PUBLIC RECORD

Dates: 22/01/2024 - 01/02/2024

Medical Practitioner's name:	Dr Keith SUTTIE
GMC reference number:	3550106
Primary medical qualification:	MB ChB 1991 University of Dundee

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

Summary of outcome

No warning

Tribunal:

Legally Qualified Chair	Miss Annie Hockaday
Lay Tribunal Member:	Mrs Barbara Larkin
Medical Tribunal Member:	Dr Louise Crabtree

Tribunal Clerk:	Mx Nate Caruso-Kelly

Attendance and Representation:

Medical Practitioner:	Present, not represented
GMC Representative:	Ms Chloe Fairley, Counsel

Attendance of Press / Public

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

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 and Impairment - 31/01/2024

1. This determination will be handed down in private. However, as this case concerns Dr Suttie's misconduct a redacted version will be published at the close of the hearing.

Background

2. Dr Suttie qualified in 1991 at the University of Dundee. At the time of the events on 10 November 2017, Dr Suttie was practising as a specialty doctor in Obstetrics and Gynaecology at Ninewells Hospital ('the hospital') NHS Tayside. He had joined the department in 2014 as a specialty doctor.

3. The allegation that has led to Dr Suttie's hearing arises out of his conduct at the hospital in relation to the care of Patient A on 10 November 2017 during one period of time, from 12:08 until the delivery of Baby C at 12:43. Counsel for the GMC introduced the case as a failure by Dr Suttie to respond to the emergency that was unfolding before him. No allegation is made by the GMC in relation to his conduct prior to 12:08.

4. The GMC allege failings from 12:08 while consulting with Patient A under three stems as follows:

> Dr Suttie failed to manage Patient A for a uterine rupture with the need for urgent delivery, despite Patient A having a trial of a vaginal birth after caesarean section ('c-section'), previous examinations identifying fetal malposition with a deflexed head, Patient A having failed to progress beyond nine centimetres dilation for four hours, and being advised of the onset of fetal bradycardia at or around 12.08;
>
> Dr Suttie failed to respond to the fetal bradycardia by minimising the interval between his call at or around 12.08 and delivery at or around 12.43, despite arrangements already being in place for an emergency c-section, Patient A already being set to be transferred to the operating theatre by the time of his arrival, his being called and attending promptly when the fetal bradycardia was first recognised, clear evidence of fetal bradycardia on the cardiotocography, and urgent delivery being warranted upon recognition of the fetal bradycardia;
>
> Dr Suttie failed to take the lead in Patient A's care over the interventions that followed from the time of his involvement, in that he failed to adequately

communicate with the anaesthetist and confirm the optimal mode of anaesthesia; ensure the c-section was performed with the urgency required and change its category from '2' to '1'; or scrub and perform the c-section himself as the senior obstetrician present.

5. The initial concerns were raised with the GMC in November 2022 by Patient A.

6. The hearing was held remotely. Dr Suttie joined the hearing without a legal representative. He confirmed that he does not have legal representation and represents himself. He did not apply for an adjournment for the purpose of obtaining legal representation. The Tribunal explained the potential for him to ask to have someone, such as a family member or friend, sit with him during the hearing to provide moral support and take notes to assist him, but he did not do so. He took part throughout the hearing.

The Outcome of Applications Made during the Facts Stage

7. The Tribunal granted the GMC's application, made under Rule 35(4) of Fitness to Practise Rules (2004, as amended) ('the Rules') that Patient A, Mr B, and Baby C be anonymised as such throughout the hearing, due to the status of Patient A and Mr B as vulnerable witnesses and their concerns that they may be identified during the proceedings. Dr Suttie did not oppose the application.

The Allegation and the Doctor's Response

8. The Allegation made against Dr Suttie is as follows:

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

1. On 10 November 2017 you consulted with Patient A and you failed to:

    a. manage Patient A for a uterine rupture with the need for urgent delivery, despite:

        i. Patient A having a trial of a vaginal birth after caesarean section ('c-section');

        Admitted and found proved.

        ii. previous examinations identifying fetal malposition with a deflexed head;

        Admitted and found proved.

iii. Patient A having failed to progress beyond nine centimetres dilation for four hours;

Admitted and found proved.

iv. being advised of the onset of fetal bradycardia at or around 12:08;

Admitted and found proved.

b. respond to the fetal bradycardia by minimising the interval between your call at or around 12:08 and delivery at or around 12:43, despite:

i. arrangements already being in place for an emergency c-section;

Admitted and found proved.

ii. Patient A already being set to be transferred to the operating theatre by the time of your arrival;

Admitted and found proved.

iii. you being called and attending promptly when the fetal bradycardia was first recognised;

Admitted and found proved.

iv. clear evidence of fetal bradycardia on the cardiotocography;

Admitted and found proved.

v. urgent delivery being warranted upon recognition of the fetal bradycardia;

Admitted and found proved.

c. take the lead in Patient A's care over the interventions that followed from the time of your involvement in that you failed to:

i. adequately communicate with the anaesthetist and confirm that the optimal mode of anaesthesia would have been an immediate general anaesthetic to speed up the process of the delivery;

Admitted and found proved.

ii. ensure the c-section was performed with the urgency required in that you did not change Patient A's delivery from a category 2 to category 1 c-section;

Admitted and found proved.

iii. scrub and perform the c-section yourself as the senior obstetrician present.

Admitted 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.

The Admitted Facts

9. At the outset of the hearing, Dr Suttie made admissions to all paragraphs and sub-paragraphs of the Allegation, as set out above, under Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e), the Tribunal announced the Allegation as admitted and found proved.

Impairment

10. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts found proved, Dr Suttie's fitness to practise is impaired by reason of his misconduct.

Witness Evidence

11. The Tribunal 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:

- Patient A, dated 31 August 2023;
- Mr B, Patient A's husband, dated 17 September 2023;
- Dr D, dated 2 October 2023; and
- Dr E, dated 18 January 2024, Responsible Officer for NHS Tayside.

12. Dr Suttie provided his own witness statements dated 22 January and 25 January 2024 and gave oral evidence on affirmation at the hearing. Ms Fairley did not cross-examine him. The Tribunal asked some questions.

Expert Witness Evidence

13. The GMC rely on the expert evidence of Dr D MD, FRCOG, MEWI FFFLM, who was appointed Consultant Obstetrician and Gynaecologist in 1990 and retired from clinical practice in 2022 (as more fully set out in his CV). Dr D wrote two reports dated 9 February 2023 and 10 October 2023. The Tribunal also received oral evidence from Dr F.

