PUBLIC RECORD

Dates: 29/10/2024- 08/11/2024
02/12/2024-03/12/2024
16/12/2024-20/12/2024
13/01/2025-17/01/2025
27/01/2025-30/01/2025
24/03/2025-29/03/2025
11/08/2025-15/08/2025
15/12/2025-19/12/2025

Doctor:	Dr Charity GENTRY
GMC reference number:	4566825
Primary medical qualification:	MB BS 1984 Lagos

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 12 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Remi Alabi
Lay Tribunal Member:	Mr David Propert
Registrant Tribunal Member:	Dr Anup Singh

Tribunal Clerk:	29/10/2024 – 08/11/2024: Ciara Fogarty 02/12/2024: Ciara Fogarty 03/12/2024: Olivia Gamble 16/12/2024 – 19/12/2024: Ciara Fogarty 20/12/2024: Andrew Ormsby

	13/01/2025 – 18/01/2025: Rachel Horkin 27/01/2025: Rachel Horkin 28/01/2025: Angela Carney 30/01/2025: Rachel Horkin 11/03/2025: Francis Ekengwu 24/03/2025 – 28/03/2025: Fiona Johnston 29/03/2025: Ciara Fogarty 16/12/2025 – 19/12/2025: Ciara Fogarty

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Richard Wilson, KC, instructed by Regulation Resolution Solicitors.
GMC Representative:	29/10/2024 – 29/03/2025: Mr Ryan Donoghue, Counsel 15/12/2025 – 19/12/2025: Ms Jade Bucklow, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 15/05/2025

Background

1. Dr Gentry qualified as a medical doctor in Nigeria in 1984. Following this she registered as a medical doctor in the UK in 1998 and was appointed as a Consultant Obstetrician and Gynaecologist in 2005. At the time relevant to the allegations, Dr Gentry was employed as a Consultant Obstetrician and Gynaecologist at Watford General Hospital, which is operated by West Hertfordshire Teaching Hospitals NHS Trust. Dr Gentry had

worked for the Trust since 2011. Dr Gentry also worked at other hospitals around the time relevant to the allegations.

2. The Allegation that has led to this hearing can be summarised as; between 25 January 2017 and 27 December 2017, Dr Gentry failed to provide adequate treatment and clinical care to 5 patients. The failings include failing to interpret an ultrasound scan correctly, failing to refer a patient to a specialist colleague, failing to seek advice or a second opinion from colleagues, failing to record or document discussions with patients, failing to conduct an adequate examination of a patient, failing to adequately respond to intra-operative complications and failing to correctly administer medication.

3. It is further alleged that, on 18 February 2020, Dr Gentry gave false evidence at a Coroner's inquest into the death of a baby and that her actions were dishonest.

Further background

Patient A

4. It is alleged that on 25 January 2017, Dr Gentry commenced induction of labour on Patient A by administering a 2mg Prostin pessary, when Patient A's baby was not lying longitudinally, and it was not clear if the baby was presenting in the maternal pelvis (cephalic lie). A Prostin pessary is intended to assist with the artificial induction of labour, by releasing a hormone, prostaglandin to soften the expectant mother's cervix, in readiness for artificial rupture of membranes.

5. In Patient A's case, following the administration of the pessary in the alleged inappropriate circumstances, Patient A required an emergency caesarean section.

6. It is alleged that Dr Gentry thereby incorrectly authorised and/ or administered 2mg of Prostin pessary to achieve induction of labour in Patient A.

Patient B

7. Patient B had a history of two previous pregnancies resulting in one miscarriage and one birth, in which delivery was induced at gestation 36 + 2 weeks, due to a clinical impression that the baby was small for its gestational age. On 24 January 2017, Patient B attended an antenatal clinic with her third pregnancy at gestation 30 + 1 weeks. She was

seen by Mr H, a Consultant Obstetrician and was subsequently referred to Dr Gentry by him for a follow up obstetrics ultrasound scan due to concerns about the foetus' growth.

8. Patient B attended Watford General Hospital for the ultrasound scan on 27 January 2017 at gestation 30 + 4 weeks. The scan was undertaken by Dr Gentry. Patient B recalled Dr Gentry stating words to the effect of ''your labour isn't going as expected we can't continue it any further''. She recalled Dr Gentry telling her at the time that she would have to have a caesarean section if a bed could be found. Dr Gentry recorded various notes relating to that ultrasound scan and foetal assessment.

9. Patient B was booked for a caesarean section the following week and subsequently delivered a baby on 3 February 2017 at gestation 31 + 4 weeks.

10. It is alleged that during the scan, when completing the Doppler study of the Umbilical Artery, Dr Gentry failed to interpret the pattern of End Diastolic Flow and the Pulsatility Index within expected practice, failed to recognise that the Pulsatility Index was normal and failed to recognise that there was an End Diastolic Flow present.

11. It is also alleged that following these failings, Dr Gentry made a recommendation for Patient B to have an early delivery at less than 32 weeks, which was not clinically indicated and contrary to guidance from the Royal College of Obstetricians and Gynaecologists (RCOG). The RCOG guidance ('The Investigation and Management of the Small-for-Gestational-Age Fetus' 2013) states that in such cases '*where the umbilical artery Doppler Study is normal, consider delivery at greater than 34 weeks, if there has been static growth over 3 weeks.'*

12. Patient B's baby was only 30 plus four weeks at the point of Dr Gentry's scan and assessment and gestation 31 + 4 weeks at the point of delivery. The RCOG guidance states that, *'for babies who are small for gestational age but with Doppler readings within the normal range, the recommendation is for further surveillance of foetal growth and to repeat the umbilical artery Doppler studies, rather than proceed to delivery.'*

13. It is further alleged that Dr Gentry failed to refer Patient B to a colleague with an interest or sub-specialist training in foetal medicine and/or failed to discuss her findings and plan with another consultant colleague for a second opinion.

14. Dr Gentry accepted that she failed to adequately record the discussions of her recommendation of a caesarian section before the foetus was 32 weeks old.

Patient C

15. On 12 July 2017, Patient C was in labour with her first baby. At the time, Dr Gentry was the consultant on-call for the Delivery Suite. Patient C had slow progress in labour and there were concerns regarding the foetal heart. Dr Gentry attended the Delivery Suite at 11:31am on 12 July 2017. Dr Gentry examined Patient C and found the cervix to be fully dilated the presenting part at 0 + 1cm. She decided on a forceps delivery. The first blade was inserted easily. The second blade was inserted easily but did not lock (Patient C was feeling pain) and a decision was made immediately to transfer Patient C to theatre as she could not tolerate further intervention. It was documented that the Registrar had felt the presenting part of the foetus in the OA (occiput anterior) position. However, the midwife recorded that the head was in the ROT position (right occiput transverse). Whilst in theatre Dr Gentry also found the foetus in the ROT position. She attempted a manual rotation that was unsuccessful and subsequently kiwi suction was applied and after three pulls the baby was successfully delivered.

16. It is accepted by all parties that the correct position before the application of non-rotational forceps is OA.

17. The GMC's instructed expert, Dr I, reviewed the notes and considered that non-rotational forceps appeared to be the type used in this case. Dr I explained that non-rotational forceps should not be applied when a foetal head is in the occiput-transverse position, as this position of the foetal head means the forceps blades present a risk of facial injury to the foetus. Dr I noted that Dr Gentry was required to perform a vaginal examination to confirm the position and the descent of the foetal head before applying an instrument for delivery. Dr I saw no evidence of such an examination taking place.

18. Dr I concluded that failing to conduct a vaginal examination to determine the position of the baby's head before attempting to use forceps to bring about delivery, fell seriously below standard given the associated risk of harm to the foetus.

19. It is alleged, based on Dr I's findings, that Dr Gentry's application of non-rotational forceps, which was not clinically appropriate, occurred as either Dr Gentry believed the foetal head to be in the right occiput transverse position or that she failed to identify that the foetal head was in the right occiput-transverse position.

Patient D

20. On 23 September 2017, Patient D, was admitted to hospital for induction of labour, due to a history of reduced foetal movements. Dr Gentry was involved in Patient D's care on 26 September 2017 and also had contact with her on 28 September 2017 after the baby had been delivered.

21. Patient D received an administration of a Propess pessary and four Prostin pessaries over 23 and 25 September 2017, which did not lead to a successful induction of labour. On the evening of 25 September 2017, Patient D had a discussion with her midwife, Ms J. It was suggested by the midwife that Patient D may be able to proceed to a Caesarean Section ('CS') or to stay in hospital for 12-24 hours and attempt induction again, and that it would be her choice.

22. Patient D's birthing preference was for a natural birth and to attempt hypnobirthing, but if this was not possible, they would be open to interventions. As at 25 September 2017, Patient D's preference was to have repeat rounds of induced labour, failing which she would have a caesarean section.

23. On 26 September 2017, Patient D's attending midwife Ms J found that it was not feasible to proceed with induction of labour. Dr K, a registrar, reviewed Patient D at around 10am that morning and confirmed the previous attempts at induction of labour had failed. Subsequently, Dr K discussed the option of a CS with Patient D and explained this would need to be authorised by a consultant. There was a note made in Patient D's medical records by Dr K stating there had been a discussion with Dr Gentry, that the patient had an unfavourable cervix and the patient 'may go home' to return to the clinic the following week. After the discussion with Ms J, Patient D also discussed the option of having a CS with a relative via WhatsApp messenger.

24. Dr Gentry reviewed Patient D. Patient D said she was not offered a CS by Dr Gentry. Patient D recalls no discussion with Dr Gentry of the risks, treatment or management of her labour. Patient D said Dr Gentry sent her home with a plan for her to be reviewed in the Maternity Day Assessment Unit on 29 September 2017 and 2 October 2017 and a further review at Dr Gentry's clinic on 3 October 2017.

25. On 28 September 2017, Patient D attended and was admitted to hospital with contractions. After transfer to the delivery suite, the foetal heart rate dropped and did not recover. Patient D's baby was delivered by CS at 10:36am on 28 September 2017.

26. Patient D's baby, Baby E was born in poor condition and was transferred to another hospital for cooling therapy. Despite attempted interventions from the neonatal team, the baby died at 6:15pm on 5 October 2017.

27. It is alleged that Dr Gentry failed to offer CS delivery to Patient D after failed induction of labour, failed to recognise the clinical indication for CS at the stage necessary and failed to advise adequately of all treatment options available to Patient D, including the management and the relevant risks of each option.

28. At the inquest into Baby E's death, Dr Gentry stated that Patient D was suitable to undergo Artificial Rupture of Membranes (ARM). Based on the other examinations recorded and in view of the circumstances, Dr I opined that it is difficult to explain how Dr Gentry could have made findings that were in-keeping with Patient D being suitable for Artificial Rupture of Membranes. Dr I therefore concluded that it was unlikely that Dr Gentry actually examined Patient D.

29. It is alleged that Dr Gentry failed on 26 September 2017, to check whether an ultrasound scan had been completed within the previous week, ensure such a scan had been completed if it had not been and failed to adequately assess foetal and maternal wellbeing.

30. It is also alleged that Dr Gentry failed to document Patient D's wishes to proceed to CS and/or failed to document any other of her conversations with Patient D on 27 September 2017.

31. The allegations of non-clinical misconduct against Dr Gentry arise from her oral evidence at the inquest into the death of Patient D's baby. The GMC asserts that several statements made by Dr Gentry during the inquest were inaccurate and dishonest, as she allegedly knew they were false at the time she made them. These statements are detailed in Confidential Schedule 1 and the transcript of inquest proceedings.

32. During the inquest, Dr Gentry made several key claims about her conversations with Patient D. The GMC disputes these assertions by Dr Gentry on the grounds that they

contradict both contemporaneous evidence and the recollections of Patient D and her husband.

33. Alleged Conversation About Caesarean Section:

- Dr Gentry's Statement: Patient D wanted to go home after three days in hospital and had declined a caesarean section offered by the registrar, preferring a natural birth.
- GMC Allegation: No caesarean section was actually offered and Patient D did not say she wanted to go home. Therefore, Dr Gentry's statement was false and misleading.

34. Claim that Patient D Left "Against Advice":

- Dr Gentry's Statement: She advised Patient D to stay in hospital, saying labour would likely start within 24–48 hours, but that Patient D insisted on leaving "against medical advice."
- GMC Allegation: the decision for discharge was made by Dr Gentry herself. Patient D did not go home against advice. Therefore, Dr Gentry's statement is untrue.

35. Alleged Interaction After Delivery

- Dr Gentry's Statement: After Baby E's delivery, Patient D broke down, cried, and embraced her.
- GMC Allegation: Patient D denies this occurred, and the GMC claims it is a fabricated account.

36. Claim of Telephone Number Exchange

- Dr Gentry's Statement: Following delivery, Patient D gave Dr Gentry her phone number during a consoling conversation.
- GMC Allegation: Patient D denies this and her husband supports her account, saying she was in no condition to do so. The GMC states this was another false claim.

37. Claim That Patient D Returned to Hospital Multiple Times

- Dr Gentry's Statement: Patient D told her she returned to hospital three times and was sent home twice.

- GMC Allegation: Patient D denies ever making this statement, making it another alleged falsehood.

Patient F

38. Patient F, conceived via IVF and was admitted to hospital on 25 December 2017 following spontaneous rupture of membranes at term. Labour was induced on 26 December 2017, and the delivery took place under the care of Dr Gentry on 27 December 2017.

39. It is alleged that the management of this delivery was inadequate both in relation to clinical decision-making and communication with the patient.

40. Patient F underwent induction of labour with the intention of achieving a vaginal delivery. Initial induction with Prostin gel was unsuccessful. Subsequently, Patient F was taken to the theatre for delivery. Dr Gentry attended to assist with the delivery. Whilst in the theatre, Dr Gentry carried out an instrumental assisted vaginal delivery first using a Kiwi vacuum device (ventouse), followed by the use of obstetric forceps. Manual removal of the placenta was performed and the patient sustained a tear which was subsequently repaired.

41. It is alleged that Dr Gentry made five pulls using the ventouse, followed by further traction using forceps. A midwife documented that seven pulls in total had been made. According to RCOG guidance in operation at the time ('Operative Vaginal Delivery 2011'), *''Operative vaginal delivery should be abandoned where there is no evidence of progressive descent with moderate traction during each contraction or where delivery is not imminent following three contractions of a correctly applied instrument by an experienced operator.''* The guidelines further state that, *''the use of sequential instruments is associated with an increased risk of trauma to the infant; however, the operator must balance the risk of a CS following failed vacuum extraction with the risks of forceps delivery following failed vacuum extraction.*'' Dr I concluded that the number of traction attempts by Dr Gentry significantly exceeded accepted practice and that there was no clinical justification for Dr Gentry's failure to abandon the instrumental delivery and escalate to caesarean section.

42. Accordingly, it is alleged that Dr Gentry:

- Failed to adequately respond to intra-operative complications (paragraph 9a);
- Failed to heed midwifery staff observations regarding the number of pulls already made (paragraph 9b);

- Failed to convert to caesarean section in a timely and appropriate manner (paragraph 9e).

43. Following unsuccessful attempts with the ventouse, Dr Gentry proceeded to use forceps. Dr I noted as per the guidelines that sequential use of instruments (vacuum followed by forceps) is associated with increased neonatal trauma and should be undertaken only with clear clinical justification. Dr Gentry allegedly removed and then reapplied the forceps, a step described by Dr I as "truly extraordinary" and without any rational clinical basis. The use and reapplication of forceps in these circumstances is alleged to have constituted a serious failing.

44. Patient F recalled that she was sedated and disoriented due to the effects of medication, and that while she expressed a preference for 'one more try' at instrumental vaginal delivery, she was not advised that the course of action proposed (namely reapplying forceps) was outside accepted clinical practice. Dr I stated that Dr Gentry should have declined to proceed with reapplication and clearly communicated the risks and deviation from standard care. The failure to provide this explanation, and to obtain informed consent in these circumstances, is alleged to have constituted a further breach of duty (paragraph 9d).

The Outcome of Applications made during the Facts Stage

45. On 29 October 2024, the Tribunal granted Mr Wilson's application on behalf of Dr Gentry, made pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that Dr Gentry's witness statement dated 27 October 2024, that further exhibits and the expert report of Mr L be admitted into evidence. The Tribunal's full decision on the application is included at Annex A.

46. On 20 December 2024 the Tribunal granted Mr Wilson's application for an adjournment made pursuant to Rule 29(2) 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 B.

47. On 30 January 2025, the Tribunal granted Mr Donoghue's application on behalf of the GMC pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that the admission of further evidence, namely an updated bundle of intrapartum notes containing medical records pertaining to Patient A, two supplementary reports of Dr I dated 8 January 2025 and 17 January 2025 and a timeline of requests and

responses for Patient A and Patient D's medical reports between the GMC and the West Hertfordshire NHS Trust (the Trust) be admitted into evidence. The Tribunal's full decision on the application is included at Annex C.

48. On 30 January 2025, the Tribunal granted Mr Wilson's application on behalf of Dr Gentry pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that the admission of further evidence, namely two supplementary statements provided by Dr Gentry dated 9 January 2025 and 14 January 2025 together with exhibits, and a supplementary report provided by Mr L. Mr L's report was yet to be concluded at the time of the application; however, it was provided and considered by the Tribunal before reaching the determination on the application. The Tribunal's full decision on the application is included at Annex D.

The Allegation and the Doctor's Response

49. The Allegation made against Dr Gentry is as follows:

Patient A

1. On 25 January 2017 you incorrectly authorised and/or administered 2mg of Prostin pessary to achieve induction of labour of Patient A when you were aware:

    a. their baby was not lying longitudinally; ***To be determined***

    b. it was not clear the baby's head was presenting to maternal pelvis (Cephalic Lie). ***To be determined***

Patient B

2. On 27 January 2017 you performed an obstetric ultrasound scan on Patient B and you:

    a. completed a Doppler study of the Umbilical Artery and you failed to:

        i. interpret the pattern of the End Diastolic Flow ('EDF') and Pulsatility Index ('PI') within accepted practice; ***To be determined***

        ii. recognise the PI was normal; ***To be determined***

iii. recognise there was an EDF; ***To be determined***

b. made a recommendation for Patient B to have early delivery at less than 32 weeks which was:

i. not clinically indicated; ***To be determined***

ii. contrary to applicable guidance from the Royal College of Obstetricians and Gynaecologists; ***To be determined***

c. failed to:

i. refer Patient B to a colleague with an interest or sub-speciality training in Fetal Medicine; and/ or ***To be determined***

ii. discuss your findings and plan with another consultant colleague for a second opinion; ***To be determined***

iii. adequately record the discussion of your recommendation for caesarean section ('CS') before 32 weeks. ***Admitted and found proved***

Patient C

3. On 12 July 2017 you were the Consultant on Call for delivery suite when Patient C was in labour and you:

a. applied non-rotational forceps, which was not clinically appropriate as:

i. you believed the fetal head to be in the right occiput-transverse position; ***To be determined***

ii. in the alternative to paragraph 3.a.i., you failed to identify the fetal head was in the right occiput-transverse position. ***To be determined***

Patient D

4. Between 26-29 September 2017 you were involved in the care of Patient D after Patient D had undergone attempted unsuccessful induction of labour received a Propess pessary and four other vaginal Prostin pessaries, and you failed:

    a. to offer CS after failed induction; ***To be determined***

    b. to recognise the clinical indication for CS; ***To be determined***

    c. to advise adequately of all treatment and management options available to Patient D including the relevant risks of each; ***To be determined***

    d. to conduct an adequate vaginal examination of Patient D; ***To be determined***

    e. on 26 September 2017 to:

        i. check whether an ultrasound had been completed within the previous week; ***To be determined***

        ii. ensure an ultrasound was completed if it had not been completed within the preceding week; ***To be determined***

        iii. adequately assessing fetal and maternal wellbeing. ***To be determined***

    f. to document:

        i. Patient D's wishes to proceed to CS; and/ or ***To be determined***

        ii. any other aspect of your conversations on 27 September 2017. ***To be determined***

5. On 18 February 2020 you gave evidence at the Coroner's Inquest regarding the death of Baby E and the events discussed above at paragraph 4, the details of which are set out in Confidential Schedule 1. ***Admitted and found proved***

6. When giving evidence to the Coroner as described at paragraph 5, you knew that

on 26 September 2017 when you met Patient D that:

a. you said there was no clinical indication for a CS or words to this effect; ***To be determined***

b. you did not offer Patient D the option of a CS; ***To be determined***

c. Patient D did not self-discharge against medical advice. ***To be determined***

7. When giving evidence to the Coroner as described at paragraph 5, you knew that on 29 September 2017 when you met Patient D that Patient D:

a. had not embraced you or offered to embrace you; ***To be determined***

b. did not give you her phone number; ***To be determined***

c. did not say she attended the Hospital three times between 26-28 September 2017. ***To be determined***

8. Your actions as described at paragraph 5 were dishonest by reason of:

a. paragraph 6; ***To be determined***

b. paragraph 7. ***To be determined***

Patient F

9. On 27 December 2017 you were the Consultant present at Patient F's delivery, and you failed to:

a. adequately respond to intra-operative complications during the instrumental delivery; ***To be determined***

b. consider the input of the midwifery staff regarding the number of pulls already applied as you persisted with instrumental delivery regardless; ***To be determined***

c. adequately perform the forceps delivery given how many additional pulls were applied with use of forceps as a second instrument; ***To be determined***

d. communicate adequately with Patient F in that you did not explain to Patient F that it is not accepted practice to reapply forceps; ***To be determined***

e. convert to delivery by CS after the third pull. ***To be determined***

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

The Admitted Facts

50. At the outset of these proceedings, through her counsel, Mr Wilson, Dr Gentry 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.

