PUBLIC RECORD

Dates: 12/02/2024 - 23/02/2024

Medical Practitioner's name: Dr Luke CASCARINI

GMC reference number: 4746717

Primary medical qualification: MB BCh 2000 University of Wales

Type of case
New - Misconduct

Outcome on facts
Facts relevant to impairment found proved

Outcome on impairment
Consideration of impairment not reached

Summary of outcome
Case concluded

Tribunal:

Legally Qualified Chair	Ms Margaret Obi
Lay Tribunal Member:	Mr George Ritchie
Medical Tribunal Member:	Dr Candida Borsada

Tribunal Clerk:	Mr Josh Dayco

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Christopher Geering, Counsel, instructed by DWF Law
GMC Representative:	Mr David Claxton, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 22/02/2024

Background

1. Dr Cascarini qualified in 2000 having obtained a Bachelor of Medicine and Bachelor of Surgery degree from the University of Wales. Prior to his medical degree, he obtained a Bachelor of Dental Surgery degree from the University of Bristol Dental School in 1995.

2. Dr Cascarini was appointed as a Consultant Oral and Maxillofacial Surgeon in 2010. He held various surgical posts at North West London Hospitals NHS Trust from January 2010 to July 2014 and Guy's and St Thomas' NHS Foundation Trust from July 2014 to April 2019. Dr Cascarini ceased working as an NHS Oral and Maxillofacial Consultant in April 2019. At the time of the events, Dr Cascarini was practising privately as a Consultant Oral and Maxillofacial Surgeon at the Harley Street Specialist Hospital ('the Hospital'). He is the head of the Maxillofacial Department at the Hospital and a member of the Medical Advisory Committee. He also holds practising privileges at the Sloane Hospital (Circle Health) in Kent and the London Clinic.

3. Prior to Patient A's referral to Dr Cascarini, he had been carrying out orthognathic surgery (jaw surgery) for 8 years since his appointment as a consultant.

4. The allegation that has led to these proceedings can be summarised as follows.

5. On 28 August 2018, Patient A was referred to Dr Cascarini by an Ear Nose and Throat (ENT) surgeon due to pain in her left ear. Patient A indicated that she had been experiencing this pain for years and it was getting worse. Patient A's first consultation with Dr Cascarini took place on 21 September 2018. At that consultation, Dr Cascarini arranged for an MRI scan of Patient A's temporomandibular joints ('TMJ'). The MRI scan took place on 25 September 2018. Dr Cascarini, having reviewed the MRI scan, formed

the opinion that Patient A's pain was most likely due to bilateral cross bites (misalignment of the teeth) and an anterior open bite (front upper and lower teeth do not touch when closed), which was putting a strain on Patient A's jaw joints and muscles. Dr Cascarini took the view that Patient A would most likely require a combination of orthodontic treatment and orthognathic surgery to correct this.

6. Dr Cascarini referred Patient A to an orthodontist but ultimately Patient A was seen by Ms B, a Consultant Orthodontist, via self-referral. Patient A's first appointment with Ms B took place on 19 August 2019. In October 2019, Dr Cascarini received a letter from Ms B, who had assessed Patient A and discussed her treatment options. Ms B agreed with Dr Cascarini that Patient A's TMJ pain was most likely due to her jaw anatomy. Ms B advised that for Patient A to achieve skeletal correction, she would require a combination of orthodontic and orthognathic surgery in the form of: surgically assisted rapid palatal expansion ('SARPE'); pre-surgical orthodontic treatment; possible mandibular (lower jaw) and maxillary (upper jaw) osteotomies (i.e. bimaxillary bone-cutting surgery) for definitive dento-facial correction; and post-surgical orthodontic treatment. Ms B stated that Patient A had done extensive reading around the procedure and was highly motivated to undertake treatment as soon as possible.

7. On 3 December 2019, Dr Cascarini saw Patient A in a joint consultation with Ms B. The various treatment options were discussed during this consultation. Dr Cascarini wrote to Patient A on the same date (3 December 2019), summarising the treatment plan.

8. The SARPE procedure was carried out on 13 January 2020, without complication, and Patient A was discharged the following day. Thereafter, the orthodontic treatment proceeded and in July 2021, Dr Cascarini received a letter from Ms B confirming that Patient A had completed her pre-surgical treatment in preparation for bimaxillary surgery.

9. On 15 July 2021, Dr Cascarini saw Patient A in a multi-disciplinary orthognathic clinic with Ms B and Mr E, Consultant Oral and Maxillofacial Surgeon. It was agreed that the orthodontic preparation was almost complete, and that Patient A would soon be ready for orthognathic surgery. A bimaxillary osteotomy, combined with a genioplasty (chin surgery) was recommended. The primary purpose of the surgery was to address Patient A's malocclusion (misalignment of the teeth). Patient A had only limited contact on her back teeth which with a steep occlusal plane (biting surface) seemed to put an excessive

load on her jaw joints and Dr Cascarini believed that this was a factor in her TMJ problem.

10. On 10 August 2021, Dr Cascarini sent a pre-operative letter to Patient A confirming the planned procedure which was '*Osteotomy of the maxilla* (*and bilateral) + Septoplasty of nose (including attention to turbinates) + Genioplasty*'. In addition, a post-operative information sheet was sent to Patient A, and this was signed by her, confirming that she had understood the information it contained.

11. On 26 August 2021, Dr Cascarini performed a bilateral maxillary osteotomy and a genioplasty ('the Procedure') on Patient A. Prior to the operation, Dr Cascarini went through the consent form with Patient A. Dr Cascarini carried out the Procedure jointly with his consultant colleague, Mr D ('the Surgeons'). The operation did not run as smoothly as the Surgeons would have hoped. Firstly, they carried out the planned maxillary osteotomy and used an intermediate wafer (also referred to as an interpositional wafer) to guide the maxilla into the pre-planned position. The Surgeons found the positioning of the wafer to be difficult and struggled to obtain the intended positioning of the maxilla (known as 'impaction'). The Surgeons concluded that they needed to remove additional bone posteriorly and this took them longer than expected. After the maxilla was positioned and fixed, the Surgeons proceeded to the mandibular surgery.

12. Mr D then osteotomised the left side of the mandible without complication. On the right side, Dr Cascarini carried out the usual cuts but when he osteotomised the mandible, the splits did not follow the intended pattern (known as an '*unfavourable'* or '*adverse'* split) and he was left with a condyle (round prominence at the end of the jaw bone) still attached to the distal fragment. The Surgeons discussed the options at this stage and decided to attempt a high condylar osteotomy in order to allow completion of the operation. They fixed a fractured piece of the bone back to the mandible. They then positioned the mandible into the final wafer and applied the fixings.

13. The Surgeons agreed that in view of the adverse split, Patient A would require post-operative intermaxillary fixation using tight elastics.

14. Later that afternoon (26 August 2021), when Patient A had woken up from the anaesthetic, she was told by Dr Cascarini that unfortunately she had had an unfavourable split on the right side, and it would be necessary for him to apply tight elastics. During his

oral evidence, Dr Cascarini stated that he applied the tight elastics whilst Patient A was in recovery. Mr D reviewed Patient A on 27 August 2021 and she was discharged later that day.

15. Following the discharge, Patient A and Dr Cascarini remained in contact. Subsequently, concerns were raised about the outcome of the operation.

16. It is alleged that Dr Cascarini failed to provide Patient A with good clinical care in that he:

- failed to adequately record his discussions with Patient A concerning the risk that the planned occlusion (contact between the upper and lower teeth) may not be achieved;
- failed to use simple measurements following the failure of the interpositional wafer; and
- failed to consider re-operating within a few days of the Procedure.

17. It is also alleged that Dr Cascarini failed to discharge his duty of candour and acted dishonestly, in assuring Patient A that the Procedure had been a success, and he was pleased under the circumstances when he knew that the Procedure had not been successful. It is further alleged that it was not until the consultation with Patient A and Ms B, that Dr Cascarini answered in the affirmative when he was asked the question '*Did the surgery go wrong*?.'

The Outcome of Applications Made during the Facts Stage

18. At the outset of the hearing, the Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to withdraw particular paragraphs and amend a paragraph of the Allegation. The Tribunal's full decision on the application is included at Annex A.

19. On 15 February 2024, the Tribunal granted the application made by Mr Geering, on behalf of Dr Cascarini, under Rule 17(2)(g) of the Rules, apart from the application in relation to paragraph 1(a)(ii) of the Allegation. The Tribunal's full decision on the application is included at Annex B.