14. Dr Suttie did not provide expert evidence. Dr Suttie did not challenge the expert reports of Dr D or question Dr D. Dr Suttie told the Tribunal that he agreed with what Dr F had written in his reports.

Documentary Evidence

15. The Tribunal had regard to the documentary evidence provided by the parties (as redacted). This evidence included but was not limited to:

- Patient A's medical records;
- The report of the Local Adverse Event Review ('LAER') dated 11 January 2018 following the meeting held on 21 December 2017;
- Patient A's questions for the LAER meeting;
- Notes from a meeting between Patient A and NHS Tayside dated 23 February 2018 and additions to those notes by Patient A;
- Patient A's letters of complaint to NHS Tayside dated 1 March 2018 and 21 July 2018;
- NHS Tayside's responses to Patient A dated 3 July 2018 and 12 October 2018;
- Patient A's timeline of events;
- An External Review Report dated 4 September 2018 by NHS Forth Valley; and
- Five testimonials from colleagues of Dr Suttie, dated January 2024.

Submissions

<u>On behalf of the GMC</u>

16. On behalf of the GMC, Ms Fairley submitted that the Tribunal must have in mind the three limbs of the statutory overarching objective. She submitted that the Tribunal must adopt a two-stage approach to the issue of impairment of fitness to practice: (i) whether there has been serious misconduct, and, if there has, (ii) whether as a result of that serious misconduct the fitness to practise of Dr Suttie is currently impaired. She provided written legal submissions.

17. Ms Fairley submitted that the Proved Facts amount to serious misconduct. She submitted that Dr Suttie had departed from paragraph 15 (a) and (b) of Good Medical Practice (2013, as amended) ('GMP') as follows:

'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. promptly provide or arrange suitable advice, investigations or treatment where necessary … '

18. Ms Fairley submitted that the Tribunal should take into account the expert reports of Dr F. Ms Fairley submitted that the conclusion which Dr F reaches in his reports is clear, that the failings by Dr Suttie reflect conduct which is 'seriously below' the standards expected of a reasonably competent specialty doctor, and reminded the Tribunal that this conclusion is unchallenged by Dr Suttie. Ms Fairley referred to Dr F's opinion that Dr Suttie's failings led to a delay in the delivery at a time when Baby C was being subject to an acute profound hypoxic insult.

19. Ms Fairley submitted that in his reflections, Dr Suttie has addressed his failure to consider a uterine rupture until it was seen by Dr D in theatre after she had started the c-section, however he had failed to appreciate the significance of the fetal bradycardia. Ms Fairley reminded the Tribunal of Dr F's written and oral evidence, that fetal bradycardia, in and of itself, warranted urgent action and urgent delivery. Ms Fairley noted that Dr F was not critical of Dr Suttie prior to 12:08. Dr Suttie had been informed at around 11:50 of Dr D's decision to proceed with a Category 2 c-section. It was Dr Suttie's failings from 12:08, as the most senior doctor and the doctor notified of the fetal bradycardia, in a time critical situation in respect of the health of both mother and baby which form the basis of the misconduct. Ms Fairley submitted that the failings by Dr Suttie were 'seriously below' the expected standard, because of, as stated by Dr F, '*the implications and repercussions of the clinical situation unfolding and the potentially serious outcomes*.' In summary, Ms Fairley submitted that the failings admitted by Dr Suttie, though part of a single episode, could not properly be characterised as anything other than particularly grave in the circumstances and met the threshold for serious misconduct.

20. In regard to impairment, Ms Fairley submitted that paragraphs 34, 55, 61, and 73 of GMP were relevant:

> *'34 When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support*

55 You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

a put matters right (if that is possible)

b offer an apology

c explain fully and promptly what has happened and the likely short-term and long-term effects.

61 You must respond promptly, fully and honestly to complaints and apologise when appropriate. …

73 You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality.'

21. Ms Fairley submitted that Dr Suttie's insight and remediation are at a relatively early stage. She acknowledged that Dr Suttie has made full admissions and not sought to challenge the witness evidence, which is to his credit, however, his admissions were not apparent until the first day of the hearing. She suggested that had his admissions been indicated at an earlier stage, Patient A and Mr B would have been spared the uncertainty and anguish that comes with waiting, as witnesses of fact, for the case to come before the Tribunal. XXX.

22. Ms Fairley submitted that while there is reference in the statement of Dr Suttie's Responsible Officer, Dr E, to an expression of apology by Dr Suttie in the NHS Tayside letter to Patient A dated 12 October 2018, Patient A has stated that she did not receive any explanation or direct apology from Dr Suttie while she was in the hospital. Ms Fairley submitted that Dr Suttie's comment that it did not occur to him to write a letter to Patient A after her discharge indicates a failure to reflect properly, and there has been no attempt to provide a letter of apology during the GMC investigation or hearing preparation.

23. Ms Fairley submitted that there is little reflection, explanation or acknowledgement within the documents provided by Dr Suttie relating to the impact on Patient A and her family of his failings or of his delay in admitting the facts found proved. She submitted that Dr Suttie's insight cannot be said to be complete and he has not expressed any reflection on the potential impact his conduct has had on public confidence in the profession.

24. In regard to remediation, Ms Fairley submitted that there is limited evidence of courses undertaken by Dr Suttie following the incident, and that the training he has undertaken is to be expected in the ordinary course of his employment. She noted his stated intention to do a further course in relation to communication skills. Ms Fairley submitted that

while there may be some sympathy towards Dr Suttie XXX, he has had ample opportunity to have undertaken relevant courses in the period since the incident. Ms Fairley acknowledged that there are signs that Dr Suttie is willing to remediate, but remediation cannot be said to be complete.

25. Ms Fairley submitted that Dr Suttie has in the past acted so as to put a patient and her baby at unwarranted risk of harm and has in the past and/or is liable in the future to breach one of the fundamental tenets of the medical profession, to provide a good standard of practice and care as set out in paragraph 15 of GMP.

26. Ms Fairley submitted that all three limbs of the overarching objective are engaged in this case (protection of patients, upholding proper professional standards, and maintaining public confidence in the profession) and would be undermined if a finding of impairment were not made in the particular circumstances of this case.