Witness Evidence

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

- Patient D, via video link
- Mr G (Patient D's husband), via video link
- Patient A, via video link
- Dr K, junior speciality registrar, via video link
- Ms J, midwife, via video link
- Patient F, via video link
- Ms M, Head of Employee Relations at West Hertfordshire Hospitals NHS Trust, via video link

52. Dr Gentry provided her own witness statements and also gave oral evidence at the hearing.

Expert Witness Evidence

53. The Tribunal also received evidence from two expert witnesses.

54. Dr I, Consultant in Obstetrics and Gynaecology, provided expert evidence on behalf of the GMC. She provided an expert report dated 6 January 2022, and provided a supplemental report dated 15 April 2024. Dr I provided a further supplemental report on 8 January 2025. Dr I also gave oral evidence to the Tribunal via video link.

55. Mr L, Consultant Obstetrician and Obstetrician, provided expert evidence on behalf of Dr Gentry. Mr L provided an expert report dated October 2024. He also provided a supplemental report dated 15 January 2025. Mr L also gave oral evidence to the Tribunal via video link.

56. Dr I and Mr L provided evidence to assist the Tribunal in understanding the professional standards to be expected of a Consultant Obstetrician and Gynaecologist.

57. They provided a joint expert report dated 2 December 2024 in which they provided clarification on their positions in respect of the Allegation.

Expert Opinion Re Patient A

Administration of Prostin

58. Both experts agreed that Dr Gentry authorised and administered 2mg Prostin despite a non-longitudinal lie and uncertain cephalic presentation. Dr I opined that this practice was not in keeping with that of a reasonably competent consultant and fell seriously below expected standards. Mr L opined that in acknowledging the risks, Dr Gentry acted appropriately based on a full patient discussion, consultation with the Clinical Director, and Multidisciplinary Team ('MDT') involvement. If, however, the MDT discussion is not substantiated, Mr L concurred with Dr I that Dr Gentry's practice in this instance fell seriously below expected standards.

Expert Opinion re Patient B

Foetal Assessment and Early Delivery Decision

59. Doppler Interpretation: Both experts agree that the End Diastolic Flow (EDF) and Pulsatility Index (PI) were interpreted as normal by Dr Gentry.

60. Dr I's position was that the RCOG guidelines ('The Investigation and Management of the Small-for-Gestational-Age Fetus' 2013) did not support delivery at under 32 weeks in this context. She opined that without corroborated foetal medicine specialists discussion, early delivery fell seriously below the expected standard.

61. Mr L states that Dr Gentry's actions were outside the guidelines set by the RCOG. However, there were several important clinical factors involved and such that Mr L believes that a reasonably competent body of foetal medicine specialists would have likely supported a decision to deliver the baby.

Referral and Documentation Failures

62. Both experts agree documentation was substandard. Dr I considers the failure to document risk counselling as serious; Mr L believes it fell below, but not seriously below, the expected standard due to time pressures in an overbooked clinic.

Expert Opinion Re Patient C

Instrumental Delivery

63. Regarding the use of forceps: If Dr Gentry's position regarding foetal head positioning is accepted both experts agree her conduct did not fall below the expected standard.

Expert Opinion Re Patient D

Induction of Labour and Subsequent Management

64. Regarding the vaginal examination, both experts agree that if Dr Gentry's version is accepted, her conduct met the expected standard. Regarding the ultrasound and wellbeing assessment, Dr I concluded that rechecking ultrasound within a week was warranted as the

information was necessary for discussions on risks and options. Mr L concluded it was not clinically necessary given previous 36-week scan findings.

Expert Opinion Re Patient F

Forceps Delivery and Response to Complications

65. The experts agree that there are significant factual conflicts between Dr Gentry's account and other statements which must be resolved by the Tribunal.

Documentary Evidence

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

- Inquest Witness Statement from Patient D dated 14 February 2020
- WhatsApp messages between Patient D and family members dated September 2017
- Statements provided by Coroner's office dated from September to October 2019
- Patient D's medical record dated 26 September 2019
- MHPS Investigation, including meeting notes, Dr Gentry's response and reflections dated July to August 2018
- Patient D's complaint dated 29 May 2018
- Patient A's medical records
- Patient B's medical records
- Patient C's medical records
- Patient F's medical records
- Intrapartum notes for Patients A, C, D and F
- Dr Gentry's Disciplinary Investigation report, dated 6 November 2018
- Coroner's inquest transcript
- MHPS Report and Outcome Letter, dated 25 May 2020
- Induction of Labour Guidelines, Greater Manchester and Eastern Cheshire dated April 2022
- Patient A's Intrapartum notes 26 January 2017
- Copy of email from Ms O (Employment Relations Manager) of the West Hertfordshire Hospitals Trust dated 15 May 2018
- Midwife, Ms P's, witness statement dated 3 February 2017

The Tribunal's Approach

67. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Gentry does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.

68. The Tribunal was advised it is the sole judge of fact. It must decide what evidence to accept or reject, what facts are proved, and what conclusions can be drawn from accepted evidence. In making its findings, the Tribunal must exercise reasoned judgment and carefully consider all the evidence presented.

69. The Tribunal was reminded it may find a fact proved if it is more likely than not to have occurred. The inherent probability or improbability of alleged conduct is a relevant factor. Not every peripheral fact must be proved; it is sufficient that the core material facts making up the allegation are proved to this standard. The Tribunal was directed to *Byrne v GMC EWHC 2237 (Admin)* which stresses the necessity of careful analysis of serious allegations.

70. The Tribunal was advised that where an allegation has been admitted at the outset of proceedings it is deemed proved by virtue of the admission. No further deliberation is required on the admitted allegations at the fact-finding stage unless the Tribunal finds the admissions to be equivocal.

71. The Tribunal was reminded that each factual allegation, including stems and sub-stems, must be considered on its own merits. The Tribunal must determine whether the acts alleged occurred on the balance of probabilities. If the Tribunal is not satisfied that an alleged act occurred within the specified timeframe, the allegation must fail. The Tribunal must not make any findings on impairment or sanction at this stage.

72. The Tribunal may consider the context and background of allegations when assessing the facts. While a finding on one allegation may assist with another, it does not automatically follow that one proven fact supports another.

73. The Tribunal was advised that it must assess the credibility and reliability of each witness, including the doctor. It may accept or reject all or part of a witness's evidence. The Tribunal should not cherry-pick evidence to support a preconceived conclusion, nor should it

enter into speculation. Relevant case law cited included *R(on the application of Dutta v GMC [2020] EWHC 1974* which notes that honest witnesses may give varying accounts due to memory limitations, especially over time.

74. The Tribunal was reminded of the case of S*oni v General Medical Council [2015] EWHC 364 (Admin*) where it was noted that factual findings may be drawn from inference where supported by documentary or oral evidence. Inferences can also be drawn from common sense and the surrounding circumstances. The Tribunal should apply careful scrutiny when making findings of inference. Inferences must be based on reliable evidence that safely excludes other explanations.

75. The Tribunal was advised that when considering hearsay evidence (statements made outside oral testimony), it may be admissible but should be treated with caution. The Tribunal should consider its source, independence, accuracy, and whether the evidence has been tested in cross-examination. The weight assigned to hearsay must reflect the Tribunal's assessment of its reliability and probative value.

76. The Tribunal was reminded of the definition and tests for dishonesty prescribed in the case of *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords) [2017] UKSC 67 (25 October 2017)* and confirmed in the case of *R v Barton and Booth (2020) EWCA Crim 575.*

77. The Tribunal was advised where expert evidence is given, the tribunal is not bound by the expert opinion but any rejection of it should be reasoned and explained. Conflicting expert views must be analysed on their coherence, consistency, and evidential foundation.

78. The Tribunal may consider submissions made by or on behalf of the parties, but must remember that submissions are not evidence. Findings must be based solely on the evidence received during the hearing.

79. The Tribunal must bear in mind the overarching objective: to protect, promote and maintain the health and safety of the public, public confidence in the profession, and proper professional standards. While there is no general duty to give reasons for findings of fact, it is in the interest of justice to do so clearly so that both parties understand the reasoning.

The Tribunal's Analysis of the Evidence and Findings

80. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

Paragraph 1a and b, Patient A

81. In evaluating this paragraph of the Allegation, the Tribunal had regard to the applicable clinical guidelines and took into account the clinical context and surrounding circumstances. It noted that no evidence was received directly from Patient A, and it therefore relied exclusively on the medical notes provided by the GMC, documentation provided by Dr Gentry, including the intrapartum notes and the opinion of the experts.

82. With regards to the intrapartum records the Tribunal notes that it was recorded on 25 January 2017 at 16:06pm: ''the plan:- 2mg of Prostin inserted.'' It also noted that this entry was also stamped with the batch number and 'use before date' of the Prostin used. Furthermore the entry of the attending midwife at 17:55pm also states " ….. Prostin 2mg PV by Ms Gentry @ 16:00 …." The Tribunal found this to be compelling and corroborative evidence.

83. The Tribunal also had regard to the witness statement of the midwife Ms P who recorded that the Prostin pessary was administered around that time.

''Following the examination at 16.06 the Consultant went on to explain that the baby was not cephalic and the reason she adminstered the prostin was in the hope that it would soften her cervix and make it more favourable for a controlled artificial rupture of the membranes (breaking of the waters) after another attempt at external cephalic version in the morning. The couple were happy with this, so much so the husband was going to go home and wait until morning to return when the Consultant would review.''

84. The Tribunal found that it was not clear from the evidence whether the patient had been informed of the risks associated with the use of Prostin before or after its administration.

85. The Tribunal noted that the NICE guidelines (Inducing Labour CG70 2008) do not recommend administration of induced labour where the baby is not in a cephalic lie position. It acknowledged that a deviation from clinical guidelines may be appropriate in certain

situations, particularly where a baby's position is unstable as in the case of Patient A. It considered that anything other than a cephalic lie introduces clinical risk (such as cord prolapse and cord entanglement etc) and recognised that this was a high-risk situation. The Tribunal was also mindful of Ms P's statement and noted that she had expressed concern at the time the pessary was inserted, suggesting it was not consistent with guidance.

86. The Tribunal considered the experts evidence. It found Dr I's interpretation to be firmly grounded in the strict adherence to the guidelines, while Mr L demonstrated a broader consideration of the surrounding clinical issues. Of note, the records included documentation from Ms P in the intrapartum notes at 17:30, which supported the timeline surrounding the administration of the pessary and a transverse lie.

87. The Tribunal noted that there was no contention that the baby was not in a longitudinal lie and that Dr Gentry did administer the pessary. It accepted Dr Gentry's evidence that she discussed risks with the patient. The Tribunal found from the contemporaneous medical records that Dr Gentry had inserted the Prostin pessary at 16:06 and MDT discussion was documented at 18:10. The Tribunal therefore did not accept Dr Gentry's assertion that she engaged in discussion with a multidisciplinary team prior to administration of the Prostin. The Tribunal considered this to have been an important and necessary step for the correct administration of the Prostin, given the known risks and irreversibility of its effects.

88. The Tribunal found Dr Gentry's evidence in this regard to be conflicting. It noted discrepancies between her oral evidence, her written statement, and her earlier testimony to the coroner. While in oral evidence she maintained that she believed she made the correct decision, her documentary evidence included admissions that this was not the ideal course of action.

89. Weighing the conflicting accounts, the Tribunal concluded that the documentary evidence was contemporaneous and, in this instance, more reliable.

90. Accordingly, the Tribunal found paragraphs 1a and 1b proved in their entirety.

Paragraph 2, Patient B

Paragraph 2(a)

91. The Tribunal considered whether, on 27 January 2017, Dr Gentry misinterpreted the Umbilical Artery Doppler, specifically:

- (i) whether the pattern of the End Diastolic Flow (EDF) and Pulsatility Index were interpreted within accepted practice;
- (ii) whether she failed to recognise the PI was normal; and
- (iii) whether she failed to recognise there was an EDF.

92. In assessing this paragraph of the allegation, the Tribunal took into account the evidence of Patient B, the available medical notes, the evidence of Dr Gentry and the opinion of the experts.

93. In relation to sub-paragraph 2(a)(i), the Tribunal considered whether Dr Gentry's interpretation fell within accepted practice. Dr I was of the view that recommending delivery in light of normal EDF and PI was not in accordance with accepted clinical standards. Mr L, however, stated that given additional clinical concerns—namely foetal growth restriction, reduced foetal movements, and an estimated foetal weight below the 1st centile—Dr Gentry's interpretation and subsequent actions were reasonable and within accepted practice.

94. The Tribunal preferred the evidence of Mr L. His opinion considered the broader clinical picture and was supported by contemporaneous clinical documentation.

95. The Tribunal noted that both expert witnesses, Dr I and Mr L, agreed that Dr Gentry correctly recognised that the EDF and PI were normal. Accordingly, the Tribunal was satisfied that sub-paragraphs 2(a)(ii) and 2(a)(iii) were not proved.

96. Accordingly, the Tribunal found paragraph 2(a)(i) (ii) and (iii) not proved. Paragraph 2(a) was therefore not proved in its entirety.

Paragraph 2(b)

97. In respect of sub-paragraph 2(b)(i), the Tribunal accepted that this was a complex clinical decision made under pressure and in the context of a potential foetal demise. It noted evidence from Mr L that the foetus was showing signs of growth restriction and reduced foetal movements. The Tribunal accepted that Dr Gentry, as a senior clinician, was entitled to exercise her clinical judgment. It concluded that the GMC had not provided sufficient evidence to prove that Dr Gentry's decision (of there being clinical indication for the early delivery of Patient B's baby at that time) was incorrect.

98. In respect of sub-paragraph 2(b)(ii), the Tribunal was satisfied that although the decision may have fallen outside the precise parameters of the NICE guidance, it was not contrary to it. The guidance is not prescriptive and allows for clinical discretion. The Tribunal noted that Dr I's opinion was rigid and her interpretation of the foetal growth data was inconsistent with the actual growth chart evidenced in the joint expert report.

99. Specifically, the Tribunal had regard to the Joint Expert Report and the customised growth chart produced by Dr I, which indicated a decline in predicted foetal growth. Further, the Tribunal noted that in Dr I's oral evidence and supplementary report she suggested minimal or no foetal growth. The Tribunal found Dr I's evidence on this point to be inconsistent.

100. The Tribunal had regard to Dr Gentry's witness statement in regard to this baby's weight:

''A repeat growth scan 2 weeks later (30+1 weeks) showed a drop in abdominal circumference from above 50th centile at 28 weeks, to below 50th centile at 30+1 weeks. The abdominal circumference had only increased by 3 mm. This indicated that the baby was not growing as it should have been. The amniotic fluid index (AFI) and umbilical artery Dopplers (blood flow from mother to baby) were normal. The estimated fetal weight at that point, was 1350 grams. These readings were significant because the growth velocity was reduced compared to the previous scan 2 weeks earlier. All of which indicated that the baby was not growing at the expected rate. ''

101. The Tribunal preferred the evidence of Mr L, whose opinion in this instance was supported by the contemporaneous records and a holistic appreciation of the specific

context and clinical uncertainties. In contrast, the Tribunal considered that Dr I's analysis was undermined by her inconsistent interpretation of the foetal growth data.

102. Accordingly, the Tribunal found both sub-paragraph 2(b)(i) and 2(b)(ii) not proved. Paragraph 2(b) was therefore not proved in its entirety.

Paragraph 2(c)(i)

103. The Tribunal accepted Dr Gentry's evidence that she discussed the case with Mr H, who had an interest in foetal medicine, as noted in his profile summary. It further accepted that she sought advice from Mr Q, neonatal consultant. While this may not have constituted a formal referral to a foetal medicine unit, the allegation does not require this. The Tribunal was satisfied that Dr Gentry sought appropriate input.

104. The Tribunal had regard to the MHPS Investigation meeting notes (Maintaining High Professional Standards), in which Dr Gentry retrospectively considered:

''I mean in hindsight, what I didn't do which I should have done, when I called for them to scan her, if it's in here, sometimes a problem to get a patient in, they told me there was no space to put her in, I should have immediately referred UCLH and this is one of the things I have reflected on because, my issue at the moment was that there was something happening, there was something that was making this baby not grow, in fact if I send her, I don't know if I would lose her, I don't know if the baby will die by the time she comes back to see me. In hindsight, should I have sent her to Saint Mary's before the delivery?''

105. Accordingly, the Tribunal therefore found paragraph 2(c)(i) not proved.

Paragraph 2(c)(ii)

106. The Tribunal considered that although Dr Gentry did not formally document this discussion, the Tribunal accepted her oral evidence that she did consult another consultant. In the absence of evidence to the contrary, the Tribunal was satisfied on the balance of probabilities that this discussion occurred.

107. The Tribunal therefore found paragraph 2(c)(ii) not proved.

Paragraph 3, Patient C

108. The Tribunal noted and accepted that it was not disputed that Dr Gentry was the consultant on call and applied non-rotational forceps to aid the delivery of Patient C's baby. The issue is that Dr Gentry applied non-rotational forceps in circumstances where it was not clinically appropriate.

109. The Tribunal considered the key issues for consideration to be whether Dr Gentry performed a necessary vaginal examination (VE) to consider the position of the baby's head before applying the forceps; whether the foetal head was in the ROT position at the time of forceps application, whether Dr Gentry knowingly applied forceps when the foetal head was in an inappropriate position and whether there was sufficient documentation or corroborative evidence to support or refute the above.

110. The Tribunal considered that there was conflicting evidence regarding whether Dr Gentry conducted a VE. The Tribunal accepted the expert evidence of Mr L that it would be inconceivable for an experienced Obstetrician and Gynecology consultant to apply forceps without first determining the position of the foetal head. While Dr Gentry did not document the position of the foetal head, the Tribunal accepted her evidence on the balance of probabilities that she did perform a VE in regard to Patient C.

111. The GMC did not provide any direct evidence from Patient C or from anybody present during the index event but the Tribunal had regard to Patient C's medical note written by Dr Gentry retrospectively on 13 July 2017. The Tribunal concluded that these notes indicated Patient C's cervix was fully dilated:

''I performed VE. Cx fully dilated, pp at 0+1cm,. PP felt OA by Registrar. Forcep delivery decided. Fetal heart located and normal. First blade inserted easily. 2nd blade inserted easily but did not lock – was feeling pain. Decision made immediately to transfer to theatre as did not tolerate further VE.''

112. The Tribunal noted that the registrar recorded the foetal head as being in the occiput-anterior (OA) position. The Tribunal considered that Dr Gentry's oral evidence, as well as her written statements, referenced that she examined the patient and assessed the foetal head position:

'I reviewed Patient C at 10.00 hrs and conducted an abdominal examination. The abdomen was soft, and the fetal head showed cephalic presentation (i.e. the head coming first, and that there was no part of the head palpable per abdomen. My VE with consent at 10:05 hrs, showed her to be fully dilated with the baby's head in the Right Occipito-Posterior (ROP) position and at ischial spines +1 cm.10 This meant that the "station" (head of the fetus) was now 1 cm below the ischial spines. There was no moulding and no caput. I allowed her a passive hour for fetal head descent, especially as she was on an epidural drip.';

113. On the balance of probabilities, the Tribunal accepts that Dr Gentry did perform a vaginal examination, despite the lack of documentation of the foetal head's position.

114. The Tribunal considered that the central issue is whether the foetal head was in ROT at the time of forceps application and, if so, whether Dr Gentry recognised this.