The Allegation and the Doctor's Response

20. The Allegation made against Dr Cascarini is as follows:

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

1. Between 21 September 2018 and 6 December 2021 you consulted with Patient A and you failed to provide good clinical care in that:
   a. on 26 August 2021 you performed a bilateral maxillary osteotomy and/or a genioplasty ('the Procedure') and you:
      ~~i. failed to obtain informed consent from Patient A as you did not:~~
         ~~1. advise Patient A of the risk that the planned occlusion may not be achieved;~~
         Deleted following successful application under Rule 17(2)(g)
         ~~2. outline to Patient A that a sub optimal outcome was possible;~~
         Deleted following successful application under Rule 17(2)(g)
      ii. in the alternative failed to adequately record your discussions with Patient A as described at paragraph 1. a. i.;
      Admitted and found proved in relation to paragraph 1(a)(i)(1)
      To be determined in relation to paragraph 1(a)(i)(2)
      ~~iii. planned the Procedure inappropriately in that Patient A had a Class II dental base relationship which contraindicated the use of a sagittal split osteotomy to reposition her mandible backwards, since it was already relatively retrusive;~~
      Withdrawn under Rule 17(6)
      iv. failed to adequately carry out the Procedure in that:
         1. following the suggested failure of the interpositional wafer you failed to use:
            ~~a. the anterior nasal spine to judge the midline of the maxillary advancement in relation to the nasal septum; and / or~~
            Withdrawn under Rule 17(6)

b. simple measurements to achieve an appropriate level of maxillary ~~advancement~~ movement;

Amended under Rule 17(6)

~~2. you did not address the mandibular condyle being left on the buccal fragment of the mandible ('the adverse split'):~~

~~a. by creating a second bone cut separating the mandibular condyle from the rest of the lower jaw and to repair the fractured buccal plate; and / or~~

Withdrawn under Rule 17(6)

~~b. placing Patient A into intermaxillary fixation for a period of weeks to allow bone healing to take place;~~

Withdrawn under Rule 17(6)

b. following the Procedure you failed to:

i. adequately consider re-operating within a few days of the Procedure to properly position both the mandible and maxilla in relation to each other in order to provide an appropriate surgical outcome;

To be determined

ii. explain to Patient A the likely consequences of not re-operating.

To be determined

2. You failed to record the failure of the interpositional wafer.

To be determined

3. You failed to adequately discharge your duty of candour in that:

a. following the Procedure you failed to inform Patient A:

i. of the difficulties that had been experienced during her Procedure;

To be determined

ii. that the Procedure had not gone according to plan with regards to the maxilla;

To be determined

b. during a consultation on 31 August 2021 you:

~~i. told Patient A that she had had an unfavourable split but you had managed to fix it, or words to that effect;~~

Withdrawn under Rule 17(6)

ii. assured Patient A that the Procedure had been a success and that 'you were pleased under the circumstances', or words to that effect;

To be determined

c. it was not until a consultation with Patient A and Miss B on 4 October 2021 when Patient A asked you 'Did the surgery go wrong?' that you answered 'Yes', or words to that effect.

To be determined

4. You knew that:

~~a. the adverse split had not been fixed;~~

Withdrawn under Rule 17(6)

b. the Procedure had not been successful.

To be determined

5. Your conduct as set out at paragraph 3. b. was dishonest by reason of paragraph 4.

To be determined

6. You failed to maintain adequate medical records in that you did not adequately record:

~~a. the planned orthognathic movements for the Procedure;~~

Withdrawn under Rule 17(6)

~~b. a documented plan;~~

Withdrawn under Rule 17(6)

~~c. the decisions made;~~

Deleted following successful application under Rule 17(2)(g)

d. the information provided to Patient A;

Admitted and found proved

e. a description within the operation note of the problems relating to the interpositional wafer;

To be determined

f. the post-operative findings.

Admitted and found proved

~~7. You inappropriately invoiced Patient A's insurers for a septoplasty as a separate and chargeable procedure.~~

Deleted following successful application under Rule 17(2)(g)

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

21. At the outset of these proceedings and on Day Five of the hearing, Mr Geering, on behalf of Dr Cascarini, made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Expert Witness Evidence

22. The Tribunal received evidence from two expert witnesses:

- Mr F, Consultant Oral and Maxillofacial Surgeon, instructed on behalf of the GMC. He provided an expert report dated 4 January 2023. In addition, he provided four supplemental expert reports dated 24 January 2023, 2 March 2023, 25 August 2023, and 28 December 2023.
- Mr G, Consultant Oral and Maxillofacial Surgeon, instructed on behalf of Dr Cascarini. He provided an expert report dated 12 December 2023. In addition, he provided a witness statement dated 2 February 2024.
- A joint expert report was also produced and was signed by both expert witnesses on 12 February 2024.

23. Mr G in his witness statement, dated 2 February 2024, set out the adverse comments that Mr F had made about Dr Cascarini at the outset of their first joint expert meeting on 5 January 2024.

Witness Evidence

24. The Tribunal heard oral evidence, on behalf of the GMC, from Patient A, in person. The Tribunal also received evidence, on behalf of the GMC, in the form of a witness

statement from Ms B, dated 9 August 2023, and a supplemental witness statement dated 6 December 2023. Ms B was not called to give oral evidence.

25. Dr Cascarini provided the Tribunal with a witness statement dated 10 December 2023 and chose to give oral evidence at the hearing. In addition, the Tribunal was provided with a witness statement from Mr D who, with Dr Cascarini, had jointly performed the surgery on Patient A. Mr D's witness statement is dated 10 December 2023 and he gave oral evidence via video-link.

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

- Mr E - Consultant Oral and Maxillofacial Surgeon (dated 11 December 2023);
- Mr H - General Manager at LycaHealth (dated 14 November 2023);
- Mr I - Consultant Oral and Maxillofacial Surgeon (dated 26 November 2023);
- Patient C (dated 22 January 2024).

27. Patient C is a patient of Dr Cascarini. She was referred to Dr Cascarini sometime in 2020. Patient C stated that during the during the course of the litigation of her personal injury claim against the other driver, she had to be examined by the defendant's expert, who was Mr F. In her witness statement, Patient C described the adverse comments that Mr F made about Dr Cascarini.

Summary of Dr Cascarini's oral evidence

28. Dr Cascarini, having identified several minor errors within his witness statement that needed to be corrected, adopted the statement as his evidence in chief. Dr Cascarini outlined his professional career as a surgeon and confirmed no adverse findings have been made against him by any court or Tribunal, nor has he been subject to any disciplinary procedures.

29. Dr Cascarini accepted that his documentation of the consent process in relation to Patient A was poor. He accepted that he should have recorded his discussion with Patient A that the planned occlusion may not be achieved.

30. Dr Cascarini explained what took place during the Procedure. He stated that although there had been difficulties with the interpositional wafer, by the end of the surgery

Patient A was in Class 1 occlusion (normal relationship between upper teeth, lower teeth, and jaw) with no anterior bite and despite the unfavourable split, the final wafer fitted correctly. He stated that he was satisfied that the planned movements had been achieved. It was agreed in discussion with Mr D that given the complication that had arisen, Patient A would require post-operative intermaxillary fixation. Dr Cascarini believed that the maxilla and mandible were in a reasonable position. He stated that if the maxilla had been pulled down, it would have been glaringly obvious, and he would have taken steps to re-position it during the Procedure. Dr Cascarini assured the Tribunal that neither he nor Mr D would simply ignore a maxilla which was clearly positioned incorrectly.

31. Immediately postoperatively, Dr Cascarini did not notice anything remarkable about Patient A's face. He said that Patient A looked as he would expect her to look in terms of the swelling, etc.

32. On 7 September 2021, Patient A sent Dr Cascarini a WhatsApp message about a hole appearing in her gum and sent photographs of her face. Dr Cascarini reassured her. However, on 9 September 2021, he messaged Patient A to inform her that the maxilla appeared to have moved to a lower position. He made arrangements to see her as soon as possible.

33. Dr Cascarini reviewed Patient A with Mr D on 14 September 2021. He noticed that the maxilla was slightly lower on the right side. Dr Cascarini thought that the tight elastics may have caused the adverse movement. He lightened and adjusted the elastics. He recommended a wait and see approach to assess how things would settle for Patient A before re-operating.

34. A further review of Patient A took place with Dr Cascarini and Ms B on 4 October 2021. Dr Cascarini noted that Patient A's upper jaw was vertically excessive, and she was showing more gum than she wanted. He stated that he explained to Patient A what had happened during the Procedure. However, it was unclear to him why her maxilla appeared to be vertically excessive as it had been correctly positioned at the end of the surgery.

35. With the benefit of hindsight, Dr Cascarini believes that the asymmetry developed post-operatively and was probably due to the elastics, the length of time the brackets were

de-bonded and some sag from the adverse split.