Dr Suttie's Submissions

27. Dr Suttie began by submitting that he has always accepted his mistake on 10 November 2017. He does not deny its seriousness. He said that the proper characterisation of his mistake was not for him to say, as it is for the Tribunal to decide whether it was serious professional misconduct. Overall, he submitted that his fitness to practise is not currently impaired.

28. In response to Ms Fairley, Dr Suttie acknowledged that while he did not mention the impact on Patient A, Baby C and their family in his reflective statement, he submitted that it was self-evident that he regretted the impact of his actions and he has regretted it every day since it happened. Dr Suttie submitted that the testimonials submitted on his behalf show that he is sensitive to the needs and feelings of patients and communicates well.

29. Dr Suttie accepted that he did not offer his reflections before the hearing began. He said that he had been struggling to deal with the GMC regulatory process XXX, although he does not seek to make excuses for his mistake on 10 November 2017. He submitted that XXX was a separate issue from his ability to engage with this regulatory process. He submitted that Ms Fairley does not know how he has been feeling since the incident or during the GMC's process, and that he was not sure until very recently whether he would be able to attend the hearing but realised it would be to his detriment if he did not.

30. Dr Suttie did not deny the seriousness of his mistake but submitted that he is fit to continue practising medicine. He submitted that he has worked for six years since the incident with no problems and with the full support of his department and NHS Tayside, and

that those who see his work directly and on a day-to-day basis have no concerns about his practice. He submitted that in regard to training since November 2017, he has undertaken courses on Cardiotocography ('CTG') and Obstetric emergencies that would be part of his usual ongoing learning, and this was sufficient for him to be revalidated in August 2022. In relation to training of direct relevance to the incident, he does not see what more he could have done to enable him to practise at the required level.

31. Finally, Dr Suttie submitted that his reflection on this incident will never stop, and he will have it in his mind for the rest of his career. He stated that he has reflected on the incident almost every day since it happened. He stated that, notwithstanding this terrible incident, he believes he is a good doctor, he loves his job, the people he works with and the interaction, and to be prevented from practising medicine would be extremely difficult for him.

The Relevant Legal Principles

32. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof, and the decision of impairment is a matter for the Tribunal's judgement alone. The Tribunal is concerned with the regulatory function of the overarching objective under section 1A and 1B of the Medical Act 1983.

33. The Tribunal must follow a two-stage process: (i) to consider whether the Proved Facts amount to misconduct that is serious, and, if it does, (ii) to consider whether the doctor's fitness to practice is currently impaired by reason of that serious misconduct.

34. Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The Tribunal is guided by the standards set out in GMP. The threshold for disciplinary intervention is serious professional misconduct.

35. The facts found proved involve failings in the standard of practice and care in relation to Dr Suttie's treatment of Patient A and her baby on one date. The Tribunal is assisted by *Calhaem v GMC* [2007] EWHC 2606 (Admin) in which Mr Justice Jackson states [at 26 and 39]:

- *"The word "misconduct" in section 35C(2)(a) does not mean any breach of the duty owed by a doctor to his patient; it connotes a serious breach which indicates that the doctor's fitness to practise is impaired."*

- That from his review of the authorities, he derives the following principles:

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

36. The Tribunal must determine whether Dr Suttie's fitness to practise is impaired today, taking into account his conduct at the time and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition (*Cohen v GMC* (2008) EWHC 581 at [62-65]).

37. There is no statutory definition of impairment, but the Tribunal is assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report, as adopted by Mrs Justice Cox in *CHRE v NMC and Paula Grant* [2011] EWHC 927 Admin. The Tribunal will consider whether the Proved Facts show that the doctor's fitness to practise is impaired in the sense that he:

a. Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b. *[not relied on by the GMC or relevant in this case];* and/or
c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
d. *[not relied on by the GMC or relevant in this case]"*

38. The Tribunal must pay close attention to the doctor's current understanding of and attitude towards what he has done and whether the insight shown and/or remediation undertaken addresses the true seriousness of the case found proved against him (*GMC v Khetyar* [2018] EWHC 813).

39. The Tribunal will consider all relevant mitigation material provided by the doctor. However, the Tribunal will bear in mind that matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice, because the overarching concern of the professional regulator is the protection of the public (*Sanusi v GMC* [2019] EWCA Civ 1172 at [95]).

40. The Tribunal is guided by Mrs Justice Cox in *Grant* (above) at [74] as follows:

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

Further Background

41. The course of events from when Patient A arrived at the hospital on the evening of 9 November 2017 through to the delivery of Baby C on 10 November 2017 resulted in a very serious adverse outcome for Baby C. The Tribunal acknowledges how distressing the experience was for Patient A, Mr B and those close to them and the extent of the challenge for them to process what happened. The Tribunal acknowledges and thanks Patient A and Mr B for their contribution to this regulatory process as witnesses of fact.

42. The Tribunal was mindful that the facts found proved relate only to Dr Suttie's conduct between 12:08 and 12:42 on 10 November 2017. It considered that the context of and background to that period was relevant to understanding the nature and extent of Dr Suttie's failings during that period. The Tribunal therefore set out further background, as established by Patient A's medical records and the LAER Report, and as interpreted in the expert reports and oral evidence of Dr F.

43. Patient A's due date was 12 November 2017. Patient A attended a series of antenatal appointments during this pregnancy and before her care at the hospital on 9 November and continuing overnight into 10 November 2017. She had previously had one child by emergency c-section. Patient A decided to have an elective repeat c-section, due to her concerns about the risks involved in attempting a vaginal birth after caesarean ('VBAC'). The Tribunal considered that it was clear that Patient A had made her decision to have an elective c-section by late August 2017. The hospital scheduled an elective c-section for 07:30 on 10 November 2017. A booking form completed on 10 October 2017 by a midwife notes *'*[Patient A] *very keen to avoid a VBAC due to her previous experience and plan is for a planned section'*.

44. Patient A attended the hospital on 9 November 2017 to have pre-operative bloods taken. Patient A was beginning to experience some pain which was believed to be early labour, she was examined and went home. Patient A telephoned later that evening to report on developments and was advised to come in. She arrived at the hospital at about 20:10 on 9 November. Details of events overnight while Patient A was in triage or Ward 38 are set out in the medical records. She was seen by Dr G, the consultant who had been involved in her

antenatal care, at about 02:30 on 10 November. Dr G noted that Patient A was in established labour and that Patient A was keen on a c-section, Dr G thought the labour was progressing very fast and the plan was to transfer Patient A to the labour suite, with a review to be carried out in 30 minutes. As documented in the LAER Report, a medical review after 30 minutes did not occur.