115. The Tribunal noted that the GMC's position was based on circumstantial evidence, primarily the fact that the forceps blades did not initially lock and that the patient experienced pain. However, the Tribunal noted that the registrar's documentation stated the foetal head was in the OA position. The Tribunal considered that in her written evidence, Dr Gentry maintained that the head was initially in an occiput-transverse (OT) position, and she manually rotated it to OA before applying forceps;

'I carried out a successful manual rotation of the fetal head, to change the position of the head from ROT (right occipito-transverse) to OA (occipito-anterior). Whilst holding the fetal head in that OA position, I then applied the Neville Barnes forceps accordingly. Both processes were easily done. I then tried to lock the forceps, but it did not lock immediately. I quickly removed the forceps. I did so because Patient C was in a lot of pain as the epidural had stopped working effectively. By this time the baby's heartbeat had normalised.''

116. The Tribunal also noted Mr L's opinion that foetal head positions can change during labour.

117. The Tribunal determined that the evidence does not support the conclusion that the foetal head was in a persistent ROT position at the time of forceps application, and the possibility that the head rotated from OA to ROT (or vice versa) is plausible and medically recognised.

118. The Tribunal next considered whether it was clinically inappropriate for Dr Gentry to proceed with forceps in the circumstances. The Tribunal noted that Dr Gentry is an experienced consultant and she had described the clinical rationale for her decision, explaining the sequence of events, including the rotation manoeuvre;

''When we went into theatre, I conducted a further VE with consent and found that the baby's head had now reverted back to ROT. I then asked the Registrar to conduct a further VE with consent herself, because she had earlier stated that she had found the baby's head to be in an OA position on her earlier examination (prior to 11:30 hrs). This finding could not have been correct in my view, as when I conducted my own VE shortly after responding to the emergency buzzer (which sounded at 11:31 hrs), I had found the baby to be in a ROT position. So, I asked the Specialist Registrar (as part of her training process), to examine Patient C again. Following this further VE the Registrar confirmed that the baby was indeed in an ROT position. ''

119. The Tribunal accepted Mr Wilson's submissions that it would be deemed implausible that a consultant of her experience would knowingly apply forceps to a foetal head in a ROT position without correction.

''It is highly implausible that Dr Gentry (a) "believed" the fetal head to be in the ROT position when she applied the forceps, or (b) that the fetal head "was" in the ROT position at the time she applied the forceps.''

120. The Tribunal considered that the GMC's suggestion that the failure of the blades to lock proved malposition. The Tribunal noted this as an inadequate basis to infer the head was in ROT, it had regard to Patient C's medical notes:

''12:39 EUA by Ms Gentry, assisted by Dr R
12:41 Kiwi locked
12:42 1st pull
12:45 2nd pull
12:49 3rd pull
12:50 episiotomy by Dr R
12:51 4th pull
12:51 baby out, delivered to an alive baby boy''

121. The Tribunal accepted Dr Gentry's account that she rotated the foetal head before applying forceps. The Tribunal determined that the GMC has not provided direct or

compelling circumstantial evidence to prove that Dr Gentry applied forceps in a knowingly inappropriate manner.

122. The Tribunal acknowledged that Dr Gentry did not document the foetal head position at the time of examination. However, it determined that the absence of documentation is not sufficient proof of clinical failure. The Tribunal determined that the GMC failed to meet the burden of proof that the foetal head was in ROT at the time forceps were applied. It had further regard to Dr Gentry's witness statement;

''At 11:31 hrs, an emergency buzzer was sounded for Patient C, and I made my way to her room. Patient C's midwife informed me that there was no fetal heart sound. I suggested putting in a fetal scalp electrode electrode (FSE). The midwife said that the FSE had already been applied. I observed that there was an absence of fetal heart sound. I then requested an instrumental delivery trolley, which would have forceps and ventouse equipments. I then conducted VE with consent. I found that the fetal head was in ROT (Right Occipito-Transverse) position, at ischial spines +1 station.''

123. The Tribunal determined that Dr Gentry's explanation was consistent across oral and written evidence.

124. Accordingly the Tribunal accepted that Dr Gentry performed a VE, likely identified the foetal head's position, and acted within the bounds of reasonable clinical judgment. The Tribunal found that the GMC's case, based primarily on inference from equipment function and retrospective documentation, does not meet the required standard of proof. The Tribunal found that the GMC has not discharged the burden of proof required to substantiate paragraphs 3a(i) and 3a(ii).

125. Accordingly, the Tribunal found paragraphs 3a(i) and 3a(ii) of the Allegation not proved.

Paragraph 4, Patient D

Paragraph 4a

126. The Tribunal found that clinical records and witness evidence indicate that at least four doses of Prostin were administered to induce labour. Patient D underwent a prolonged assisted induction of labour. Based on the noted inadequate dilation of Patient D's cervix the

Tribunal concluded that the induction of labour was unsuccessful. NICE guidance (CG70 2008) states, ''*If induction fails the subsequent management options include a further attempt to induce labour or a CS*.'' Therefore the Tribunal found, in this case that a CS would be clinically appropriate as at least four doses of Prostin had been administered.

127. The Tribunal had regard to the transcript of the evidence given by Dr K at the inquest. The Tribunal noted that Dr K explained that according to guidelines, a patient in this situation should have been offered another round of induction or Caesarean section.

C: Thank you Dr K. Can I just ask you this, what after a period of failed induction like that 3 days someone has been in and in the position that she is which is unfavourable Bishops score what would you expect to happen in a circumstance like that?

DR: So what I would expect to happen in according to the guidelines which we follow is for the patient to be given the option to have either another round of induction or a caesarean section and given the facts to make that decision. I would expect a patient as long as there are no other risk factors not to have any, there was some talk about discharging the patient at the time did not have any risk factor in retrospect when I look at it you know according to our policy now the patient would obviously stay in. I was not aware of the policy then but at the same time I did not have any strong feeling with Miss Gentrys ´plan which was to have the patient followed up come back in, in my mind it the follow up was for her to basically have that conversation again or someone to have that conversation again with her to make sure that the baby was OK yeah.''

128. The Tribunal noted that Patient D gave clear and credible evidence that she was not offered a CS, and that she would have accepted one if it had been presented as a necessary option. Her testimony was supported by contemporaneous WhatsApp messages to her sister-in-law prior to her discharge from hospital. This indicated her openness to intervention and her confusion about being sent home without further action:

´´Thanks for the c section advice! Initially we thought that decision would be up to us but they´ve said there´s no clinical indication for one, and actually I´m glad the decision has been taken out of my hands. Felt like maybe I was being selfish wanting him out when he´s not obviously ready. The idea of abdominal healing rather than vaginal is actually quite appealing but I was really anxious about not being able to drive so long! Out of curiosity why did you swell up after the c section? Was really frustrated and emotional this morning.. ´´

129. The Tribunal had regard to Patient D's birthing plan. It noted it explicitly read that Patient D's preference was a hypnobirth but she was open to interventions:

''We are having a hypnobirth and would like to stay at the ABC if possible. While we would like to follow a natural, active labour and birth plan, we realise things don't always go to plan and are open to other interventions if they are explained to us. ''

130. The Tribunal noted that Dr Gentry said in both her oral and documentary evidence that she offered Patent D the option of having a CS delivery at several times but Patent D declined the option and insisted on going home. Dr Gentry said she made a note of this in the patient's medical record.

131. The Tribunal was not provided with any patient notes nor documentation evidencing that Dr Gentry had offered Patent D a caesarean section. The Tribunal had regard to the evidence of Ms M regarding possible missing notes but did not find it helpful in reaching its determination. It noted that Dr Gentry attributed the missing notes to misplacement by the NHS Trust. However, the Tribunal found there was no corroborating evidence from the other attending clinicians supporting the claim by Dr Gentry that she had offered Patient D a CS. Notably, there was no self-discharge form completed, despite the assertion that Patient D insisted on going home against advice. The Tribunal determined that this further undermined the account provided by Dr Gentry.

132. In light of the Tribunal's finding of clear clinical indication, the absence of supportive documentation offering a CS, and the credibility of Patient D's account, the Tribunal finds that Dr Gentry failed to offer a caesarean section when it was clinically indicated.

133. Accordingly, the Tribunal determined paragraph 4(a) of the Allegation as proved.

Paragraph 4(b)

134. The Tribunal was satisfied that a caesarean section was clinically indicated due to the failure of multiple induction attempts and lack of labour progression. Patient D's cervix was noted to be unfavourable on more than one occasion. Specifically, the records show that both midwife Ms J and Dr K documented a Bishop score of 3, confirming that the cervix was not favourable or 'armable'. Meaning unsuitable for artificial rupture of the membrane.

135. The Tribunal considered that Dr Gentry maintained in her evidence that she had

performed a vaginal examination and considered the cervix to be 'armable'. It had regard to the MHPS Meeting notes;

''CG: I had seen this woman, the patient I had seen her 3 days before and it was a very difficult decision and a difficult conversation because she had had 2 lots of medication for starting her labour and they hadn't worked so I was called to see
her because apparently she was my patient but I hadn't seen her before. But you know if a patient is booked under a consultant now so I had to go and see her. Before I went to see her, I looked at her notes, I saw that she had 2 episodes of reduced foetal movement so what I had in my mind was to section her and then I went to go and speak to her and she told me categorically she was not going to have a C-Section. She said she wanted to have a normal delivery. The registrar had already spoken to her about it, she said no. she was doing Hypno-baths, doing everything to have a vagina delivery. She still refused so I then had to examine her because before I made any decision, she was not favourable to have waters broken so I had to examine her and she was favourable, it was possible to break her water.
Unfortunately, there is a big page which is missing, I examined her she had a bishop's score of more than 6 so I went to call the core midwife, it was [Ms AH]…''

136. However, the Tribunal found this position to be inconsistent with the contemporaneous notes made by midwife Ms J at 26 September 2017 at 01:45am and Dr K at 10:03am on 26 September 2017.

137. The Tribunal noted that Dr Gentry stated in her written and oral evidence that she had examined Patient D found her 'armable' and offered her a CS which she says she documented on a piece of paper and entered into the clinical notes. This, she claims, had gone missing. The Tribunal considered its findings regarding paragraph 4(a) of the Allegation which did not support Dr Gentry's assertion that she had offered Patient D a CS. Consequently, it did not consider it credible that there were missing notes in this instance either. Furthermore, it appears that the notes that are available are consistent and in chronological order. The Tribunal therefore concluded that it is unlikely that the said clinical notes were written and are now missing.

138. The Tribunal concluded that coupled with the absence of any clinical note from Dr Gentry documenting the details of her alleged 'armable" assessment, it was more likely than not that Dr Gentry did not conduct a vaginal examination on Patient D and found her to be 'armable'.

139. The Tribunal considered that even in the event of Patient D being 'armable', the expert position of Dr I that multiple failed induction attempts, without progression to contractions or cervical change, necessitated escalation to caesarean section. Dr Gentry's inaction in the face of this clinical scenario therefore indicates a failure to recognise the clinical indication, and/or a failure to act upon that recognition.

140. Accordingly, it found paragraph 4(b) of the Allegation proved.

Paragraph 4(c)

141. The Tribunal considered whether Patient D had been adequately advised of the full range of treatment and management options, including the risks associated with each. These options included continued induction, caesarean section, and the possibility of discharge and follow-up.

142. The Tribunal noted that Patient D gave evidence that she was not advised of the risks associated with any of these options, particularly the risks of continuing the pregnancy versus proceeding to CS. Her husband's testimony supported her account and added credibility to the overall picture. The absence of documentation, combined with conflicting narratives from other clinical staff, reinforced the Tribunal's concern about the inadequacy of communication.

143. The Tribunal noted that Dr Gentry asserted that she had advised the patient of all options and that the patient had declined a CS and insisted on going home. However, there is no clinical documentation supporting this claim, nor was there evidence of a signed self-discharge form. The Tribunal noted Dr K stated that a self-discharge form would be expected in such circumstances.

144. The Tribunal found the evidence of Patient D and her husband to be compelling and credible. Their accounts were internally consistent, corroborated by digital communications, and were given with clarity. Conversely, Dr Gentry's evidence relied heavily on undocumented claims and was contradicted by multiple contemporaneous records and other clinical witnesses.

145. The Tribunal concluded that, in the absence of a clear record and given the credibility of Patient D's account, it cannot be accepted that adequate advice was provided about all

relevant treatment options and associated risks. The failure to offer a CS is, in itself, indicative of a failure to present all appropriate options.

146. Accordingly, the Tribunal found paragraph 4(c) of the Allegation proved.

Paragraph 4(d)

147. The Tribunal accepted expert evidence that a vaginal examination is essential in determining cervix favourability and assessing the Bishop score. The Tribunal noted that there was no contemporaneous entry in the clinical notes confirming that a vaginal examination (VE) was undertaken by Dr Gentry. In light of the significance of such an examination in the context of failed induction and assessing clinical progress, the Tribunal found the absence of any written record to be a serious omission. While Dr Gentry stated that her entries in Patient D's medical notes were missing, the Tribunal concluded that had a VE been conducted, it would have been documented, particularly given the implications for Patient D's ongoing care.

148. The Tribunal took into account Mr Wilson's submission that it was highly probable that she conducted a VE given Dr Gentry's role. The Tribunal also considered that Dr Gentry cited Ms J's involvement and said she brought the VE equipment. However, the Tribunal found that while this may have occurred it does not alone evidence that the procedure took place.

149. The Tribunal also had regard to Ms J's response at the inquest about the VE:

Q: What I am putting to you is that cannot comment on whether Dr Gentry examined Patient D?
A: I was not witness to a VE from Dr G to Patient D. Can I ask if there was one in the notes.

150. The Tribunal noted that Patient D stated that the vaginal examination was performed by Dr K, not Dr Gentry. Ms J, the midwife involved in Patient D's care, did not recall Dr Gentry conducting a VE, nor did she recall witnessing one. The Tribunal had regard to the Coroner's Inquest transcript. While Dr Gentry stated at the inquest that she had asked Ms J to bring in VE equipment, this was not corroborated in a way that established the examination took place.

''Then I said OK can I examine you and then discussed the examination and doing a sweep which Patient D agreed, that was when I then called Ms J to he Patient D me with the bringing the things that I needed for the examination,''

151. The Tribunal also noted that in her written statement some seven years after the event, Dr Gentry recalled her precise Bishop score readings and assigning a Bishop Score of 8 to Patient D. These appeared to have been done from memory, despite the absence of supporting clinical records. The Tribunal considered this detailed recollection of the readings to be implausible. The level of detail claimed was inconsistent with what could reliably be remembered in such circumstances and was found to be a retrospective construction of the events rather than the result of an actual clinical assessment. The Tribunal considered it more likely that Dr Gentry had relied on the findings of Dr K and/or other clinicians rather than performing her own examination.

152. The Tribunal noted the submission on behalf of Dr Gentry which invited the tribunal to infer that in view of the obvious loss or misplacement by the NHS of the medical notes of Patient A the same was highly likely in respect of notes relating to Patient D. The Tribunal however found the medical notes in relation to Patient D to be chronological and concluded that it was unlikely that there were any missing notes.

153. In the absence of contemporaneous documentation, the implausibility of the claimed recall of the Bishop score in spite of alleged missing notes, and the contradictory evidence from Patient D and other clinical staff, the Tribunal determined that it was more likely than not that Dr Gentry did not perform a VE of Patient D. Accordingly, the Tribunal found paragraph 4(d) proved.

Paragraph 4(e) (i)

154. The Tribunal first considered paragraph 4(e). The Tribunal had regard to the oral evidence of Dr Gentry during which she stated that she reviewed the clinical notes upon attending to Patient D on 26 September 2017. The Tribunal noted that it was documented that an ultrasound scan was conducted on Patient D on 8 September 2017. In the absence of any evidence to the contrary, the Tribunal accepted Dr Gentry's position that she had checked for recent ultrasound scans at that time.

155. The Tribunal had regard to Patient D's medical records. It noted a foetal growth scan had taken place at 36 weeks 5 days.

156. The Tribunal noted that no scan had been performed within the preceding week, but concluded that Dr Gentry did take steps to check whether one had been completed.

157. Accordingly, the Tribunal found paragraph 4(e)(i) is not proved.

Paragraph 4(e)(ii)

158. In considering paragraph 4(e)(ii), the Tribunal noted that it was accepted by all parties that no ultrasound scan had taken place in the week prior to Dr Gentry's assessment. The issue therefore was whether Dr Gentry ought to have arranged one in light of that fact.

159. In the absence of any direct evidence from any witnesses other than Dr Gentry, the Tribunal had regard to the opinion of the experts. Dr I noted that information from such a scan would inform discussions on risks and options. Mr L acknowledged that an ultrasound would have been helpful, particularly given the history of two episodes of reduced foetal movement but concluded that it was not mandatory. The Tribunal noted that the GMC did not provide any clinical guideline or authoritative reference indicating that a scan must be performed under these circumstances.

160. Furthermore, the Tribunal had regard to Appendix 1 of Dr I's supplemental expert report (algorithm taken from the Green-top Guideline No. 57 *Reduced Fetal Movements* from the Royal College of Obstetricians and Gynaecologists, published in February 2011) and identified that the guideline was inconclusive on the necessity of an ultrasound scan at this point. The Tribunal therefore accepted that this was a matter of clinical judgment, and Dr Gentry was entitled to rely on her discretion in deciding not to request an additional scan.

161. Accordingly, the Tribunal determined paragraph 4(e)ii is not proved.

Paragraph 4(e)iii

162. The Tribunal noted that there was no evidence from Patient D or her husband suggesting that her wellbeing had not been properly attended to. It also acknowledged that Patient D underwent CTG monitoring, was reviewed by consultants, and was examined multiple times during her admission beginning on 23 September 2017 due to reduced foetal movements.

163. The GMC did not provide a clear standard or guideline against which an inadequate assessment could be judged. The Tribunal also noted the absence of any specific concerns raised by the patient or her family regarding Dr Gentry's care.

164. The Tribunal concluded that there was insufficient evidence to demonstrate that Dr Gentry failed in any of the respects alleged in paragraph 4(e)(iii).

165. The Tribunal determined that Paragraph 4(e)iii is therefore found not proved.

Paragraph 4f

166. The Tribunal considered whether Dr Gentry documented Patient D's wishes regarding a CS delivery. Dr Gentry's position was that she did not believe Patient D wished to proceed to CS, and therefore did not record that preference.

167. The Tribunal accepted that Patient D had clearly expressed that she was open to the possibility of CS, despite initially wishing for a natural birth. It was noted that Dr Gentry maintained before the Tribunal that Patient D did not want a CS, but there was no documentation of the conversation on this point. The Tribunal found that in light of the seriousness consequences of the decision to discharge Patient D, and the fact that a CS was later performed, it was necessary for Dr Gentry to fully record Patient D's wishes at this point, despite there being possible ambiguity or uncertainty.

168. On 27 September 2017 Patient D was seen and examined by Dr K. Subsequently it is documented at 10:03am that clinical findings were discussed with Dr Gentry regarding the patient's unfavorable cervix and it was deemed that the patient 'may go home' with a follow up in MDAU and also Dr Gentry's clinic. The Tribunal found that Dr Gentry was involved in the planning and decision making for Patient D's care but there was no evidence of Dr Gentry documenting Patient D's plan, as Dr Gentry states clinical records were missing.

169. On the balance of probabilities, the Tribunal concluded there was a failure to document Patient D's evolving views, particularly given other available evidence indicating her openness to CS. The Tribunal determined that there were no missing notes as there was consistent chronology in the clinical notes to indicate that there were unlikely to be gaps in documentation regarding any such interaction. The Tribunal also considered its previous findings regarding paragraph 4(a) of the Allegation which did not support Dr Gentry's assertion that she had recorded the patient's wishes not to proceed with a CS.

170. Accordingly, paragraph 4(f)(i) is found proved.

171. The Tribunal next considered paragraph 4(f)(ii), the Tribunal determined as in paragraph 4(f)(i) there were unlikely to be missing documents in the records concerning Patient D's care.

172. The Tribunal again noted Dr Gentry's assertion that some handwritten notes and supporting paperwork may not have been preserved, but found that this did not amount to definitive evidence that she had documented relevant conversations. It was noted that Dr K's documentation showed a continuous clinical narrative, suggesting no obvious omission of expected entries from Dr Gentry during the relevant timeframe.

173. Accordingly, paragraph 4(f)(ii) is found proved.

Paragraph 5 - Statements at the Coroner's Inquest

174. Paragraph 5 was accepted during cross examination of Dr Gentry. The tribunal found the acceptance to be unambiguous and therefore found the allegation in paragraph 5 proved.

