Record of Determinations – Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 29/05/2019 - 07/06/2019, 12/08/2019 and 14/10/2019 to 17/10/2019

Medical Practitioner’s name: Dr Arun RANJIT

GMC reference number: 6119148

Primary medical qualification: MB BS 1997 University of Kerala

Type of case
New - Misconduct

Outcome on impairment
Not Impaired

Summary of outcome
No action (warning not considered)

Tribunal:

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legally Qualified Chair</td>
<td>Mrs Nessa Sharkett</td>
</tr>
<tr>
<td>Lay Tribunal Member:</td>
<td>Ms Colette Neville</td>
</tr>
<tr>
<td>Medical Tribunal Member:</td>
<td>Dr David Geddes</td>
</tr>
</tbody>
</table>

Tribunal Clerk: Ms Angela Carney

Attendance and Representation:

<table>
<thead>
<tr>
<th>Role</th>
<th>Representation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Practitioner:</td>
<td>Present and represented</td>
</tr>
<tr>
<td>Medical Practitioner’s Representative:</td>
<td>Mr Anthony Haycroft, Counsel, instructed by the MDU</td>
</tr>
<tr>
<td>GMC Representative:</td>
<td>Ms Chloe Fairley, Counsel</td>
</tr>
</tbody>
</table>

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.
Record of Determinations – Medical Practitioners Tribunal

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 - 15/10/2019

Background

1. Dr Ranjit qualified as a doctor in 1997. In December 2005 Dr Ranjit completed cardiology training from the Postgraduate Institute of Medical Education and Research in Chandigarh, India. In 2005 Dr Ranjit moved to the UK to continue his training and undertake a MRCP at the Royal College of Physicians. Dr Ranjit gained further experience at a number of hospital cardiac centres in England before being appointed to his first consultant position at Leicester Royal Infirmary in January 2009. In September 2009 Dr Ranjit moved to Aintree University Hospital NHS Foundation Trust, (The Trust) where he was practising as a Consultant Cardiologist at the time of the events that led to the Allegation. Dr Ranjit continues to practise at the Trust.

2. The Allegation that has led to this hearing can be summarised that, on 4 September 2015 Dr Ranjit failed in the care provided to Patient A. It is also alleged that Dr Ranjit discriminated against Patient A on the grounds of a protected characteristic in his treatment of her.

3. The initial concerns were raised with the GMC in an email dated 7 November 2017 by Ms B, Patient A’s sister. Patient A was born with Down’s syndrome. On 31 August 2015 Patient A visited her GP as she was feeling unwell. Her GP referred her to hospital where she was admitted to the Respiratory ward and treated for pneumonia, subsequently developing sepsis and pleural and pericardial effusion. On the weekend of 4-6 September 2015 Dr Ranjit was the Cardiologist on-call at the Trust.

The Outcome of Applications Made during the Facts Stage

4. The Tribunal granted Mr Haycroft’s application, made pursuant to Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004 as amended (‘the Rules’). The Tribunal’s full decision on the application is included at Annex A.

5. The Tribunal granted the GMC’s application, made pursuant to Rule 17(6) of the Rules, to amend the Allegation and withdraw paragraphs 1c, 1d, 1e, 1f, and 1n(iii) to 1n(vi). Mr Haycroft, on behalf of Dr Ranjit made no objection to the
amendments. The Tribunal determined that it was in the interests of fairness to amend the Allegation.

6. The Tribunal granted the GMC’s application, made pursuant to Rule 17(6) of the Rules, to amend the Allegation and withdraw paragraphs 1a and 1b in relation to paragraph 2. Mr Haycroft, on behalf of Dr Ranjit made no objection to the amendments. The Tribunal determined that it was in the interests of fairness to amend the Allegation.

The Allegation and the Doctor’s Response

7. The Allegation made against Dr Ranjit is as follows:

1. On 04 September 2015 you reviewed Patient A and you failed to:
   a. adequately assess whether Patient A had capacity, communication and support needs;
      To be determined
   b. take venous pressure;
      To be determined
   e. check whether Patient A had a positive Kussmul sign;
      Withdrawn under Rule 17(6)
   d. review CT chest scans or report;
      Withdrawn under Rule 17(6)
   e. adequately consider unstable hemodynamic readings;
      Withdrawn under Rule 17(6)
   f. adequately consider cardiac tamponade;
      Withdrawn under Rule 17(6)
   g. conduct an urgent echocardiogram;
      Admitted and found proved
   h. provide adequate instructions to staff of when to reconsider intervention to assess pericardial effusion;
      To be determined
   i. adequately supervise Patient A’s cardiac problems;
      To be determined
   j. discuss Patient A’s quality of life with her family;
Record of Determinations –
Medical Practitioners Tribunal

To be determined

k. adequately explain your treatment plan to Patient A or their family;
To be determined

l. discuss with Patient A or their family the risks and benefits of your treatment plan as opposed to early intervention;
To be determined

m. discuss with Patient A or their family the risks and benefits of a pericardiocentesis
To be determined

n. adequately record having undertaken the actions outlined in paragraphs:

i. 1a;
To be determined

ii. 1b;
Admitted and found proved

iii. 1c;
Withdrawn under Rule 17(6)

iv. 1d;
Withdrawn under Rule 17(6)

v. 1e;
Withdrawn under Rule 17(6)

vi. 1f;
Withdrawn under Rule 17(6)

vii. 1g
To be determined

viii. 1h;
To be determined

ix. 1i;
To be determined

x. 1j;
Record of Determinations – Medical Practitioners Tribunal

To be determined

xi. 1m.

To be determined

2. You discriminated against Patient A on the grounds of a protected characteristic in making your decisions about her treatment plan as described in paragraphs 1 to 1n.

Paragraphs 1h, 1i, 1j and 1n in relation to paragraph 2 deleted
following a successful Rule 17(2)(g) application
Paragraph 2 to be determined in relation to paragraphs 1g, 1k, 1l and 1m

The Admitted Facts

8. At the outset of these proceedings, through his counsel, Dr Ranjit 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.

The Facts to be Determined

9. In light of Dr Ranjit’s response to the Allegation made against him, the Tribunal is required to determine, save for his failure to conduct an urgent echocardiogram, or record having taken venous pressure, whether he failed in the care provided to Patient A and whether he discriminated against her on the grounds of a protected characteristic in making decisions about her treatment plan.

Factual Witness Evidence

10. The Tribunal received evidence on behalf of the GMC from the following witnesses:

• Ms C, in person

11. Dr Ranjit provided his own witness statement dated 4 April 2019 and also gave oral evidence at Stage one.

12. The Tribunal noted that Dr Ranjit accepted that his witness statement was a composite statement with reference to the documentation. He stated that he could not recollect all of the details and where he could not recall specifically he stated what his usual practice was.
Expert Witness Evidence

13. The Tribunal also received evidence from expert witnesses. Dr D, Consultant Cardiologist, instructed on behalf of the GMC and Dr E, Consultant Cardiologist, instructed on behalf of Dr Ranjit. Dr D provided a report dated 1 March 2018 and supplementary reports dated 11 May 2018, 21 November 2018 and 8 January 2019. Dr E provided a report dated, 29 June 2018 and a supplemental report dated 4 April 2019. The Tribunal received a joint expert report dated 7 May 2019. Both experts assisted the Tribunal in understanding the professional standards to be expected of a Consultant Cardiologist.

Documentary Evidence

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

- Ms C’s GMC witness statement dated 10 January 2019
- Ms C’s Police statement dated 28 September 2015
- Email from Ms B to the GMC enclosing a written complaint dated 7 November 2017
- Patient A’s medical and nursing records
- Dr Ranjit’s statement to the Coroner dated 19 October 2015
- The Trust’s Root Cause Analysis report produced on 11 December 2015
- The Trust’s resuscitation policy and standard operating procedure
- The Trust’s policy for care of patients with learning disabilities
- The Trust’s mental capacity act policy
- Dr Ranjit’s Curriculum Vitae
- Composite table of Patient A’s blood pressure readings 1-9 September 2015
- ESC Guidelines for the diagnosis and management of pericardial diseases
- Statement to the Coroner by Mrs F, Patient A’s mother

The Tribunal’s Approach

15. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC. 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. Whilst there is no sliding scale and it is a single and unvarying standard, it is clear that when considering the standard of proof, the less probable the proposition put through the charges, the more cogent is the evidence that the Tribunal will require to satisfy the burden. Dr Ranjit is required to neither prove nor disprove what is alleged against him. The Tribunal notes that Dr Ranjit has no previous fitness to practise history with his regulator and is of good character.

Medical Terminology
Record of Determinations – Medical Practitioners Tribunal

16. From the evidence heard, the Tribunal’s understanding of the medical terminology referred to in this hearing, is as follows:

17. Computerised Tomography scan (CT Scan)
A computerised tomography (CT) scan combines a series of X-ray images taken from different angles around the body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels and soft tissues inside the body. CT scan images provide more-detailed information than plain X-rays do.

18. Echocardiogram (echo)
An echocardiogram is a scan which gives a detailed view of the structures of the heart, and which can show how well the heart is working. The scan uses a probe that sends out ultrasound waves, which are reflected back by the muscles and tissues in the heart.

19. Pericardium/pericardial cavity
The pericardium is a double-walled sac which surrounds the heart. The pericardial sac has two layers, the space between which is the pericardial cavity which usually contains a small amount (50mls) of pericardial fluid.

20. Pericardial effusion
Pericardial effusion (‘fluid around the heart’) is an abnormal accumulation of fluid in the pericardial cavity. Because of the limited amount of space in the pericardial cavity, a significant fluid accumulation can lead to increased pressure which can negatively affect heart function.

21. Pericardiocentesis
Pericardiocentesis, also called a pericardial tap, is an invasive procedure that involves using a needle and catheter to remove excessive fluid (called a pericardial effusion) from the sac around the heart (the pericardium).

22. Venous pressure
Venous pressure is a term that represents the average blood pressure within the venous system (blood vessels returning blood to the heart). The term ‘central venous pressure’ (CVP) describes the pressure in the large veins as they enter the right side of the heart. An increased central venous pressure can result in visible distention of the jugular veins in the neck. The jugular venous pressure (JVP) is a clinically assessed sign used in the assessment of different forms of heart and lung disease.

23. Cardiac tamponade (Tamponade)
Cardiac tamponade is a clinical syndrome caused by the accumulation of fluid in the pericardial space, resulting in reduced filling of the chambers of the heart, compromising heart function. The condition is a medical emergency, the complications of which include fluid in the lungs, shock, and death.
The Tribunal’s Analysis of the Evidence and Findings

24. In considering each outstanding paragraph of the Allegation separately, the Tribunal has considered all the oral and documentary evidence before it and the submissions of Ms Fairley on behalf of the GMC and Mr Haycroft on behalf of Dr Ranjit.

Paragraph 1a

25. The Tribunal noted paragraph 32 of Good Medical Practice (2013) (the GMP), which states:

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

26. The Tribunal first considered whether when Dr Ranjit reviewed Patient A he was under a duty to adequately assess whether she had capacity, communication and support needs. The Tribunal was satisfied that Dr Ranjit had a duty to give information to Patient A that she wanted or needed to know in a way she could understand.