45. Patient A was moved to the labour suite shortly before 03:00 on 10 November. The records reflect that the midwives on the labour suite were under the impression that Patient A wished to trial a VBAC. However, Patient A believed she was still scheduled to undergo the planned c-section at 07:30 that morning. The hospital has since acknowledged that Patient A did not ever request to attempt a VBAC. The notes of the meeting on 23 February 2018 refer to the lack of a medical review after transfer to the labour suite and that it was confirmed that this would have been an opportunity to clarify that Patient A did not want a VBAC. An epidural was placed at around 04:40. Patient A was unaware that the planned c-section had been cancelled.

46. On arrival at the hospital on the morning of 10 November to begin his shift, Dr Suttie was asked to provide senior cover for the labour suite, to enable the duty consultant, Dr H, to perform other duties. Dr Suttie's role that day included the supervision of Dr D, a Specialty Trainee 5 ('ST5') at the time, who described Dr Suttie as '*the supervisor/acting consultant on floor*' that day. The Tribunal notes that the LAER Report, at section 9, poses the question *'Is Speciality doctor accepted organisationally as senior Labour suite member of staff – how and when does communication occur to a consultant*'.

47. Dr F explained to the Tribunal the difference between a Category 1 and Category 2 c-section, in that a Category 2 is *'immediate need to deliver baby'* and the more urgent Category 1 is *'immediate risk to life of mother/baby'* and that they have different target times set out in NICE guidelines. He further explained the importance of communicating to the whole team the change in urgency following a fetal bradycardia.

48. Dr D sets out her understanding of the expectations of her as a ST5 in relation to two categories of c-sections. Dr D explains that there was a general expectation that she would carry out and lead a patient's delivery, including if they required a Category 2 c-section; that she was expected to start such a procedure and if she encountered any complications during the procedure, she would have been able to call her senior to assist. Dr D explained that in relation to a more urgent Category 1 c-section, there is no set decision about what would be expected of ST5 trainees and it would depend on the ST5 trainee's capabilities and whether the consultant was already physically present, and that a risk assessment would be

undertaken, of who was best placed to undertake the c-section, and a decision made on a case-by-case basis.

49. Dr F did not differ in principle from what was stated by NHS Tayside in their letter dated 12 October 2018 to the effect that specialty trainee doctors from the stage of ST3 are considered competent to perform unsupervised Category 1 c-sections and that Dr D was not outside her scope of practice by leading this delivery. Dr F said that often the only person available might be a ST3, ST4 or ST5, but that each case must be seen on its merits or otherwise. He said that in this case, with the various factors that were present, as set out in the medical records, it behoved the more senior surgeon to intervene because of having greater experience to handle a difficult situation.

50. Dr Suttie said that while working in the department since 2014 as a specialty doctor, his working day generally involved work on the consultant rota except the labour suite. He said that a few times prior to the request that was made of him on 10 November 2017, he had been the 'acting consultant' on the labour suite with a nominated consultant available.

51. Dr F explained that the normal range of fetal heart rate is 110-160 beats per minute ('bpm') and that a significant 'fetal bradycardia' means a sustained slowing of the fetal heart rate to less than 110 bpm for 3 minutes or more. The CTG is used to record the fetal heart rate and uterine contractions.

52. Dr Suttie's first contact with Patient A was during a morning ward round with Dr D at approximately 09:30 to 09:50. Dr Suttie and Dr D had agreed that Dr D would carry out this review as a training exercise and take the lead. Dr D performed a vaginal examination and determined that Patient A's labour had not progressed since her last examination by a midwife at 07:10 and she was still 9cm dilated. Dr D noted that the CTG was 'reactive' and noted her management plan to *'give 2 more hours to decide, Pt aware that if no progress consider emergency CS'*. Dr D discussed with Dr Suttie the plan to wait for two hours and if no further progress was made to consider an emergency c-section. Dr Suttie states that it would be his usual practice to leave the room while a colleague carries out an intimate examination out of consideration for the patient. Dr Suttie trusted Dr D's judgment that Patient A still had a realistic chance of reaching full dilatation and agreed with the plan to continue and to reassess in two hours.

53. Patient A's medical records show various midwife entries during the next period until 11:50. At 11:50 Dr D carried out her second vaginal examination and wrote up her notes. It appears that Dr Suttie was not present at this examination. Dr D determined that Patient A's labour had not progressed and she therefore decided to deliver Baby C by c-section. Dr D

wrote '*P [Plan] For EmCS & stat Category 2, Consent [tick] - pt and partner happy with plan'*. Dr D listed the team members informed of the plan, including Dr Suttie. Dr D was then called away to an urgent request in the antenatal ward, and Patient A was prepared for theatre.

54. The Tribunal noted Dr F's evidence that at this point a Category 2 c-section was appropriate and there is no criticism of this decision. The expert opinion of Dr F is that Dr Suttie's actions, in endorsing Dr D's management plan at 09:50 and decision to proceed with a Category 2 c-section at 11:50, were reasonable.

The key period

55. At 12:05 a midwife noted that Baby C's heart rate had dropped to 89bpm on the CTG and was not recovering, that Patient A was rolled onto her left side and the heart rate increased to 99bpm. These rates were significant because they were below 110bpm. At 12:08 a midwife noted that Dr Suttie was informed of a decreased fetal heart rate and asked to attend Patient A and noted a rate of 88bpm.

56. The Tribunal accepted the evidence of Dr F that the CTG print-out shows a significant drop in Baby C's heart rate for about 30 seconds between 12:05 and 12:06 before recovering, and then a second significant drop at 12:08 to rates below 80bpm. Dr F explained that the chart indicates a brief attempt to recover at about 12:10 but this was an incomplete recovery, and the heart rate did not recover to more than 100bpm. The rate remained in the range 80-100bpm until the chart ends at 12:15pm.

57. The notes state that at 12:15 Patient A was transferred to theatre, all monitors were attached and the fetal heart rate was 98bpm; that at 12:18 the heart rate was 103bpm, the epidural was topped-up, 'paeds' were asked to attend and Dr D was now in theatre; that at 12:22 the heart rate was 111bpm and Patient A's bladder was catheterised by Dr Suttie; that at 12:23 Dr Suttie removed the fetal scalp electrode and at 12:31 Dr D began the c-section operation with 'knife to skin'.