Paragraph 6, Dishonesty

Paragraph 6(a)

175. The Tribunal reminded itself of its findings regarding a clinical indication for a CS in paragraph 4b of the allegation. However, it also noted the relevant statements made by Dr Gentry at the Coroner's inquest and recognised that the statements did not indicate that Dr Gentry had specifically told Patent D that there was no clinical indication for a CS. The tribunal found that the actual words used were more reflective of Dr Gentry's clinical opinion at the time, rather than an intentional falsehood. Dr Gentry's mindset and reasoning were evaluated in the context of the evidence. The Tribunal concluded that the evidence did not meet the threshold to establish that she knowingly misled or deceived the Coroner.

''CG: If she had been on admission for induction of labour and her induction is not working and she decides at any point in time to have a c-section she would have that c-section that is

the way it works. It is not like someone walking in from the streets coming and saying I want a c-section

C: She has already been there you are saying

CG: Yeah

C: For a while

CG: Yes, so what I said to her is if you must go home against my advice she should do, and before then I said to her because of the cervix condition, the condition of her cervix she was most likely to go into labour within the next 24 to 48 hours and that if she started contracting again please she should back to triage. And I said if the baby's movements become a concern again to come straight back. I told her these things to come back and to attend the triage also if her waters went and then to come to Maternity Day Assessment unit alternate days and then if she did not deliver by Tuesday, which was my clinic at Hemel, that she should just come to the clinic and I will make sure that she delivered that day or the following day. She didn't have to have an appointment to come she can just come to the clinic. That is what I said to Patient D,''

176. The Tribunal also had regard to a written statement provided by Dr Gentry to the Coroner's Office, in which she stated:

''Patient D refused to continue staying in the hospital despite my advice to stay in for artificial rupture of membranes (ARM).''

177. The Tribunal noted this document corroborates the evidence that Dr Gentry later gave at the Coroner's inquest. It noted Dr Gentry did not reference a clinical indication for a CS but stated that the decision not to proceed with a CS was based on Patient D's refusal. The Tribunal noted this statement was written after the event and before the inquest but remained consistent and therefore probative.

178. Accordingly, paragraph 6(a) is found not proved.

Paragraph 6B

179. The Tribunal reminded itself of its findings in paragraph 4(a) that Dr Gentry did not offer Patient D the option of a caesarean section on 26 September 2017. The Tribunal noted Dr K's evidence to the Coroner and to this Tribunal that he could not recall whether the option of a CS had been offered to Patient D by Dr Gentry.

180. The Tribunal noted however, that Dr Gentry later told the Coroner that a CS was offered, which the Tribunal found to be false, bearing in mind contemporaneous WhatsApp messages (as detailed previously) further supporting that a CS had not been offered. The Tribunal had regard to Dr Gentry's evidence to the coroner.

''C: But if she was suitable for ARM why was your preference in terms of procedure, why was the c-section your preference then

CG: That was offered before I examined her

C: OK right

CG: Because it was already offered before I just wanted to know whether that is something that she would accept

C: OK having found that what did you then do

CG: I then discussed the results with Ms J, sorry with Patient D telling her what I had found and that I was going to discuss with the labour Ward co-ordinator to see when they were able to bring her up to do her ARM.''

181. The Tribunal concluded Dr Gentry knowingly misled the Coroner in relation to this matter.

182. Accordingly, paragraph 6(b) is found proved.

Paragraph 6C

183. The Tribunal considered that Dr Gentry had claimed that Patient D insisted on going home against her advice. However, it noted that no evidence supported this claim. There was

no signed self-discharge form, and none of the clinical staff involved, including Dr K, Ms J, or the attending midwives, documented or recalled the patient expressing a desire to leave contrary to medical advice. The available evidence suggested that the decision for Patient D to return home was a medically-led decision. The Tribunal had regard to Dr Gentry's evidence to the coroner:

''C: I have heard evidence that there is a form that's to be filled in if someone discharges against advice

CG: I really didn't have it, we did not have a form where you can sign. I've worked in other units that did it where they have a form you complete but our unit did not have it and you can only write in the notes. I don't whether they have it now but they did not have it then

C: So you are saying that they didn't have a discharge against advice form

CG: We didn't have the form

C: At that time

CG: Yes and that is one of the things that I wanted to develop following this incident, two things
that were heavy on mind was that and the guideline for reduced foetal movement which I was working on

C: Yes and at what stage, you mentioned earlier about making detailed notes, as I am sure you
know, they are not in the medical notes that I have had a look at

CG: Mhm

C: So when did you make the notes that you did?

CG: After the discussion with Patient D and she was determined to go home I then went to look for her notes I could not find her medical notes and I took the sheet of paper then to write..''

……

''CG: What I can say is that I do not recollect Patient D saying to me in any way at all that she wanted
to have a c-section

C; In addition to that…sorry, yes go on

CG: So I was just trying to explain, if she had asked for a c-section she would have had it because she was at that point she could have had the continuation of her induction to have a natural birth or to have a c-section this is what we practice, that's the way we do it and so I wouldn't find any reason in my head and I have tried to find why I would not want her to have a c-section. It is in not in my hands it is in her hands, if she wanted it, the c-section like I said it would have been documented in the notes of the midwife looking after her and the registrar that she wanted a c-section. If she wanted a c-section as well and if you look at the notes these is no where it has been documented and also if she wanted a c-section it would have been documented in the original RCA that was done, that's the root cause analysis. There have been 3 root cause analysis that have been provided to me. The first one was provided to me shor…''

184. The Tribunal considered this evidence supported the Tribunal's conclusion that Dr Gentry's statement to the Coroner on this point was knowingly false.

185. Accordingly, paragraph 6(c) is found proved

Paragraph 7, Patient D

Paragraph 7(a)

186. The Tribunal reminded itself that Dr Gentry stated during the Coroner's inquest that Patient D embraced her, or offered to do so, upon seeing her on 29 September 2017. This is denied by both Patient D and her husband in their oral evidence to the Tribunal. The Tribunal acknowledged that Patient D confirmed she had recently undergone a caesarean section and was groggy, in pain, and unlikely to have initiated physical contact. The Tribunal also had regard to Patient D's evidence to the coroner:

''C: After you delivered Baby E do you recall meeting Dr Gentry

PATIENT D: Very briefly, obviously my memory is a bit fuzzy because I had just come round from a general anaesthetic but Mr G has told me she was there yes.
C: It is her evidence is that you embraced essentially, is that your recollection?
PATIENT D: No, I had just had major abdominal surgery I could barely lean forward to see my son in his incubator. ''

The Tribunal further had regard to Patient D's husband witness statement,

''I recollect that that Ms Gentry came over to Patient D and grabbed her arm and she said she was so sorry this happened.''

187. The Tribunal noted that while Patient D's husband recalled Dr Gentry grabbed Patient D's arm to express sympathy, this does not support Dr Gentry's account of an embrace from Patient D.

188. The Tribunal noted that Dr Gentry's account was challenged under cross-examination at the inquest:

"MC: Because she agrees that you did come and see her briefly but, but she did not open her arms and embrace you, she was just coming round from a general anaesthetic having had a caesarean section.
CG: Yes but what OK…let me wait for you to finish
MC: Sorry I couldn't hear that
CG: Are you asking me a question?
MC: What am I saying is that it didn't happen
CG: It did happen, because in terms of her management I have absolutely no reason to say that when it didn't happen, I could have just gone there, seen her without her crying or hugging her, I could have just gone there just seen her with nothing happening, it was still that I went to see her, it was the way that she was crying as we hugged each other
MC: You didn't hug each other
CG: I did, that made me feel so distressed myself that I was hiding this because I couldn't break down in front of her.''

189. The oral evidence of both Patient D and her husband were further cross examined and it became clear to the Tribunal that both their recollections were unclear.

190. The Tribunal considered that while it is possible that some physical contact occurred in an emotionally charged setting, the evidence on this point was inherently vague and inconsistent. The Tribunal concluded that it could not be satisfied that the embrace occurred as alleged, and accordingly, the GMC had not discharged the burden of proof in relation to Paragraph 7(a).

191. Accordingly, the Tribunal determined paragraph 7(a) of the Allegation not proved.

Paragraph 7(b)

192. Dr Gentry gave evidence to the Coroner that Patient D provided her with a personal phone number. Patient D and her husband both deny that this occurred. Patient D in her oral evidence said she remembered giving her phone number to another doctor, Dr S, who was concerned with her aftercare, but not to Dr Gentry. She recalled in hindsight it was highly unlikely that she would have given her phone number to Dr Gentry because she was not sufficiently familiar with Dr Gentry for such an exchange. The Tribunal had regard to the evidence Patient D gave to the coroner:

''C: There is a suggestion I think that you gave your phone number?
Patient D: I did give my phone number to Dr S because he phoned us a few times over the next week while we were still at Luton and Dunstable and he was very kind and wanted to know how things were getting on I spoke to him a few times.
C: Right, not Dr Gentry.
Patient D: No''

193. The Tribunal further noted that Dr Gentry exhibited a slip of paper with Patient D's number on it which Patient D confirmed was hers. Dr Gentry explained that Patient D had given it to her. No evidence was provided to the contrary. The Tribunal considered that Dr S would have had the telephone number for clinical reasons and there was no evidence presented that Dr Gentry obtained it through him.

194. During the inquest, Dr Gentry claimed that Patient D had personally provided her with the number. Given the uncertainty of the evidence from Patient D and her husband, the Tribunal preferred Dr Gentry's version of the events.

195. Accordingly, the Tribunal found that Dr Gentry did not provide a false and dishonest statement to the Coroner in this regard. Paragraph 7(b) is therefore found not proved.

Paragraph 7(c)

196. Dr Gentry told the Coroner that Patient D said she had returned to hospital on three separate occasions between 26 and 28 September 2017. The Tribunal noted that this statement is not supported by medical records. The Tribunal noted that Patient D categorically denies stating that she returned on multiple occasions.

''C: Having been discharged then on 26th did you return to the hospital prior to the 28th, the early hours of the 28th
PATIENT D: No''

197. The Tribunal also had regard to the statement made by Dr Gentry to the Coroner

CG: So when I went there and saw it was Patient D, Oh God I felt really horrible for her because the baby was in a bad condition, so I went to see her. My recollection was once that Patient D saw me she broke down crying and she did that and I went to hug her and then she was really crying and I had tears in my eyes as well because I felt…I felt for her, so I then told her I was going to see Baby E before I left she said to me "Miss Gentry you won't believe I came back 3 times" that is what I thought I heard …"I came back 3 times after I went home, the first time they sent me back home, I came back a second time and they sent me back again…."

198. The Tribunal considered that while Dr Gentry suggested that Patient D said this in an emotional moment, there is no evidence of missing triage records, and there was no plausible reason why Patient D would have fabricated this account or even inadvertently made it. Patient D's husband did not corroborate this claim, and the Tribunal found no credible basis for believing she had made such a statement. The Tribunal decided that it was more likely that Dr Gentry attempted to reinforce her own account of patient management in making the statement to the Coroner.

199. On the balance of probabilities, the Tribunal finds Paragraph 7(c) proved.

Paragraph 8

200. In determining paragraph 8 of the allegation, the Tribunal considered the admissions of Dr Gentry regarding the evidence she gave at the Coroner's Inquest described at

paragraph 5. It also bore in mind the conduct found proved in paragraphs 6 and 7. In doing so, it applied the legal test for dishonesty as set out in the case of *Ivey v Genting Casinos [2017] UKSC 67* to its findings.

8(a) – In relation to Paragraph 6

201. The Tribunal noted that it was recorded that whilst giving evidence to the Coroner that at times Dr Gentry was XXX.

''C: OK and tell me the circumstances what led you to first meet Patient D?
CG: OK. It was I think it was Tuesday morning
C: Was that the 26th
CG: 26th yes because I am [XXX] so I have to refer to notes quite a bit.''

202. However, the Tribunal drew inference from common knowledge that the proceedings would have been halted had Dr Gentry been XXX to not give her best evidence. The Tribunal was therefore satisfied that she was of XXX to provide evidence and to understand the nature of the questions asked and the responses she gave during those proceedings. The Tribunal concluded that Dr Gentry was not mistaken or confused when giving evidence by reason of XXX. The Tribunal found that in view of paragraphs found proved, Dr Gentry was dishonest rather than mistaken in giving evidence to at the Coroner's Inquest. The Tribunal was of the view that a reasonable and ordinary decent person would consider giving false evidence especially under oath to be dishonest. It further determined that Dr Gentry's account, as presented to the Coroner, had been constructed in order to conceal or justify her decision to discharge Patient D.

203. Accordingly paragraph 8(a) in relation to paragraph 6(b) and 6(c) is found proved.

8(b) – In relation to Paragraph 7

204. The Tribunal carefully considered whether the actions set out in paragraph 7 were dishonest. In view of finding paragraphs 7(a) and (b) not proved due to the unclarity in the GMC's evidence, the Tribunal considered whether Dr Gentry genuinely believed that Patient D had embraced her and given her a phone number. Due to the ambiguity in oral and written evidence regarding the nature of the physical contact between Dr Gentry and Patient D as well as the lack of evidence to prove Dr Gentry had not obtained Patient D's phone number directly from her the Tribunal determined that paragraph 7(a) and (b) was not dishonest.

205. In relation to paragraph 7(c), the Tribunal noted Dr Gentry's claim that Patient D returned to hospital three times. However, the evidence indicated that Patient D did not return between her discharge and her re-attendance on 28 September 2017. The Tribunal concluded that Dr Gentry was aware of the true position and nevertheless provided a false account to the Coroner. It therefore found paragraph 7(c), to be dishonest.

206. In reaching its conclusions on dishonesty, the Tribunal applied the objective standards of ordinary decent people, having first considered Dr Gentry's state of knowledge or belief. It found that where Dr Gentry knowingly provided false information in her statements, particularly in an attempt to justify her actions or mislead the Coroner, her conduct was dishonest.

207. Accordingly, the Tribunal determined that regarding paragraph 8 the conduct set out in paragraphs 6(b) and 6(c), and 7(c), only was dishonest.

Paragraph 9, Patient F

208. The Tribunal considered the allegations arising from the care provided by Dr Gentry during the delivery of Patient F's baby on 27 December 2017. The Tribunal reviewed documentary evidence, oral evidence from Dr Gentry and other witnesses, expert reports, clinical guidelines, and contemporaneous clinical notes. It also considered the submissions from both parties and reflected on the broader clinical and professional context of the delivery.

Paragraph 9(a)

209. The Tribunal noted that the birth was not straightforward and that complications arose during the application of the instrumental assistance. It noted that the instruments used by Dr Gentry to assist the delivery were first a suction cup (kiwi) and later forceps. The baby was born with multiple injuries to the face and body as well as a shoulder dystocia and brachial plexus injury. The baby was later diagnosed with Erb's palsy. Patient F also suffered a grade 3 perineal tear. The Tribunal considered whether Dr Gentry's overall response to intra-operative complications was adequate.

210. The Tribunal considered the use of each instrument separately. Regarding the use of the suction cup, the Tribunal noted Dr Gentry recorded in the patient's intrapartum notes

that after the fourth pull the cup became detached from the baby's head and this instrument was abandoned on the fifth pull. In her evidence to the Tribunal Dr Gentry explained that she continued with the number of pulls noted because there was progressive decent of the baby's head. The Tribunal took note of the Royal College of Obstetricians and Gynaecologists, Operative Vaginal Delivery Guidelines January 2011:

''5.4 When should operative vaginal delivery be abandoned?

Operative vaginal delivery should not be attempted unless the criteria for safe delivery have been met (see Table 3).

Operative vaginal delivery should be abandoned where there is no evidence of progressive descent with moderate traction during each contraction or where delivery is not imminent following three contractions of a correctly applied instrument by an experienced operator.''

211. The Tribunal noted the guidance further comments that:

"*The bulk of malpractice litigation results from failure to abandon the procedure at the appropriate time, particularly the failure to eschew prolonged, repeated or excessive traction efforts in the presence of poor progress*".

212. The Tribunal noted that the guidelines provide discretion based on clinical judgement but found that Dr Gentry's decision to persist went against these recommendations.

213. The Tribunal noted that in her final written statement to the Tribunal, Dr Gentry stated at paragraphs 204 and 205:

"204. Kiwi rotation was unsuccessful in rotating the baby's head from occiput-posterior (OP) to occiput-anterior (OA). Effective maternal pushing or effort is needed for the Kiwi ventouse delivery to be successful, and Patient F had poor maternal effort. By that, all I mean is, that Patient F did not push well, as she was understandably exhausted having been in labour for many hours. Nonetheless, the Kiwi rotation did produce a significant descent. The first and second moderate pulls achieved descent of the fetal head from +1 cm to +2 cm below the ischial spines, which means that the Kiwi was effective in bringing the fetal head down.

205. I therefore decided to continue the delivery with the Kiwi cup. By the 3rd moderate pull, maternal effort was almost absent and the cup was losing pressure and detaching. I stopped

on a few occasions and pumped up the pressure by using the hand held pump, but it continued losing pressure. The same thing happened with the 4th moderate pull at which time, the fetal head was at the introitus (the external opening of the vaginal canal).16 The cup detached completely with the 5th pull."

214. The Tribunal found that in this instance, on the third pull, any descent of the baby's head would have been poor due to the detachment of the cup and absent maternal effort. The procedure therefore should have been abandoned after the third pull as there was no or poor progression of descent of the baby's head.

215. The Tribunal also noted Dr Gentry's response to the MHPS investigation. In her account Dr Gentry acknowledges that she had reached the guideline limit for the number of pulls with the instrument and recognised the associated risks of continuing. Despite this she elected to proceed with one further pull rather than convert to a caesarean section, which she described as the more dangerous option:

''It is a very well-known clinically that caesarean section while the fetal head has reached a very low station in the pelvis is fraught with difficulty. I had commenced to perform an instrumental delivery on this patient. The vertex was descending along with a reassuring CTG, which gave me a logical reason to continue. The indisputable evidence that the fetal head was descending with each delivery was the fact that the baby was delivered vaginally. The reason I stopped to consider other options when had I completed the prescriptive number of pulls and felt that any more pulls may be against current guidelines of safe practice. At that moment in time, I had two options both equally viable/feasible but both accompanied with risk factors. One was to perform a cesearean section, which I felt was the more dangerous option as the vertex was at +2 station. It so low and such that the risk of significant uterine damage and damage to the baby was very high. The other option was to continue with the instrumental delivery for one extra pull. I felt the second option was the safer one as the vertex was so low such that I felt she would deliver with an episiotomy. Accordingly, I continued with one pull and delivered the baby.''

216. The Tribunal also considered the subsequent use of forceps by Dr Gentry after the failure of the kiwi suction and again referred to the guidance which states at paragraph 5.5

"5.5 The use of sequential instruments is associated with an increased risk of trauma to the infant; however, the operator must balance the risks of a caesarean section following failed vacuum extraction with the risks of forceps delivery following failed vacuum extraction."

217. The Tribunal noted that Dr Gentry justified her actions by citing that the baby's head was descending. The Tribunal found that the guidelines are clear; continuation beyond the recommended number of pulls should be avoided, and in this circumstance the Tribunal also found that proceeding to the use of forceps was a further inadequate response to the intra-operative complications. It concluded her response as outlined reflects a conscious deviation from established guidelines in a high-risk scenario.

218. The Tribunal noted that Dr I stated that Dr Gentry should have abandoned the instrumental delivery, whereas Mr L relied heavily on Dr Gentry's account, which limited the objectivity of his evidence. The Tribunal accepted Dr I's opinion and concluded that Dr Gentry made the wrong judgment call in a highly stressful situation, and consequently failed to adequately respond to the intra-operative complications.

219. Accordingly, the Tribunal found paragraph 9(a) of the Allegation proved.

Paragraph 9(b)

220. The Tribunal considered whether Dr Gentry took into account the concerns raised by midwifery staff during the delivery. The Tribunal noted from the MHPS investigation documentation that the midwife did raise concerns after the third noted pull. Dr Gentry does not deny this. Dr Gentry in her evidence explained that she did not believe the midwife's concerns were valid because Dr Gentry thought she was in a better position to assess the situation and also that the midwife may not have fully understood the guidelines.

221. Dr Gentry further explained that during the delivery she had acknowledged the midwife's concerns by nodding her head but did not immediately address the concerns verbally as she was concerned as she did not agree with the midwife's concerns and did not want to appear unprofessional in front of the patient.

222. The Tribunal also found that the MHPS investigation transcript noted that Dr Gentry did say after the application of the forceps that the baby would be born with the 'next contraction', albeit, this was not a direct response to the specific issue raised by the midwife.

223. The Tribunal concluded that although there was no indication in the records nor was there any direct evidence that Dr Gentry did not engage meaningfully with these concerns, this was insufficient to demonstrate that Dr Gentry did not give proper consideration of the

midwives' concerns. The Tribunal determined that the requisite burden of proof was not met to demonstrate that Dr Gentry failed to consider the input of the midwifery staff.