27. The Tribunal noted Dr Ranjit’s witness statement:

'18. I attended Patient A in the respiratory ward where she had been admitted to. I was already aware from my conversation with the SHO, referred to above, that Patient A had Down’s syndrome.

19. Before I saw Patient A I first looked at her medical notes which are kept on the ward, this is my standard practice. I looked at the patient’s admission notes, progress notes and choice of antibiotics.

20. I also looked through Patient A’s nursing notes, this is part of my standard practice. Commonly the nursing notes are within the patient’s bay, however sometimes they are not. I do not remember where I was when I reviewed the nursing notes but I know that I reviewed them before I examined Patient A. It is common for more information to be available in the nursing records than in the medical notes and this is the reason why I review the nursing notes.

21. ... I recall that the ‘nursing admission booklet’ had been completed, this is the document which sets out in significant detail a number of matters, including the fact that the patient had a learning disability, see [page 163], and that she needed various care plans, see [pages 163 and 164]. At the time
Record of Determinations –
Medical Practitioners Tribunal

I did not go through the nursing booklet in great detail, as it was not relevant to my treatment plan at that time.’

28. The Tribunal noted Dr D’s opinion in the joint report in respect of paragraph 1a:

‘No record by Dr. Ranjit. When anticipating performing a procedure, I would obtain informed consent from the patient if they had capacity. Relatives may be included here. In this case an ECHO was not done but I would expect the reasons for doing it and possible actions with risks and benefits to be discussed in advance.’

29. The Tribunal noted Dr E’s report dated 4 April 2019:

‘5.1.1 In my opinion, at this point (around 5pm on 4th September 2015) there was no issue of capacity, communication or support. There was no indication to perform an invasive procedure at 16:55 on 4th September 2015 and so the issue of capacity to give consent was not relevant. Patient A had already been assessed generally in this regard.

5.1.2 The diagnosis of tamponade does not require enhanced communication but relies more on physical signs and observations.

5.1.3 When Dr Ranjit attended to patient A on 4th September 2015, his responsibility was that of a consultant called to give a specialist opinion on the cardiovascular aspects of her condition. He was not taking over all aspects of her care.

5.1.4 His responsibility was to assess whether urgent cardiology input was required and to give advice about his opinion of best management.

5.1.5 In my opinion, on 4th September 2015, patient A’s communication and support needs had no impact on the cardiac diagnosis.

5.1.6 In my opinion Dr Ranjit made an accurate diagnosis - that patient A had an infection which was the cause of the effusions around the lung and heart - and he gave advice about her management. None of this was in my opinion contingent on her support or communication needs.

5.1.7 I would not expect a consultant cardiologist to have recorded any comment about communication or support needs in the notes when called to assess a patient with infection and secondary effusions who was not under his / her ongoing care.
Record of Determinations –
Medical Practitioners Tribunal

5.1.8 Doctors in a Hospital work as part of a very large team. It is normally a shared responsibility with the nursing team to document communication and support needs. Patient A was not under the care of Dr Ranjit; but under another team (Consultant physician Dr G), and there is documentation about the assessment of patient A’s capacity, communication and support needs already documented in the notes; I will review this further.

5.1.9 I note that the Emergency Admissions Proforma contains the documentation of patient A’s needs, specifically mentioning her need for help with ADL’s.

5.1.10 The Acute Medicine Daily Ward Round record documents that patient A was felt to be mobile and independent in her house; later, consent for an intravenous cannula was documented; later nursing notes document dealing with assistance with personal care.

5.1.11 The bundle contains nursing assessments that there is no need for a care plan re communication; and nursing plans re support for distress due to condition and admission; able to consent to treatment; presence of learning disability; and underlying Downs Syndrome. No safeguarding needs were identified.

5.1.12 Nursing notes contain further assessment of care and communication needs; detailed accounts of how patient A’s mum is dealing with much personal care and helps with communication; including patient A’s mum ‘feeding her sweets’ all night.’

30. The Tribunal noted that Dr Ranjit was the Cardiologist on-call for the weekend of 4-6 September 2015. He explained that he was telephoned around 16.00hrs by a junior doctor who informed him that Patient A, who was born with Down’s syndrome, was being treated for pneumonia, sepsis and pleural effusion. Dr Ranjit was advised that Patient A had had a CT scan which demonstrated a small pericardial effusion and he was asked to attend for a cardiology review. Patient A was being treated by a multi-disciplinary team under the care of respiratory Physician, Dr G (The Parent Team).

31. The Tribunal noted that Dr Ranjit is level 2 trained in Cardiac CT. The Tribunal accepted that Dr Ranjit viewed Patient A’s CT scan image in the Coronary Care Unit as the image was available on the system but had not been formally reported by a Radiologist. It was clear from the documents that this information was available on the system at the time Dr Ranjit says he viewed it. The Tribunal accepted that Dr Ranjit suggested to the junior doctor that Patient A should have an echocardiogram ("echo") to quantify the effusion and was told that the echo had already been requested and scheduled for Monday 6 September 2015.
32. Prior to seeing Patient A, Dr Ranjit’s evidence is that there was a pericardial effusion visible on the CT Scan. He stated that it appeared that the inferior vena cava (IVC) and superior vena cava (SVC) were not dilated compared to the aorta and there was no radiological evidence of tamponade based on his review. Patient A also had pleural effusions which Dr Ranjit explained he was not trained to interpret.

33. The Tribunal considered the role in which Dr Ranjit was attending Patient A and determined that it was in the capacity of a cardiologist who had been asked to assess Patient A by the lead consultant of the Parent Team, Dr G. The Tribunal accepted that it would be Dr Ranjit’s usual practice to familiarise himself with the notes of a patient before attending them and it was satisfied from both his oral and documentary evidence that he had done so. Within these notes references to Patient A’s capacity, communication and support needs were clearly documented.

34. The Tribunal considered capacity and the ability to communicate in the context of the type of examination that Dr Ranjit undertook at that time. He had already established the absence of radiological evidence of tamponade and sought to confirm this by carrying out a clinical examination on Patient A, this involved listening to her chest, taking her blood pressure, and observing the veins in her neck. These were non-invasive procedures. The Tribunal was satisfied that Patient A cooperated with Dr Ranjit’s examination because this was confirmed by her sister Ms C, although it accepts that Ms C did agree confirm the extent of the examination.

35. The Tribunal had regard to Dr E’s evidence that it is possible for a doctor to carry out a quick assessment of a patient’s capacity to understand and ability to communicate as soon as they enter the room and speak to the patient. The Tribunal also noted Dr D’s opinion that it was necessary for doctors to undertake a full capacity assessment on every occasion a patient is seen. He was however unable to explain the basis upon which he expressed this opinion other than it was what he would do himself. Dr E’s opinion was based on his experience of current working practices in NHS Hospitals. Dr E also directed the Tribunal to Patient A’s medical notes which recorded the findings of members of the team responsible for Patient A’s care which did not give rise to particular issues of concern in relation to capacity or ability to communicate.

36. In relation to Patient A’s support needs the Tribunal was satisfied that Dr Ranjit was aware of the medical and nursing notes which state ‘Can communicate basic needs also family may assist’. The Tribunal noted that Ms C was present in the room and able to assist if requested. The Tribunal was not satisfied that Dr Ranjit had a duty to further assess Patient A’s support needs for the purposes of his examination, as this had already been done by the Parent Team.

37. The Tribunal preferred the reasoned explanation given by Dr E and that in the circumstances of this examination a further assessment of Patient A’s capacity,
communication and support needs was not necessary. Accordingly, the Tribunal found paragraph 1a, not proved.

**Paragraph 1b**

38. The Tribunal noted that Jugular Venous Pressure (JVP) or Central Venous Pressure (CVP) is assessed by physical examination of the visible veins beginning at the root of a patient’s neck. An increased CVP can result in visible distention of the jugular veins in the neck. The JVP can be difficult to see in overweight patients, and is significantly raised in cardiac tamponade.

39. The Tribunal noted that ‘Beck’s triad’ is described as a combination of three physical signs showing - when present in combination - a high likelihood of cardiac tamponade: muffled heart sounds, engorged neck veins, low blood pressure.

40. The Tribunal has had sight of Dr Ranjit’s note in Patient A’s medical records on 4 September 2015 timed at 16.55, which states:

> ‘4/9/15 Cardiology review (RANJIT)
> 1655
> History noted. Has consolidation and pleuropericardial effusion.
> ↑ WCC & ↑ CRP
> Chest – A/E ↓ bilateral bases CVS – S1 S2 + no rubs / murmurs.
> Plan – blood culture x 3, WTU
> – micro advice regarding choice of antibiotics
> Cardio continued
> - Echo as inpatient urgently
> Chase CT report
> - No evidence of tamponade – so would not normally intervene for pericardial effusion: should improve with I/V antibiotics
> - Please let me know of echo result when it is done’

41. The Tribunal has noted Dr Ranjit’s witness statement:

> ‘32. I listened at the front to Patient A’s chest to hear her heart sounds and make an assessment of her cardiovascular system, having done so, as set out above, I recorded “S1 S2 present; no rubs/ murmurs”, had there been muffled heart sounds, this would have been a fundamental sign of cardiac tamponade (one of Beck’s triad). I also listened from the back to observe Patient A’s breathing and her lungs, having done so I recorded “Air entry bilateral bases”.

> 33…’
34. It is my standard practice to look at jugular venous pressure (JVP). I do this with all cardiac patients and I recall that I looked at Patient A’s JVP and it was not raised...’

42. In relation to paragraph 1b, the Tribunal then had regard to the experts’ joint report, in which Dr D noted:

‘No mention of venous pressure but CT venous pressure not assessed’.

43. It was Dr E’s opinion in the joint report:

‘Dr Ranjit should have made a specific contemporaneous record of his assessment of venous pressure in his note made at around 5pm on 4th September 2015. Dr Ranjit recorded his overall impression that there was no evidence of tamponade, he did not record the details of the cardinal signs of blood pressure, heart sounds and venous pressure.’

44. In Dr E’s supplementary report dated 4 April 2019 he stated:

‘5.2.1 In my opinion, Dr Ranjit documented that in his opinion there was no evidence of tamponade. He documented his integrated clinical assessment but did not specifically mention venous pressure. In my opinion it was unlikely that Patient A had developed tamponade at this point, which I believe developed at about 11 pm on the evening of 4th September.

5.2.2 An elevated venous pressure (assessment of the ‘height’ of the visible neck veins) can be of assistance in the diagnosis of tamponade, amongst other signs. The classical three physical signs are elevated venous pressure, quiet heart sounds and low blood pressure, so called ‘Beck’s triad’. When Dr Ranjit examined patient A at around 5pm on 4th September 2015, she did not have a low blood pressure. Beck’s triad was not present.’