58. It is common ground that Dr D then saw that Baby C was outside the uterus because the previous uterine incision had ruptured. Dr D immediately asked Dr Suttie to scrub in, which he did. Dr Suttie took over at 12:42 (with Dr D assisting him) and Dr Suttie delivered Baby C at 12:43 and sutured the uterus. Baby C was delivered in very poor condition and was attended to by paediatric doctors in theatre, before being taken to the Neonatal Intensive Care Unit. There is no criticism of Dr Suttie for his actions once he was scrubbed in and delivering Baby C.

59. Following Baby C's delivery, at 13:00 Dr Suttie and Dr H, the duty consultant, met to discuss events. At 14:10 Dr Suttie and Dr H saw Patient A to discuss the sequence of events; the Tribunal accept that Dr Suttie did not personally speak to Patient A during this meeting. At 16:30, the team involved in the delivery met with Dr H and Dr Suttie to discuss events, and later that evening Dr Suttie wrote a retrospective entry in Patient A's medical notes.

The Tribunal's Determination on Impairment

Misconduct

60. The Tribunal bore in mind that the facts found proved relate only to Dr Suttie's actions between 12:08 and 12:42 on 10 November 2017.

61. The Tribunal addressed the question of the seriousness of the conduct and whether it crossed the dividing line between (a) a mere breach of professional duty or (b) serious professional misconduct relevant to fitness to practise.

62. The Tribunal took into account Dr F's expert opinion that the conduct of Dr Suttie, once he was called at 12:08 and informed of the fetal bradycardia and asked to attend on Patient A was *'seriously below'* the standard to be expected of a reasonably competent specialty doctor. In his first report, Dr F stated:

> *'Dr Suttie did not act appropriately following the onset of the fetal bradycardia despite its recognition from 12.05 hours onwards on 10 November 2017. Faced with a fetal bradycardia in a woman having a trial of a vaginal birth after caesarean section, with failure to progress beyond 9 cm dilatation for four hours and a fetal malposition with a deflexed head, then the working diagnosis should have been that of uterine rupture with the need for urgent delivery of the baby, although the bradycardia warranted urgent delivery in its own right regardless of the cause. He failed to take the lead over the interventions that followed from the time of his involvement after he was called at 12.08 hours on 10 November 2017, request immediate general anaesthesia, scrub and perform the caesarean section himself as the more senior obstetrician present.*
>
> *By failing to take the lead with the management of the immediate caesarean section and carry out appropriate actions to expedite delivery as described above, Dr Suttie failed to reduce the decision to delivery time interval at a time that the fetus was suffering an ongoing acute profound hypoxic insult.*
>
> *Dr Suttie's overall standard of care was seriously below the standard expected of a reasonably competent Speciality Doctor given his failures to respond appropriately to*

the fetal bradycardia, expedite the delivery, call for a general anaesthetic and perform the caesarean section himself as the senior obstetrician present, thereby delaying delivery at a time that Baby C was being subject to an acute profound hypoxic insult linked to a uterine rupture.'

63. Dr F was asked to prepare a supplemental report after being provided with some additional documents. Dr F confirmed his opinions that the conduct of Dr Suttie fell '*seriously below'* the standard to be expected. The Tribunal also took into account the oral evidence of Dr F in response to questions from the Tribunal.

64. Dr Suttie did not challenge the expert reports of Dr F or question Dr F at the hearing. Dr Suttie told the Tribunal that he agreed with what Dr F had written in his reports. Dr Suttie told the Tribunal that he has always accepted his mistake and does not deny its seriousness.

65. The Tribunal also took into account the adverse factor noted in the LAER Report *'CAT 1 EMCS call not made when urgency changed'*, and what was stated by NHS Tayside in their letter to Patient A dated 12 October 2018, as follows:

'Dr Suttie has discussed Baby C's delivery in detail with Dr H, Clinical Director for Obstetrics & Gynaecology. He has reflected on the care that day and extends his sincere and heartfelt apologies. Dr Suttie recognises that an earlier delivery would have prevented this outcome, and that calling a category 1 would have hastened Baby C's delivery.'

66. The Tribunal considered that the core of the conduct is that, after being called at 12:08 and attending promptly to Patient A's bedside, Dr Suttie failed to accelerate the Category 2 c-section, for which preparations were under way. The Tribunal noted that the facts found proved divide into three main stems:

- Failing to manage Patient A for a uterine rupture with the need for urgent delivery;
- Failing to respond to the fetal bradycardia by minimising the interval between his call at 12:08 and the delivery at 12:43;
- Failing to take the lead from 12:08 in failing to (i) communicate with the anaesthetist for a general anaesthetic, (ii) change the category to 1 or (iii) scrub in and perform the c-section himself from the outset in theatre.

67. The Tribunal considered that the overall failure to accelerate the delivery from 12:08 was because Dr Suttie mis-appreciated the clinical signs in all the circumstances of Patient A's case. He failed to appreciate the inherent risk to Baby C from the fetal bradycardia and failed

to appreciate that once the fetal bradycardia had occurred, the working diagnosis or assumption had to be uterine rupture until proved otherwise, as stated by Dr F. Dr Suttie's mis-appreciation of the clinical signs is directly linked to his omissions by failing to act as set out in the facts found proved.

68. The Tribunal considered that there was no allegation, and no evidence, of chosen behaviour which showed a deliberate choice on the part of Dr Suttie or any moral failing. This was not a case of a doctor showing a deliberate or reckless disregard for patient safety or being absent when called to attend.

69. The Tribunal took into account that Dr Suttie had been asked, on arrival at the hospital that morning, to cover as the 'acting consultant' while the duty consultant was operating elsewhere, meaning that he was in a position of responsibility to cover emergencies in the labour suite. The Tribunal considered that while others were involved in Patient A's care on 9 and 10 November 2017, Dr Suttie was, in the period 12:08 to 12:42, the most senior doctor present and must bear principal responsibility for his conduct once called at 12:08.

70. The Tribunal reminded itself of the principles stated in *Calhaem* above. The Tribunal was mindful that this was a single episode of treatment on one day. However, it was more than one single moment of making a mistake in clinical diagnosis or a decision about treatment. The three divisions of the facts found proved involve more than that. From the time of his call at 12:08, during the transfer of Patient A to theatre, once in theatre and while waiting for the anaesthetist to be satisfied that the epidural had taken effect to allow the operation to begin at 12:31, there was a continuing period of time in which to appreciate the clinical signs of the fetal bradycardia and a working diagnosis of uterine rupture and the urgency of the situation, and to take the lead in relation to a faster method of anaesthesia and scrubbing in to perform the operation himself.