224. Accordingly, paragraph 9(b) of the Allegation is not proved.

Paragraph 9(c)

225. In considering paragraph 9(c) the Tribunal had regard to Dr Gentry's initial use of the kiwi instrument. Having found that the recommended number of pulls using the kiwi instrument had been exceeded the Tribunal found that Dr Gentry should not have proceeded to the use of the forceps as a second instrument. RCOG Operative Vaginal Delivery 2011:

''The use of sequential instruments is associated with an increased risk of trauma to the infant; however, the operator must balance the risks of a CS following failed vacuum extraction with the risks of forceps delivery following failed vacuum extraction. ''

''Obstetricians should be aware of increased neonatal morbidity with failed operative vaginal delivery and/or sequential use of instruments and should inform the neonatologist when this occurs to ensure an appropriate management of the baby.''

226. The Tribunal considered the documentary evidence presented to it in relation to the forceps delivery of Patient F's baby, specifically the account recorded between 15:23 and 15:30 in the patient notes, which details the number and sequence of instrumental pulls.

227. Notably, Dr Gentry was reminded on the third pull that the recommended limit had been reached. Despite this, Dr Gentry continued, believing the baby would be delivered with the next pull. The fifth pull was ultimately aborted due to detachment of the suction cup. Following this, the Tribunal noted that the registrar declined to assist further in the forceps delivery. Dr Gentry, documented in the medical notes that she initially abandoned the forceps delivery after the first pull but resumed at Patient F's request. She further documented that right blade of the forceps had to be re-applied. This sequence of events, including exceeding the recommended number of pulls, reattaching of the forceps blade, the unease of her colleagues, and restarting a previously abandoned instrumental delivery, informed the Tribunal's assessment.

228. The Tribunal acknowledged that during delivery, Dr Gentry was faced with several difficult decisions in a high pressure situation. However, given the totality of the evidence, the Tribunal found that Dr Gentry failed to adequately perform the forceps delivery.

229. Accordingly, paragraph 9(c) of the Allegation is found proved.

Paragraph 9(d)

230. The Tribunal considered whether Dr Gentry adequately communicated with Patient F, specifically whether she explained that it is not accepted practice to reapply forceps. The Tribunal noted that no such explanation was recorded or relayed in evidence although there was a verbal exchange between Patient F and Dr Gentry in which she was urged by the patient to try 'one more try' (with the forceps). The Tribunal found that it would be necessary for Dr Gentry to explain to Patient F the risks involved with further pulls using the forceps.

231. The Tribunal found that the necessary communication did not occur and therefore concluded that Dr Gentry failed to communicate adequately with Patient F.

232. Accordingly, paragraph 9(d) of the Allegation is found proved.

Paragraph 9(e)

233. In light of its findings on sub-paragraphs (a) and (c), the Tribunal determined that Dr Gentry should have converted to delivery by caesarean section after the third pull. Converting to a CS in this circumstance was consistent with the guidance and the expert evidence.

234. Accordingly, paragraph 9(e) is found proved.

The Tribunal's Overall Determination on the Facts

235. The Tribunal has determined the facts as follows:

Patient A

1. On 25 January 2017 you incorrectly authorised and/or administered 2mg of Prostin pessary to achieve induction of labour of Patient A when you were aware:

a. their baby was not lying longitudinally; ***Determined and found proved***

b. it was not clear the baby's head was presenting to maternal pelvis (Cephalic Lie). ***Determined and found proved***

Patient B

2. On 27 January 2017 you performed an obstetric ultrasound scan on Patient B and you:

   a. completed a Doppler study of the Umbilical Artery and you failed to:

      i. interpret the pattern of the End Diastolic Flow ('EDF') and Pulsatility Index ('PI') within accepted practice; ***Not proved***

      ii. recognise the PI was normal; ***Not proved***

      iii. recognise there was an EDF; ***Not proved***

   b. made a recommendation for Patient B to have early delivery at less than 32 weeks which was:

      i. not clinically indicated; ***Not proved***

      ii. contrary to applicable guidance from the Royal College of Obstetricians and Gynaecologists; ***Not proved***

   c. failed to:

      i. refer Patient B to a colleague with an interest or sub-speciality training in Fetal Medicine; and/ or ***not proved***

      ii. discuss your findings and plan with another consultant colleague for a second opinion; ***Not proved***

      iii. adequately record the discussion of your recommendation

for caesarean section ('CS') before 32 weeks. ***Admitted and found proved***

Patient C

3. On 12 July 2017 you were the Consultant on Call for delivery suite when Patient C was in labour and you:

   a applied non-rotational forceps, which was not clinically appropriate as:

      i. you believed the foetal head to be in the right occiput-transverse position; ***Not proved***

      ii. in the alternative to paragraph 3.a.i., you failed to identify the foetal head was in the right occiput-transverse position. ***Not proved***

Patient D

4. Between 26-29 September 2017 you were involved in the care of Patient D after Patient D had undergone attempted unsuccessful induction of labour received a Propess pessary and four other vaginal Prostin pessaries, and you failed:

   a. to offer CS after failed induction; ***Determined and found proved***
   b. to recognise the clinical indication for CS; ***Determined and found proved***

   c. to advise adequately of all treatment and management options available to Patient D including the relevant risks of each; ***Determined and found proved***

   d. to conduct an adequate vaginal examination of Patient D; ***Determined and found proved***

   e. on 26 September 2017 to:

      i. check whether an ultrasound had been completed within the previous week; ***Not proved***

ii. ensure an ultrasound was completed if it had not been completed within the preceding week; ***Not proved***

iii. adequately assessing fetal and maternal wellbeing. ***Not proved***

f. to document:

i. Patient D's wishes to proceed to CS; and/ or ***Determined and found proved***

ii. any other aspect of your conversations on 27 September 2017. ***Determined and found proved***

5. On 18 February 2020 you gave evidence at the Coroner's Inquest regarding the death of Baby E and the events discussed above at paragraph 4, the details of which are set out in Confidential Schedule 1 ***Admitted and found proved***

6. When giving evidence to the Coroner as described at paragraph 5, you knew that on 26 September 2017 when you met Patient D that:

a. you said there was no clinical indication for a CS or words to this effect; ***Not proved***

b. you did not offer Patient D the option of a CS; ***Determined and found proved***

c. Patient D did not self-discharge against medical advice. ***Determined and found proved***

7. When giving evidence to the Coroner as described at paragraph 5, you knew that on 29 September 2017 when you met Patient D that Patient D:

a. had not embraced you or offered to embrace you; ***Not proved***

b. did not give you her phone number; ***Not proved***

c. did not say she attended the Hospital three times between 26-28 September 2017. ***Determined and found proved***

8. Your actions as described at paragraph 5 were dishonest by reason of:

a. paragraph 6; ***Determined and found proved in respect of 6(b) and 6(c)only***

b. paragraph 7. ***Determined and found proved in respect of paragraph 7c only***

Patient F

9. On 27 December 2017 you were the Consultant present at Patient F's delivery, and you failed to:

a. adequately respond to intra-operative complications during the instrumental delivery; ***Determined and found proved***

b. consider the input of the midwifery staff regarding the number of pulls already applied as you persisted with instrumental delivery regardless; ***Not proved***

c. adequately perform the forceps delivery given how many additional pulls were applied with use of forceps as a second instrument; ***Determined and found proved***

d. communicate adequately with Patient F in that you did not explain to Patient F that it is not accepted practice to reapply forceps; ***Determined and found proved***

e. convert to delivery by CS after the third pull. ***Determined and found proved***

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

Determination on Impairment - 17/12/2025

236. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential.

237. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts admitted and those which it has found proved as set out before, Dr Gentry's fitness to practise is impaired by reason of misconduct and/or deficient professional performance.

The outcome of applications made during the impairment stage

238. The Tribunal refused the application made on behalf of Dr Gentry, pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise) Rules 2004 (as amended) ("the Rules"), to adduce further documentary evidence during Stage 2 of the proceedings.

239. The application, advanced by Mr Wilson, sought to introduce a document relating to the re-application of forceps, which he submitted was relevant to the Tribunal's assessment of the seriousness of the misconduct found proved at the facts stage and, in turn, the extent to which Dr Gentry's conduct represented a departure from accepted clinical practice. Mr Wilson submitted that the document was not advanced to challenge the Tribunal's factual findings, but to assist in evaluating how far outside accepted practice the conduct lay, and whether the concern was capable of remediation.

5. On behalf of the GMC, Ms Bucklow, opposed the application, she submitted that the document could have been applicable and ought to have been adduced at Stage 1 and considered by the expert witnesses. Ms Bucklow submitted that the document was untested, of unclear provenance, and that it would be unfair for the Tribunal to draw conclusions as to seriousness on the basis of evidence that had not been scrutinized by experts. She invited the tribunal to attach little weight to the evidence if it was not with her on the issue of its admissibility.

240. The Tribunal was advised on the admissibility of evidence under Rule 34(1), including the principles set out in *Thornycroft v NMC (2014),* adopting *Bonhoeffer v GMC (2011)* and *Ogbonna v NMC (2010).* The Tribunal was reminded that it must consider relevance and

fairness when determining admissibility, and that issues of weight arise only if evidence is admitted.

241. Having considered the submissions, the document itself, and the legal advice, the Tribunal determined that the document did not meet the threshold of relevance required for admission. The Tribunal was unable to verify the document's provenance, and its contents could not be tested by cross-examination or expert scrutiny. The Tribunal concluded that in the light of all other evidence available and the submissions made by both parties, the document was unlikely to significantly assist it in considering the seriousness of the concerns or in determining impairment.

242. Accordingly, the Tribunal determined that the document would not be admitted into evidence, and it would place no reliance upon it.

The Evidence

243. The Tribunal has reviewed its findings of fact and in addition, the Tribunal received further evidence as follows:

- Character Reference from Ms T– dated 26 October 2025
- Character Reference from Dr U– dated 11 November 2025
- Character Reference from Dr V– dated 30 October 2025
- Character Reference from Mr W– dated 24 October 2025
- Character Reference from Mr X– dated 28 October 2025
- Character Reference from Dr Y– dated 1 November 2025
- Doctor 360° Colleague Feedback Report (Edgecumbe) – dated 5 December 2014
- Testimonial from Dr Z and Mr AB, Watford General Hospital – dated 2020
- Testimonial from Ms AC– dated 1 September 2021
- Testimonial from Ms AD and Dr AE– dated 27 August / 2 September 2021
- Testimonial from Ms AF– dated 23 February 2022
- Testimonial from Ms AG– dated 23 February 2022
- Patient Testimonials from Watford General Hospital – dated 27 February 2022
- Patient Testimonials from Portsmouth – dated 2022–2023
- Team Observation Set – QA Portsmouth MDT – dated 24–26 August 2021
- Team Observation Set from Consultant and MDT Colleagues, QA Portsmouth – dated 25 August 2021
- Certificate of Attendance: Practical Skills for Effective Communication – dated 30 January 2019

- Appraisal Training Workshop Certificate – dated 4 February 2019
- RCOG Certificate: Risk Management and Medico-Legal Issues in Women's Health Care – dated 9–10 May 2019
- RCOG Annual Professional Development Conference Certificate – dated 17–19 November 2020
- Basic Life Support (BLS) Certificate – dated 20 August 2020
- Practical Obstetric Multi-Professional Training Certificate – dated 20 October 2022
- Mandatory Training Certificates (Healthier Business Group) – completed 2020–2022
- Certificate of Completion: Probity, Ethics and Professionalism – dated 10 September 2025

244. In Dr Gentry's reflective piece, she acknowledged the seriousness of the Tribunal's factual findings and detailed her insight into the shortcomings in her practice. She accepted that her approach to documentation, communication, and professional conduct, including her evidence at the coroner's inquest, fell below the standards expected under Good Medical Practice ('GMP') (2013), regardless of her thoughts and intentions at the time.

245. Dr Gentry identified the root causes of her failings as an over-reliance on memory, a culture of prioritising efficiency over contemporaneous record-keeping, and an incorrect belief that some clinical interactions could be regarded as "informal" and therefore undocumented. She accepted that these practices created risks to patient safety, continuity of care, and public confidence in the profession.

246. Dr Gentry reflected specifically on Patients A, B, D and F, accepting that she failed to adequately document high-risk decisions, discussions of options and risks, and, in relation to Patient D, the evidence she gave at the Coroner's inquest was given without proper qualification in the absence of contemporaneous notes. While maintaining that she did not intend to be dishonest, she accepted the Tribunal's finding of dishonesty.

247. Dr Gentry described the personal and professional impact of the proceedings had on her and stated that the process had led to a significant shift in her understanding of regulatory standards, probity, and the importance of transparency and accurate records.

14 Dr Gentry outlined the extent of her remediation, which included targeted training in documentation, communication, probity, ethics, and medico-legal issues, as well as changes to her day-to-day clinical practice. She set out concrete safeguards for future practice,

including strict contemporaneous documentation, elimination of informal clinical encounters, structured patient communication, verification of significant decisions, and honesty where records are absent.

248. She concluded that the process had been transformative, expressed a commitment to maintaining these changes, and asked the Tribunal to accept her statement as evidence of developing insight and remediation.

Submissions

Submissions on behalf of the GMC

249. Ms Bucklow, Counsel, submitted that the findings proved in this case amount to serious misconduct and deficient professional performance and that a finding of current impairment is required in order to meet all three limbs of the overarching objective.

250. Ms Bucklow submitted that misconduct is a matter of judgement for the Tribunal, applying the principles in *Roylance v GMC [1999] UKPC* 16, and that the conduct found proved fell seriously below the standards expected of a reasonably competent consultant obstetrician and gynaecologist.

251. In relation to Patient A, Ms Bucklow submitted that Dr Gentry's decision to authorise and administer a Prostin pessary despite a non-longitudinal lie and uncertainty as to the foetal presentation, fell seriously below acceptable standards. She reminded the Tribunal of its findings that it rejected Dr Gentry's account of prior MDT discussion, and she submitted that Dr Gentry had acted unilaterally in taking an irreversible step in circumstances involving well-known and significant risks. Her conduct therefore amounted to serious misconduct.

252. In relation to Patient B, Ms Bucklow submitted that Dr Gentry's failure to document counselling regarding caesarean section prior to 32 weeks, constituted a serious breach of GMP. Given the clinical significance of the decision and the serious risks involved, the absence of clear documentation of options, risks and consent, fell seriously below the required standard. The GMC invited the Tribunal to prefer the evidence of Dr I as to seriousness.

253. In relation to Patient D, Ms Bucklow submitted that the findings were the most serious in the case and concerned events preceding the tragic death of Patient D's child. The

findings included multiple serious clinical failings and a finding of dishonesty at the coroner's inquest. Dr Gentry failed to recognise and offer a clinically indicated caesarean section, failed to advise Patient D of the available options and risks, failed to perform an essential vaginal examination, and failed to document key discussions and Patient D's wishes. She submitted that these failures fell seriously below acceptable standards and amounted to serious misconduct.

254. Ms Bucklow further submitted that Dr Gentry's dishonesty lay at the top end of the spectrum. The Tribunal found that her evidence at the inquest was deliberately constructed to conceal her own failings and to shift responsibility onto Patient D by falsely asserting that she discharged herself against medical advice. This represented a serious departure from paragraphs 65 and 72 of GMP and fundamentally undermined trust in the profession.

255. In relation to Patient F, Ms Bucklow submitted that Dr Gentry's conduct during the instrumental delivery fell seriously below acceptable standards. She persisted with a failed forceps delivery beyond recommended limits, re-applied forceps after abandonment, acted contrary to guidance, failed to convert to caesarean section when indicated, and failed to adequately explain the risks to the patient. This conduct amounted to serious misconduct.

256. Ms Bucklow reminded the Tribunal that impairment is forward-looking and must be assessed in accordance with the principles in Dame Janet Smith in the Fifth Shipman Report, as adopted by the High Court in *Grant v NMC 2011EWCH92 (Admin)(Grant)*. She submitted that Dr Gentry continues to pose a serious risk to patient safety arising from both her clinical failings and her probity concerns. The failings were wide-ranging, affected multiple patients, involved core obstetric competencies, and occurred in circumstances that were neither rare nor exceptional, demonstrating deficient clinical judgement placing patients at risk of serious harm.

257. Ms Bucklow submitted that the dishonesty at the inquest directly engaged patient safety, as it undermined the purpose of the inquest process, impeded learning to prevent future deaths, and prioritised Dr Gentry's self-interest over transparency and accountability. She further submitted that public confidence would be seriously undermined if a finding of impairment were not made, particularly given the breadth of the clinical failings and the seriousness of the dishonesty, which related directly to clinical care following a neonatal death and was motivated by self-protection.

258. Ms Bucklow submitted that Dr Gentry has demonstrated insufficient insight, particularly in relation to dishonesty. While admission is not required to demonstrate insight, Dr Gentry has continued to deny the dishonesty findings and to advance detailed retrospective accounts unsupported by contemporaneous records, which the Tribunal previously found implausible. She submitted that Dr Gentry has sought to explain failings by reference to missing notes or the actions of others, including blaming Patient D, and has failed to fully acknowledge the harm caused.

259. Ms Bucklow submitted that remediation in cases of dishonesty is difficult but possible; however, in this case, Dr Gentry's dishonesty appears entrenched and persistent across the entirety of her treatment and care of patient D and extended to her conduct at the coroner's inquest. The probity training undertaken was of limited value in the absence of genuine insight. She submitted that there remains a significant risk of repetition which is not mitigated by insight or sufficient remediation.

260. Accordingly, Ms Bucklow submitted that a finding of current impairment is required in order to protect patients, maintain public confidence, and uphold proper professional standards.

Submissions on behalf of Dr Gentry

261. On behalf of Dr Gentry, Mr Wilson, KC, submitted that it was open to the Tribunal to find Dr Gentry's fitness to practise impaired on the basis of deficient professional performance, misconduct by reason of dishonesty, or both. Dr Gentry contended that her fitness to practise was not impaired by reason of deficient professional performance. However, in light of the Tribunal's findings of dishonesty, she accepted that her fitness to practise was impaired on the public confidence limb of the overarching objective.

262. Mr Wilson reminded the Tribunal that impairment is concerned only with misconduct or deficient professional performance and is a forward-looking assessment. He submitted that Dr Gentry has an unqualified right of appeal against the Stage 1 findings on both clinical performance and conduct, and that it is well-established that maintaining a position consistent with that right must not be treated as a lack of insight or absence of remediation. He submitted that to do so would amount to an error of law and a material misdirection.

263. Mr Wilson submitted that fitness to practise is an assessment of a doctor's current ability to practise safely and effectively, having regard to performance, behaviour, and public confidence. He submitted that there is a clear distinction between the public confidence limb

and the patient safety and professional standards limbs, and that Dr Gentry accepted impairment only on the former, by reason of the dishonesty findings.

264. Turning to clinical performance, Mr Wilson submitted that in respect of certain findings, Dr Gentry's conduct did not amount to a serious departure from professional standards. Alternatively, in the event that the Tribunal finds that there had been a serious departure, he submitted that Dr Gentry's insight and substantial remediation meant that her fitness to practise was not currently impaired in respect of her clinical conduct.

265. In relation to Patient A, Mr Wilson submitted that the decision to administer Prostin gel in the context of a slightly oblique lie was a judgement call made after appropriate consideration of patient autonomy, risks and safeguards. He submitted that there was no NICE or RCOG guidance prohibiting such a course of action, nor was there any requirement for prior MDT approval. He pointed out that while the Tribunal found that the MDT discussion occurred after administration of the Prostin gel, it made no finding that Dr Gentry had not consulted the Clinical Director beforehand. Mr Wilson submitted that Dr Gentry should therefore be given the benefit of the doubt, particularly as consultation with the Clinical Director was an appropriate safeguard.

266. Mr Wilson submitted that the patient and her husband were strongly opposed to caesarean section and that patient autonomy was a legitimate and relevant factor. He further submitted that similar practice had been undertaken by senior colleagues without adverse outcomes, that the incident was isolated, and that Dr Gentry put in place safeguards, including remaining on the labour ward beyond her shift. In any event, Dr Gentry's reflective statement has sufficiently demonstrated insight into deficiencies in documentation and set out clear changes to her practice to prevent repetition.

267. In relation to Patient B, Mr Wilson accepted that the failure to document counselling was a departure from professional standards, but submitted that it was not a serious departure. He emphasised the context in which Dr Gentry was assisting a colleague under time pressure, that she intended but failed to return to the notes, and that she subsequently accepted fault. He submitted that the relevant risks were covered by written materials and consent processes. He invited the tribunal to accept Mr L's opinion that the documentation fell below, but not seriously below, the expected standard.