Documentary Evidence

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

- Various text messages between Dr Cascarini and Patient A;
- Various letters and email correspondence sent by Dr Cascarini to Patient A;
- Various photographs of Patient A;
- MRI scan report from Dr J dated 19 October 2018;
- Reports from Dr K following the facial bone scan dated 3 August 2021 and 26 September 2021;
- Medical notes of Patient A from Harley Street Specialist Hospital;
- Complaint from Patient A to Dr Cascarini dated 10 November 2021;
- Correspondence from Ms M, Consultant Oral Maxillofacial Surgeon, to Patient A;
- Various correspondence between Patient A and Patient A's new consultant;
- Various correspondence between Dr Cascarini and Ms B;
- Patient A's clinic notes;
- Patient information leaflets provided by Ms B to Patient A;
- Various emails between Dr Cascarini and the GMC;
- Dental notes for Patient A from Ms B;
- Various email correspondence from Patient A to the GMC;
- Dr Cascarini's Curriculum Vitae;
- Email correspondence from Mr L of ProtoMed to Dr Cascarini and Ms B;
- Final ProtoMed plan signed off by Dr Cascarini;
- Various text messages between Dr Cascarini and Mr D;
- Dr Cascarini's mobile phone records;
- Various character reference and testimonials from Dr Cascarini's professional colleagues and acquaintances.

The Tribunal's Approach

37. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Cascarini does not need to prove anything. The standard of proof is that applicable to civil proceedings,

namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.

38. In relation to paragraph 5 of the Allegation, the Tribunal accepted the advice of the Legally Qualified Chair that it should apply the test for dishonesty set out in *Ivey v Genting Casinos (UK) Limited (t/a Crockfords Club) [2017] UKSC 67*.

> *'When dishonesty is in question the fact-finding Tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

39. The Tribunal also accepted the advice of the Legally Qualified Chair that it was for the Tribunal to decide to what extent Dr Cascarini's previous good character and admissions assist it in determining the facts, and what weight, if any, to attach to these features.

The Tribunal's Analysis of the Evidence and Findings

40. The Tribunal considered each outstanding paragraph of the Allegation separately and evaluated the evidence to reach findings on the facts.

41. In considering paragraph 1 of the Allegation, the Tribunal noted the stem of paragraph 1, which states as follows: *'Between 21 September 2018 and 6 December 2021 you consulted with Patient A and you failed to provide good clinical care in that:'*.

Paragraph 1(a)(ii) of the Allegation

42. The Tribunal noted that this allegation refers to two sub-paragraphs of the Allegation. First, Dr Cascarini's failure to adequately record his discussions with Patient A relating to the risk that the planned occlusion may not be achieved. The Tribunal noted that informed consent is a continuous process, not a singular event. Ms B stated in her

witness statement, dated 9 August 2023, that during the joint consultation with Dr Cascarini which took place on 15 July 2021, he advised Patient A "*that potentially her jaw problem may not improve, but he hoped after the jaw surgery to improve her bite, so more of her teeth would come into contact with each other, the jaw problem would also improve however he made no promises*." Dr Cascarini admitted that he had not made a record of his discussions with regard to the risk that the planned occlusion may not be achieved and was found proved by the Tribunal.

43. Second, Dr Cascarini's failure to adequately record his discussions with Patient A outlining that a sub-optimal outcome was possible. This was the issue the Tribunal was required to determine, in relation to paragraph 1(a)(ii).

44. The Tribunal noted that the consent form signed by Patient A on 26 August 2021 recorded that Dr Cascarini discussed the risks of the Procedure with Patient A. The list of risks were handwritten and included "*…pain, swelling, bleeding, infection, numbness lips and face, relapse, nasal changes, change in appearance, (you may not like it)*". Patient A had limited recollection of the discussion with Dr Cascarini on the day of the Procedure and doubted that she had been advised of the risk that there may be changes to her appearance that she would not like. This was unsurprising given the passage of time. However, the Tribunal took the view that as the consent form is a contemporaneous record, greater reliance could be placed on it than on the imperfect memory of Patient A several years after the event.

45. The Tribunal concluded that lasting numbness, relapse, and facial changes were not the incidental consequences of surgery but long-term adverse consequences which are appropriately characterised as sub-optimal outcomes. Therefore, the Tribunal was satisfied that Dr Cascarini had adequately recorded his discussions with Patient A with regard to possible sub-optimal outcomes.

46. The Tribunal noted that based on the witness statement of Ms B, dated 9 August 2023, there was evidence that Dr Cascarini had a discussion with Patient A about the possible sub-optimal outcomes prior to the date of the Procedure. These discussions took place on 3 December 2019 and 15 July 2021 and included nerve damage and numbness. There was no evidence before the Tribunal that Dr Cascarini had recorded these discussions.

47. As stated above, the Tribunal was mindful that informed consent is a continuous process rather than a singular event. Although the consent process culminated in the consent

form signed by Patient A on 26 August 2021, the Tribunal concluded that the earlier discussions were part of that process. A restrictive interpretation of the allegation, based solely on the information given on the date of the signed consent form, was not in the interests of justice.

48. Therefore, for these reasons, the Tribunal found paragraph 1(a)(ii) of the Allegation proved.

Paragraph 1(a)(iv)(1)(b) of the Allegation

49. The Tribunal considered whether Dr Cascarini failed to adequately carry out the Procedure in that following the suggested failure of the interpositional wafer, he failed to use simple measurements to achieve an appropriate level of maxillary movement.

50. In considering this paragraph of the Allegation, the Tribunal noted that the GMC's case was based on the expert evidence of Mr F. The opinion evidence of Mr F was challenged by Mr Geering on a number of fronts. He invited the Tribunal to disregard the entirety of Mr F's evidence. He submitted that Mr F's opinions could only have evidential value if he is demonstrably impartial. Mr Geering further submitted that Mr F had demonstrated real and tangible bias which had been compounded by a lack of professionalism and lack of preparedness.

51. The Tribunal considered the unchallenged witness statement of Patient C dated 22 January 2024. She stated:

> *'First, [Mr F] started asking me a series of questions including who had referred me to [Dr Cascarini] and why they had referred me to him.*
>
> *Mr F then said that [Dr Cascarini] was not good at his job and that he had operated on me unnecessarily as there was nothing wrong with my jaw.*
>
> *I told Mr F that [Dr Cascarini] had advised that I may potentially need jaw replacement surgery. He said that [Dr Cascarini] was only saying that in order to take my money.*
>
> *I found Mr F rude and arrogant and his comments about [Dr Cascarini] wholly unprofessional.'*

52. The Tribunal also considered the unchallenged witness statement of Mr G dated 2 February 2024. He stated:

> *'This statement is made from my recollection of joint expert discussions held with Mr F…*
>
> *It became apparent during my discussions with [Mr F] that he has a history with [Dr Cascarini] which has caused him to have a pre-conceived view of [Dr Cascarini] which appeared overwhelmingly negative to me.*
>
> *Even before we began discussing the allegations for this matter, [Mr F] explained to me that he had come across [Dr Cascarini] in the past following a previous GMC investigation. He also told me that he knew Patient A had issued a separate medical negligence claim against [Dr Cascarini] but he did not divulge how he came about this information.*
>
> *[Mr F] went on to say that he knew a couple of professional colleagues who are involved in medico-legal work where they have dealt previously with civil cases involving [Dr Cascarini].*
>
> *I was concerned that [Mr F] was quite disparaging of [Dr Cascarini]. I told [Mr F] that I take every case on its merit and I do not want to be influenced by what I had heard from others about previous cases or investigations.*
>
> *[Mr F] spent a lot of time discussing his concern over the sum of money [Dr Cascarini] had charged Patient A for the procedure…*
>
> *I feel that [Mr F] let his personal opinion of [Dr Cascarini] dictate his response to the allegations we are considering in this matter. I felt that he had a very negative opinion of [Dr Cascarini], his surgical ability and professional motivation which was based not on the facts of this matter but rather a historic view…'*

53. The Tribunal noted that during cross-examination Mr F stated that he could not recall the remarks and attitude attributed to him by Patient C. He also denied having a pre-conceived view of Dr Cascarini. However, he conceded that during his conversation with Mr G he wanted to know if Mr G was aware of Dr Cascarini's history. The Tribunal

concluded that it was highly unlikely that two people (Patient C and Mr G) with no connection would both independently form the view that Mr F had a negative opinion of Dr Cascarini unless their accounts were true and accurate. The Tribunal was satisfied that Mr F had made the comments that were attributed to him by Mr G and Patient C. The Tribunal concluded that the comments made to Mr G were inappropriate, and he ought to have known they were inappropriate. Experts must be able to provide impartial, unbiased, objective evidence on matters within their field of expertise. Any potential conflict must be disclosed as soon as possible so that an informed decision can be made as to whether the expert is impartial. The Tribunal concluded that had Mr F applied his mind to his professional duties as an expert witness he would not have made the following declaration in his first report dated 4 January 2023: "*I confirm that I do not have a conflict of interest, and see no reason why I am unable to prepare this report*." nor would he have made the following declaration on subsequent reports: *"I can confirm that there is no conflict of interest relating to this case. I have not met nor do I know Mr Cascarini".*

54. Although Mr F stated that his opinion evidence was not influenced by his prior knowledge of Dr Cascarini, the Tribunal concluded that the appearance of bias was sufficient to significantly undermine his opinion evidence. The Tribunal's view was reinforced having noted that Mr F only made concessions in Dr Cascarini's favour when he was compelled to do so because his original opinion could not be substantiated. For example, when he criticised the consent procedures, without regard to Ms B's recollection of Dr Cascarini's conversations with Patient A.