45. In his oral evidence Dr E told the Tribunal that an experienced Consultant cardiologist could easily visually assess venous pressure without anyone else being aware of it. The Tribunal was of the understanding that assessing the JVP becomes second nature to a consultant in this field. It was Dr E’s criticism that Dr Ranjit did not record the venous pressure in Patient A’s medical notes at 16.55 hrs. He reminded the Tribunal however, that the medical notes did record that JVP was not visible at 06.10 hrs on 4 September 2015 when the Medical Emergency Team (MET) had been called.

46. It was Dr Ranjit’s evidence that he visually assessed Patient A’s venous pressure when he was examining her. He said that it was his usual practice to write the venous pressure at the beginning of his medical note, but on this occasion failed
Record of Determinations –
Medical Practitioners Tribunal

to do so. He suggested that this may have been because in order to properly
measure Patient A’s blood pressure he needed a manual blood pressure machine,
there was none on the ward and so he had to wait until one was obtained from
elsewhere. This, Dr Ranjit says, may have distracted him from recording the Venous
Pressure in the patient’s notes.

47. The Tribunal noted that it was agreed between the experts that at 16.55hrs
on 4 September 2015 Patient A did not have tamponade.

48. It is the GMC’s position that because Dr Ranjit did not record the Venous
Pressure in Patient A’s medical notes he did not undertake it.

49. The Tribunal noted that it was Ms C’s evidence that Dr Ranjit undertook a
brief examination of Patient A. She stated:

‘10. Dr Ranjit did not say or do anything to acknowledge what I had said and
began his examination. He told [Patient A] to lean forwards which she
did and then he put a stethoscope on her back and listened. I do not
remember him carrying out any further types of physical examination.’

50. The Tribunal had regard to the fact that the purpose of Dr Ranjit’s
assessment was to establish whether Patient A had cardiac tamponade. The Tribunal
also had regard to the fact that an assessment of the JVP would form part of Dr
Ranjit’s assessment of tamponade, as agreed by both experts. The Tribunal
accepted Dr E’s evidence that the assessment of JVP is an integral and routine
assessment for a cardiac consultant. The Tribunal found that it is unlikely that Dr
Ranjit did not undertake this assessment. Given that Dr Ranjit has recorded
‘No evidence of tamponade’ it is more than likely, on the balance of probabilities that Dr
Ranjit took Patient A’s Venous Pressure. Accordingly, the Tribunal found paragraph
1b not proved.

Paragraph 1h

51. The Tribunal reminded itself that Dr Ranjit reviewed Patient A at 16.55 hrs on
4 September 2015. Prior to his examination the MET had already been called out to
Patient A at 06.10 hrs that morning. At some stage after the MET call Patient A was
reviewed by Dr G who left written instructions that should her condition deteriorate
she should be referred to the High Dependency Unit for transfer. Dr G also recorded
that should it be needed ‘consideration should be given for full escalation including
invasive ventilation.’ The Tribunal noted this is further confirmed in the nursing
notes which state:

‘NB: if deteriorates for HDU to include invasive ventilation’

52. Following Dr Ranjit’s assessment the Tribunal noted the nursing records state:
It further noted that the MET reviewed Patient A at 21.15 hrs on 4 September 2015. It was clear from the medical notes that the MET did consider cardiac complications, including pericarditis/myocarditis and pericardial effusion.

Following the MET call Patient A was further assessed at 23.15 hrs by a Foundation Year 2 doctor.

The Tribunal noted the joint expert report which states:

'We agreed that there were abundant, detailed, adequate and appropriate instructions to escalate care already documented and recorded in the notes and in hospital policies which, if followed, would have prevented mishap and kept Patient A safe. The disagreement is described.'

It was Dr D’s opinion in the joint report:

'No strict instructions. I said he should be making it clear and not assume protocols either known or followed by staff on duty.'

Dr E told the Tribunal that METs have worked within the NHS for some time and was surprised with Dr D’s opinion that staff would not familiarise themselves with the protocols.

The Tribunal noted that the Trust’s MET policy references, amongst others; Comprehensive Critical Care (2000) DH and NICE Clinical Guideline 50 (2007) Acutely Ill Patients in Hospital. A key recommendation is the need for a clinical team with critical care competencies and diagnostic skills to provide rapid response in the event of a clinical deterioration.

The Tribunal noted the Trust’s policy document ‘The Aims of the Aintree MET’ which are:

- To provide 24 hour, 7 days per week multi-specialty expertise at the point of need to all patients requiring senior medical review or cardio-pulmonary resuscitation regardless of their geographical location on the Aintree Hospital site.

- To rapidly respond to ALL emergency calls (including cardiorespiratory arrests) when MET calling criteria are recognised. The MET ‘Calling Criteria’ are based upon the clinical parameters diagnostic of cardiopulmonary arrest, and physiological changes which are precursors to life threatening illness.'
... It is the responsibility of the MET Team Leader to document parameters for the MET to be recalled to a patient, and to ensure that this information is communicated to relevant ward staff.

...

4.6. The Ongoing Care of a patient following a MET call

- The MET will NOT replace the patients Parent Team who will remain the primary care provider.

- The responsibility for implementation of the MET Management Plan and the ongoing care of patients who remain on a ward following a MET call; lies with the patient’s Parent Team or out of hours the ‘On-Call’ Medical or Surgical Team.

- The patient’s Parent Team should be informed of MET attendance to their patients. During normal hours the MET Team Leader will attempt to contact a doctor from the patient’s ‘Parent Team’ during or immediately following a MET Call. If contact cannot be made, then this will be documented in the patient’s case notes and the ward nursing staff will be asked to make contact with the ‘Parent Team’ at the earliest opportunity.

- In the event that the patients Parent Team are unavailable and if the call is between 09:00-17:00, then the ‘On-Call’ Medical or Surgical Specialty Team will be notified of the call’.

60. It was Dr E’s opinion in the joint report:

‘The hypotension at 11pm and subsequent unrecordable blood pressure were gross markers of shock. There was no need for a consultant cardiologist to leave an instruction that shock should be dealt with - the pericardial effusion had been identified on CT, and shock is a medical emergency, and may have many causes or differential diagnoses. The nursing notes were clear in documenting already, before Dr Ranjit’s review, that deterioration in clinical status should prompt escalation of care to the critical care team. There was a detailed MET protocol which was not followed by the ward team.’

61. In line with the Trust’s policy and NICE Guidelines the Tribunal is of the opinion that Dr G and the Parent Team had overall responsibility for Patient A’s ongoing care and treatment plans but the staff involved in delivering this treatment might change depending on shifts.

62. The Tribunal noted that Dr D’s opinion was based on what he thought
Record of Determinations –
Medical Practitioners Tribunal

Dr Ranjit should have done, or what he would have done, as opposed to what were the accepted protocols of the hospital. The Tribunal found that there would be little point of putting protocols in place to address medical emergencies if senior clinicians could not have confidence in them or were not prepared to follow them. This, the Tribunal found, was part of working collaboratively with colleagues.

63. In the light of the Trust’s existing MET policy, the Tribunal must decide whether Dr Ranjit had a duty to give further explicit guidance about when he should be contacted. The Tribunal found that the staff in charge of Patient A’s care were already in possession of clear instructions as to actions that should be taken if Patient A’s condition deteriorated. Therefore, the Tribunal determined that it was not necessary for Dr Ranjit to add to this as there was nothing further that needed to be added and Dr Ranjit had no duty to do so.

64. Given Patient A was under the care of Dr G and the Parent Team on the respiratory ward and had a very complex presentation there were a number of complications that may have arisen. The Tribunal considered that Dr Ranjit was entitled to rely on the team responsible for Patient A’s care should her condition deteriorate, to notify him of any change relevant to his speciality.

65. The Tribunal found that, Dr Ranjit having satisfied himself that no immediate action needed be taken at that time from a cardiological perspective, it was reasonable for him to leave the existing treatment plan in place, given that there were specific instructions from Patient A’s treating Consultant, Dr G. The Tribunal was satisfied that there were adequate ‘standing orders’ in place as set out in the MET protocol that gave clear instructions for caring for Patient A. Accordingly, the Tribunal found paragraph 1h not proved.

Paragraph 1i

66. The Tribunal considered that the meaning of the word ‘supervise’ in paragraph 1i was not to supervise staff, but ‘to supervise’ Patient A’s cardiac condition. The Tribunal considered that it was not Dr Ranjit’s responsibility to supervise the staff involved in caring for Patient A as that was the responsibility of the Consultant in charge of the Parent Team.

67. The Tribunal first considered the involvement of Dr Ranjit in Patient A’s treatment. He had been asked to provide a specialist assessment as a Consultant cardiologist. Having been given initial information about Patient A and having viewed the CT scan, Dr Ranjit had recommended that an urgent echo be carried out and was told that one had already been arranged for Monday.

68. In his witness statement Dr Ranjit explained that:
'12. It was during this initial telephone discussion with the junior doctor that I suggested that Patient A should have an echocardiogram (“echo”) to quantify the effusion, however I was told that the echo had already been ordered. It is the case that everyone with effusion will have an echo at some point. A routine echo will be performed in 2 – 3 days, an urgent echo should usually be performed within 24 hours during Monday - Friday. If an urgent echo is requested on a Friday then due to the weekend it would usually wait until Monday. If an echo is required as an emergency I then perform it myself at the bedside of the patient and I would not make an urgent request as there would be no need.’

69. Although the Tribunal was not provided with documentary evidence to support Dr Ranjit’s description of the Trust’s working practice in relation to undertaking urgent echos at the weekend, it accepted that this is the practice in Aintree University Hospital NHS Foundation Trust.

70. In respect of the management of Patient A the opinions of the two experts in the joint report were:

71. Dr D:

‘Early review and specific advice not given as in my report. I would have reassessed the patient either later that evening or at the beginning of my post take ward round having the benefit of performing the initial ECHO on 4th.
In my practice, and my opinion the post take round should always start with the sickest patients on either ITU, CCU or A&E).’

72. Dr E:

‘Responsibility for managing Patient A remained with the team in charge of her care. There was a plan to monitor patient A and to escalate her care to critical care and ventilation if necessary, if her observations deteriorated. Patient A’s death was caused because grossly abnormal and desperately worrying abnormalities developed 6 hours after Dr Ranjit’s review, were recorded but not acted upon.’

73. It was Dr E’s oral evidence that an echo should have been carried out within 24 hours of the CT scan and that it was Dr Ranjit’s responsibility to have ensured that this was done, whether he did it himself or arranged for it to have been done within that time scale. Dr E stated ‘There is no enhanced duty to do an echo if one has been missed as sometimes patients do get better but the issue in this case was the severity of her condition.’
Record of Determinations –
Medical Practitioners Tribunal

74. Dr D agreed that a planned urgent echo (as opposed to an emergency echo) should have been undertaken within 24 hours of the CT scan.

75. The Tribunal noted that Dr Ranjit accepted ‘with the benefit of hindsight I accept that the echocardiogram should have been performed within 24 hours of the original request in any event.’

