, the context removes any suggestion that his actions were rooted in a personal or attitudinal failing of his, but rather an error made within that prevailing context.

176. Mr Rich reminded the Tribunal that it had stated in its determination on impairment that they were satisfied that Dr Rosewarne was now acutely aware of his professional responsibilities and was assured that he would never impose a triage role on himself again.

177. Mr Rich stated that the impact on the public was something the Tribunal was entitled to consider. He submitted that if a member of the public reading the Tribunal's determination would be satisfied that Dr Rosewarne does not need a warning against him,

then this should impact significantly on whether the Tribunal finds that a warning is needed in the interest of the public.

178. Mr Rich submitted that the Tribunal had found Dr Rosewarne's misconduct at the lower end of the spectrum of seriousness, there was no real risk of repetition and that he was acutely aware of his responsibilities. Accordingly, he submitted that a warning would not be necessary to maintain confidence in the profession.

179. Mr Rich accepted in his submission that there had been a finding of a clear and specific departure from GMP as it had found misconduct. However, he submitted that his interpretation of the determination was that the Tribunal had found that Dr Rosewarne's misconduct was far below the threshold for impairment.

180. In assessing whether repetition of poor performance would lead to a finding of impairment in the future, Mr Rich submitted that the Tribunal had found that there was no real risk of repetition. He reminded the Tribunal that this was an isolated incident and that Dr Rosewarne had no relevant fitness to practise history before or since the incident.

181. Mr Rich submitted that the Tribunal had found Dr Rosewarne's level of insight incomplete, but sufficient. He further submitted that, although the Tribunal had not received any evidence of a direct apology or expression of remorse from Dr Rosewarne in either his written or oral evidence, it had quoted his RO statement in which Dr Rosewarne's concern and empathy for Patient A's family was mentioned.

The Tribunal's Determination on warning

182. The Tribunal has taken account of its earlier conclusions at the facts and impairment stages. It has also taken account of Part D of Section three: MPT hearings of the Guidance for MPTS Tribunals as to the purpose of warnings and the factors to be borne in mind when considering whether or not a warning is required.

183. The Tribunal noted paragraph 15 of the Guidance which states that a warning will be appropriate where facts have been found proved that indicate the doctor's behaviour or performance has fallen below the professional standards expected, the MPT has determined the doctor's fitness to practise is not currently impaired, but it is necessary to signal to them that repeating the same, or similar, behaviour or poor performance is likely to result in a future finding of impairment.

184. The Tribunal also noted the Guidance which states that in order to decide if a warning is required the Tribunal will first consider if there has been a clear and specific departure from the professional standards. If so, provided the allegation just fell short of the Tribunal finding that the doctor's fitness to practise is impaired, the Tribunal will go on to consider the question that if the behaviour or poor performance was repeated, would it likely result in a finding that the doctor's fitness to practise is impaired? A warning will usually be required if the Tribunal reaches a view that it would.

185. The Tribunal accepted the GMC's submission that Dr Rosewarne had breached the standards of Good Medical Practice, specifically paragraphs 1, 6 and 7. The Tribunal determined that Dr Rosewarne's failures to fulfil his duty to fully review Patient A's scan, and to identify clear abnormalities in the scan constituted a clear and specific departure from GMP and that Dr E's evidence was clear on this point. The Tribunal determined that these departures from GMP just fell short of a finding that Dr Rosewarne's fitness to practise is impaired.

186. Having found this, the Tribunal conducted an exercise of finely balancing Dr Rosewarne's failures against the context in which they occurred. It also balanced Dr Rosewarne's level of insight and remediation against the likelihood of repetition.

187. Considering the impact of repetition, the Tribunal paid particular attention to their findings in respect to Dr Rosewarne's level of insight into the allegations. Whilst it had determined that Dr Rosewarne's level of insight was sufficient, it determined that it was also incomplete and it had received no evidence of any apology or expressions of remorse directly by Dr Rosewarne in either his written or oral evidence. The Tribunal noted that Mr Rich acknowledged this in his submissions.

188. Whilst it had found that there was no real risk of repetition, the Tribunal found that, were he to repeat these failings, it would lead to a conclusion that Dr Rosewarne's fitness to practise is impaired. It determined that a warning is required to indicate restrictive action would be necessary if poor performance were repeated.

189. While satisfied that Dr Rosewarne is now acutely aware of responsibilities, the Tribunal determined, under paragraph 10 of the Guidance, that the purpose of a warning was

to send a message to other members of the profession and members of the public, and that this carries more weight than Dr Rosewarne's interests.

190. The Tribunal therefore determined that it was necessary to give Dr Rosewarne a warning as to his future behaviour or performance to maintain public protection.

Warning

'Dr Rosewarne

On the 1st July 2023 you reviewed Patient A's peripheral CT angiogram scan images at the request of a junior radiological Trainee Dr B and you failed to diagnose the presence of an aortic dissection.

Your failures were two-fold. First, you failed to review Patient A's scans in their entirety as you were duty bound to do so. Second, you failed to identify the abnormalities on the parts of the scan that you did review. The consequence of these two failures led to the failure to diagnose the aortic dissection.

This represents a clear and specific departure from the professional standards expected of a doctor. The required standards are set out in Good Medical Practice and associated Guidance.

This behaviour and poor performance impacts on all three parts of public protection.
In light of this being a single incident with significant mitigation which includes the context in which these failings occurred, the Tribunal has determined that your fitness to practice is not currently impaired and therefore no restriction will be placed on your registration. However, if repeated, the conduct would likely result in a conclusion that your fitness to practise is impaired. It is therefore necessary to issue a formal warning to place you on notice about your future conduct and behaviour.

You must always review patients' scans in their entirety when it is your duty to do so.
This warning will be published on the medical register in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy.'

191. There is no interim order to revoke.

192. That concludes this case.