55. The Tribunal also noted that at the outset of Mr F's oral evidence, he stated that he had not recently read his reports prior to giving evidence before the Tribunal and at times his expert evidence fell short of the standards expected. The following examples are illustrative:

    - In his first report, dated 4 January 2023, Mr F stated "*Given the extent of the malocclusion that has resulted, it is difficult to see how this could not have been apparent to [Dr Cascarini] at the time of surgery. That is, it should have been obvious at the end of the operation that the jaw position achieved, was incorrect*." This opinion underpinned the GMC's allegation that Dr Cascarini demonstrated a lack of integrity and dishonesty. During cross-examination, when he was asked to explain the basis for this opinion, he suggested it was the witness evidence of Ms B. However, he had not been provided with Ms B's evidence when he produced

his first report. When this was drawn to Mr F's attention he stated that he could only "*assume*" that he was referring to "*photographs*" he had been sent.

- Mr F also criticised the failure to measure the position of the maxilla by reference to the anterior nasal spine but then conceded under cross-examination that this was not an appropriate criticism, given that Patient A had undergone the SARPE procedure. It was unclear to the Tribunal why Mr F had ever made that criticism given Patient A's witness statement refers to the SARPE procedure and he had been provided with that statement when he wrote his first report.

- In his first report, Mr F also criticised Dr Cascarini for planning to move the mandible backwards. This report stated: "*The pre-operative skeletal analysis based on the lateral cephalometric radiographs all appear to show that she had a Class II dental base relationship, which would contraindicate the use of a sagittal split osteotomy to reposition her mandible backwards, since it was already relatively retrusive. Therefore, it is clear that the surgery that was planned was planned inappropriately.*" Mr F appeared to base this opinion on the fact that this is what ultimately happened and seemed to be unaware, until it was brought to his attention, that based on Ms B's witness statement the plan was to move the mandible forward. Ms B's witness statement was disclosed in August 2023, but he had not made any correction to his December 2023 report.

56. The issues referred to above led the Tribunal to conclude that Mr F did not have a sound evidential basis for some of his opinions. Overall, the Tribunal was concerned by Mr F's professional conduct and deficiencies in his preparedness. As a consequence of these concerns, the Tribunal was unable to rely on Mr F's evidence when it conflicted with the opinion evidence of Mr G. The Panel noted that the opinion evidence of Mr G was clear, evidence-based, and impartial.

57. In considering paragraph 1(a)(iv)(1)(b) of the Allegation, the Tribunal considered the word 'failure' in the context of the interpositional wafer. Dr Cascarini acknowledged that using the wafer was difficult. It was difficult to fit and unwieldy. As a consequence, it took much longer to fit it. Mr D stated during his evidence that he and Dr Cascarini used the wafer to assist with the poisoning of the maxilla in conjunction with their professional judgment "*to a certain degree*" but he acknowledged that the "*intermediate wafer was not entirely 100% effective*". There was no evidence before the Tribunal that the wafer was discarded during the Procedure in favour of professional judgment alone.

The Tribunal accepted the factual evidence of Dr Cascarini and Mr D that ultimately the wafer served the purpose for which it was designed and that both were satisfied by the end of the Procedure that the maxilla had been appropriately positioned. Therefore, the Tribunal concluded that there was no proper basis for characterising the use of the interpositional wafer as a failure. The Tribunal accepted the submission of Mr Geering that at its highest, in accordance with the view expressed by Mr D, the wafer was partially successful.

58. The Tribunal also accepted the evidence of Mr G that all orthognathic surgery requires the exercise of clinical judgment. He stated that the difficulties with using a wafer are not unusual, but it does not mean the wafer has ceased to be of any assistance.

59. For this reason alone the Tribunal concluded that paragraph 1(a)(iv)(1)(b) of the Allegation was not proved.

60. The Tribunal noted that, even if the difficulty with the wafer could be accurately described as a 'failure,' the use of simple measurements was unlikely to be reliable. The Tribunal accepted the evidence of Mr G in respect of the use of simple measurements. He stated in his expert report:

> *'Simple measurements to achieve an appropriate level of maxillary advancement could have been utilised if the anterior nasal spine had not been moved during the SARPE. However, the anterior nasal spine had been moved hence such measurements would have been unreliable. Ultimately it was not necessary to use simple measurements because it was possible to achieve inter-digitation between the intermediate wafer and the teeth of the maxilla and mandible.'*

61. Therefore, the Tribunal found paragraph 1(a)(iv)(1)(b) of the Allegation not proved.

<u>Paragraph 6(e) of the Allegation</u>

62. The Tribunal considered whether Dr Cascarini failed to maintain adequate records in that he did not adequately record a description within the operation note of the problems relating to the interpositional wafer.

63. The Tribunal considered its findings in relation to paragraph 1(a)(iv)(1)(b) above. It concluded that as there had been no failure of the interpositional wafer there was no

requirement to record the difficulties Dr Cascarini and Mr D experienced during the Procedure. In reaching this conclusion the Tribunal accepted the evidence of Mr G that he would not expect a record to be made of problems with a wafer in circumstances where the wafer had been utilised as this was not an unusual event.

64. Therefore, the Tribunal found paragraph 6(e) of the Allegation not proved.

Paragraph 1(b)(i) of the Allegation

65. The Tribunal considered whether following the Procedure, Dr Cascarini failed to adequately consider re-operating within a few days of the Procedure to properly position both the mandible and maxilla in relation to each other in order to provide an appropriate surgical outcome.

66. The Tribunal noted that the premise of this allegation was that the maxilla and mandible were not appropriately positioned at the end of the Procedure. Mr F's initial report suggests the malocclusion must have been apparent to Dr Cascarini. Mr F listed various factors to support his conclusion that the misaligned maxilla was obvious: (i) the lack of maxillary impaction; (ii) the amount of tooth showing; and (iii) the relative position of the centrelines. However, during cross-examination, Mr F accepted that there was no plan to address the height of the maxilla and the amount of tooth on display. He also accepted that the dental midlines were in alignment as of 31 August 2021, but the facial midline was off by 1.5 mm 11 days after surgery. The Tribunal accepted that this may not have been appreciable by eye in the midst of an operation, even if this misalignment existed at that time.

67. The Tribunal considered the evidence of Mr D. In his witness statement, dated 10 December 2023, he stated:

> *'The final surgical wafer fitted well so, at the end of surgery, we were satisfied that in spite of the unfavourable split, we had achieved a reasonable jaw repositioning with a bite in line with the pre-surgical plan. The patient was not therefore left in a situation where her jaws were grossly misaligned. Based on our clinical judgement at the time in terms of how much [Patient A's] top teeth were showing, the position of her jaws and chin in comparison to her facial anatomy and the position of her lower teeth in comparison to her upper teeth, [Dr Cascarini] and I considered that, despite the*

complications encountered, [Patient A] had a reasonable, albeit imperfect, surgical outcome.'

68. It also considered the expert evidence of Mr G. He stated:

'I have not seen any evidence that [Dr Cascarini] had encountered any issues with the position of the maxilla that would have encouraged him to consider early re-operation. Even if he had, an early re-operation was contraindicated because of the adverse mandibular split.

Due to the complicated nature of the adverse split the management decision taken by [Dr Cascarini] to place the patient into IMF (inter-maxillary fixation) and wait for healing to occur was the correct decision. This decision would be the same decision made by a reasonable body of experienced orthognathic facial surgeons and was borne out by the additional consultant opinions Patient A received following her surgery.

I do not agree with [Mr F] that the patient should have been taken back to the operating theatre at an early date, primarily because of the occurrence of the adverse split.'

69. The Tribunal accepted the evidence of Mr D and Mr G. The Tribunal concluded that if it was not obvious there had been an error with the positioning of the maxilla, there would be no clinical justification for reoperating.

70. Therefore, the Tribunal determined and found paragraph 1(b)(i) of the Allegation not proved.

Paragraph 1(b)(ii) of the Allegation

71. The Tribunal considered whether following the Procedure, Dr Cascarini failed to explain to Patient A the likely consequences of not re-operating.

72. The Tribunal took into account its findings in relation to paragraph 1(b)(i) of the Allegation and adopts the same reasoning within this paragraph of the Allegation. The need for re-operating did not arise.

73. Therefore, the Tribunal found paragraph 1(b)(ii) of the Allegation not proved.

Paragraph 2 of the Allegation

74. The Tribunal considered whether Dr Cascarini failed to record the failure of the interpositional wafer.

75. The Tribunal took into account its findings in relation to paragraph 1(a)(iv)(1)(b) of the Allegation and adopts the same reasoning within this paragraph of the Allegation. Given the Tribunal's finding that there was no failure of the interpositional wafer, there can be no duty to record an event that did not happen.

76. Therefore, the Tribunal found paragraph 2 of the Allegation not proved.

Paragraph 3(a)(i) of the Allegation

77. The Tribunal considered whether Dr Cascarini failed to adequately discharge his duty of candour in that following the Procedure, he failed to inform Patient A of the difficulties that had been experienced during her procedure.