76. The Tribunal noted the article ‘Imaging Findings in Cardiac Tamponade with Emphasis on CT’, which states:

    ‘Echocardiography is the imaging technique of choice for diagnosis of pericardial effusion and cardiac tamponade. It is readily available and portable, lacks ionizing radiation, and is highly sensitive for detection of pericardial effusion. It is also very specific for diagnosis of pericardial tamponade if the characteristic imaging findings are identified.’

77. The Tribunal found that Patient A’s ongoing treatment and care were the overall responsibility of the Parent Team. It noted that Dr Ranjit was asked to review Patient A’s cardiac condition and, in his clinical judgement, at 16.55 hrs when he examined her he was of the view that as the CT scan and his clinical examination of her had shown no evidence of cardiac tamponade he decided that it would be reasonable to take a ‘calculated risk’ and wait until Monday for the echo. Dr Ranjit now accepts that a planned urgent echo should have been carried out within 24 hours as agreed by both experts.

78. The Tribunal were told that an echo would have established a functional base on which to compare Patient A’s worsening or improving cardiac effusion. Whilst there was no clinical indication to conduct the echo immediately at 16.55 hrs it should have been conducted, as agreed by the experts within 24 hours, to establish that functional base. As the duty cardiologist on-call, this was the responsibility of Dr Ranjit to either carry out the procedure himself or instruct someone else to do it. In failing to do so Dr Ranjit failed adequately to supervise Patient A’s cardiac problems. Accordingly, the Tribunal found paragraph 1i proved.

Paragraph 1j

79. The Tribunal noted that Dr D was of the view that Patient A’s quality of life was a matter that should have been discussed with the family as opposed to Patient A. The Tribunal took some time to understand Dr D’s opinion in his oral evidence. It understood Dr D’s opinion to be predicated on the fact that Dr Ranjit was going to potentially undertake a pericardiocentesis on Patient A.

80. The Tribunal noted that following Dr Ranjit’s examination of Patient A he determined that undertaking pericardiocentesis was not clinically indicated or appropriate in her case at that time. Dr Ranjit’s examination of Patient A was to
establish whether there was clinical evidence of tamponade. Having established that there was no need for any immediate action to be taken, Dr Ranjit decided that Patient A’s treatment plan put in place by the Parent Team did not necessitate any change following his assessment of Patient A. Given that Dr Ranjit did not propose to undertake any further intervention the Tribunal found that there could have been no reason, at that time, to discuss the quality of Patient A’s life with her family. The Tribunal found that it would in fact have been inappropriate to do so as it would only have served to have caused unnecessary distress and anxiety to the family in circumstances where the need for a pericardiocentesis may never have arisen. Accordingly, as there was no duty on Dr Ranjit in this regard, the Tribunal found paragraph 1j not proved.

**Paragraph 1k**

81. The Tribunal had to determine whether Dr Ranjit had to formulate a treatment plan and if so, whether he failed to adequately explain it to Patient A or her family.

82. The Tribunal noted that Dr G had reviewed Patient A at 16.00 hrs and Dr Ranjit examined Patient A at 16.55 hrs following her CT scan. Dr Ranjit’s entry in Patient A’s medical notes state:

   ‘No evidence of tamponade – so would not normally intervene for pericardial effusion: should improve with I/V antibiotics.’

83. The Tribunal noted that Dr Ranjit found no evidence of tamponade and concluded that cardiac intervention was not required at that time. The Tribunal was satisfied that Dr Ranjit saw no need to make any change to Dr G’s treatment plan.

84. The Tribunal was satisfied that Dr G’s treatment plan remained in place and technically Dr Ranjit had not formulated a new or amended treatment plan for Patient A. The Tribunal was therefore satisfied that Dr Ranjit did not have duty to discuss a plan.

85. However, the Tribunal went on to consider whether or not Dr Ranjit had a duty to discuss his findings with Patient A or her family either during or following his assessment of her and if he did whether he complied with that duty.

86. The Tribunal determined that there is a reasonable expectation that any clinician attending a patient would communicate with them and explain what they were doing. Dr Ranjit told the Tribunal that he had difficulty recollecting exactly what took place that day. He explained that this was because the consultation was not out of the ordinary and a considerable period of time had passed since then. Dr Ranjit was reliant on what would be his usual practice. In considering Dr Ranjit’s practice and the weight the Tribunal placed on what he described his practice to be,
it noted that he is an experienced consultant involved in the teaching of students and who is of good character, whose fitness to practise has not previously been called into question.

87. The Tribunal had regard to Dr Ranjit’s witness statement in which he states:

’72. I deny this allegation. The treatment plan was to continue with the intravenous antibiotics. There would have been a Nurse present when I explained to Patient A’s family that she had fluid around her heart and that the treatment plan was to continue to take the intravenous antibiotics as this should resolve it and that she should be monitored in the meantime. As referred to earlier in this statement there is a Nursing record which was made and which reflects the plan, this is set out at [page 206].’

88. The Tribunal took account of the entry in the nursing notes. Whilst there is no time recorded save for ‘PM’. The nursing note states:


89. The Tribunal had close regard to the evidence of Ms C. In her witness statement to the police she states:

’At 3.15 pm [Patient A] was taken for a CT Scan by a porter. When we came back up, the doctor Dr H came back to try and gets bloods again. He was followed in by a cardiology doctor who listened to [Patient A’s] chest and was asking if the CT scan results were done. Dr H said they weren’t and they were trying to obtain bloods again. They had also booked in for an echo exam of the heart to be done on the Monday following the coming weekend.’

90. In Ms C’s subsequent witness statement:

’8. Dr Ranjit did not introduce himself to [Patient A] or myself or explain who he was or what he was there to do. In the statement I gave to the Police, I only knew he was a cardiologist as I asked Dr H after he had left and he told me.

9. Dr Ranjit first spoke to Dr H and asked if [Patient A] had been for a CT scan. Dr H did not know and looked to me for confirmation. Before he asked me anything I responded and said ‘we’ve just come back’.

10. Dr Ranjit did not say or do anything to acknowledge what I had said and began his examination. He told [Patient A] to lean forwards which she did and then he put a stethoscope on her back and listened. I do not remember him carrying out any further types of physical examination.
Record of Determinations – Medical Practitioners Tribunal

11. After the examination Dr Ranjit asked Dr H if an echocardiogram had been booked for [Patient A]. Dr H confirmed it had been arranged for Monday.

12. Dr Ranjit also discussed with Dr H the awaited CT scan results. I think he said he would wait for the results or possibly go and find them.

13. Dr Ranjit then left [Patient A’s] bedside. He did not say goodbye to [Patient A] or me.’

91. In oral evidence the Tribunal found Ms C gave a clear account of what her recollections were. The Tribunal however, had some concerns about the reliability of her evidence because, for example, she was adamant that Patient A’s blood pressure (BP) had not been measured at all when there is clear documentary evidence that it was. In addition, the Tribunal having accepted that Dr Ranjit had viewed the CT scan prior to seeing Patient A it does not make sense that he would ask whether it had been done when he was in the room, as was the recollection of Ms C in her witness statement. The Tribunal was of the view that it would have been unlikely that Dr Ranjit would have seen Patient A without first looking at her medical notes. The Tribunal noted that the medical notes record that an echo had already been requested and therefore, Dr Ranjit would have had no need to enquire with ‘Dr H’ about this as recorded by Ms C.

92. The Tribunal was mindful of the relationship between Patient A and her sister and acknowledged that this would have been a stressful time where Ms C’s attention would have been focussed on her sister. This in turn may have impacted on her observation of the activities or presence of others in the room at the time. The Tribunal found this to be completely understandable especially in light of the time that has passed since these events.

93. The Tribunal noted that it was Ms C’s oral evidence that Dr Ranjit did not speak to her or Patient A at all. However, Ms C was present in the room and had clearly obtained some information about Patient A’s treatment.

94. The Tribunal considered what information Dr Ranjit had said he was likely to have given to Patient A when he entered her room. It was Dr Ranjit’s evidence that when consulting with patients he always introduces himself and discusses his findings. The Tribunal considered that it would be unlikely that any doctor would be able to examine a patient without some form of communication.

95. The Tribunal considered that whilst Ms C may have felt she and Patient A were not communicated with sufficiently, it noted that this consultation occurred during a time that was clearly stressful. For the reasons given above the Tribunal is unable to rely on Ms C’s account of this consultation because of the inconsistencies.
in her recollection. Having regard to all the evidence before it, the Tribunal
determined that, it is more likely than not, Dr Ranjit did follow his usual practice in
communicating with Patient A.

96. In the circumstances the Tribunal is of the opinion that the GMC has failed to
discharge its burden of proof. Dr Ranjit did not fail to adequately explain his
treatment plan to Patient A or her family because he had no duty to do so.
Accordingly, the Tribunal found paragraph 1k not proved.

Paragraph 1l

97. The Tribunal understood the term ‘early intervention’ could mean any cardiac
intervention but primarily in this case it related to pericardiocentesis. The Tribunal
were not specifically addressed on ‘risks and benefits’ save for the fact that carrying
out a pericardiocentesis where there is only a small amount of fluid present was
highly dangerous and could puncture a patient’s heart.

98. The Tribunal noted that Dr E’s opinion was that there was no duty for
Dr Ranjit to explain risks or benefits on any cardiac procedure that was not at that
time being planned. He noted that:

‘No single nor definite early intervention planned, so risks and benefit
irrelevant.’

99. Following his cardiac review of Patient A, Dr Ranjit decided that no change
was needed to Dr G’s treatment plan, which should remain in place. He expected to
review the echo when it had been completed on Monday. It was his clinical opinion
that he would not perform a pericardiocentesis at that time, as according to the CT
scan there was not enough fluid around Patient A’s heart to warrant
pericardiocentesis and indeed to attempt to do so would also have put Patient A at
unnecessary risk.

100. The Tribunal was of the view that if Dr Ranjit had considered any cardiac
intervention necessary he had a duty to discuss it with Patient A and her family.
However, the Tribunal was satisfied that Patient A was to remain on the treatment
plan prescribed by Dr G and the Parent Team. As Dr Ranjit had not considered any
cardiac intervention necessary the Tribunal considered that any discussion about
risks or benefits would be premature and he did not have a duty to discuss this with
Patient A and her family. Accordingly, the Tribunal found paragraph 1l not proved.

Paragraph 1m

101. The Tribunal accepted Dr Ranjit’s evidence that, having seen Patient A’s CT
scan and following his examination of her, which established the absence of
tamponade, it was not his intention to undertake a pericardiocentesis. It was in fact
his evidence that to have attempted the same would have been contra indicated, and it would have given no clinical benefit and, given the size of the pericardial effusion on the CT Scan at that time, to do so would have been highly dangerous to Patient A.

102. The Tribunal noted Dr E’s opinion that:

‘Such a discussion could only have been undertaken and commenced if and when Dr Ranjit had felt that the pericardiocentesis was indicated.’