71. The Tribunal considered that Dr Suttie had shown a sustained lack of judgment and poor decision making for more than 20 minutes, in a time-critical situation, as 'acting consultant' on the labour suite and carrying out a vital and life-preserving function. The Tribunal accepted Dr F's expert opinion that the facts found proved fell seriously below the standard to be expected of a reasonably competent specialty doctor. The Tribunal considered that Dr Suttie's failure to appreciate the clinical picture and act accordingly during the time critical period was significant and serious. It considered that his failings demonstrated a serious departure from good clinical practice and care in paragraph 15(a) and (b) of the GMP as set out above. The Tribunal determined that his failings put Patient A and Baby C at risk and could damage confidence in the profession. Bearing in mind the

principles in *Calhaem*, the Tribunal considered that it had not been an obvious case to evaluate. Despite it being a single episode of treatment, the Tribunal considered that when all the elements of the proved facts are taken together, they present a particularly serious picture and just cross the threshold into serious professional misconduct relevant to fitness to practice.

72. The Tribunal has therefore concluded that Dr Suttie's conduct fell so far short of the standards of conduct reasonably to be expected of a specialty doctor as to amount to serious professional misconduct.

Impairment

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

74. The Tribunal determined that the misconduct in this case was a mistake made in a clinical setting which is remediable.

75. The Tribunal considered whether Dr Suttie had apologised to Patient A. The Tribunal noted Patient A's account that when Dr H and Dr Suttie attended on her later on 10 November 2017, Dr Suttie had sat with his head down and had not spoken or made an apology. Dr Suttie does not dispute Patient A's account. The Tribunal was mindful that Dr H was the consultant on duty that day and would reasonably have been expected to lead the conversation with Patient A. Dr Suttie, in his witness statement, stated that his lack of communication after the event during this debrief and during the remainder of Patient A's stay in hospital was largely due to the upset and guilt that he was feeling at the time, and noted that this does not justify a lack of communication at the time. He says that he realises that a direct apology at the time would have been appropriate and that he regrets that it did not occur to him to write a direct letter after her discharge. This is corroborated by his Responsible Officer, Dr E, *'Dr Suttie has also stated that he regrets not speaking to or debriefing the Patient'.*

76. The Tribunal found that Dr Suttie provided a written account for the purposes of the LAER meeting held on 21 December 2017. His Responsible Officer states that he did so and the LAER Report mentions '*review of individual statements'*. The Tribunal was informed by Counsel for the GMC that the GMC had requested a copy of this document but unfortunately NHS Tayside had been unable to locate or provide a copy. The Tribunal was not able to determine whether or not his written account contained an apology.

77. The Tribunal noted the NHS Tayside letter to Patient A on 12 October 2018 which set out that Dr Suttie extended his *'sincere and heartfelt apologies'* (quoted more fully above). The Tribunal concluded that while Dr Suttie had been slow to express his apology to Patient A and had not done so directly, he had made an unqualified apology and admitted his error four years before Patient A complained to the GMC in November 2022. His apology in the October 2018 letter was not prompted by learning of a GMC investigation. The Tribunal also noted the absence of any hint from Dr Suttie of an attempt to evade responsibility or blame anyone else for his conduct in the relevant period from 12:08.

78. The Tribunal then considered Dr Suttie's engagement with the GMC regulatory process. Dr Suttie represented himself at the First Listing Telephone Conference on 10 July 2023, but did not take part in the Pre-hearing Meeting on 2 November 2023. He did not meet the Case Management deadlines for the disclosure of documents, which the Tribunal acknowledged frustrated the GMC's preparations and led to Patient A, Mr B and Dr D having to prepare to give oral evidence. However, the Tribunal further considered that Dr Suttie had engaged in the week before the hearing began, by meeting with Special Counsel appointed under Rule 36(2) to cross examine two vulnerable witnesses and had represented himself at the hearing with commitment and respect for the process. He also provided written testimonials, two witness statements, and presented himself for oral examination. The Tribunal further took into account that Dr Suttie admitted the Allegation in full and did not seek to challenge the evidence of Patient A, Mr B or Dr D in relation to the Allegation, or the expert evidence of Dr F. XXX The Tribunal therefore concluded that, while it was late in the process, Dr Suttie had engaged with the hearing and offered relevant information to assist the Tribunal.

79. The Tribunal next considered Dr Suttie's employment in the period since 10 November 2017. Dr Suttie remains at the hospital, employed by NHS Tayside, in the same department, as a specialty doctor. His Responsible Officer, Dr E, stated that there have been no complaints against him in that time. The Tribunal noted that Dr Suttie has no previous findings of impaired fitness to practise.

80. The Tribunal took into account Dr E's statement, *'In order to prevent reoccurrence Dr Suttie self-reflected and discussed with the service his role and responsibilities which resulted in realignment of duties and he was removed from the consultant rota'.*

81. On the basis of the evidence of Dr E and Dr Suttie, coupled with what is stated in the testimonials, the Tribunal found that Dr Suttie has continued to work in the department since November 2017, with three periods of absence XXX. As stated above, since November 2023 he has been working full-time.

82. The Tribunal accepted the evidence of Dr Suttie that while working in the department since 2014 as a specialty doctor, his working day generally involved work on the consultant rota except the labour suite; and that a few times prior to the request that was made of him on 10 November 2017, he had been the 'acting consultant' on the labour suite with a nominated consultant available. The Tribunal understands that since November 2017, he is not asked to step in as acting consultant in the labour suite, although he is still, in effect, on the consultant rota for his daytime, non-emergency duties and works with consultant cover available.