78. The Tribunal noted that Dr Cascarini and Mr D found it difficult to position the interpositional wafer and had to partly rely on their judgement to deal with this issue. After the maxilla was positioned, there was an adverse split in Patient A's mandible. Patient A was informed about the adverse split by Mr D and Dr Cascarini. The Tribunal was not persuaded that the duty of candour is engaged simply because a procedure turns out to be more difficult than anticipated. Nor does the duty of candour require a detailed narrative of the entire procedure. The duty is engaged if an operation goes wrong, if harm is caused or if there is potential for harm. There was no reliable evidence before the Tribunal that the maxilla was misaligned, and that Dr Cascarini and Mr D knew this but decided to leave it in the incorrect position. On the contrary, the Tribunal accepted the evidence of the Surgeons that they were content that the maxilla was in a reasonable position, the adverse split had been fixed, and therefore an adequate outcome had been achieved and there was no patient harm.

79. The Tribunal also accepted the expert evidence of Mr G. He stated that:

'…Because of the shape of the intermediate wafer and the arrangement of the maxillary and mandibular teeth it is likely that it was challenging to fix the wafer between the upper and lower orthodontic arch wires and surgical hooks to enable the osteotomy to be fixated using bone plates.

When this happens, particularly in maxillary impaction procedures, it can be challenging to produce smooth and even contact between the cut ends of the bones of the maxilla. Those difficulties I would consider to be routine and not an exceptionally unusual experience. As such there would not be any reason to discuss the intermediate wafer challenges with the patient.'

80. Therefore, the Tribunal found paragraph 3(a)(i) of the Allegation not proved.

Paragraph 3(a)(ii) of the Allegation

81. The Tribunal considered whether Dr Cascarini failed to adequately discharge his duty of candour in that following the Procedure, he failed to inform Patient A of the Procedure had not gone according to plan with regard to the maxilla.

82. The Tribunal took into account its findings in relation to paragraph 3(a)(i) of the Allegation and adopts the same reasoning within this paragraph of the Allegation. The Tribunal also took into account and accepted the evidence of Dr Cascarini within his witness statement dated 10 December 2023. He stated:

'We were satisfied, however, that we had positioned the maxilla correctly before we proceeded to mandibular surgery.'

83. The Tribunal also accepted the evidence of Mr D. He stated:

'The final surgical wafer fitted well so, at the end of surgery, we were satisfied that in spite of the unfavourable split, we had achieved a reasonable jaw repositioning with a bite in line with the pre-surgical plan. The patient was not therefore left in a situation where her jaws were grossly misaligned.'

84. The Tribunal noted that Mr G stated:

'At the end of a procedure of this nature, it can be difficult to assess whether

or not the maxilla is in the correct position due to the degree of swelling. On the basis of the GMC's evidence alone, I cannot see any evidence to indicate that either [Dr Cascarini] or [Mr D] were concerned that the maxilla might be in an incorrect position.'

85. In these circumstances, the Tribunal was satisfied that Dr Cascarini had no concerns that the Procedure had not gone to plan regarding the maxilla. Mr D also did not have any concerns regarding the maxilla. It noted that the evidence suggested that the maxilla was appropriately placed and an adequate outcome was achieved.

86. Therefore, the Tribunal found paragraph 3(a)(ii) of the Allegation not proved.

Paragraph 3(b)(ii) of the Allegation

87. The Tribunal considered whether Dr Cascarini failed to adequately discharge his duty of candour in that during a consultation on 31 August 2021, Dr Cascarini assured Patient A that the Procedure had been a success and that he was pleased under the circumstances, or words to that effect.

88. The Tribunal noted that Patient A stated in her witness statement, dated 9 September 2022, that:

'[Dr Cascarini] took an x-ray, reviewed it, and confirmed that he was pleased under the circumstances. [Dr Cascarini] assured me the surgery had been a success.'

89. The Tribunal also considered the evidence of both Dr Cascarini and Mr D, as quoted above, that they were satisfied with the outcome of the Procedure. Both Surgeons, at the time, believed that the maxilla was in the right place and the mandible was within the acceptable range. Dr Cascarini in his letter to Ms B on 31 August 2021, stated that he was "*pleased under the circumstances*" but he did not use the word "*success*" in that letter or any letter. He was self-critical, in that he stated that he referred to the unfavourable split and stated that he *"probably should have removed that wisdom tooth prior to the surgery"* and was "*perhaps trying to be a little bit too clever*."

90. The Tribunal noted that his reference to being "*pleased under the circumstances*" was in the context of the preceding words, "*post-op x-ray it looks good*." At this time the x-ray showed the reattached condyle was in the fossa and Patient A was healing well. The Tribunal also accepted that Dr Cascarini's expression of pleasure was in the context of

having achieved a reasonable result in challenging circumstances. This was a view shared by Mr D. The Tribunal was satisfied that this was a reasonable assessment based on the information that was known at that time.

91. Mr G informed the Tribunal that he was not critical of Dr Cascarini for not advising Patient A that the elastics may cause the maxilla to move as this is a very rare complication. He stated that having conducted approximately 1500 orthognathic procedures he had only experienced adverse splits on 7 or 8 occasions and only some of those had been in the context of bimaxillary surgery. Therefore, he was not surprised that Dr Cascarini had not appreciated the risks associated with applying tight elastics in these circumstances.

92. The Tribunal concluded there were no concerns to raise with Patient A, given the state of Dr Cascarini's knowledge at the relevant time.

93. Therefore, the Tribunal found paragraph 3(b)(ii) of the Allegation not proved.

Paragraph 3(c) of the Allegation

94. The Tribunal considered whether Dr Cascarini failed to adequately discharge his duty of candour in that it was not until a consultation with Patient A and Ms B on 4 October 2021, when Patient A asked Dr Cascarini 'Did the surgery go wrong' and Dr Cascarini responded 'Yes', or words to that effect.

95. The Tribunal considered the WhatsApp messages between Dr Cascarini and Patient A in September 2021. It noted that, on 7 September 2021, Patient A had sent pictures of her mouth and expressed concern about a hole in her gum. Having reassured her about this, on 9 September 2021, Dr Cascarini further replied:

> *'im afraid i think your upper jaw has been pulled down a bit [with] [the] [elastics] – i think we need to see you on monday'*

96. The Tribunal noted that these messages were then followed by conversations relating to appointments Patient A would need to attend with Dr Cascarini, Mr D, and Ms B.

97. The Tribunal concluded that there was insufficient evidence to support a finding Dr Cascarini failed to adequately discharge his duty of candour. On the contrary, as soon as

Dr Cascarini noticed that Patient A's maxilla looked as if it had dropped, he made arrangements to see Patient A with Mr D.

98. Therefore, the Tribunal found paragraph 3(c) of the Allegation not proved.

Paragraph 4(b) of the Allegation

99. The Tribunal considered whether Dr Cascarini knew that the Procedure had not been successful.

100. The Tribunal relied upon its findings and reasoning in respect of the previous paragraphs of the Allegation. The Tribunal was satisfied that the Procedure had not failed and that both Surgeons were content with the outcome given the circumstances. In addition, both Surgeons believed that the maxilla was in the right place and the mandible was within the acceptable range.

101. Therefore, the Tribunal found paragraph 4(b) of the Allegation not proved.

Paragraph 5 of the Allegation

102. The Tribunal considered whether Dr Cascarini's conduct as set out in paragraph 3(b) was dishonest by reason of paragraph 4 of the Allegation.

103. The Tribunal noted that both paragraphs 3(b) and 4 of the Allegation were found not proved. Therefore, this paragraph of the Allegation must also fall.

104. Accordingly, the Tribunal found paragraph 5 of the Allegation not proved.

The Tribunal's Overall Determination on the Facts

105. The Tribunal has determined the facts as follows:

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

1. Between 21 September 2018 and 6 December 2021 you consulted with Patient A and you failed to provide good clinical care in that:

a. on 26 August 2021 you performed a bilateral maxillary osteotomy and / or a genioplasty ('the Procedure') and you:

~~i. failed to obtain informed consent from Patient A as you did not:~~

~~1. advise Patient A of the risk that the planned occlusion may not be achieved;~~

Deleted following successful application under Rule 17(2)(g)

~~2. outline to Patient A that a sub optimal outcome was possible;~~

Deleted following successful application under Rule 17(2)(g)

ii. in the alternative failed to adequately record your discussions with Patient A as described at paragraph 1. a. i.;

Admitted and found proved in relation to paragraph 1(a)(i)(1)
Determined and found proved in relation to paragraph 1(a)(i)(2)

~~iii. planned the Procedure inappropriately in that Patient A had a Class II dental base relationship which contraindicated the use of a sagittal split osteotomy to reposition her mandible backwards, since it was already relatively retrusive;~~

Withdrawn under Rule 17(6)

iv. failed to adequately carry out the Procedure in that:

1. following the suggested failure of the interpositional wafer you failed to use:

~~a. the anterior nasal spine to judge the midline of the maxillary advancement in relation to the nasal septum; and / or~~

Withdrawn under Rule 17(6)

b. simple measurements to achieve an appropriate level of maxillary ~~advancement~~ movement;

Amended under Rule 17(6)
Not proved

~~2. you did not address the mandibular condyle being left on the buccal fragment of the mandible ('the adverse split');~~

~~a. by creating a second bone cut separating the mandibular condyle from the rest of the lower jaw and to repair the fractured buccal plate; and / or~~

Withdrawn under Rule 17(6)

~~b. placing Patient A into intermaxillary fixation for a period of weeks to allow bone healing to take place;~~

Withdrawn under Rule 17(6)

b. following the Procedure you failed to:

i. adequately consider re-operating within a few days of the Procedure to properly position both the mandible and maxilla in relation to each other in order to provide an appropriate surgical outcome;

Not proved

ii. explain to Patient A the likely consequences of not re-operating.