103. The Tribunal was satisfied that Dr Ranjit did not have a duty to discuss with Patient A or her family the risks and benefits of a pericardiocentesis as he had no intention of performing it at that time. The Tribunal considered that discussing pericardiocentesis at 16.55 hrs on 4 September 2015, was not appropriate because there was no tamponade and doing so could have caused undue distress to Patient A and her family. Accordingly, the Tribunal found paragraph 1m not proved.

Paragraph 1n(i)

104. The Tribunal noted paragraphs 19 and 21 of Good Medical Practice. which state:

‘19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

21. Clinical records should include:

a. relevant clinical findings

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c. the information given to patients

d. any drugs prescribed or other investigation or treatment

e. who is making the record and when.’

105. The Tribunal found paragraph 1a not proved. It found that Dr Ranjit had already established from Patient A’s medical notes that Patient A’s capacity, communication and support needs had been assessed and recorded by the Parent Team. The Tribunal was satisfied, in the absence of any change in Patient A’s capacity, communication and support needs, as documented, Dr Ranjit did not have a duty to further document it. Accordingly, the Tribunal found paragraph 1n(i) in relation to paragraph 1a, not proved.

Paragraph 1n(ii)
106. At the outset of the hearing Dr Ranjit admitted and the Tribunal found paragraph 1n(ii) proved that he had failed to record the venous pressure.

**Paragraph 1n(vii) in relation to paragraph 1h**

107. The Tribunal found paragraph 1h not proved. The Tribunal noted that both experts agreed there were detailed, adequate and appropriate instructions for the staff to know when an escalation of care should occur. These instructions were contained not only in Patient A’s medical records but also formed part of the MET protocol. The Tribunal found that there was no duty on Dr Ranjit to provide additional instructions to staff of when to reconsider intervention to assess pericardial effusion, as this was already documented. Whilst not specifically referred to it was clear what would be expected from the documented information. Accordingly, the Tribunal found paragraph 1n(vii) in relation to paragraph 1h not proved.

**Paragraph 1n(viii)**

108. The Tribunal found paragraph 1j not proved. The Tribunal found that in the circumstances and at that time Dr Ranjit did not have a duty to discuss Patient A’s quality of life with her family. Therefore, Dr Ranjit did not have a duty to record it. Accordingly, the Tribunal found paragraph 1n(viii) in relation to paragraph 1j not proved.

**Paragraph 1n(ix) in relation to paragraph 1k**

109. The Tribunal found paragraph 1k not proved, for the reasons given above, that Dr Ranjit had not formulated a treatment plan but simply endorsed Dr G’s existing treatment plan. Dr Ranjit did not have a duty to explain the plan to Patient A or her family and therefore had no duty to record it in the medical notes. Accordingly, the Tribunal found paragraph 1n(ix) in relation to paragraph 1k not proved.

**Paragraph 1n(x) in relation to paragraph 1l**

110. The Tribunal found paragraph 1l not proved. It was satisfied that Dr Ranjit had not planned any cardiac intervention therefore he did not have a duty to discuss any risks and benefits with Patient A or her family. The Tribunal was satisfied that Dr Ranjit did not have a duty to document it in the medical notes. Accordingly, the Tribunal found paragraph 1n(x) in relation to paragraph 1l not proved.

**Paragraph 1n(xi) in relation to paragraph 1m**
Record of Determinations –
Medical Practitioners Tribunal

111. The Tribunal found paragraph 1m not proved. It was satisfied that as Dr Ranjit had no intention to perform pericardiocentesis at that time, he did not have a duty to discuss the risks and benefits with Patient A or her family. The Tribunal was satisfied that Dr Ranjit did not have a duty to document it in the medical notes. Accordingly, the Tribunal found paragraph 1n(xi) in relation to paragraph 1m not proved.

Discrimination

112. The Tribunal took account of the Legally Qualified Chair’s legal advice and the application of the Equality Act 2010 (Eq Act 2010), which both parties agreed with.

113. In respect of paragraph 2 of the Allegation, the charge of discrimination arising from Patient A’s disability, the GMC allege that the treatment of her by Dr Ranjit was unlawful discrimination that arose as a consequence of her disability.

114. It might be helpful to point out at this stage that it is the GMC’s case that the condition of Down’s syndrome amounts to a disability for the purposes of Section 6 of the Eq Act 2010. The Tribunal noted that whilst Down’s syndrome is not a deemed disability for the purposes of the Eq Act 2010 it has not been disputed that in Patient A’s circumstances the condition amounted to a disability.

115. It is the GMC’s case that the learning difficulties experienced by Patient arose as a consequence of her disability and that Dr Ranjit’s perception of how these learning difficulties would impact on his treatment of her led him to treat her in the manner in which he did.

116. The Tribunal reminded itself of the Legally Qualified Chair’s legal advice and the application of the Eq Act 2010. In particular it had regard to Section 15 which provides:

1. A person (A) discriminates against a disabled person (B) if—
   (a) A treats B unfavourably because of something arising in consequence of B’s disability, and
   (b) A cannot show that the treatment is a proportionate means of achieving a legitimate aim.
   (2) Subsection (1) does not apply if A shows that A did not know, and could not reasonably have been expected to know, that B had the disability.”

117. The GMC say that the unfavourable treatment relied on, is that listed at paragraphs 1g, 1k, 1l and 1m.

118. In looking at the allegation of unlawful discrimination at paragraph 2 the Tribunal is required to ask two questions which go to causation:
Record of Determinations –
Medical Practitioners Tribunal

i. Do the allegations at paragraphs 1g, 1k, 1l and 1m amount to unfavourable treatment?

ii. What was the reason for the unfavourable treatment? – focusing on what was in the mind of Dr Ranjit when he treated Patient A as he did? There may be more than one reason but the ‘something’ must have a significant (or more than trivial influence) on the unfavourable treatment and so amount to an effective reason or cause of it. It is not a requirement that a discriminatory motive must be present as motive is not a core consideration.

119. The test is, looked at objectively (i.e. as a matter of fact rather than belief) did the ‘something arise as a consequence of Patient A’s disability (the learning difficulties)’ and Dr Ranjit’s perception of how this may impact on his treatment of her. The thought processes of Dr Ranjit are not relevant at this stage. Put in perhaps a simpler way:

i. What was the ‘something’ that the GMC relies upon? – The Tribunal was told it was Patient A’s learning difficulties and the perception of Dr Ranjit on how that would impact on his treatment of her.

ii. In respect of each of the allegations at paragraphs 1g, 1k, 1l and 1m, did Dr Ranjit treat Patient A unfavourably because of that?

120. The Tribunal will need to find proved that Dr Ranjit’s treatment of Patient A was because of her learning difficulties and his perception of how this might impact on his treatment of her, and that the treatment of her at paragraphs 1g, 1k, 1l and 1m was unfavourable.

121. The Tribunal was mindful that the burden is on the GMC. If the Tribunal concludes on the evidence before it that Dr Ranjit treated Patient A unfavourably because of her learning difficulties and his perception of the effect of the same on his treatment of her - then the burden will shift to Dr Ranjit to show that even though he did treat her in the way alleged he did so because he was seeking to achieve a legitimate aim and the treatment was a proportionate way of achieving it. If he is unable to do this then the paragraph must succeed.

122. The Tribunal will be cautious not to confuse this type of discrimination with that of direct discrimination which requires a finding of less favourable treatment for a reason related to the disability of Patient A, whereby having shown facts from which the Tribunal could conclude the treatment was unlawful, the burden would then shift to Dr Ranjit to show that the reason for the treatment of Patient A was in no way connected to her disability at all. The GMC confirmed that it does not rely on this type of discrimination in the allegation at paragraph 2.

Paragraph 2 in relation to paragraph 1g
123. The Tribunal had regard to the basis on which the GMC brought this charge. In opening Ms Fairley told the Tribunal that it was reasonable to infer, in the absence of any other explanation, that the reason that Dr Ranjit failed to carry out an urgent echo, despite the fact that Patient A had been identified as needing one, was because he believed that due to her learning difficulties a general anaesthetic would be needed for further intervention resulting from the findings of any echo and it was this that influenced his decision not to carry out the echo in the 24 hours after he had seen her.

124. The Tribunal notes that there is no direct evidence that Dr Ranjit perceived that Patient A’s learning difficulties would impact negatively on any potential treatment that would be prescribed. In determining the issue of whether the failure to carry out an urgent echo amounted to unlawful discrimination arising out of Patient A’s disability, the Tribunal addressed its mind to the question of whether the failure amounted to unfavourable treatment. In doing so it had regard to the evidence of both experts who agreed that an urgent echo should have been carried out within 24 hours. The Tribunal concluded that in the circumstances of this case the failure to carry out an urgent echo within that time, was unfavourable treatment.

125. The Tribunal then addressed the second question of what was the reason for the unfavourable treatment. Dr Ranjit explained that the reason he did not carry out the echo immediately was because the echo was already scheduled for after the weekend i.e. on Monday. When he assessed Patient at 16.55 hrs on 4 September 2015, he had already viewed the CT images and decided that there was no clinical indication to undertake an echo at that time. He does now accept that he should have done it but at the time he thought that in light of his clinical assessment of her he could take what he has described as a ‘calculated risk’ and wait until Monday. In oral evidence Dr Ranjit explained that his reference to Patient A potentially needing sedation to undergo an echo was not a bar to the procedure but rather was an observation of what may be required should an urgent procedure become necessary. Looked at objectively the Tribunal found that Dr Ranjit had provided a reasoned explanation for why he did not conduct an urgent echo within the agreed 24 hour period. The Tribunal found that Dr Ranjit’s decision was based on documented clinical findings and was not influenced by Patient A’s learning difficulties.

126. The Tribunal found that whilst Patient A was subjected to unfavourable treatment when Dr Ranjit took the decision to wait for an echo to be carried out, this unfavourable treatment did not arise as a consequence of Patient A’s disability and Dr Ranjit’s perception of the same and the claim of unlawful discrimination under Section 15 of the Eq Act 2010 is not made out. Accordingly, the Tribunal found Paragraph 2 in relation to paragraph 1g, not proved.

**Paragraph 2 in relation to paragraph 1k**
The Tribunal first addressed its mind to whether by not explaining his treatment plan to Patient A or her family Dr Ranjit subjected Patient A to unfavourable treatment. In doing so the Tribunal considered what effect this had on Patient A and her family. Given that Patient A and her family were aware through others of the treatment plan put in place by Dr G and that Dr Ranjit made no change to that treatment plan Patient A and her family cannot be said to have been put at any disadvantage or have suffered detriment as a result of Dr Ranjit not discussing Dr G’s treatment plan with them.

The Tribunal found that Dr Ranjit’s actions in not discussing the treatment plan with Patient A and her family was in any event not influenced by any perception he may have had about her learning difficulties. The Tribunal made this finding because it accepts Dr Ranjit’s evidence that he did not consider it necessary to discuss the treatment plan further because he was not making any changes to the plan already in place. For the sake of completeness and the reasons set out in relation to paragraph 1k, the Tribunal found that Dr Ranjit did follow his usual practice when he carried out an assessment of Patient A at 16.55 hrs on 4 September 2015.

