Decision of the Medical and Dental Council in the case brought by the Health Care Agency against FRE-13-10-1-M-4

1. Allegations:

That while on duty on 8th November 2015, FRE-13-10-1-M-4

(1) Repeatedly ordered intravenous fluids for a patient without examining or reviewing the chart of the patient

(2) Failed to document orders in the medical notes

(3) Failed to review the patient after he was informed by the nurse that the blood pressure of the patient was low

The Health Care Agency requested the Council to determine

(4) Whether the care given to the patient was adequate

(5) To what extent the death of the patient is a direct consequence of the respondent's actions or lack thereof.

2. The Council's Findings

The investigation committee found that the allegation that FRE-13-10-1-M-4

(1) repeatedly ordered intravenous fluids for a patient without examining or reviewing the chart of the patient was **not admitted and not proven**

(2) failed to document orders in the medical notes was **admitted and proven**

(3) failed to review the patient after he was informed by the nurse that the blood pressure of the patient was low was **admitted and proven**

3. Decision of the Council

The Council after consideration of certain attenuating circumstances

(1) FRE-13-10-1-M-4 was busy with other duties when he was informed of the low BP, and there was no way he could have abandoned those duties to go an examine the patient

(2) FRE-13-10-1-M-4 is a junior medical practitioner in the hierarchy of responsibility and he was not the person ultimately responsible for the management of the patient

(3) At least one (possibly two) senior colleagues, with both the authority and moral obligation to alter the management of the patient if deemed necessary, had had ample opportunity to do so

finds that the **grounds set out in the complaint though established do not constitute serious professional misconduct** as per the ***Section 3 of the Medical Practitioners and Dentists (Disciplinary Inquiries) Regulations 1995*** and **has dismissed the complaint** as per Section 8 (1) (b) of the same Regulations.

The Council finds further that BOR-11-20-1-M-13 was the doctor ultimately responsible for the management of the patient. He had both the authority and the moral obligation to change the management of the patient if deemed necessary. However, he did not do so. The council is of the view that disciplinary proceedings should have been initiated against BOR-11-20-1-M-13. The Council will initiate disciplinary proceedings against BOR-11-20-1-M-13, should he return to the Seychelles.

End of Decision 10 August 2016