Not proved

2. You failed to record the failure of the interpositional wafer.

Not proved

3. You failed to adequately discharge your duty of candour in that:

a. following the Procedure you failed to inform Patient A:

i. of the difficulties that had been experienced during her Procedure;

Not proved

iii. that the Procedure had not gone according to plan with regards to the maxilla;

Not proved

b. during a consultation on 31 August 2021 you:

~~i. told Patient A that she had had an unfavourable split but you had managed to fix it, or words to that effect;~~

Withdrawn under Rule 17(6)

ii. assured Patient A that the Procedure had been a success and that 'you were pleased under the circumstances', or words to

that effect;

Not proved

c. it was not until a consultation with Patient A and Miss B on 4 October 2021 when Patient A asked you 'Did the surgery go wrong?' that you answered 'Yes', or words to that effect.

Not proved

4. You knew that:

~~a. the adverse split had not been fixed;~~

Withdrawn under Rule 17(6)

b. the Procedure had not been successful.

Not proved

5. Your conduct as set out at paragraph 3. b. was dishonest by reason of paragraph 4.

Not proved

6. You failed to maintain adequate medical records in that you did not adequately record:

~~a. the planned orthognathic movements for the Procedure;~~

Withdrawn under Rule 17(6)

~~b. a documented plan;~~

Withdrawn under Rule 17(6)

~~c. the decisions made;~~

Deleted following successful application under Rule 17(2)(g)

d. the information provided to Patient A;

Admitted and found proved

e. a description within the operation note of the problems relating to the interpositional wafer;

Not proved

f. the post-operative findings.

Admitted and found proved

~~7. You inappropriately invoiced Patient A's insurers for a septoplasty as a separate and chargeable procedure.~~

Deleted following successful application under Rule 17(2)(g)

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 - 23/02/2024

106. Both Mr Claxton and Mr Geering invited the Tribunal to consider the issue of misconduct as a separate 'stand-alone' stage. Mr Geering submitted that if the Tribunal finds that Dr Cascarini's record-keeping failures amount to misconduct, he will rely on further evidence and may recall Dr Cascarini to give oral evidence with regard to whether his fitness to practise is impaired. However, Mr Geering suggested that this additional evidence will be unnecessary if the Tribunal accepts his primary submission that the record-keeping failures do not amount to misconduct. This suggested approach was accepted by the Tribunal.

107. 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 Cascarini's actions amount to misconduct.

The Evidence

108. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

Submissions

109. Mr Claxton, on behalf of the GMC, adopted a neutral position regarding misconduct. He did not advance any positive submissions to persuade the Tribunal that the threshold of serious misconduct has been met in respect of the paragraphs of the Allegation that have been found proved.

110. Mr Geering, on behalf of Dr Cascarini, submitted that the allegations found proved solely relate to poor record-keeping and do not amount to misconduct. He submitted that Dr Cascarini accepts that his record-keeping fell short of the standards expected. However, he further submitted that there was no suggestion that Dr Cascarini's poor record-keeping had an impact on patient care or had the potential to impact upon patient care. Nor, in his submission, did the poor record-keeping indicate an attitudinal problem.

111. Mr Geering invited the Tribunal to conclude that Dr Cascarini's record-keeping failures were isolated incidents relating to a single patient and although his record keeping fell below the standards expected of a reasonably competent practitioner they were not sufficiently serious to be characterised as 'deplorable' by fellow practitioners.

The Relevant Legal Principles

112. 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.

113. In approaching the decision, the Tribunal had regard to the case of *Roylance v General Medical Council (No.2) [2000]1 AC 311 (UKPC)* which states:

> *Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [medical] practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word professional which links the misconduct to the profession [of medicine]. Secondly, the misconduct is qualified by the word serious. It is not any professional misconduct which would qualify. The professional misconduct must be serious.*

The Tribunal's Determination on Misconduct

114. The Tribunal began by assessing the facts it had found proved.

115. First, the Tribunal considered its finding that Dr Cascarini had failed to adequately record his discussions with Patient A regarding the proposed procedure. In particular, the Tribunal noted that Dr Cascarini did not adequately record the advice he gave to Patient A with regard to the risk that the planned occlusion may not be achieved and that a sub optimal outcome was possible.

116. The Tribunal was mindful that good record keeping is an important component of quality evidence-based patient care. Clinical records of discussions with patients and treatment plans are essential for providing safe continuity of care and must be clear, accurate and

legible. The records should include relevant clinical findings, decisions made, actions taken, and the information given to patients. GMC guidance makes it clear that doctors should make the records at the same time as the events being recorded (contemporaneously) or as soon as possible afterwards.

117. The Tribunal concluded that the absence of a record of the discussions Dr Cascarini had with Patient A was a failing which fell below the high standards expected of a medical practitioner. However, the Tribunal noted that this was an isolated incident, in that, it related to a single patient. The Tribunal also noted that the wider context did not indicate a pattern of poor patient care or a cavalier attitude to patient care. In these circumstances, the Tribunal concluded that Dr Cascarini's failure did not fall seriously below the standards expected of a competent medical practitioner. In particular, the Tribunal concluded that this failing did not call into question Dr Cascarini's fitness to practise and could not be properly described as a failing that fellow practitioners would refer to as 'deplorable'.

118. Therefore, the Tribunal determined that Dr Cascarini's poor record keeping in relation to paragraph 1(a)(ii) of the Allegation does not amount to misconduct.

119. Second, the Tribunal considered its finding that Dr Cascarini failed to maintain adequate medical records in that he did not adequately record the information provided.

120. The Tribunal noted that this paragraph of the Allegation was admitted by Dr Cascarini and appears to be connected to paragraph 1(a)(ii) of the Allegation. The Tribunal took into account its findings in relation to paragraph 1(a)(ii) and adopted the reasoning referred to above. The Tribunal determined that Dr Cascarini's failure fell below the standard expected of a reasonably competent practitioner, but not seriously below the standard.

121. Therefore, the Tribunal determined that Dr Cascarini's failure to maintain adequate medical records in relation to paragraph 6(d) of the Allegation does not amount to misconduct.

122. Third, the Tribunal considered its finding that Dr Cascarini failed to maintain adequate medical records in that he did not adequately record the post-operative findings.

123. The Tribunal noted that this paragraph of the Allegation was admitted by Dr Cascarini. Although the absence of a clinical record of Dr Cascarini's post-operative findings demonstrated poor practice, the Tribunal was mindful that there was no evidence of systemic failings likely to have an impact on patient care. The Tribunal took into account its findings in relation to paragraph 1(a)(ii) and adopted the reasoning referred to above. The Tribunal determined that Dr Cascarini's failure fell below the standard expected of a reasonably competent practitioner, but not fall seriously below the standard.

124. Therefore, the Tribunal determined that Dr Cascarini's failure to maintain adequate medical records in relation to paragraph 6(e) of the Allegation does not amount to misconduct.

125. The Tribunal then considered whether, taking all of the allegations together, the record-keeping failings would amount to misconduct. Again, the Tribunal noted that the allegations relate to a single patient and a single procedure, and the lack of patient records did not cause harm to Patient A or place her at risk of harm. Whilst the Tribunal concluded that there were three similar record-keeping failings within the context of a series of consultations with a single patient, there were no particular features of this case which indicated that the failings related to an attitudinal problem. In these circumstances, the Tribunal concluded that there was no proper basis for adopting a cumulative approach.

126. Therefore, the allegations found proved by the Tribunal, do not amount to misconduct.

127. There is no interim order to be revoked.

128. That concludes the case.

ANNEX A – 12/02/2024

Application to withdraw paragraphs and amend a paragraph of the Allegation

129. On 12 February 2024, on behalf of the GMC, Mr Claxton, Counsel, made an application pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to withdraw paragraphs 1(a)(iii), 1(a)(iv)(1)(a), 1(a)(iv)(2)(a), 1(a)(iv)(2)(b), 3(b)(i), 4(a), 6(a) and 6(b) of the Allegation and amend paragraph 1(a)(iv)(1)(b).