For the reasons given above the Tribunal found that Patient A was not subjected to unfavourable treatment when Dr Ranjit did not discuss a treatment plan with her. The claim of unlawful discrimination arising out of Patient A’s disability and Dr Ranjit’s alleged perception of the same under Section 15 of the Eq Act 2010 is not well founded. Accordingly, the Tribunal found paragraph 2 in relation to paragraph 1k, not proved.

Paragraph 2 in relation to paragraph 1l

The Tribunal first considered whether Dr Ranjit’s actions in failing to discuss with Patient A or her family the risks and benefits of his treatment plan as opposed to early intervention amounted to unfavourable treatment. The Tribunal has already found that Dr Ranjit was not proposing any intervention at that time and it is agreed that attempting a pericardiocentesis would have put Patient A at risk of harm. The question of whether Patient A and her family would have benefitted from such conversation is speculative and the Tribunal found that it is more likely that a discussion about an invasive procedure that might never be needed would cause unnecessary anxiety both to Patient A and her family. Consequently, the Tribunal found that Dr Ranjit’s decision not to have a discussion with Patient A or her family about the risks and benefits of the treatment plan in place as opposed to early intervention did not amount to unfavourable treatment. The claim of unlawful discrimination arising out of Patient A’s disability and Dr Ranjit’s alleged perception of the same under Section 15 of the Eq Act 2010 is not well founded. Accordingly, the Tribunal found Paragraph 2 in relation to paragraph 1l, not proved.
131. For the reasons set out in paragraph 11 above the Tribunal was satisfied that at 16.55 hrs on 4 September 2015 Dr Ranjit did not intend to undertake a pericardiocentesis and any discussion about the risks and benefits of the same would have served no practical purpose at that time. The lack of such a discussion did not amount to unfavourable treatment. The allegation of unlawful discrimination arising out of Patient A’s disability and Dr Ranjit’s alleged perception of the same under Section 15 of the Eq Act 2010 is not well founded. Accordingly, the Tribunal found Paragraph 2 in relation to paragraph 1m, not proved.

The Tribunal’s Overall Determination on the Facts

132. The Tribunal has determined the facts as follows:

1. On 04 September 2015 you reviewed Patient A and you failed to:

   a. adequately assess whether Patient A had capacity, communication and support needs; 
   Found Not Proved

   b. take venous pressure; 
   Found Not Proved

   c. check whether Patient A had a positive Kussmuł sign; 
   Withdrawn under Rule 17(6)

   d. review CT chest scans or report; 
   Withdrawn under Rule 17(6)

   e. adequately consider unstable hemodynamic readings; 
   Withdrawn under Rule 17(6)

   f. adequately consider cardiac tamponade; 
   Withdrawn under Rule 17(6)

   g. conduct an urgent echocardiogram; 
   Admitted and found proved

   h. provide adequate instructions to staff of when to reconsider intervention to assess pericardial effusion; 
   Found Not Proved

   i. adequately supervise Patient A’s cardiac problems; 
   Found Proved
Record of Determinations – Medical Practitioners Tribunal

j. discuss Patient A's quality of life with her family;
   **Found Not Proved**

k. adequately explain your treatment plan to Patient A or their family;
   **Found Not Proved**

l. discuss with Patient A or their family the risks and benefits of your treatment plan as opposed to early intervention;
   **Found Not Proved**

m. discuss with Patient A or their family the risks and benefits of a pericardiocentesis
   **Found Not Proved**

n. adequately record having undertaken the actions outlined in paragraphs:
   i. 1a;
      **Found Not Proved**
   ii. 1b;
      **Admitted and found proved**
   iii. 1c;
      **Withdrawn under Rule 17(6)**
   iv. 1d;
      **Withdrawn under Rule 17(6)**
   v. 1e;
      **Withdrawn under Rule 17(6)**
   vi. 1f;
      **Withdrawn under Rule 17(6)**
   vii. 1h
      **Found Not Proved**
   viii. 1j;
      **Found Not Proved**
   ix. 1k;
      **Found Not Proved**
Record of Determinations – Medical Practitioners Tribunal

x.  1l;
   FOUND NOT PROVED

xi.  1m.
   FOUND NOT PROVED

2. You discriminated against Patient A on the grounds of a protected characteristic in making your decisions about her treatment plan as described at paragraph 1.

Paragraphs 1h, 1i, 1j and 1n in relation to paragraph 2 deleted following a Rule 17(2)(g) application

FOUND NOT PROVED in relation to paragraphs 1g, 1k, 1l and 1m

Determination on Impairment - 17/10/2019

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

The Evidence

2. The Tribunal has had regard to the evidence received during the facts stage of the hearing, both oral and documentary and the submissions made by both counsel on behalf of the parties. In addition, the Tribunal received further evidence as follows.

3. The Tribunal had regard to the documentary evidence provided by Dr Ranjit. This evidence included, but was not limited to:

- Dr Ranjit’s Appraisal documents 2016, 2017, 2018 and 2019
- Dr Ranjit’s reflections on the course ‘Principles of Consent incorporating MCA & DoLS (Essential Training)’, attended 12 March 2018
- Dr Ranjit’s reflection on the case of Patient A
- Dr Ranjit’s reflections on multiple cases of pericardial effusion he has managed
- CDP Certificates on Record Keeping
- CDP Certificates on Cardiac CT Course Level 1 & 2

4. Dr Ranjit also provided four testimonials from:

- Dr I, Clinical Director for Cardiology, Aintree University Hospitals dated 9 April 2019
- Dr J, Consultant Cardiologist, Aintree University Hospitals, dated 10 April 2019
- Dr L, Consultant Cardiologist, Aintree University Hospitals, dated 25 April 2019
- Dr K, Consultant Cardiologist, Aintree University Hospitals, dated 7 May 2019
Ms Fairley’s Submissions

5. On behalf of the GMC, Ms Fairley reminded the Tribunal that impairment is a matter for the Tribunal’s own independent judgement and is a two-stage process.

6. Ms Fairley reminded the Tribunal that Dr D, the GMC’s expert, gave clear and consistent evidence for the need for an urgent echo to be carried out and that it was a missed opportunity to fully appreciate Patient A’s condition.

7. Ms Fairley referred the Tribunal to Dr E’s report which stated that Dr Ranjit should have ensured that an urgent echo was carried out within a 24-hour period. She said that the purpose behind the need to conduct an echo was set out in Dr Ranjit’s letter to the Coroner and that on Dr Ranjit’s own evidence the meaning of ‘urgent’ meant within 24 hours.

8. Ms Fairley stated that Dr Ranjit left the hospital in the full knowledge that an echo had not been carried out and would not be carried out for, at a minimum 64 hours, (assuming it was the first echo carried out on the Monday). She said that Dr Ranjit knew he was the only person that could carry out an echo, which was not a difficult procedure, because he was the consultant cardiologist for the weekend. She stated that Dr Ranjit could have done a bedside echo. She reminded the Tribunal that Dr Ranjit took a ‘calculated risk’ to leave the echo until Monday. She said this was an unnecessary risk that he placed Patient A under and which need not have been taken. Ms Fairley submitted that the failure to carry out the echo was seriously below the standard of a consultant cardiologist and the failure amounts to misconduct.

9. Ms Fairley stated that in order to form a view on impairment the Tribunal must take into account how the practitioner has acted in the past. She submitted that Dr Ranjit placed Patient A at unwarranted risk of harm.

10. Ms Fairley referred the Tribunal to the case of Cohen v GMC [2008] EWCA 581 (Admin) and the need to protect patients and the collective need to maintain confidence in the profession as well as upholding proper standards of behaviour.

11. Ms Fairley submitted that Dr Ranjit’s insight is questionable. She reminded the Tribunal that Dr Ranjit appeared to suggest that he was satisfied with his own judgement of the CT scan and that his judgement was sufficient. Ms Fairley referred the Tribunal to Dr Ranjit’s undated reflective note and submitted that it appears to focus on the absence of qualified technicians to undertake echos out of hours and the scarcity of resources at the hospital. She submitted that Dr Ranjit failed to address and reflect that he himself had the responsibility for Patient A and could have undertaken the echo.

12. Ms Fairley submitted that public confidence in the profession would be undermined, given the serious nature of this incident, if a finding of impairment were not made in this case.
Mr Haycroft’s Submissions

13. On behalf of Dr Ranjit, Mr Haycroft submitted that none of the facts found proved passed the threshold of misconduct. He stated that the failure to undertake an echo was below the standard expected. He reminded the Tribunal that this was a complex case, Patient A had a number of issues and Dr Ranjit was only involved with the cardiac aspect. He stated that the responsibility for Patient A lay with the Parent Team. He reminded the Tribunal that the CT scan had led Dr Ranjit to follow the hospital policy at that time. Mr Haycroft acknowledged that, on reflection, Dr Ranjit should have overridden the hospital policy. He reminded the Tribunal that Dr Ranjit always intended to undertake an echo.

14. Mr Haycroft submitted that the Tribunal rejected Dr D’s opinion. He stated that Dr Ranjit’s actions did not amount to misconduct but were failings. He submitted that Patient A was not put at risk by his failures. He reminded the Tribunal that, had Dr Ranjit undertaken an echo at that time, there would have been no cardiac intervention. He said there was a safety net which was Dr Ranjit’s instructions to escalate, which were not followed by the doctors or nurses in the respiratory unit. He reminded the Tribunal that Dr Ranjit was on-call and available to intervene if needed to do so. When he was eventually called Dr Ranjit did attend and carried out an emergency pericardiocentesis, within the 24-hour time frame. Mr Haycroft stated that the Tribunal had found that Dr Ranjit had a reasoned explanation for why he had not undertaken an echo at 16.55 hrs.

15. Mr Haycroft submitted that this was a single event, which was below the standard only and not capable of amounting to misconduct. He reminded the Tribunal that Dr Ranjit’s recording error was a single event and although he failed to expressly record the JVP it was implicit that it had been checked as his conclusion involved assessment of the venous pressure. Mr Haycroft submitted that even the combined effect of Dr Ranjit’s three failings cannot amount to misconduct.

The Relevant Legal Principles

16. 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.

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

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

The Tribunal’s Determination on Impairment

Misconduct

19. The Tribunal found that on 4 September 2015 Dr Ranjit reviewed Patient A and failed to conduct an urgent echocardiogram, adequately supervise her cardiac problems and to adequately record her venous pressure. The Tribunal noted that the facts found proved all relate to one patient, Patient A, and one consultation.

20. The Tribunal noted that Patient A was admitted to the Respiratory ward and treated for pneumonia, subsequently developing sepsis and pleural and pericardial effusion. Patient A subsequently died. The Tribunal has borne in mind that it has not had sight of the coroner’s report and there is no evidence before it, nor is it alleged, that Patient A’s death was as a result of Dr Ranjit’s failings.