83. The Tribunal then considered Dr Suttie's Continuing Professional Development ('CPD') since the event. The Tribunal took into account the statement of Dr E that:

> *'Dr Suttie has completed a Perinatal Training Programme (PTP), copy of certificate attached, and has attended PROMPT (Practical Obstetric Multi-Professional Training) however Dr Suttie requires to provide the certificate.'*

84. Dr Suttie, in his witness statement gives more details of his CPD as follows:

> *'- Regular attendance at Clinical Effectiveness days (all day departmental dedicated training and update sessions, often run jointly with the anaesthetic and neonatal departments).*
> *- Attendance at practical skills and emergency training days (PROMPT – Practical Obstetric Multiprofessional Training). This is a biannual multidisciplinary training session in obstetric emergencies run within our department and used in a large number of units nationally and internationally). My Clinical Director has indicated that she would like to add me to the teaching faculty for this.*
> *- Regular completion of the K2 perinatal training package (fetal monitoring) to help ensure ongoing accurate CTG interpretation.'*

85. The GMC did not challenge Dr Suttie on this evidence about training when he presented himself for oral examination. Dr Suttie gave more details orally and told the Tribunal that this was the normal training expected of him as part of his role, and he has not undertaken additional courses as a result of the incident. XXX. It was common ground that Dr Suttie had a successful appraisal and revalidated his licence to practise on 7 August 2022. The Tribunal was mindful that there was no allegation of impairment by deficient professional performance, nor was there an allegation of any lack of knowledge on Dr Suttie's part. The Tribunal considered the positive testimonials provided by five of Dr Suttie's consultant colleagues, and the LAER Report which does not identify a deficiency in Dr Suttie's

knowledge. The Tribunal considered that training of direct relevance to the incident was part of his CPD, some of which is provided by external providers. The Tribunal concluded that Dr Suttie's ongoing training and successful revalidation show that he has kept his skills and knowledge up to date, and there has not been a failure to remedy a lack of knowledge or training.

86. The Tribunal noted that in response to reading the witness statement of Patient A, Dr Suttie intends to take an extra external course on advanced patient communication skills (dates in March/April 2024), even though this falls outside the scope of the facts found proved. The Tribunal considered that this extra course was not necessary to remediate his misconduct, but it accepted that Dr Suttie is sincere in his intention to do the course.

87. In regard to the testimonials provided, the Tribunal gave most weight to the testimonial of Dr I, Consultant Obstetrician and Gynaecologist at the hospital who had known Dr Suttie since he joined the team in 2014. Dr I was clinical director at the time of the events of 10 November 2017 and had assisted in the LAER process and had later met Patient A to discuss the LAER Report and was therefore well aware of events on 10 November 2017. Dr I stated:

> *'In my opinion Dr Suttie is a kind, safe and competent doctor and I have never had concerns about his clinical performance. Although he has the clinical skills to perform the duties of a Consultant, he has always worked in Tayside at a level below this when providing emergency care. When providing emergency care he supports the O&G Registrar Rota and when he works on the labour ward, he has Consultant supervision. Nevertheless, in my opinion Dr Suttie has the skills to manage labour and birth and perform operative births [Caesarean Section and Operative Vaginal Birth] independently.'*

88. The Tribunal further took into account the testimonial provided by Dr J, who has worked with Dr Suttie at NHS Tayside for almost ten years, *'I believe that he is a compassionate doctor with a safe pair of hands and he is an asset to both our department and the patients under his care.'*

89. The Tribunal, taking into account Dr Suttie's apology, engagement with the LAER, engagement with the GMC, ongoing training, and continuing work at the hospital, determined that he has remediated sufficiently.

90. The Tribunal next considered whether Dr Suttie has shown insight into his misconduct. The Tribunal considered the submissions of Ms Fairley that '*there is little*

reflection, explanation or acknowledgement within the documents provided by Dr Suttie relating to the impact on Patient A and her family both of his index failures and his delay in admitting the allegations. Therefore the GMC submit that Dr Suttie's insight could not properly be said to be complete'. The Tribunal found that whilst this unrepresented doctor did not express this aspect of insight in the manner desired by the GMC, he nonetheless demonstrated insight through his earnest reflections on all these matters throughout the hearing.

91. The Tribunal considered that Dr Suttie apologised to Patient A via the NHS Tayside letter in October 2018, and had not, at any point, sought to place blame on others or deny his mistake.

92. The Tribunal considered the evidence of Dr E that Dr Suttie self-reflected and expressed regret and the evidence of Dr I in his testimonial about the effects that the case of Patient A and Baby C has had on Dr Suttie.

93. The Tribunal considered Dr Suttie's statement, in which he stated:

> *'I have always realised I made a serious mistake that day in not immediately suspecting a uterine rupture when the fetal bradycardia occurred, and then acting accordingly by calling a category 1 caesarean section. … I have always accepted that I should have acted with greater urgency in response to the bradycardia. … . I deeply regret this and have regretted this every day since it happened, and I have continued to self reflect on this since then.'*

94. The Tribunal also considered Dr Suttie's oral evidence, in which he said his reflection on the case will never stop and will be in his mind for the rest of his career. He stated that he has reflected on this event almost every day since it happened. In response to the criticism that he had not set out in his written statement his understanding of the impact on Patient A, Baby C, and their family, Dr Suttie stated that it was 'self-evident' that he has had regret every day since it happened and has talked about the impact on Patient A at length. The Tribunal accepted his position that the impact on Patient A and Baby C was clear from the outcome which very sadly occurred, and it was not incumbent on Dr Suttie to produce a written piece which stated every item he had reflected on in the last six years.

95. The Tribunal found that Dr Suttie's actions since the events, and the reflections he has provided to this Tribunal, have been sincere and compelling in regard to his insight. The Tribunal accept that this regulatory process will have been extremely stressful for Dr Suttie XXX. The Tribunal found that Dr Suttie was perceptive, insightful and credible, and that he

was sincere when he stated, '*my reflection will never stop, I will have it in my mind for the rest of my career*'. The Tribunal further took into account that Dr Suttie admitted the Allegation, acknowledged that his mistake was serious, accepted responsibility and feels intense regret. The Tribunal found that Dr Suttie appreciates the magnitude of his serious misconduct and the consequences for Patient A, Baby C, and their family.

96. Turning to Ms Fairley's reliance on paragraphs 34, 55, 61, and 73 of GMP, in relation to the issue of current fitness to practise, the Tribunal considered that paragraph 34 did not apply, and that there was no or no material departure from the other paragraphs by Dr Suttie.

97. The Tribunal therefore concluded that Dr Suttie has developed sufficient insight so as to address the misconduct.

98. The Tribunal then considered the risk of repetition. The Tribunal determined that Dr Suttie's misconduct on 10 November 2017 was totally out of step with the rest of his competent service at the hospital for 10 years and that he is committed to wanting to continue. The Tribunal determined that it was an isolated episode of lapse of judgement and poor decision making, rather than a deficiency in knowledge or skill. The Tribunal further took into account Dr Suttie's insight, remorse and remediation, and determined that the risk of him repeating this clinical error in the future is highly unlikely.