268. Alternatively, even if the Tribunal concluded that there was a serious departure, Mr Wilson submitted that the concern related to record-keeping in 2018 and was no longer a

live issue. He submitted that Dr Gentry had demonstrated insight, had undertaken targeted remediation, and had evidenced implemented robust documentation practices which mitigated any risk of repetition.

269. In relation to Patient D, Mr Wilson submitted that the Tribunal must distinguish clinical performance issues from dishonesty. He submitted that certain findings, such as failure to document discussions, amounted to a serious departure from professional standards, but that others involved subjective clinical judgement, including assessment of cervical favourability and recognition of indications for caesarean section. He submitted that the finding was not that no vaginal examination occurred, but that it was inadequate, and that reasonable clinicians may differ in such assessments.

270. He further submitted that Patient D had been given advice and safeguards by other clinicians, including the offer of caesarean section by the registrar, instructions on returning to hospital, and follow-up arrangements. He submitted that Dr Gentry's reflective statement demonstrated clear insight into the importance of contemporaneous records, particularly in the context of serious incidents, and that she had fundamentally changed her approach by treating the medical record as the primary source of truth.

271. In relation to Patient F, Mr Wilson submitted that the events represented an isolated incident in the context of hundreds of safe deliveries. He submitted that Dr Gentry was operating in an extremely high-pressure situation, that the Ventouse equipment she normally used was unavailable, and that she was faced with an unenviable clinical dilemma once the delivery had progressed beyond the recommended number of pulls. He submitted that the guidance did not clearly address the precise circumstances she faced, and that her decision was a judgement call made in the interests of maternal and foetal safety.

272. He submitted that even if the Tribunal concluded that the conduct fell outside guidance, it did not follow that it amounted to a serious departure from professional standards. He relied on Dr Gentry's reflective statement, which demonstrated clinical reflection, acceptance of the concern, and clear steps taken to improve communication, documentation and patient communication in the event of future similar situations.

273. Mr Wilson submitted that the Tribunal must assess future risk by reference to insight, remediation, training, and subsequent practice. He submitted that Dr Gentry had demonstrated insight across her reflective statement, undertaken a structured programme of remediation, updated her knowledge and skills, and practised safely under conditions at

Queen Alexandra Hospitals Portsmouth NHS Trust [from June 2021 to April 2023] without incident. He relied on team observations, testimonials, CPD certificates and patient feedback as evidence of sustained improvement and absence of repetition.

274. Mr Wilson submitted that the dishonesty findings were discrete and related to conduct away from clinical performance, and that Dr Gentry accepted impairment on public confidence grounds. He submitted that dishonesty would be further addressed at Stage 3 by way of mitigation and sanction, and should not be imported into the assessment of clinical impairment.

42. In conclusion, Mr Wilson submitted that Dr Gentry's fitness to practise was not currently impaired by reason of deficient professional performance, as any concerns had been addressed through insight and remediation and posed no ongoing risk to patients or professional standards. He accepted that impairment arose on public confidence grounds due to the dishonesty findings.

The relevant legal principles

275. There is no burden or standard of proof at this stage of the proceedings and the decision of impairment is a matter for the Tribunal's judgment alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so the Tribunal was also mindful of the overarching objective which is to protect, promote, and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the profession, and to promote and maintain proper professional standards and conduct.

276. The Tribunal was referred to the case of *Cheatle v General Medical Council [2009] EWHC 645 (Admin),* and in approaching its decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious and then whether the finding of that misconduct which was serious poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

277. The key question for the Tribunal is whether, on the basis of those facts, the doctor's fitness to practise is impaired now.

278. The Tribunal was advised that there is no statutory definition of impairment. However, section 35C(2) of the Medical Act 1983 provides guidance which includes that a

person's fitness to practise shall be regarded as impaired by reason of misconduct or deficient professional performance. In applying this section, the Tribunal had regard to two broad categories of cases concerning serious professional misconduct and cases concerning serious deficient professional performance.

279. In relation to deficient professional performance, the Tribunal was advised that deficiency must be judged against the standard of professional work reasonably expected of a practitioner at the relevant level, as established in *Holton v General Medical Council [2006] EWHC 2053 (Admin).* This approach is consistent with *Calhaem v General Medical Council [2001] EWCA Civ 884,* where it was confirmed that the Tribunal must focus on the standard of work actually undertaken by the practitioner. The assessment is objective and based on the nature of the work performed, not the doctor's personal characteristics such as education, training or personality.

280. In relation to misconduct, the Tribunal was advised that it must determine whether the conduct admitted or found proved amounts to misconduct that is serious. This is a matter of judgement for the Tribunal alone, exercised on the facts and circumstances of the case. Guidance on the assessment of misconduct can be found in the case of *Roylance v GMC ([2000] 1 AC 311,* where misconduct was described as *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances*'.

281. Misconduct must be both professional and serious, however, not every departure from professional standards will amount to serious professional misconduct. Conduct may amount to professional misconduct even if it occurs outside the direct exercise of clinical practice, provided it brings the profession into disrepute.

282. The Tribunal was further advised that seriousness has been described in *Nandi v General Medical Council [2004] EWHC 2317 (Admin) and* approved in *Meadow v General Medical Council [2007] EWCA Civ 1390* as conduct that would be regarded as deplorable by fellow practitioners. Negligence alone will not usually amount to misconduct unless it is of a particularly high degree. A single act or omission may amount to misconduct if sufficiently grave, although multiple acts or omissions are more likely to cross the threshold.

283. The Tribunal was advised that misconduct may take two principal forms, as identified in *Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin):* serious misconduct

in the exercise of professional practice, or morally culpable or disgraceful conduct occurring outside clinical practice which nonetheless undermines public trust in the profession.

284. In relation to dishonesty, the Tribunal was advised to have regard to several case law including *GMC v Nwachuku [2017]EWHC 2085, PSA v GMC & Igwilo [2016] EWHC 524, and Hassan v General Optical Council [2013] EWHC 1887* which confirmed that dishonesty encompasses a wide range of conduct and that any instance of dishonesty is likely to impair a professional person's fitness to practise. Dishonesty represents a breach of a fundamental tenet of the medical profession and lies at the top end of the spectrum of misconduct. However, a finding of dishonesty does not automatically result in a finding of impairment, and impairment remains a separate and distinct exercise.

285. The Tribunal was reminded that doctors are entitled to maintain their innocence and to defend allegations against them. The mere fact of denying allegations should not, of itself, be treated as a lack of insight. The Tribunal was referred to *Satwani v General Medical Council [2022] EWHC 998 (Admin*), which provides guidance on how rejected defences may be considered when assessing insight. The Tribunal should consider the nature of the allegation, whether primary or secondary facts were denied, whether there is evidence of lack of insight beyond the rejected defence, and the nature and quality of the defence itself, including whether it involved fabrication, blame-shifting, or allegations against others.

286. The Tribunal was also referred to *Professional Standards Authority v Health and Care Professions Council and GNA [2016] EWHC 2566 (Admin*), which emphasises that deliberate dishonesty ranks highly on the scale of misconduct, particularly where it risks harm to patients. Repeated dishonesty, failure to acknowledge wrongdoing, or attempts to shift blame may demonstrate an ongoing risk and are relevant to impairment.

287. In considering impairment arising from deficient professional performance, the Tribunal was advised to refer to GMP. The Tribunal was reminded of the principles in *Cohen v General Medical Council [2008] EWHC 581 (Admin*), which confirm that impairment requires consideration of patient protection, public confidence, and the maintenance of professional standards. Relevant factors include the seriousness of the misconduct or deficiency, insight, remediation, expert evidence, previous history, and whether the conduct is easily remediable.

288. The Tribunal was advised that impairment is a forward-looking assessment. While past conduct must be considered, the purpose of proceedings is not to punish but to protect

the public. This approach was reaffirmed in *Meadow v General Medical Council [2007] EWCA Civ 1390*, where the Court of Appeal confirmed that past conduct is relevant only insofar as it informs present fitness to practise.

289. The LQC reminded the Tribunal that it is assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report, as adopted by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin*. The Tribunal noted that any of the following features are likely to be present when a doctor's fitness to practise is found to be impaired:

a. 'Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b. Has in the past and/or is liable in the future to bring the medical profession into disrepute; and/or
c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The Tribunal's determination on impairment

290. In reaching its decision the Tribunal had regard to the legal advice, all the evidence it had received, the GMP and the submissions of both parties.

Misconduct

Patient A

291. The Tribunal considered whether the facts found proved in respect of paragraphs 1(a) and 1(b) of the Allegation, relating to Patient A, amounted to misconduct and, if so, whether that misconduct was sufficiently serious to cross the threshold of serious professional misconduct.

292. The Tribunal noted that the clinical deficiencies identified in respect of Patient A were serious in nature. Dr Gentry authorised and/or administered a 2mg Prostin pessary in circumstances where she was aware that the baby was not lying in the correct longitudinal position and where baby's head was otherwise, not presenting cephalically. The Tribunal accepted that this was a high-risk clinical decision and that Dr Gentry, as a consultant obstetrician, was personally accountable for that decision.

293. The Tribunal considered the relevant standards in GMP and was satisfied that Dr Gentry's conduct departed from paragraphs 15(a),15(b) 16(b) 19,21(b) and (c). The Tribunal found that these departures amounted to misconduct.

> *15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
> *a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
> *b promptly provide or arrange suitable advice, investigations or treatment where necessary*
> *16 In providing clinical care you must:*
> *…*
> *b provide effective treatments based on the best available evidence.*
> *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:*
>
> > *…*
> > *b the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
> > *c the information given to patient*

294. The Tribunal then carefully considered whether the misconduct reached the level of seriousness required to amount to serious professional misconduct. In doing so, the Tribunal took into account the clinical context and the circumstances in which the decision was made as well as any actual or potential harm caused.

295. The Tribunal noted that this was a situation involving clinical judgement in a recognised grey area of medical practice, where clinicians may reasonably differ. The Tribunal noted the fact that the two expert witnesses were not in agreement as to whether Dr Gentry's actions breached acceptable clinical standards to the extent alleged. The Tribunal further noted that there was no evidence of serious harm arising to Patient A or her baby, and that the birth outcome was satisfactory.

64. The Tribunal accepted that the decision carried risk but was not wholly outside the range of decisions that might be taken by a reasonably experienced consultant obstetrician faced with similar circumstances. The Tribunal accepted that Patient A had been informed

that the procedure was high risk, that she did not object to the proposed course of action, and that she expressed a strong preference to avoid caesarean section. The Tribunal was satisfied that Dr Gentry sought to balance clinical risk with patient autonomy.

296. The Tribunal also took into account that high-risk clinical decision-making does not of itself amount to misconduct. Medicine is not a discipline governed solely by rigid rules, and deviation from guidelines, particularly in complex or pressured situations, does not automatically equate to misconduct, let alone serious misconduct.

297. While the Tribunal found that Dr Gentry's documentation of actions and decisions taken was deficient in terms of the timing and quality and that this absence of clear contemporaneous records was a significant failing, it was satisfied that this did not result in any actual or potential serious risk of harm to the patient and therefore did not elevate the misconduct into the category of conduct that would be regarded as deplorable by fellow practitioners. The Tribunal further noted that Dr Gentry's reflective statement demonstrated recognition of the documentation deficiencies and that the risk of repetition was low.

298. Having regard to all these matters, including the circumstances in which the decision was taken, the absence of harm, the divergence in expert opinion, and the positive outcome for Patient A, the Tribunal concluded that, although the actions amounted to misconduct, it did not meet the threshold of seriousness required to constitute serious professional misconduct.

299. Accordingly, the Tribunal determined that the facts found proved in relation to Patient A constituted misconduct, but not serious professional misconduct.

Patient B

300. The Tribunal noted the matter found proved in relation to Patient B, was paragraph 2 (c) (iii) that Dr Gentry failed to adequately record the discussion of her recommendation for caesarean section before 32 weeks' gestation. The Tribunal was satisfied that this engaged paragraphs 19, 21(a) and (b) of GMP and amounted to misconduct.

> *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*

301. The Tribunal determined that it would be wholly disproportionate to characterise this failing as serious professional misconduct. The failing arose in a highly pressured clinical situation, where Dr Gentry was asked at short notice to assist with a patient who was not under her routine care, in the context of workload and staffing pressures outside her control.

302. The Tribunal noted that the discussion was recorded, albeit inadequately, and that this was not a case where no record was made. The inadequacy of the documentation did not affect subsequent clinical decision-making, did not impede continuity of care, and did not result in harm to Patient B or her baby. The Tribunal further noted that the clinical decision itself was appropriate and that the outcome for the baby was satisfactory.

303. Taking the matter holistically, the Tribunal concluded that the misconduct related solely to record-keeping and did not undermine patient safety or clinical judgement in this case. Accordingly, the Tribunal determined that paragraph 2(c)(iii) of the Allegation amounted to misconduct, but did not meet the threshold for serious professional misconduct.

Patient D

304. The Tribunal reminded itself that paragraph 4 of the Allegation concerned Dr Gentry's involvement in the care of Patient D following a failed induction of labour, and that sub-paragraphs (a) to (d) and (f) had been found proved. The Tribunal noted that the allegations involved multiple and ongoing clinical failings rather than an isolated lapse.

74. The Tribunal considered the relevant standards in GMP and was satisfied that Dr Gentry's conduct breached paragraphs 15(a),15(b), 16(b), 31, 49(a), and 52. The Tribunal concluded that these breaches amounted to misconduct.

> *31 You must listen to patients, take account of their views, and respond honestly to their questions.*
> *49 You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:*
> *a: their condition, its likely progression and the options for treatment, including associated risks and uncertainties.*
> *52 You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure*

they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.

305. The Tribunal found that Dr Gentry failed to recognise and act upon a clear clinical indication for caesarean section, failed to offer caesarean section after a failed induction, failed to adequately advise Patient D of her treatment options and risks, and failed to conduct an adequate vaginal examination. The Tribunal noted that Dr Gentry relied on examinations performed by others and did not herself adequately reassess Patient D, despite the evolving clinical picture.

306. The Tribunal accepted that the incident occurred in a fast paced, pressurised and challenging clinical environment. However, it was satisfied that these factors did not excuse the failings especially of a doctor of Dr Gentry's position and experience. Patient D required a caesarean section, and there was a significant window of opportunity during which this could and should have been offered and undertaken.

307. The Tribunal further found that Patient D was discharged without an appropriate discharge process, based on Dr Gentry's assertion that Patient D was opposed to caesarean section. The Tribunal accepted Patient D's evidence that she would not have gone home had a caesarean section been properly offered. The Tribunal found that Dr Gentry failed to take Patient D's views into account and that Patient D was seriously let down by her care.

308. The Tribunal considered that, while the tragic outcome was not attributable to one clinician alone, Dr Gentry's failings were the first in a chain of events and were compounded by how she dealt with matters thereafter. The Tribunal concluded that the clinical failings, taken together, represented a serious departure from the standards expected of a consultant obstetrician and carried a clear potential for serious harm, not only to Patient D but also to subsequent care by other healthcare professionals.

309. The Tribunal found that this dishonesty was serious, extended over time, and was motivated by a desire to protect her own position. Dr Gentry attempted to shift blame onto Patient D and continued to do when giving evidence to the Tribunal. The Tribunal noted the significant distress caused to Patient D, who was appalled by Dr Gentry's lack of honesty. The Tribunal considered that members of the public would be similarly appalled.

310. The Tribunal concluded that Dr Gentry's conduct in respect of Patient D, both clinically, crossed the threshold of seriousness. The treatment and care of Patient D were found to be deplorable, inexcusable, and wholly unacceptable of any doctor let alone a doctor of Dr Gentry's standing and experience.

311. Accordingly, the Tribunal determined that the facts found proved in respect of paragraph 4 of the Allegation amounted to serious professional misconduct.

312. The Tribunal noted that paragraph 5 of the Allegation was a neutral factual allegation. Dr Gentry was required to give evidence at the Coroner's Inquest and the Tribunal did not find that the act of giving evidence, of itself, amounted to a breach of GMP.

313. The Tribunal then considered paragraphs 6, 7 and 8 of the Allegation in the round.

314. The Tribunal considered the relevant standards in GMP and was satisfied that Dr Gentry's conduct breached paragraphs 55(a) (b) and (C), 65, and 72 (a) and (b) noting the impact of Dr Gentry's conduct on Patient D, who suffered significant distress as a result of the dishonesty.

> *55 You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:*
> *a put matters right (if that is possible)*
> *b offer an apology*
> *c explain fully and promptly what has happened and the likely short-term and long-term effects*
>
> *65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
>
> *72 You must be honest and trustworthy when giving evidence to courts or tribunals.28 You must make sure that any evidence you give or documents you write or sign are not false or misleading.*
> *a You must take reasonable steps to check the information is correct.*
> *b You must not deliberately leave out relevant information.*

85. The Tribunal considered the dishonesty arising from Dr Gentry's conduct following the events as a separate issue to the clinical failings. The Tribunal found that Dr Gentry was

not open or honest about her clinical failings to the coroner and that she sought to cover up her actions. The Tribunal found clear evidence that Dr Gentry gave untruthful evidence, whilst under oath at the coroner's inquest, maintaining that Patient D wished to go home and had declined a caesarean section. The Tribunal noted that Dr Gentry was not obliged to speculate or reconstruct events where she was unsure, yet chose to present a false account.

315. The Tribunal found that Dr Gentry's dishonesty was serious. The evidence was given under oath at a Coroner's Inquest into the death of a baby. Dr Gentry was not obliged to speculate or to give definitive evidence where she was unsure, yet she chose to present an account that was untrue. The Tribunal found that this dishonesty was motivated by a desire to cover up her own clinical failings and to shift responsibility onto Patient D.

87. The Tribunal was particularly concerned that Dr Gentry was emphatic about her account when giving evidence to the Coroner and inferred that it was Patient D who was being untruthful when giving evidence to the Tribunal. The Tribunal found this to be a clear demonstration of dishonest intent. The Tribunal accepted the evidence that Patient D was appalled by Dr Gentry's dishonesty and suffered additional distress as a result.

316. The Tribunal concluded that the dishonesty went beyond a momentary lapse. It extended over time and was directly connected to serious clinical events. The Tribunal was satisfied that members of the public would be appalled by such conduct and that it fundamentally undermined the public's trust in the medical profession.

317. Accordingly, the Tribunal determined that Dr Gentry's conduct in respect of paragraphs 6, 7 and 8 of the Allegation amounted to serious professional misconduct.

Patient F

318. The Tribunal noted paragraph 9 (a), 9 (c), (d), and (e) was regarding deficient professional performance in relation to Patient F. The Tribunal considered the relevant standards in GMP and was satisfied that Dr Gentry's conduct engaged paragraphs 16(b), 49(a) and (b) and 55. The Tribunal concluded that these departures amounted to misconduct.

> *49 You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:*
> *a their condition, its likely progression and the options for treatment, including associated risks and uncertainties*

b the progress of their care, and your role and responsibilities in the team

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

a put matters right (if that is possible)

b offer an apology

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

319. The Tribunal then considered the seriousness of the misconduct. It noted that this was a difficult and highly pressured clinical situation requiring rapid decision-making as the baby's head was in the birth canal. The Tribunal accepted that there was disagreement as to the appropriate method and number of pulls, and that expert opinion on this issue was divided. The Tribunal noted that the guidance was not prescriptive in respect of the precise scenario faced by Dr Gentry and that clinical judgement was required.

320. The Tribunal found that, in the difficult circumstances at the time, Dr Gentry made a judgement call that took the delivery to a point where in her opinion, conversion to caesarean section was no longer the safer option. The Tribunal accepted that, at that stage, Dr Gentry considered that proceeding with the use of forceps was the safer option for both mother and baby. The Tribunal noted that the baby was delivered successfully and that no harm resulted to Patient F.

321. The Tribunal considered whether Dr Gentry's actions would be regarded as deplorable by fellow practitioners. While the Tribunal accepted that the concerns in respect of Patient F were more serious than those relating to Patient A, it was satisfied that the decision-making occurred in a high-risk, fast-moving situation and did not fall wholly outside the range of clinical responses open to a consultant obstetrician. The Tribunal considered the absence of harm and the lack of consensus between experts as to the correct course of action.

322. Taking the matter as a whole, the Tribunal concluded that Dr Gentry's conduct in respect of Patient F amounted to misconduct, but did not meet the threshold for serious professional misconduct. The Tribunal was satisfied that, although the situation involved high risk, the decision-making was not so egregious as to be characterised as deplorable or wholly unacceptable professional behaviour.

323. Accordingly, the Tribunal determined that the facts found proved in respect of Allegation 9 amounted to misconduct, but not to serious professional misconduct.