Failure to record venous pressure

21. The Tribunal took account of paragraphs 19 and 21 of the GMC’s guidance, Good Medical Practice, 2013 (the GMP), in relation to record keeping, which states:

'Record your work clearly, accurately and legibly

19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

21. Clinical records should include:

a. relevant clinical findings
b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions
c. the information given to patients
d. any drugs prescribed or other investigation or treatment
e. who is making the record and when.’

22. The Tribunal considered whether Dr Ranjit accurately recorded his findings. The Tribunal noted Dr Ranjit’s clinical record included some but not all of his clinical findings, rather, he recorded his clinical conclusion of ‘no tamponade’. Whist Dr Ranjit did not specifically record Patient A’s venous pressure, he recorded the information which was pertinent in reaching his diagnosis by recording ‘no tamponade’.
23. The Tribunal was satisfied that Dr Ranjit’s record made it clear to any future clinician treating Patient A what his conclusion was, ‘no tamponade’. The Tribunal determined that Dr Ranjit’s failure was in relation to failing to record the basis on which he had reached that conclusion. Accordingly, the Tribunal determined that Dr Ranjit’s failure to record Patient A’s venous pressure fell below the standard expected in the GMP and did not amount to misconduct.

24. In considering whether the failure of Dr Ranjit to carry out an urgent echo and adequately supervise Patient A’s cardiac problems was conduct that fell seriously below the standard expected of a reasonably competent cardiac consultant, the Tribunal reminded itself of the findings of the experts in this regard.

Dr D’s opinion was that:

‘Earlier ECHO required, ? I said after he had seen her and definitely before 23:00. The diagnosis of cardiac tamponade cannot be excluded by clinical signs (Beck’s Triad) hence the role of an ECHO. Without an ECHO there is no certainty and the investigation is essential to assess the risk. The patient also had ECG changes and other causes of cardiac failure might be revealed or example cardiomyopathy, or silent valve disease, often associated with congenital conditions.’

Dr E’s opinion was:

‘The applicable standard of care was to perform or arrange to be performed, an echocardiogram within 24 hours because Dr Ranjit felt tamponade was not present at the time he assessed patient A at or around 5pm on 4th September 2015; and because of the possibility of progressing towards tamponade, or the presence of sub-acute tamponade.’

They jointly agreed:

‘We agree that tamponade was not present at 5pm, and that an echocardiogram at 5pm would not have resulted in immediate pericardiocentesis; we agree that leaving the echocardiogram until after a whole weekend would not have been adequate or satisfactory; but have struggled to find an objective basis with external evidence to agree on a timeline i.e. within 6hrs vs 24hrs for urgency.’

25. In respect of Dr Ranjit’s failure to adequately supervise Patient A’s cardiac problems.

Dr D’s opinion was:
Record of Determinations –
Medical Practitioners Tribunal

‘Early review and specific advice not given as in my report. I would have reassessed the patient either later that evening or at the beginning of my post take ward round having the benefit of performing the initial ECHO on 4th. In my practice, and my Opinion the post take round should always start with the sickest patients on either ITU, CCU or A&E.’

Dr E’s opinion was:

Responsibility for managing Patient A remained with the team in charge of her care. There was a plan to monitor patient A and to escalate her care to critical care and ventilation if necessary, if her observations deteriorated. Patient A’s death was caused because grossly abnormal and desperately worrying abnormalities developed 6 hours after Dr Ranjit’s review, were recorded but not acted upon.

26. The Tribunal noted that the experts had not provided a joint opinion on Dr Ranjit’s failure to adequately supervise Patient A’s cardiac problems. The Tribunal noted that it was agreed that there was no tamponade present at 16.55 hrs on 4 September 2015 and there was no clinical indication that an immediate echo should have been undertaken at that time but an echo should have been done within 24 hours. The Tribunal heard that had the echo been done at 16.55 hrs it would have provided a base line on which to monitor Patient A’s improving or worsening cardiac condition.

27. Dr Ranjit told the Tribunal that at 16.55 hrs he took a ‘calculated risk’, based on the CT scan and physical examination of Patient A that the echo could wait until the Monday. In hindsight Dr Ranjit realises and agrees with the experts that this was the wrong decision.

28. Patient A was under the care of the Parent Team for monitoring and observation with instructions in place to escalate if her conditions worsened.

29. Dr Ranjit was the consultant cardiologist on call that weekend and he was not alerted to a deterioration in Patient A’s condition nor was he called to conduct a further assessment or echo at any later stage until he was notified of the need for the emergency echo. The Tribunal was in no doubt that had Dr Ranjit been called to attend Patient A, he would have attended.

30. In considering whether Dr Ranjit’s failings amounted to serious misconduct the Tribunal was of the view that it was important to establish what would be accepted practice of a reasonable body of consultant cardiologists. In this respect it reminded itself of the expert opinions.

31. The Tribunal noted Dr D’s opinion was based upon what he would have done had he been in Dr Ranjit’s position, albeit at the stage of preparing his report the
Tribunal noted that he was aware of the subsequent events that occurred and appeared to place undue weight on these in giving his opinion. In Dr D’s initial report he based his opinion on an incorrect assumption that Dr Ranjit had not assessed Patient A’s CT Scan. The Tribunal heard that Dr D was not in possession of all of the documentation when he produced his first report. In his supplementary report, with the knowledge that Dr Ranjit had in fact viewed the CT Scan, Dr D’s position did not change and he failed to explain why. The Tribunal noted that even in his oral evidence Dr D was giving opinions which were based on clinical observations that developed after the time Patient A was reviewed by Dr Ranjit.

32. Dr D was of the opinion that failing to carry out an urgent echo and supervise Patient A’s cardiac problems fell seriously below the standards of a reasonably competent consultant cardiologist. However, Dr D did not explain the basis upon which he reached that conclusion with reference to accepted practice of consultant cardiologist, but rather as already stated it appeared to be based on what he personally would have done. Consequently, the Tribunal found his opinion was of little assistance in establishing what would be the level of accepted practice by a reasonable body of competent consultant cardiologists.

33. Having previously found that Dr E’s opinion was based on his experience of current working practices in NHS Hospitals, the Tribunal considered that Dr E’s opinion, in his report dated 29 June 2018, was balanced and objective. Dr E stated:

‘3.9 In my opinion, a large body of consultant cardiologists, probably the majority, would have organised or performed an echocardiogram the same day during the evening of the 4th September 2015.

3.10 Possibly not all consultant cardiologists would have done so, but the standard of care would have been as a minimum for the team managing the patient to respond to hypertension or drop in blood pressure by immediate escalation and suspicion of tamponade, given the findings in the CT.’

34. The Tribunal was of the opinion that Dr Ranjit’s ‘calculated risk’ at 16.55 hrs, was based on his initial clinical findings which included Patient A’s CT scan and his physical examination of her. The Tribunal noted that Dr Ranjit is an experienced consultant cardiologist.

35. Patient A was under the care of the Parent Team who had clear instructions on what to do if her condition deteriorated. Dr Ranjit was the cardiac consultant on call and would have attended had he been called. There was no other cardiologist on duty over that weekend so Dr Ranjit was the only cardiologist responsible for Patient A’s cardiac care.

36. The Tribunal was satisfied that Dr Ranjit was entitled to rely on the team responsible for Patient A’s care to notify him of any change relevant to his speciality.
37. The Tribunal found that although Dr Ranjit described his actions as a ‘calculated risk’ it was in fact an exercise of his clinical judgement, something which patients rely on doctors to do as part of their normal practice on a daily basis. On this occasion he got it wrong.

38. Having viewed the CT scan and carried out a physical examination of Patient A, Dr Ranjit had established there was no immediate need for an echo. He knew that he was the cardiologist on call for the weekend and had a reasonable expectation that he would be called to review Patient A should the position change. The Tribunal found that although not all consultant cardiologists would have taken the decision he did, there were, as Dr E indicated in his report, some that may have done.

39. The Tribunal was satisfied that Dr Ranjit’s failures related to one patient and one error of clinical judgement. The Tribunal concluded that Dr Ranjit’s conduct did not fall so far short of the standards of conduct reasonably to be expected of a consultant cardiologist as to amount to misconduct.

40. Having established that Dr Ranjit’s conduct did not amount to serious misconduct, the Tribunal was not required to go on to consider stage two of the test for impairment. For the sake of completeness, it nonetheless, went on to consider what the outcome may have been had a finding of serious misconduct been made. The Tribunal noted the evidence of the extensive remediation and reflection that Dr Ranjit has undertaken and it was satisfied that he has fully reflected on his failures and has sought to further improve his clinical practice. The Tribunal noted that Dr Ranjit’s practice has changed in managing pericardial effusions, as a result of the impact of this particular case.

41. Having determined that the facts in this case do not amount to misconduct, the Tribunal has accordingly determined that Dr Ranjit’s fitness to practise is not impaired.

42. Case concluded.

Confirmed
Date 17 October 2019
Mrs Nessa Sharkett, Chair
Mr Haycroft’s submissions

1. Mr Haycroft submitted that there is insufficient evidence for the Tribunal to find paragraph 2 of the Allegation proved. Paragraph 2 states:

   ‘2. You discriminated against Patient A on the grounds of a protected characteristic in making your decisions about her treatment plan as described at paragraph 1 paragraphs 1g to 1n.’

2. Mr Haycroft referred the Tribunal to the case of Regina v Galbraith [1981] 1 W.L.R. 1039 (Galbraith).

3. Mr Haycroft stated that the GMC’s case, at its highest, is that the Tribunal cannot find, on the balance of probabilities, paragraph 2 proved. He stated that there is no evidence in reference to paragraph 2. He stated that the GMC’s case appears to be based on inference only, that inference being from Dr Ranjit’s letter to the Coroner.

4. Mr Haycroft stated that the GMC’s case in relation to paragraph 2 has been fluid. He stated that initially the GMC submitted that it was direct discrimination but on day 2 of the hearing the GMC submitted that they no longer sought to rely on a claim of direct discrimination but instead said that the allegation was one of discrimination arising from Patient A’s disability. He stated that there has effectively been a change in position.

5. Mr Haycroft stated that there is a legal objection to proving paragraph 2 on the wording itself. Mr Haycroft said that under the current reading of paragraph 2 it means ‘Dr Ranjit discriminated against Patient A on the grounds of her Down’s Syndrome, in making his decisions about her treatment plan at paragraph 1’. Mr Haycroft submitted that Dr Ranjit made no treatment plan under paragraph 1.

6. Mr Haycroft submitted that the wording of paragraph 2 is not made out because Dr Ranjit did not make a treatment plan. Having established that there was no cardiac tamponade, he made no amendment to the treatment plan in place recommending it continued and asked that he be informed of the outcome of the CT report and the echocardiogram.

7. Mr Haycroft submitted that in relation to paragraph 2, it is irrelevant whether or not Dr Ranjit was right about the cardiac tamponade and his decision not to
intervene. He stated that there was nothing in Dr Ranjit’s actions that were discriminatory.

8. Mr Haycroft reminded the Tribunal that on day 2 of the hearing the GMC explained how they interpreted Dr Ranjit’s letter to the Coroner’s office, which was:

‘Because of Patient A’s disability he assumed that she could have learning difficulties and difficulties cooperating with the procedure. Further he did not do the echo assuming it would be more difficult to do the procedure.’