Submissions

Application to withdraw paragraphs of the Allegation

130. Mr Claxton made an application to withdraw paragraphs 1(a)(iii), 1(a)(iv)(1)(a), 1(a)(iv)(2)(a), 1(a)(iv)(2)(b), 3(b)(i), 4(a), 6(a) and 6(b) of the Allegation. He explained that the allegations placed reliance on the opinions of the GMC's expert witness, Mr F. However, Mr Claxton submitted that, in accordance with Mr F's duty as an expert witness, following meetings with Mr G, his analysis has been modified in a material way and as a consequence, his opinion no longer supports the paragraphs of the Allegation referred to above. In these circumstances, Mr Claxton submitted that these factual paragraphs should be withdrawn.

131. On behalf of Dr Cascarini, Mr Geering, Counsel, concurred with the submissions made by the GMC.

Application to amend paragraph 1(a)(iv)(1)(b) of the Allegation

132. Mr Claxton submitted that the word 'advancement' within paragraph 1(a)(iv)(1)(b) should be amended and replaced by the word 'movement'. He submitted that following discussions with Mr F, it had become apparent that the word 'advancement', which refers to movement in only one of several planes, is too restrictive. Mr Claxton submitted that the proposed amendment is not fundamental and could be made without causing any injustice.

133. On behalf of Dr Cascarini, Mr Geering, opposed the application made by the GMC. He submitted that the case has been advanced, and Dr Cascarini's defence prepared, on a

particular basis and now without any further evidence, that basis has changed. Mr Geering invited the Tribunal to conclude that the proposed amendment would be unfair to Dr Cascarini.

The Tribunal's Decision

Application to withdraw paragraphs of the Allegation

134. The Tribunal noted that there can be no public interest in pursuing paragraphs of an allegation that have no realistic prospect of being found proved. However, given the Tribunal's overarching duty to protect the public, it is also equally important for the Tribunal to be satisfied that the GMC has proper grounds for making the application to withdraw.

135. The Tribunal considered the joint expert report from Mr F and Mr G who was instructed on behalf of Dr Cascarini. The joint expert report stated:

> Paragraph 1(a)(iii) of the Allegation
> *'The experts [agreed] that there was no plan to position the mandible posteriorly, and the Protomed plan was for a mandibular advancement. The experts agree that the surgical plan was not delivered clinically post-surgery the lower jaw had moved backwards, see x-rays 22.9.21. This retrusive mandibular movement was not planned.'*
>
> Paragraph 1(a)(iv)(1)(a) of the Allegation
> *'Experts [agreed] that it was not appropriate to use the anterior nasal spine to assess the midline because of the previous SARPE procedure.'*
>
> Paragraph 1(a)(iv)(2)(a) of the Allegation
> *'The experts [agreed] that the post-operative images show that the separation of the mandibular condyle from the rest of the lower jaw was completed by [Dr Cascarini]. The experts further agree that there was no detailed reference in the operative note to the manner in which the condyle was managed.'*
>
> Paragraph 1(a)(iv)(2)(b) of the Allegation
> *'The experts [agreed] that intermaxillary fixation was utilised by [Dr Cascarini] although the nature and duration of this is not clear from the records.'*

Paragraph 3(b)(i) of the Allegation
'Experts are agreed that Patient A was told about the unfavourable [split] and about the fixation of the split. Patient A was told of the bad split on the evening of the surgery by [Dr Cascarini] and by [Mr D] when he did the ward round at the hospital the following morning.'

Paragraph 4(a) of the Allegation
'Experts are [agreed] that appropriate remedial action had been taken by [Dr Cascarini] in relation to the adverse split'.

Paragraph 6(a) of the Allegation
'Experts are agreed there was a plan and there was a record. The experts are agreed the plan was accepted by [Dr Cascarini]. The experts further agree that there is more than one method by which a good outcome could have been achieved. Neither expert would have used the plan adopted.'

Paragraph 6(b) of the Allegation
'Experts agreed there was a 19 page documented digital plan, but there was no documentary evidence why this plan was adopted in favour of a previous plan.'

136. The Tribunal determined that paragraphs 1(a)(iii), 1(a)(iv)(1)(a), 1(a)(iv)(2)(a), 1(a)(iv)(2)(b), 3(b)(i), 4(a), 6(a) and 6(b) of the Allegation particulars should be withdrawn for the following interrelated reasons:

a. The Tribunal was satisfied that in light of the contents of the joint expert report, there is insufficient evidence to support the paragraphs of the Allegation referred to above.

b. The Tribunal took the view that it would not be in the interests of the public or fair to Dr Cascarini to pursue allegations that have no realistic prospect of being found proved.

c. The Tribunal was satisfied that taken as a whole the Allegation remains viable and would not constitute 'under prosecution'.

<u>Application to amend paragraph 1(a)(iv)(1)(b) of the Allegation</u>

137. The Tribunal acknowledged that the word 'movement' is broader than the original word – 'advancement'. However, the Tribunal concluded that the proposed amendment contains the following features:

- provides helpful clarification of the GMC's case;
- more accurately reflects Mr F's expert opinion and the GMC's case;
- avoids ambiguity;
- does not substantially alter the substance or scope of the Allegation as originally drafted.

138. The Tribunal was satisfied that there is no injustice to Dr Cascarini as there will be an opportunity for him to consider and prepare his response during the course of these proceedings.

139. In these circumstances, the Tribunal determined that the word 'advancement' within paragraph 1(a)(iv)(1)(b) will be amended and replaced by the word 'movement'.

ANNEX B – 15/02/2024

Application under Rule 17(2)(g)

140. At the end of the GMC's case on facts, Mr Geering, Counsel, on behalf of Dr Cascarini, made an application under Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'). Rule 17(2)(g) states:

> *'the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld.'*

141. This application relates to paragraphs 1(a)(i)(1), 1(a)(i)(2), 1(a)(ii), 6(c) and 7 of the Allegation:

> *2. Between 21 September 2018 and 6 December 2021 you consulted with Patient A and you failed to provide good clinical care in that:*

a. on 26 August 2021 you performed a bilateral maxillary osteotomy and / or a genioplasty ('the Procedure') and you:

i. failed to obtain informed consent from Patient A as you did not:

~~1.~~ advise Patient A of the risk that the planned occlusion may not be achieved;

~~2.~~ outline to Patient A that a sub optimal outcome was possible;

ii. in the alternative failed to adequately record your discussions with Patient A as described at paragraph 1. a. i.;

7. You failed to maintain adequate medical records in that you did not adequately record:

…

c. the decisions made;

8. You inappropriately invoiced Patient A's insurers for a septoplasty as a separate and chargeable procedure.

Submissions

142. The following is a summary of submissions made by both Counsel.

<u>On behalf of Dr Cascarini</u>

143. Mr Geering referred the Tribunal to the background of the case, specifically relating to the consent process, which occurred over a substantial period of time and involved both Dr Cascarini and Ms B. In relation to paragraph 1(a)(i)(1) of the Allegation, he submitted that it is inconceivable that Patient A would not have known that it was possible that the procedure would not succeed, and that the intended occlusion may not be achieved. He further submitted that during Patient A's evidence, she accepted that she had been told that her 'bite' may stay the same or may not be improved by the surgery.

144. Mr Geering submitted that, in respect of paragraph 1(a)(i)(2) of the Allegation, the evidence of Ms B confirms that Patient A was made aware of the risks of the surgical procedure. He stated that 'sub optimal' is a high bar. He suggested that, for example,

infection, nerve damage or numbness following a procedure may be considered to be sub optimal. Mr Geering made reference to the oral evidence of Patient A where, during cross-examination, she was asked whether she was aware of a possible sub optimal outcome to which she responded: 'I accept that'. Mr Geering also submitted that Mr F conceded during his oral evidence that infection, nerve damage and numbness are some of the risks. Mr Geering referred the Tribunal to the consent form signed by Patient A, which listed these risks and the risk of a changing appearance.

145. In respect of paragraph 1(a)(ii) of the Allegation, Mr Geering submitted that numbness to the lips and the face, change of appearance, and infection, were recorded on the consent form. He further submitted that these are all matters which are indicative of a potential sub optimal outcome.

146. In relation to paragraph 6(c) of the Allegation, Mr Geering submitted that there is a paper trail of the decision being recorded. He referred the Tribunal to the letter from Dr Cascarini to Patient A dated 15 July 2021. In addition, Mr Geering submitted that Mr F's focus, during his oral evidence, was on the quality of the decision made, rather than the failure to record the decision.

147. Mr Geering submitted, in respect of paragraph 7 of the Allegation, that this was, at its highest, an honest mistake, on one occasion, in respect of a billing item with an approximate differential cost of £30.00. He stated that this was an isolated incident and, even if found proved, would not amount to misconduct as fellow practitioners would not find his actions to be 'deplorable'. Mr Geering further submitted that whilst Mr F struggled to see how the separate invoicing of a septoplasty could amount to a billing mistake, he conceded that a reasonable body of surgeons may take the view that it is appropriate to invoice separately for the septoplasty.