Impairment

324. The Tribunal, having found that the facts proved in relation to the allegations concerning dishonesty amounted to serious professional misconduct, and that other factual findings amounted to misconduct and/or deficient professional performance, went on to consider whether, as a result of those matters, Dr Gentry's fitness to practise is currently impaired.

325. In doing so, the Tribunal first considered the findings of dishonesty arising from Dr Gentry's evidence to the Coroner in relation to Patient D. The Tribunal regarded dishonesty, given on oath, as extremely serious, engaging all three limbs of the overarching objective.

326. The Tribunal accepted that dishonesty is capable of remediation, although it is often difficult to remediate and requires genuine self-reflection, acceptance of wrongdoing and an appreciation of the impact of the conduct on others. The Tribunal noted that Dr Gentry had apologised and had taken steps to remediate the findings of the Tribunal. She stated in her reflective piece that, in future, she would make clear when she did not know or could not recall matters rather than attempting to fill gaps based on her recollection. She also provided a certificate of completion of Probity, Ethics and Professionalism (Insight Works Training, Kings View Chambers) dated 10 September 2025. However, the Tribunal was not satisfied that Dr Gentry had fully demonstrated sufficient insight into the seriousness of lying under oath as she had presented no evidence of any understanding, insight or reflections on the impact and consequences of the dishonesty on Patent D, the coronial legal process or the public confidence in the profession.

327. In particular, the Tribunal found that Dr Gentry characterised the dishonesty as a "mistake" rather than deliberate misconduct. The Tribunal noted the absence of meaningful reflection on the impact of the dishonesty on Patient D, the Coroner, and other stakeholders, as well as the wider damage caused to public confidence in the medical profession. While recognising Dr Gentry's right to maintain her defence and to pursue an appeal, the Tribunal concluded that her insight into the dishonesty findings remained limited.

328. The Tribunal considered the remediation undertaken in respect of dishonesty. While there was evidence of some reflective work and an apology, the Tribunal was not satisfied

that the level of insight achieved was sufficient. The Tribunal concluded that there remained a residual risk of repetition. Accordingly, the Tribunal determined that Dr Gentry's fitness to practise is impaired by reason of misconduct on the grounds of dishonesty.

101. The Tribunal then considered whether Dr Gentry's fitness to practise is also impaired by reason of deficient professional performance. In relation to Patient D, the Tribunal noted that the deficiencies in clinical management and documentation formed part of an ongoing course of conduct and resulted in significant distress to the patient at the time of the events and afterwards. The Tribunal considered that these deficiencies undermined patient trust and public confidence in the profession.

329. In relation to Patient D, the Tribunal found that Dr Gentry's overall clinical competence was in question. The Tribunal noted that Dr Gentry accepted the deficiencies in her note-taking and aspects of clinical decision-making, and that Dr Gentry had undertaken substantial remediation, including formal training, reflections, and changes implemented in her clinical practice at Queen Alexandra Hospitals Portsmouth NHS Trust from June 2021 to April 2023. The Tribunal also took account of positive testimonials from colleagues.

330. However, the Tribunal concluded that, as a consultant, Dr Gentry was expected to demonstrate highly developed skills in documentation and clinical judgement, particularly in high-risk situations. While the Tribunal accepted that Dr Gentry had taken significant steps towards remediation and demonstrated some insight, it was concerned that her insight was self facing and lacked insight with regards the effect of the concerns on the patient and colleagues. The Tribunal concluded that this indicated incomplete insight and an insufficient appreciation of the consequences of her actions.

331. In considering the risk of repetition, the Tribunal concluded that, although the risk had been reduced by the remediation undertaken, it had not been eliminated. The Tribunal determined that the deficiencies in professional performance continued to engage the need to protect the public, to maintain professional standards, and to uphold public confidence in the profession.

332. Taking all matters together, the Tribunal determined that Dr Gentry's fitness to practise is currently impaired by reason of misconduct, in relation to Patient D.

Determination on Sanction - 19/12/2025

333. Having determined Dr Gentry's fitness to practise is impaired by reason of her misconduct and deficient professional performance, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

334. The Tribunal has reviewed its findings at the facts and impairment stages and taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction

Submissions

335. On behalf of the GMC, Ms Bucklow submitted that the appropriate sanction was one of erasure. Throughout her submissions, she referred the Tribunal to relevant paragraphs of the Sanctions Guidance (2024) ('the SG') and the Tribunal's previous determinations.

336. Ms Bucklow submitted that the seriousness of the allegations found proved in respect of Patient D was highly relevant both to the assessment of future risk and to the need to maintain public confidence.

337. Turning first to the clinical concerns in respect of Patient D, Ms Bucklow submitted that Dr Gentry failed to offer a caesarean section following a failed induction, failed to recognise the clinical indication for caesarean section, failed to advise Patient D of all available treatment options and the risks of those options, and failed to conduct an adequate vaginal examination in an evolving clinical situation, instead relying on examinations performed by others. She submitted that the Tribunal had found breaches of paragraphs 15(a) and (b), 16(b), 31, 49(a) and 52 of GMP, and that those breaches amounted to serious misconduct.

338. Ms Bucklow submitted that the Tribunal had found that there was a significant window during which a caesarean section could and should have been offered, and that Patient D was discharged without that offer, notwithstanding that she would have accepted it had it been properly made. As a result, the Tribunal found that Patient D had been seriously let down by Dr Gentry.

339. Ms Bucklow further submitted that Dr Gentry failed to document Patient D's wishes to proceed to caesarean section or the substance of her discussions with Patient D on 27 September 2017. She submitted that the seriousness of this failure must be viewed in the context that the baby later died and an inquest followed, which would have benefited from accurate contemporaneous records. In the absence of such records, Patient D was subjected to cross-examination about events that should have been objectively recorded, resulting in a long-running and avoidable dispute.

340. Ms Bucklow submitted that the seriousness of Dr Gentry's clinical failings was aggravated by the outcome in Patient D's case, namely the avoidable loss of her baby. While not attributable to Dr Gentry alone, her actions were a significant link in the chain of events and carried a clear potential for serious harm.

341. Turning to dishonesty, Ms Bucklow submitted that the dishonesty findings in respect of Patient D were at the highest end of the spectrum of probity concerns. Dr Gentry had made a serious and persistent departure from GMP, in particular paragraphs 65, 72 and 73. The dishonesty directly related to Dr Gentry's professional role and to the clinical care of a patient and posed a risk not only to public confidence but also to patient safety.

342. Ms Bucklow submitted that Dr Gentry's persistent dishonesty over many years caused Patient D significant distress, compounded her trauma, and affected her ability to grieve and process the death of her son. Being lied to and blamed by a doctor who played a significant role in the events leading to the death was an abuse of power and trust, with long-lasting consequences for Patient D's sense of safety, confidence and engagement with the medical profession.

343. Ms Bucklow submitted that Dr Gentry had shown little insight into the distress and harm caused to Patient D, and that throughout the proceedings she continued to shift blame onto the patient in an attempt to protect her own position. It was suggested on Dr Gentry's behalf that Patient D was not telling the truth. While a doctor is entitled to deny allegations, Ms Bucklow submitted that projecting blame onto a bereaved parent went far beyond denial and caused further unnecessary trauma.

344. Ms Bucklow submitted that Dr Gentry placed her own interests above those of the patient and above the proper function of the coronial process. An inquest relies on truthful evidence to identify causation and prevent future deaths, and Dr Gentry's dishonesty undermined that process.

345. Ms Bucklow submitted that dishonesty is a fundamental breach of a core tenet of the medical profession. Members of the public, fully informed of the extent and persistence of Dr Gentry's dishonesty, would find it shocking and deplorable were she permitted to remain on the register. Case law consistently places dishonesty at the top end of the spectrum of misconduct because of its corrosive effect on public confidence.

346. Despite multiple investigations over several years, Ms Bucklow submitted that Dr Gentry had not achieved full insight into the harm caused to Patient D, the coronial process, her colleagues, or the reputation of the profession. While the reflective statement acknowledged some failings, it did not reflect the true extent of the clinical failings found proved and focused primarily on poor record-keeping rather than the substantive failures in clinical decision-making.

347. In terms of remediation, Ms Bucklow submitted that dishonesty is an attitudinal and behavioural concern. While theoretically remediable, Dr Gentry's dishonesty was entrenched, having persisted across multiple inquiries over a significant period. The probity and ethics course undertaken by Dr Gentry was insufficient, both in substance and timing, and appeared to coincide with the sanction stage of proceedings rather than representing genuine remediation.

348. Ms Bucklow submitted that there remained a real risk of repetition, and that the Tribunal could not be confident that Dr Gentry would be open and honest in the future if matters went wrong.

349. Turning to the available sanctions, Ms Bucklow submitted that taking no action would be wholly inappropriate. Conditions were not suitable, particularly in relation to dishonesty, which cannot be addressed by workable conditions, and which would not maintain public confidence. She submitted that conditions also require full insight, which was absent.

350. Ms Bucklow submitted that suspension was also inappropriate. Dr Gentry's persistent dishonesty was fundamentally incompatible with continued registration, and public confidence would be seriously undermined were she allowed to return to practice following a period of suspension. Given the passage of time and the lack of effective remediation, suspension would not address the ongoing risks.

351. Ms Bucklow submitted that erasure was the only sanction capable of meeting the overarching objective. She referred in particular to paragraphs 108 and 109 (a), (b), (c), (d), (h), (i) and (j) of the SG.

> *108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.*
>
> *109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
> *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.*
> *b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*
> *c Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients*
> *d Abuse of position/trust*
> *h Dishonesty, especially where persistent and/or covered up*
> *i Putting their own interests before those of their patients*
> *j Persistent lack of insight into the seriousness of their actions or the consequences.*

352. For those reasons, Ms Bucklow submitted that erasure is the only sanction that would adequately protect the public, uphold professional standards, and maintain public confidence in the medical profession.

353. On behalf of Dr Gentry, Mr Wilson submitted that although the Tribunal had to consider all the possible sanctions, he would only address suspension and erasure. He submitted that, in light of the Stage 1 findings and the Stage 2 impairment decision, the Tribunal would inevitably be considering erasure. However, he submitted that the overarching objective could be met by imposing the maximum available suspension. He submitted that the key question for the Tribunal was the risk of repetition and whether Dr Gentry had shown sufficient insight.

354. Mr Wilson submitted that regarding the findings of dishonesty in respect of what was said at the Coroner's court and Dr Gentry's maintenance of a defence, the GMC's position came perilously close to, and in his submission, crossed, the impermissible line of treating the

maintenance of a defence as evidence of continuing dishonesty and therefore lack of insight. He urged the Tribunal not to fall into the trap of treating Dr Gentry's continued denial as a lack of insight or as an aggravating feature of the dishonesty. He submitted that what would be material would be evidence of any further dishonest conduct since February 2020, and there was none; the only dishonesty allegations before the Tribunal were those relating to the Coroner's inquest.

355. Mr Wilson submitted that the Tribunal should stand back and view the case in the round. He submitted that these were extraordinarily sad events, and that Dr Gentry was deeply affected at the time of learning of the baby's death. He submitted that she immediately attended and spoke to Patient D, and that the reaction of Patient D's husband at the time was that it was touching that a doctor took time to personally show concern and by doing so, it showed that Dr Gentry cared.

356. Mr Wilson submitted that the testimonials and character references must be taken into account. He submitted that they came from a broad section of individuals who had known Dr Gentry, some for decades, largely within the professional environment, and some as patients. He submitted that they presented a consistent picture of Dr Gentry's behaviour and conduct towards patients, colleagues and trainees. He submitted that the Patient D matters, both the clinical findings and the dishonesty findings, were aberrations in the context of a career characterised by good professional work and good works outside medicine.

357. Mr Wilson submitted that irrespective of the glowing testimonials, emotions must be put to one side and a forensic approach adopted. He submitted that Dr Gentry recognised her fitness to practise was impaired by reason of serious misconduct given the Tribunal's dishonesty findings at Stage 1, and she did not seek to contest impairment in respect of conduct.

358. Mr Wilson submitted that the Tribunal was required to consider not only whether a sanction was necessary in the public interest but also whether it was appropriate, and not excessive or disproportionate. He submitted that public protection was the predominant consideration, but there remained factors on the other side of the scale, including insight, remediation and the interests of the doctor, which must be weighed in order to reach a proportionate outcome.

359. Mr Wilson submitted that recent authority confirmed there could be no universal inflexible rule that erasure was inevitable in every case where dishonesty was found. He submitted that, while dishonesty was of particular significance especially if persistent and combined with a lack of insight, erasure was not necessarily inevitable and the individual circumstances must be considered. He submitted that a lesser sanction could be appropriate where there was compelling evidence of insight and other factors indicating the dishonesty was out of character and isolated in duration or range.

360. Mr Wilson submitted that this was such a case. He submitted that there had been no allegations of dishonesty throughout Dr Gentry's career save for the brief period during which she gave evidence at the Coroner's court, and that the dishonesty findings were of narrow compass, concerning a limited number of points arising from a short period of evidence. He submitted that this was not a case involving wide-ranging or serial dishonesty over a considerable period of time.

361. Mr Wilson submitted that the Tribunal had compelling evidence of non-repetition in the years following, particularly the period of work at Portsmouth NHS Trust in a new environment where Dr Gentry was closely assessed. He submitted that this real world experience was the best evidence of future conduct and should be put on the scales as demonstrating insight and remediation and supporting the conclusion that suspension would adequately protect the public without disproportionately damaging the profession.

362. Mr Wilson submitted that the correct focus for insight was future risk of repetition rather than remorse for past conduct. He submitted that equating the maintenance of innocence with lack of insight would be wrong in principle and would place Dr Gentry in an impermissible position, because remorse would require an admission of guilt and would undermine her ability to maintain her defence and pursue any appeal. He submitted that denial of misconduct was not a reason to increase sanction, that denial was not an absolute bar to a finding of insight, and that admission of misconduct was not a prerequisite to establishing an understanding of gravity or the unlikelihood of repetition.

363. Mr Wilson submitted that even where a tribunal concluded insight and remediation were incomplete, it remained open to impose suspension rather than erasure. He referred by way of example to the case of *Safdar v. GMC [2025] EWHC 3176 (Admin),* in which a tribunal imposed a 12-month suspension in the context of dishonesty and attitudinal issues requiring further remediation, and where that approach was upheld on appeal. He submitted that suspension could properly serve either to mark the gravity of the misconduct or to protect

the public and manage future risk, and that the Tribunal should not proceed on the basis that erasure necessarily followed from the dishonesty findings.

364. Mr Wilson submitted that, although Dr Gentry was not subject to formal interim suspension, the Tribunal should take into account the impact of the proceedings, conditions and restrictions in considering proportionality. He submitted that Dr Gentry had been able to practise only for limited periods in the last several years, and when she practised she did so subject to conditions which materially restricted her work and status. He submitted that this was relevant both to the choice between erasure and suspension and, if suspension were imposed, to its length.

365. Mr Wilson submitted that the Tribunal should treat character references and testimonials as addressing different issues. He submitted that the character references were compelling in demonstrating that the dishonesty finding was an aberration and confined to one occasion, and that the maintenance of a defence did not aggravate matters. He submitted that the testimonials primarily went to clinical performance and demonstrated insight and remediation, in particular the steps taken to improve documentation and governance, including the changes implemented during the Portsmouth period and the relevant training undertaken.

366. Mr Wilson submitted that the Tribunal should not elide the clinical performance findings with the dishonesty findings. He submitted that the absence of notes, on the Tribunal's findings, was an omission and there was no allegation that the absence of notes in September 2017 was itself a dishonest act at that time.

367. Mr Wilson submitted that the training and development undertaken by Dr Gentry supported a conclusion of remediation, including courses addressing probity, ethics and professionalism, foetal medicine and safety, GMC insight and reflection, communication, and risk management on the labour ward. He submitted that the multidisciplinary team observations from Portsmouth also supported improved practice, integrity, and appropriate escalation where Dr Gentry was unsure.

368. Turning to the seriousness of Patient D, Mr Wilson submitted that the Tribunal should proceed with caution in attributing causation of the baby's death to Dr Gentry's acts or omissions. He submitted that even if Patient D would have accepted a caesarean section, there was evidence that there was insufficient capacity on the labour ward for the patient to have had a caesarean section delivery at the relevant time. He further submitted that the

Coroner accepted lack of capacity as a key issue in the situation. He submitted that Patient D and her baby were in good health on discharge and on readmission, and that the proximate causes of the outcome lay elsewhere.

369. Mr Wilson submitted that it was incorrect to characterise Dr Gentry as seeking to blame Patient D for the baby's death. He submitted that Dr Gentry's position throughout was that she sought to enquire whether a caesarean section could be arranged and was told there was no capacity due to higher priority cases. He submitted that this was not an attempt to shift blame and should not be treated as such.

370. Mr Wilson submitted that the Tribunal's Stage 2 finding that risk had been reduced but not eliminated should not be treated as setting an unrealistically high threshold at sanction stage. He submitted that elimination of risk was not a realistic test and the Tribunal should assess the degree of future risk. He submitted that, looking forward, the combination of the Portsmouth NHS Trust experience, the remediation and training, the absence of further dishonesty allegations, and the weight of the testimonials meant the risk of repetition was negligible to the point of being non-existent.

371. Mr Wilson submitted that Dr Gentry had suffered substantial personal and professional consequences as a result of these proceedings, and that this experience itself was a powerful driver of insight when assessing the likelihood of repetition. He submitted that Dr Gentry possessed skills in significant need within the NHS, and in all the circumstances he respectfully invited the Tribunal not to impose erasure and instead to conclude that a period of suspension of appropriate length would adequately protect the public and satisfy the overarching objective.

372. Regarding the length of suspension, Mr Wilson submitted that a 9 month suspension would be appropriate.

The Relevant Legal Principles

373. The Tribunal reminded itself that the decision as to the appropriate sanction to impose, if any, is a matter for it alone, exercising its own judgement. In reaching its decision on sanction, the Tribunal had regard to the SG.

374. The Tribunal bore in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it acknowledged that any sanction

imposed may have a punitive effect. It reminded itself that in deciding what sanction, if any, to impose, it should consider the sanctions available, starting with the least restrictive.

375. Throughout its deliberations, the Tribunal had regard to the overarching objective, which includes the protection of the public, the promotion and maintenance of public confidence in the profession, and the promotion and maintenance of proper professional standards and conduct for members of the profession. It applied the principle of proportionality, balancing Dr Gentry's interests with the public interest, bearing in mind that the public interest as a whole carried more weight than the interests of the doctor.

376. The Tribunal was advised that, in approaching sanction, it must take into account all the evidence before it, as well as the submissions made by both parties. Submissions are not evidence and it is a matter for the Tribunal to determine what it accepts or rejects. The Tribunal must also consider all testimonial and character evidence. It was noted that such evidence should be assessed in light of the extent to which the authors were verified, aware of the Allegation and the findings made by the Tribunal. The tribunal was advised that it should accordingly, attach such weight to evidence as it considers appropriate.

377. The Tribunal was advised that taking no action should only be considered in exceptional, unusual or rare circumstances and, if adopted, must be clearly justified.

378. The Tribunal was advised that conditions are intended to assist a doctor in addressing health issues or remediable deficiencies in practice or knowledge, while protecting the public. Any conditions imposed must be proportionate, workable and measurable, and may not exceed three years.

379. The Tribunal was advised that suspension may be imposed for up to 12 months. Suspension may serve to mark the seriousness of the conduct and protect the public, but is not appropriate where the misconduct is so serious that continued registration is fundamentally incompatible with public confidence. Suspension is also relevant, in cases of deficient performance in which the doctor currently poses a risk of harm to patients but where there is evidence that they have gained insight into the deficiencies and have the potential to remediate if prepared to undergo a rehabilitation or retraining programme.

380. In relation to dishonesty, the Tribunal was advised that dishonesty must generally be persistent or concealed to justify the most severe sanctions. The Tribunal was referred to recent case law, including the case of *Safdar* which suggests that erasure may not be

appropriate where dishonesty is isolated or out of character and where there is compelling evidence of insight and provided a lesser sanction is sufficient to meet the overarching objective.

381. The Tribunal was advised that the existence or duration of any interim order should not be given undue weight. Interim orders are imposed on a different legal basis, without findings of fact, and serve a different purpose. Reference was made to *Adil v General Medical Council [2023] EWCA Civ 1261* in which it was held that, where suspension is imposed to address impairment or reduce the risk of repetition, time spent subject to an interim order is generally irrelevant. Credit for time spent under interim restrictions may undermine the objectives of public protection, professional standards and public confidence. It was noted that, in this case, the interim order imposed was one of conditions rather than suspension.