9. Mr Haycroft drew the Tribunal’s attention to the copies of Dr Ranjit’s letters to the Coroner, which state:

‘I went to review the patient later that day, I believe around 1630 hours. At that time I noted that she was having attempts at blood cultures being taken. She was apprehensive at the venepuncture but the family was there around her comforting her but otherwise she appeared comfortable. She had borderline tachycardia due to her sepsis and her blood pressure was within normal limits. There was no clinical evidence of cardiac tamponade at that stage. It was noted that the team had contacted the echo department and it was documented that they were out of time for an echo on the same day and this could be done only after the weekend.

...A pericardial drain in that context would be done only in the situation of a cardiac tamponade and she did not have it at that time. For an elective pericardiocentesis she would have been a candidate to have general anaesthesia, due to her learning difficulties and her inability to cooperate with such an invasive procedure, which has to be done within a few millimetres of her beating heart.’

10. Mr Haycroft submitted that a pericardial drain in that context would only be done in the situation of a cardiac tamponade which Dr Ranjit believed Patient A did not have at that time. He stated in the letter that ‘for an elective pericardiocentesis she would have been a candidate to have general anaesthesia, due to her learning difficulties’.

11. He submitted that rather than the letter being discriminatory Dr Ranjit was acknowledging Patient A’s disability and he was factoring that in, if a drain was needed.

12. Mr Haycroft submitted that if the reason Dr Ranjit did not undertake the echocardiogram was because he was worried about the carrying out an elective pericardiocentesis he would have cancelled the echocardiogram scheduled for Monday. Mr Haycroft reminded the Tribunal when Dr Ranjit was called upon on 5 September 2015 he immediately did an echocardiogram irrespective of any
Record of Determinations –  
Medical Practitioners Tribunal

cooperation from Patient A. Mr Haycroft stated that Dr Ranjit was presented with an emergency and he undertook a very risky drain procedure. Mr Haycroft submitted that Dr Ranjit has shown by his actions that the fact Patient A had Down’s Syndrome was irrelevant.

13. Mr Haycroft stated the inference that is drawn by the GMC from the letter to the Coroner, looked at in the wider evidential sense would only be able to succeed if that was the only inference to be drawn. He stated if there could be more than one inference it was not permissible to pick and choose. He stated that Dr Ranjit made a clinical decision based on his clinical findings not on the grounds of discrimination.

Ms Fairley’s submissions

14. Ms Fairley stated that Mr Haycroft’s submissions about the GMC’s were an incorrect summary. She submits that Dr Ranjit treated Patient A unfavourably under Section 15 of the Equality Act 2010. She stated that the unfavourable treatment is the failure in paragraph 1g but also paragraphs 1h to 1n. Ms Fairley stated that the GMC say that this is as a consequence of the perceived learning difficulties arising from Patient A’s Down’s Syndrome.

15. Ms Fairley reminded the Tribunal that it heard from Patient A’s sister Ms C. She stated that Ms C is one of the few witnesses present on 4 September 2019 regarding Dr Ranjit’s interaction with Patient A. She stated that there is a factual conflict between their evidence and it is for the Tribunal to assess that evidence. This can only properly be done after hearing from Dr Ranjit.

16. Ms Fairley referred the Tribunal to Dr Ranjit’s witness statement at paragraph 23, which states:

’23. My recollection is that on attendance attempts were being made to take blood cultures from Patient A and at [page 83] there is documentation recording her refusal for blood tests the day before. At the time I was aware that Patient A had Down’s syndrome and she had communication difficulties. Given my review of the notes I felt that Patient A may have been wary or frightened of me and there may have been difficulties with my planned examination.’

17. Ms Fairley submitted that Dr Ranjit, before going in to examine Patient A already had in his mind thoughts that there may be difficulties because of her Down’s syndrome.

18. She stated that in Dr Ranjit’s witness statement he sets out what his usual practice would be, albeit that his recollection of the details are not precise. She referred the Tribunal to Ms C’s statement to the Police, her GMC witness statement and to Dr D’s opinion of what would be expected of a reasonable cardiologist. She
submitted that Dr Ranjit has treated Patient A unfavourably. She stated that if the Tribunal accepts the evidence of Ms C, that Dr Ranjit did not do anything that he says he would usually do, she says it was for a reason based on Patient A’s disability.

19. Ms Fairley stated that the GMC do place some reliance on the Coroner’s letter because it infers some insight into Dr Ranjit’s thought process and that his reluctance to undertake an echocardiogram may well have been that it might lead to a general anaesthesia. She stated that at 16.55 hrs on that Friday an echocardiogram would not have been possible using normal channels and therefore Dr Ranjit would have had to undertake the echocardiogram. She submitted that, Dr Ranjit, in thinking about the difficulties of the pericardiocentesis, demonstrates that he was treating Patient A unfavourably, making a decision based on her disability.

20. Ms Fairley submitted that in effect Dr Ranjit’s failure was that in not doing anything this was his treatment plan. She submitted that a plan to do nothing is still a treatment plan.

The Tribunal’s Approach

21. The Tribunal noted Mr Haycroft’s application under Rule 17(2) (g) of the Rules, which states:

'17(2) The order of proceedings at the hearing before a Medical Practitioners Tribunal shall be as follows—

... (g) 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;’

22. The Tribunal noted that on day two of the hearing Ms Fairley clarified that paragraph 2 in relation to paragraphs 1a and 1b would no longer be relied on in respect of the charge at paragraph 2 as they were matters that occurred prior to Dr Ranjit’s decision not to carry out an echocardiogram at that time which the GMC allege is the act from which all further alleged discriminatory acts flowed. Further it noted that paragraphs 1c, 1d, 1e and 1f were withdrawn by the GMC. Therefore in relation to Mr Haycroft’s Rule 17(2)(g) application the Tribunal must consider paragraph 2 in relation to paragraphs 1g to 1n only.

23. The Tribunal agree that the test to be applied on a submission of no case to answer is that set in Galbraith as approved for use in regulatory proceedings. Galbraith states:
‘(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.’

24. The Tribunal reminded itself that, at this stage, its purpose was not to make findings of fact but to determine whether sufficient evidence existed such that a Tribunal, correctly advised as to the law, could properly find the relevant paragraphs proved to the civil standard. The Tribunal considered Mr Haycroft’s submissions and those of Ms Fairley on behalf of the GMC.

25. In assessing the sufficiency of the evidence before it the Tribunal had regard to the nature of the allegation at paragraph 2 and the underlying legislation which defines the protected characteristic relied on by the GMC and the type of discrimination alleged. Section 15 of the Equality Act 2010 states:

‘Discrimination arising from disability
(1)A person (A) discriminates against a disabled person (B) if—

(a)A treats B unfavourably because of something arising in consequence of B’s disability, and

(b)A cannot show that the treatment is a proportionate means of achieving a legitimate aim.

(2)Subsection (1) does not apply if A shows that A did not know, and could not reasonably have been expected to know, that B had the disability.’

26. In order to make out a claim under this section it would be necessary at the fact finding stage firstly to determine whether Patient A was subjected to unfavourable treatment. Secondly that it was something arising as a consequence of
her disability that resulted in the unfavourable treatment. If the two stages were made out it would then be for Dr Ranjit to show that he had a legitimate and proportionate reason for acting or failing to act as he did.

**Paragraph 2 in relation to paragraph 1g**

27. The Tribunal had regard to the oral evidence of Ms C who stated that Patient A and herself had just returned from having the CT scan and a junior doctor was attempting to take blood samples when Dr Ranjit entered the room. She stated that when Dr Ranjit entered the room he did not introduce himself to Patient A or to her. She said that Dr Ranjit spoke to the junior doctor about the CT scan but she did not remember Dr Ranjit doing anything else, save for listening to Patient A’s chest from the back. Ms C stated that Dr Ranjit did not take Patient A’s blood pressure or listen to the front of Patient A’s chest.

28. Ms C stated that Dr Ranjit did not explain what the treatment plan was to her or Patient A and explained that she was expecting her sister to be discharged at the weekend.

29. The Tribunal noted Dr Ranjit’s witness statement at paragraph 23:

‘...At the time I was aware that Patient A had Down’s syndrome and she had communication difficulties. Given my review of the notes I felt that Patient A may have been wary or frightened of me and there may have been difficulties with my planned examination.’

30. The Tribunal noted that at the outset of the hearing Dr Ranjit admitted that he failed to conduct an urgent echocardiogram. In addition both experts were of the view that an urgent echocardiogram should have been carried out at some time before the Monday when it was scheduled.

31. Whilst the Tribunal noted that it has not heard oral evidence from Dr Ranjit it has had regard to his witness statement as outlined above. It was the GMC’s submission that Dr Ranjit, before going in to examine Patient A, already had in his mind thoughts that there may be difficulties because of her Down’s Syndrome. Further that Dr Ranjit treated Patient A unfavourably. She stated that if the Tribunal accepts the evidence of Ms C, that Dr Ranjit did not do anything that he would usually do, in the absence of a reasonable explanation, it was based on Patient A’s disability.

32. Taking the evidence at its highest, the Tribunal considers that there is sufficient evidence upon which it could find paragraph 1g proved. Therefore the application under 17(2)(g) in relation to paragraph 2 in relation to paragraph 1g is refused.
Record of Determinations –
Medical Practitioners Tribunal

Paragraph 2 in relation to paragraphs 1k, 1l and 1m

33. The Tribunal found that, as submitted by Mr Haycroft, Dr Ranjit had decided upon a plan of treatment as outlined in paragraph 6.

34. In relation to paragraphs 1k, 1l and 1m the Tribunal noted that Ms C was ably cross examined by Mr Haycroft and remained consistent in her account of what occurred during the consultation with Dr Ranjit around 16.55 hrs on 4 September 2015. The Tribunal is of the view that the evidence of Ms C is not so tenuous or unreliable as to render it unsatisfactory. Dr Ranjit and Ms C are the only people who can give evidence as to what occurred on that day and each disputes the other’s evidence. The Tribunal has had sight of Dr Ranjit’s written statement but not yet heard his oral evidence which in the Tribunal’s opinion is necessary in order to resolve the dispute taking into account all the evidence, on the balance of probabilities.

35. Taking the evidence at its highest, the Tribunal considers that there is sufficient evidence upon which it could find paragraphs 1k to 1m proved. Therefore the application under 17(2)(g) in relation to paragraph 2, paragraphs 1k to 1m is refused.

Paragraph 2 in relation to paragraph 1h, 1i, 1j and 1n

36. The Tribunal find that the GMC has adduced insufficient evidence to show that any failures that may be found under paragraphs 1h, 1i, 1j and 1n could result in a finding that Dr Ranjit’s actions or failure to act amounted to unlawful discrimination arising as a consequence of Patient A’s disability.

37. Therefore, the application under 17(2)(g) in relation to paragraph 2 in relation to paragraph 1h, 1i, 1j and 1n succeeds.