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

148. Mr Claxton submitted that the GMC opposes the application in respect of paragraphs 1(a)(i)(1), 1(a)(i)(2), 1(a)(ii) of the Allegation. However, the GMC conceded that the application is appropriate in relation to paragraph 6(c) of the Allegation and maintained a neutral stance in relation to paragraph 7 of the Allegation.

149. In relation to paragraph 1(a)(i)(1) of the Allegation, Mr Claxton invited the Tribunal to consider the wording of the Allegation which refers to a failure by Dr Cascarini to advise

Patient A. Mr Claxton stated that Dr Cascarini may give evidence to the effect that he might not have advised Patient A of the risk that the planned occlusion may not be achieved but others did. However, he submitted that the merits of that position are relevant at a later stage. He submitted that is no answer to the factual allegation, which has to be assessed on its plain wording.

150. In relation to paragraph 1(a)(i)(2) of the Allegation, Mr Claxton submitted that the word 'sub optimal' is to be properly construed as a reference to the surgical outcome rather than a transient side effect of the surgery such as infection or pain. He submitted that although swelling, bruising, and infection were discussed with Patient A, these are not surgical outcomes.

151. In relation to paragraph 1(a)(ii) of the Allegation, Mr Claxton submitted that there are no records from Dr Cascarini in which he recorded the discussions that took place with Patient A concerning the risks associated with the planned occlusion.

The Tribunal's Approach

152. The Tribunal reminded itself that, at this stage, its purpose was not to make findings of fact. The purpose is to determine whether sufficient evidence, taken at its highest, had been presented by the GMC such that the Tribunal, properly directed as to the law, could find the relevant paragraphs proved to the civil standard.

153. The Tribunal considered the submissions of both parties. It also took account of all of the evidence presented by the GMC, both oral and documentary, in reaching its decision.

154. In considering the sufficiency of evidence that has been presented, the Tribunal applied the test set out in the case of *R v Galbraith [1981] 1 WLR 1039*:

(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.

(2) The difficulty arises where there is some evidence but it is of a tenuous character; for example, because of inherent weakness or vagueness, or because it is inconsistent with other evidence.

(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.

(b) Where, however, the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury. [...] *There will always* [...] *be borderline cases. They can safely be left to the discretion of the judge.'*

The Tribunal's Decision

Paragraph 1(a)(i)(1)

155. The Tribunal noted that 'informed consent' is a process rather than a singular event and that Dr Cascarini was working as part of a multi-disciplinary team. The Tribunal considered the evidence of Ms B. She stated, in her witness statement dated 9 August 2023, in reference to a meeting that took place on 3 December 2019:

'I remember Dr Cascarini discussed the surgical risks with her and what commitments he needed from [Patient A] from his perspective. I recall he explained there would be facial swelling, bruising, risks of infection and the potential of nerve damage and numbness to [Patient A]. It was agreed that [Patient A] couldn't possibly [be] expected to remember everything that was being discussed, especially in relation to the double jaw surgery, so an agreement was made that we would meet together after I had completed [Patient A's] pre surgery orthodontic preparation, before the second jaw surgery was to go ahead.'

156. Ms B further stated:

'Dr Cascarini and I had our next joint appointment with [Patient A] on 15 July 2021… Dr Cascarini stated that potentially her jaw problem may not improve, but he hoped after the jaw surgery to improve her bite, so more of her teeth would come into contact with each other, the jaw problem would also improve, however he made no promises.'

157. The Tribunal was mindful that the evidence from Ms B formed part of the GMC's case and is unchallenged. Given the content of her witness statement in the extracts quoted above, the Tribunal took the view that there is no evidence to suggest that Dr Cascarini

failed to obtain informed consent from Patient A (i.e.) that he failed to advise Patient A of the risk that the planned occlusion may not be achieved. The evidence of Ms B is that Patient A was advised by Dr Cascarini (in the presence of Ms B) that her bite may not be improved by the surgical procedure.

158. In these circumstances, the Tribunal concluded that there is no realistic possibility of paragraph 1(a)(i)(1) being found proved.

159. Therefore, the Tribunal determined that there was no case to answer in relation to paragraph 1(a)(i)(1) of the Allegation.

Paragraph 1(a)(i)(2)

160. The Tribunal first considered the phrase 'sub optimal outcome'. The Tribunal took the view that the ordinary natural meaning of this form of words is a less than desired outcome as a result of the surgery rather than the transitory side effects a patient may experience immediately following surgery.

161. The Tribunal considered the evidence of Ms B. She stated in her witness statement dated 9 August 2023:

> *'On 3 December 2019, I saw [Patient A] in conjunction with Dr Cascarini, and we discussed the problems she presented with. We ran through the options available to her of which there were three and I ensured that I gave my opinion.'*
>
> *'At this appointment, on 3 December 2019, [Patient A] chose the third option which would involve me preparing her teeth orthodontically and then Dr Cascarini would move the jaw to the correct position so that everything met well. Dr Cascarini agreed that option three was probably the best treatment option to achieve a harmonial bite, improve dentofacial appearance and proportions… The downsides of surgery were discussed which would restrict [Patient A] to a liquidized diet for about one month, and that her bite and dentofacial appearance would look worse before the double jaw surgery due to the orthodontic decompensation process of her teeth… I discussed with [Patient A] the orthodontic risks again which were that… pain and discomfort of her jaw might not improve by the proposed combined treatment as*

studies have shown that there was an equal one third possibility that her symptoms could worsen/improve/stay the same.'

'Dr Cascarini stated that potentially her jaw problem may not improve, but he hoped after the jaw surgery to improve her bite, so more of her teeth would come into contact with each other, the jaw problem would also improve, however he made no promises.'

162. The Tribunal noted that the discussions with Patient A included advice from Ms B in the presence of Dr Cascarini with regard to the risks and the '*equal one third possibility that her symptoms could worsen/improve/stay the same'.* In addition, Ms B states that Dr Cascarini specifically advised Patient A that *'potentially her jaw problem may not improve'*. The Tribunal concluded that the evidence of Ms B fundamentally undermines the allegation that Dr Cascarini failed to advise Patient A that a sub optimal outcome was possible.

163. The Tribunal concluded that in light of the evidence of Ms B there was no proper basis upon which it could conclude that Dr Cascarini had failed to obtain informed consent from Patient A, based on the risk of a sub optimal outcome.

164. Therefore, the Tribunal determined that there was no case to answer in relation to paragraph 1(a)(i)(2) of the Allegation.

Paragraph 1(a)(ii)

165. The Tribunal noted that there are records in the form of letters of the joint discussions Ms B and Dr Cascarini had with Patient A. However, there do not appear to be any records from Dr Cascarini with regard to the information provided to Patient A as part of the consent procedure, save for the consent form signed by Patient A on 26 August 2021. The Tribunal noted that the consent form indicates that Patient A was advised of some of the adverse consequences of surgery but these do not include any reference to the risk that the planned occlusion may not be achieved.

166. Therefore, the Tribunal determined that there is some evidence to support paragraph 1(a)(ii) and when taken at its highest, it could find this paragraph of the Allegation proved.

Paragraph 6(c)

167. The Tribunal considered the letter sent by Dr Cascarini to Patient A on 15 July 2021. The letter stated:

> *'…We discussed your case in some detail and agreed that your malocclusion was a factor involved in your TMJ disease and as such you have had authorisation from your insurance company for maxillary and mandibular surgery. Today we discussed your case again… We would propose now that when your orthodontic treatment is completely finished, we will get medical CT of your facial bones and [Ms B] will organise an intraoral scan. Those images will be sent for orthognathic planning, and we will imagine your surgery will require surgery to both your jaws. Also of note is that when we osteotomise and move your upper jaw, it will be necessary to carry out lower nasal septoplasty and we therefore need to add that code into the procedure. We are aiming for your surgery to be carried out here… The codes for the procedure are E0360 and V1040.'*

168. The Tribunal took the view that this was an adequate record from Dr Cascarini setting out the decisions made with regard to Patient A's procedure. In addition, the Tribunal noted that the GMC conceded that the Rule 17(2)(g) application was appropriate.

169. Therefore, the Tribunal determined that there was no case to answer in relation to paragraph 6(c) of the Allegation.

Paragraph 7

170. The Tribunal considered the evidence of Mr F. It noted that, Mr F conceded during his oral evidence that there is a reasonable body of surgeons who would invoice septoplasty separately when undertaking a maxillary osteopathy.

171. The Tribunal took the view that based on Mr F's evidence, there is no evidence to suggest that it was inappropriate for Dr Cascarini to invoice Patient A's insurers for a septoplasty as a separate and chargeable procedure.

172. The Tribunal also noted that the GMC's stance in respect of the Rule 17(2)(g) application was neutral.

173. Therefore, the Tribunal determined that there was no case to answer in relation to paragraph 7 of the Allegation.