99. The Tribunal then turned to the factors set out in the case of *Grant*. The Tribunal determined that Dr Suttie had, in the past, put a patient at unwarranted risk of harm, and breached a fundamental tenet of the profession, however it was highly unlikely that he would do so again in the future. The Tribunal found that this misconduct was an isolated episode in an otherwise unblemished career.

100. The Tribunal considered that, given its findings that the risk of repetition of the misconduct is highly unlikely, a finding of impairment is not required in order to protect, promote and maintain the health, safety and well-being of the public. With regard to promoting and maintaining both confidence in the profession and proper professional standards, the Tribunal considered that, given it has found that Dr Suttie's conduct amounts to serious misconduct, the gravity and consequence of his actions for Patient A and Baby C had been openly recorded for members of the profession and public to see. Members of the public will understand the high level of scrutiny that Dr Suttie has been under and that a finding of serious misconduct will weigh heavily on him. This public finding will be sufficient to maintain confidence in the profession. Members of the profession will recognise that there are serious implications of carrying out work seriously below the standard to be

expected, which will help to promote and maintain proper professional standards and conduct. A finding of impairment of fitness to practise is not necessary in order to promote and maintain public confidence in the medical profession, or to promote and maintain proper professional standards and conduct for members of the profession.

101. The Tribunal has therefore determined, after careful consideration of the overarching objective, that Dr Suttie's fitness to practise is not impaired.

Determination on Warning - 01/02/2024

102. As the Tribunal determined that Dr Suttie's fitness to practise was not impaired it considered whether in accordance with s35D(3) of the 1983 Act, a warning was appropriate.

Submissions

103. On behalf of the GMC, Ms Fairley submitted that a warning would be appropriate in this case. Ms Fairley referred the Tribunal to paragraphs 61-65 of The Sanctions Guidance (2020) ('SG') and the Guidance on Warnings, March 2021. Ms Fairley submitted that a warning should be used as a formal response to misconduct, in order to maintain public confidence in the profession and maintain proper professional standards. Ms Fairley further submitted that it would normally be appropriate to issue a warning following a specific breach of GMP.

104. Ms Fairley submitted that in the Tribunal's decision on impairment, it found significant and serious misconduct which demonstrated a serious departure from GMP, these failings put Patient A and Baby C at risk and could damage confidence in the profession. Ms Fairley submitted that the Tribunal should consider that Dr Suttie's failings not only put Patient A and Baby C at risk of harm, but harm did occur. Ms Fairley submitted that the factors outlined in paragraph 20 of the Guidance on Warnings are relevant in this case: there was a clear and specific breach of GMP, the particular conduct approached but fell short of a finding that Dr Suttie's fitness to practise is impaired, the concerns were sufficiently serious that a repetition would likely result in a finding of impaired fitness to practise, and there is a need to formally record the particular concerns.

105. Ms Fairley acknowledged that the factors set out at paragraph 32 of the Guidance on Warnings are met in this case, and the GMC does not submit that Dr Suttie's conduct, or current conduct indicate that any of these factors are anything other than in his favour. Nevertheless, Ms Fairley submitted that the seriousness of the departure from GMP needs to

be marked to send an appropriate signal to the public and wider profession to acknowledge the seriousness of Dr Suttie's failures. Further, she submitted that it is a proportionate response and necessary to uphold public confidence in the profession and uphold proper professional standards.

106. Dr Suttie submitted that he would hope that the factors in paragraph 32 of the Guidance on Warnings can be taken into account and would mean that a warning was not considered necessary. Dr Suttie submitted that he understands the importance of maintaining public confidence in the profession and maintaining appropriate professional standards.

The Tribunal's Determination on Warning

107. The Tribunal had regard to the overarching objective, as well as the particular circumstances of this case, and applied the principle of proportionality, weighing the interests of the public with those of Dr Suttie. The Tribunal bore in mind that the reputation of the profession as a whole is more important than the interests of any individual doctor. The Tribunal further took into account the SG, Guidance on Warnings, and its previous determination on Dr Suttie's fitness to practise.

108. The Tribunal bore in mind that this was a single episode of misconduct which formed a serious departure from the good standard of clinical care and practice as set out in paragraph 15 (a) and (b) of GMP, however it determined that Dr Suttie's conduct only just crossed the threshold into serious professional misconduct relevant to fitness to practise. The Tribunal reminded itself that this was not chosen or deliberate behaviour that arose out of a characteristic or propensity for immoral conduct. The Tribunal has found that this was an isolated episode in an otherwise unblemished career.

109. The Tribunal considered the factors set out in paragraph 32 of the Guidance on Warnings:

> *'32 If the decision makers are satisfied that the doctor's fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of factors to determine whether a warning is appropriate. These might include:*
>
> *a the level of insight into the failings*
>
> *b a genuine expression of regret/apology*
>
> *c previous good history*
>
> *d whether the incident was isolated or whether there has been any repetition*
>
> *e any indicators as to the likelihood of the concerns being repeated*

f any rehabilitative/corrective steps taken g relevant and appropriate references and testimonials.
g relevant and appropriate references and testimonials.'

110. The Tribunal, in its decision on impairment, set out that Dr Suttie has well-developed insight into his misconduct, he has acknowledged that his mistake was serious, and accepted responsibility for it. Further, the Tribunal has found that Dr Suttie has made a genuine expression of regret and apologised, has no previous adverse findings of fitness to practise, and the risk of repetition is highly unlikely. This was an isolated incident which occurred in November 2017 and his Responsible Officer has confirmed that no complaint has been raised against him since. The Tribunal also considered the five positive testimonials from consultant colleagues.

111. The Tribunal was satisfied that Dr Suttie already fully understands that his conduct on 10 November 2017 was a departure from the standards expected of him, and that it had a serious impact on Patient A, Baby C and their family. The Tribunal was satisfied that Dr Suttie feels intense regret and responsibility for his actions and has found that the risk of repetition is highly unlikely. It therefore determined that a warning is not necessary to ensure Dr Suttie understands the seriousness of his misconduct, and no further deterrent was required in this case.

112. The Tribunal concluded that the circumstances of this case do not warrant a formal response, and it would therefore not be appropriate to issue a warning.