382. Finally, the Tribunal was reminded that any sanction imposed must be proportionate, must address the level of impairment found. It must be determined with careful regard to the overarching objectives: 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.

The Tribunal's Determination on Sanction

383. The Tribunal first identified what it considered to be the aggravating and mitigating factors in this case.

Aggravating Factors

384. The Tribunal considered paragraphs 50 to 60 of the SG and found the following factors to be present in this case. The Tribunal identified the nature and seriousness of Dr Gentry's dishonesty to be a substantial aggravating factor.

385. The Tribunal noted that Dr Gentry was a senior and experienced consultant at the time of the events. She was in a position of trust and authority, and her evidence to the Coroner would reasonably have been relied upon as truthful and accurate. Her dishonesty therefore amounted to an abuse of her professional position and undermined the integrity of the coronial process and the medical profession.

386. The Tribunal placed significant weight on the context in which the dishonesty occurred. A Coroner's Court is a forum in which the obligation to be open, honest and truthful is at its highest. Dr Gentry was under oath and was required to give truthful and accurate evidence.

387. The Tribunal considered the nature and extent of the dishonesty. It was not a minor or peripheral matter but went to central issues concerning the care of Patient D and the events leading up to the death of her baby. While the tragic outcome was not directly attributable to Dr Gentry, her dishonesty was portrayed before the Coroner as the absolute truth consequently condemning the testimony of Patient D. This had the potential to blame another and obscure understanding of what had occurred.

388. The Tribunal concluded that the dishonesty was serious in nature and motivated by a desire to justify or conceal Dr Gentry's actions. The Tribunal found that the dishonesty was for personal benefit in seeking to protect her professional position, which the Tribunal considered to be an aggravating factor.

389. The Tribunal also considered Dr Gentry's level of insight in relation to the dishonesty. While it accepted that some insight was developing overall, it concluded that insight into the dishonesty was limited. Her reflections were largely inward-facing and focused on the impact of the proceedings on herself, rather than the impact of her actions on Patient D, the coronial process, the profession or public confidence. This lack of outward-facing insight was an aggravating feature.

390. In relation to the deficient clinical performance with regards Patient D, the tribunal found that Dr Gentry had shown a lack of responsibility towards her clinical duties and had caused emotional harm to Patient D

Mitigating Factors

391. In considering the mitigating factors of this case the Tribunal noted paragraphs 25 to 49 of the SG. The Tribunal first considered paragraph 25(a) of the SG. It noted that, in her reflective statement, Dr Gentry had made an attempt to acknowledge deficiencies in her record keeping, including reliance on memory rather than contemporaneous documentation, which contributed to the untruthful account later given. The Tribunal recognised that this reflected some developing insight. However, it concluded that the insight demonstrated was

partial and incomplete, as the reflection focused primarily on note taking rather than addressing the broader clinical and professional failings, particularly in relation to dishonesty.

392. The Tribunal accepted that Dr Gentry had undertaken some remediation, including taking courses relating to record keeping, professionalism and clinical practice. It also noted the evidence relating to her subsequent employment in Portsmouth NHS Trust, where she worked under conditions and appeared to have impressed colleagues. This was a relevant factor demonstrating an attempt at remediation and improvement.

393. The Tribunal considered paragraph 25(d) of the SG and accepted that Dr Gentry was working in a highly pressured clinical environment at the relevant time. It noted evidence of significant work-related stress and pressures, and that Dr Gentry had alluded to personal and XXX stressors which may have contributed to her actions. The Tribunal accepted that they provided some mitigation to the misconduct.

394. The Tribunal also considered paragraph 25(e) of the SG. It noted the significant lapse of time since the incidents in question, which occurred in 2017 and 2018. The Tribunal placed weight on the fact that there had been no repetition of similar concerns in the intervening period. Dr Gentry had worked under conditions for a prolonged period without further incident, which was a relevant mitigating factor.

395. The Tribunal gave careful consideration to the testimonial and character evidence. It noted that a large number of glowing testimonials had been provided from a wide range of colleagues and others speaking positively of Dr Gentry's professionalism, competence and integrity. While the GMC had not been able to independently verify those testimonials, the Tribunal considered that they stood on their own merit. There was no evidence to suggest that the testimonials were false or misleading, and the Tribunal was entitled to take them into account, while recognising that they had not been independently verified.

396. The Tribunal noted that Dr Gentry had apologised in general for her actions and had shown some remorse.

397. Overall, the Tribunal concluded that there were a number of mitigating features present, including evidence of developing insight, attempts at remediation, the absence of repetition, the pressures under which Dr Gentry was working at the relevant time, and the strength of the testimonial evidence. However, the Tribunal emphasised that these mitigating factors did not outweigh the seriousness of the misconduct found proved.

No action

398. In reaching its decision as to the appropriate sanction, if any, to impose in Dr Gentry's case, the Tribunal first considered whether to conclude the case by taking no action. Taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

399. The Tribunal determined that the seriousness of its findings required the imposition of a sanction. It determined that there were no 'exceptional circumstances' in this case and it would not therefore be sufficient, proportionate or in the public interest to conclude this case by taking no action.

Conditions

400. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Gentry's registration. The Tribunal had regard to paragraphs 81, and 85 of the SG, which state:

> *'81 Conditions might be most appropriate in cases:*
>
> *a involving the doctor's health*
>
> *b involving issues around the doctor's performance*
>
> *c willing to respond positively to retraining, with evidence that they are committed to keeping their knowledge and skills up to date throughout their working life, improving the quality of their work and promoting patient safety*
>
> ...
>
> *85 Conditions should be appropriate, proportionate, workable and measurable.'*

401. The Tribunal noted that the case did not fit within the examples in paragraph 81, as a type of case where conditions may be appropriate with respect to the dishonesty.

402. The Tribunal considered that no conditions could be formulated which would be appropriate, workable or measurable to address the dishonesty concerns or the public interest. Further, the Tribunal determined that the imposition of conditions would not be sufficient to mark the seriousness of Dr Gentry's actions or to address the Tribunal's findings of impairment.

403. The Tribunal concluded that an order of conditions would not be appropriate to promote and maintain public confidence in the profession, nor to promote and maintain proper professional standards and conduct for members of the profession.

Suspension

404. The Tribunal then went on to consider whether a period of suspension would adequately protect the public, maintain public confidence in the profession and uphold proper standards for its members. In considering whether to impose a period of suspension on Dr Gentry's registration, the Tribunal had regard to paragraphs 91, 92 and 93 of the SG which provide:

> *'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> *92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration…*
>
> *93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–49)'*

405. The Tribunal also considered the guidance at paragraphs 97(a), (e), (f) and (g), which it considered to be of particular relevance in this case.

> *97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> *a A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.*
>
> *…*
>
> *e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
>
> *f No evidence of repetition of similar behaviour since incident.*
>
> *g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

406. The Tribunal recognised that suspension can have a deterrent effect and may be used to send a clear message to the profession and the public about the standards expected of doctors. However, the Tribunal also recognised that suspension is not intended to be punitive, but protective and proportionate.

407. The Tribunal took careful note of the seriousness on the concerns in relation to both the dishonesty and Dr Gentry's clinical practice in the light of the level of her insight, remediation, and the three limbs of the overarching objective found to be engaged.

408. The Tribunal acknowledged that Dr Gentry is an experienced and clinically competent doctor, with a career spanning over 20 years in a highly demanding area of medicine. The Tribunal accepted that obstetrics is an intense and high-pressure specialty, and that, for the majority of her career, Dr Gentry has exercised appropriate clinical judgement and provided safe care to patients.

409. The Tribunal accepted that Dr Gentry had seriously let herself, her patient and the profession down by the found clinical failings and by giving dishonest evidence at the Coroner's Court, where the highest standards of honesty and integrity are required.

410. However, the Tribunal considered that this dishonesty arose in an extreme and specific context. It accepted that this was a one-off incident in an otherwise unblemished career which was not indicative of an entrenched or fundamentally dishonest behaviour. The Tribunal was satisfied especially in the light of all its findings that Dr Gentry's conduct was not fundamentally incompatible with continued practice.

411. The Tribunal considered Dr Gentry's reflective statement and accepted that she has begun to acknowledge her failings, particularly in relation to Patient D. While the Tribunal has found that her insight to be unsatisfactory, it accepted that her insight was developing. The Tribunal considered that a period of suspension would provide Dr Gentry with the opportunity to reflect further, to deepen her understanding of the impact of her actions on Patient D, other stakeholders and the profession, and to address fully the seriousness of dishonesty in a coronial setting.

412. The Tribunal considered that there remained some risk of repetition, particularly arising from the incomplete insight identified at the impairment stage. However, it was satisfied that this risk could be addressed through a defined period of suspension, allowing time for reflection, remediation and the development of full insight.

413. The Tribunal considered the appropriateness of a period of suspension in meeting the public interest and found that the confidence of a well informed member of the public with full knowledge of the facts and circumstances would not be shaken by a determination of a period of suspension.

414. The Tribunal took a step further to consider if erasure would be a more appropriate response to the concerns. It took into account that erasure would result in the permanent loss of a clinically competent doctor from the profession. It considered that this would be a significant loss to patients and to the healthcare system, particularly given the evidence that Dr Gentry has demonstrated a willingness to remediate and engage with reflective learning. In the light of this the Tribunal determined that an erasure would be overly punitive and disproportionate.

415. The Tribunal concluded that Dr Gentry's misconduct, while serious, was not fundamentally incompatible with continued registration. It determined that erasure would be disproportionate and would go beyond what was necessary to protect the public or maintain public confidence.

416. The Tribunal therefore determined that a period of suspension would be sufficient to protect the public, uphold professional standards, maintain public confidence in the profession, and allow Dr Gentry the opportunity to address the deficiencies identified.

Length of Suspension

417. In determining the length of the suspension, the Tribunal had regard to paragraphs 99 to 102 of SG and the table following paragraph 102.

418. The Tribunal considered the aggravating factors in this case and acknowledged that this was a serious departure from the standards set out in GMP.

419. The Tribunal also had regard to the mitigating factors of the case in considering the length of the suspension, including Dr Gentry's previous unblemished record and the positive testimonial evidence. The Tribunal acknowledged that there was a public interest in allowing an otherwise competent doctor to return to practice, whilst still upholding the statutory overarching objective.

420. The Tribunal determined that a shorter period of suspension would not provide sufficient time for Dr Gentry to develop full insight or to demonstrate meaningful remediation in relation to the dishonesty concerns. Given the seriousness of the misconduct and the high standards of integrity required when giving evidence under oath, the Tribunal concluded that a substantial period of suspension was necessary.

421. The Tribunal also took into account the context in which the misconduct arose, including the highly pressurised clinical environment in which Dr Gentry was working, and the evidence of shortcomings in departmental systems and support at the relevant time. While these factors did not excuse the misconduct, they were relevant in assessing proportionality.

422. Having weighed all of these factors, the Tribunal determined that a period of 12 months' suspension was necessary and proportionate.

423. The Tribunal was satisfied that this period would allow Dr Gentry adequate time to reflect properly on her conduct, to develop full insight into the consequences of her actions, and to take further steps towards remediation, while also maintaining public confidence in the profession and upholding proper professional standards.

Review

424. In determining whether to impose a review, the Tribunal had regard to Paragraphs 163 and 164 of the SG dealing with review hearings state:

> *'163 It is important that no doctor is allowed to resume unrestricted practice following a period of conditional registration or suspension unless the tribunal considers that they are safe to do so.*
>
> *164 In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. […]'*

425. The Tribunal determined to direct a review of Dr Gentry's case. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Gentry to demonstrate how she has further developed her insight, taken steps to remediate and reflected on her conduct. It therefore may assist the reviewing Tribunal if Dr Gentry provides:

- Evidence that she has maintained her knowledge and skills during the period of suspension.
- Evidence demonstrating further development of insight into the concerns giving rise to her impairment, including an understanding of their impact and consequences.
- Evidence of steps taken to address and remediate the concerns identified by the Tribunal.
- Evidence demonstrating how Dr Gentry would approach similar situations differently in the future.
- Any other information that she considers will assist a future Tribunal.

Determination on Immediate Order - 19/12/2025

426. Having determined to suspend Dr Gentry's name from the Medical Register for a period of 12 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether her registration should be subject to an immediate order.

Submissions

427. On behalf of the GMC, Ms Bucklow submitted that an immediate order should be imposed in this case. She submitted that an immediate order is necessary to protect the public and was in the public interest, particularly in light of the Tribunal's findings that all three limbs of the overarching objective are engaged. She submitted that, in the circumstances, immediate action needs to be taken to protect public confidence and uphold proper professional standards. She stated that it would not be appropriate for Dr Gentry to have the opportunity to partake in unrestricted practice before the substantive order can take effect. She confirmed that there was an interim order of conditions currently in place.

428. On behalf of Dr Gentry, Mr Wilson submitted that an immediate order was neither necessary nor justified on grounds of patient safety or abuse of a position of trust.

429. He submitted that there was no reasonable basis to conclude that Dr Gentry posed a risk to patient safety. The misconduct found proved related to Patient D and was an aberration in an otherwise long and unblemished clinical career. He emphasised that the Tribunal itself had found Dr Gentry to be a safe clinician and that there was no evidence of any ongoing clinical risk.

430. In relation to abuse of a position of trust, Mr Wilson submitted that the GMC's analysis was flawed. He submitted that giving evidence at a Coroner's Court, while found to be dishonest, did not amount to an abuse of a position of trust in the legal sense relied upon by the GMC, which more properly concerned breaches of trust arising from a doctor–patient relationship. In any event, he submitted that this was insufficient to justify the imposition of an immediate order.

431. Mr Wilson submitted that any suspension imposed by the Tribunal should be suspended pending the outcome of any appeal. He advanced three principal reasons. First, this would respect Dr Gentry's absolute right of appeal. Secondly, it would be unfair for Dr Gentry to suffer the effect of a sanction which might ultimately be overturned on appeal.

Thirdly, patient safety did not require immediate suspension, given that the misconduct was isolated and historic.

432. In the alternative, Mr Wilson submitted that, pending any appeal, Dr Gentry would not object to the continuation of conditions broadly similar to those previously imposed by the Interim Orders Tribunals, save for any express requirement for supervision. He submitted that Dr Gentry would be working at registrar level and would therefore be supervised as a matter of course, making an express supervision condition unnecessary. He further submitted that such a condition had materially hindered her ability to obtain work, as potential employers perceived it as requiring special or additional supervision.

433. Mr Wilson submitted that the evidence overwhelmingly demonstrated that Dr Gentry was a safe and competent practitioner. He referred to her clinical career between 2011 and 2018, during which she was involved in the delivery of approximately 3,500 babies, and her subsequent practice at Portsmouth NHS Trust, involving a further substantial number of deliveries. Against this background, impairment has been found in one patient only despite extensive scrutiny of her practice by the Trust and the GMC.

434. He submitted that the position before this Tribunal was materially different from that which existed before the Interim Orders Tribunals, when Dr Gentry faced allegations relating to XXX. He submitted that the Tribunal, having heard and determined the evidence, was in a far better position than the Interim Orders Tribunals considering matters on a provisional basis.

435. Mr Wilson further submitted that fairness required the Tribunal to balance the public interest with Dr Gentry's ability to work pending any appeal. He submitted that allowing Dr Gentry to practise under appropriate conditions during this period would enable her to demonstrate further remediation and insight in real time, which would assist any future reviewing tribunal.

11 Finally, Mr Wilson submitted that it would not be in the public interest for Dr Gentry to be prevented from practising immediately, given her considerable experience, the evidence of her value as a clinician and trainer, and the absence of any ongoing risk to patients. He invited the Tribunal to decline the GMC's submissions to impose an immediate order.

The Tribunal's Determination

436. In reaching its decision, the Tribunal considered the relevant paragraphs of the SG and exercised its own independent judgment. In particular, it took account of paragraphs 172, 173 and 178:

> '*172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. …*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> …
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'*

437. The Tribunal also took into account Rule 17(2)p of the Rules which require the Tribunal to make an order under Section 41A(3) of the Medical Act in respect of an Interim Order.

438. The Tribunal determined that an immediate order was necessary to protect members of the public and is otherwise in the public interest. Further, it was necessary in order to uphold proper professional standards. The Tribunal was of the view that public confidence would be undermined if Dr Gentry was permitted to practise unrestricted, given its finding of the serious nature of her misconduct and deficient professional performance, and the assessed risk of repetition.

439. This means that Dr Gentry's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made

in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

440. The interim order is hereby revoked.

441. That concludes this case.

ANNEX A – 29/10/2024

Rule 34(1) Application - Admission of Evidence

442. On day 1 of the hearing, prior to the case opening, Mr Richard Wilson, KC for Dr Gentry made an application under Rule 34(1) of the General Medical Council ('GMC') (Fitness to Practise) Rules 2004, as amended ('the Rules'), to have admitted into evidence, two additional documents; Dr Gentry's final witness statement dated 27 October 2024, her exhibits CG 9, 11, 12, 14 and 15 and the expert report of Mr L for Dr Gentry dated October 2024.

Submissions on behalf of Dr Gentry

443. Mr Richard Wilson submitted Dr Gentry sought to rely on her witness statement dated 27 October 2024 and the referred exhibits, served on the GMC on 28 October 2024. He submitted Dr Gentry also seeks to rely upon her expert report which was served on the GMC on 29 October 2024. Mr Wilson submitted the MPTS Case Manager granted Dr Gentry several extensions to serve her witness statement and expert report, with the final extension deadline on 14 October 2024. He submitted Dr Gentry was unable to comply with the Case Mangers directions due to XXX. He submitted that as a result, Dr Gentry has been partially incapacitated and unable to attend matters at the pace and acuity that was necessary to provide her statement.

444. Mr Wilson asked the Tribunal to take into account the substantial nature of Dr Gentry's witness statement (74 pages). He submitted it deals in detail with matters of clinical care in respect of the five patients of concern, in a specialist field, and gives a detailed response to the Allegation against her. He submitted dealing with matters has been difficult for Dr Gentry due to XXX. She had been delayed in securing an expert witness to provide a report. In regard to the expert report of Mr L, Mr Wilson submitted that Mr L had been unable to complete his report until he had had sight of Dr Gentry's witness statement as he needed to refer to it in terms of the scope of her clinical care in order to provide his expert opinion. He added that Mr L completed his report within 48 hours of receipt of Dr Gentry's statement.

445. Mr Wilson submitted that, in the circumstances, the Tribunal should grant permission for Dr Gentry to rely on her witness statement and expert report. He submitted it is inconceivable to see how Dr Gentry could be afforded a fair hearing within the meaning of

Rule 34(1) if she is not afforded permission to rely both on her witness statement, her exhibits and expert report.

446. He submitted it would make the hearing exceptionally unwieldy and cumbersome, and add considerably to its length if Dr Gentry is not permitted to rely on her witness statement as she would have to give all of her evidence in chief orally. Mr Wilson submitted given the length and substance of her witness statement and the specialist technical information contained within, it could mean oral evidence would take four to five days and there would be a lengthier period of cross examination. He submitted any increase in length of hearing due to oral examination not only is contrary to the overriding objective which under the Medical Act is applicable in this case; dealing with matters expeditiously and fairly, which includes taking into account, measures to reduce costs, waste of resources and unnecessary time spent note taking that would have to be done by the tribunal members and counsel for both parties.

447. Mr Wilson submitted if Dr Gentry is not able to rely on her experts report there can be no equality of arms. He submitted this would breach Dr Gentry's right to a fair hearing.

448. Mr Wilson submitted this tribunal should grant Dr Gentry permission to rely on all the documents at the substantive hearing. He submitted such an outcome would be consistent with the overriding objective, which is to deal with cases fairly and justly.

Submissions on behalf of the GMC

449. Mr Ryan Donoghue, Counsel for the GMC, opposed the application. He reminded the Tribunal of the test set out in Rule 34, which raises the questions of fairness and relevance. He accepted that Dr Gentry's statement is relevant. However, the key concern of the GMC is the issue of fairness. Mr Donoghue submitted that fairness to the GMC represents the public interest in these proceedings. He submitted unfairness has to be considered in terms of the GMC preparation of its case and the attendance of witnesses.

450. Mr Donoghue referred the Tribunal to Rule 16A which sets out potential consequences of failure to comply with case management directions. He submitted that the Tribunal has the discretion to refuse to admit the evidence, admit it and/ or award costs. He invited the Tribunal to not admit the evidence. He referred the Tribunal to Paragraph 25 of the guidance for Medical Practitioners Tribunals on case management and exercising powers under Rule 16A which sets out that:

"…the purpose of the power to refuse to admit evidence is to protect the fairness of the proceedings and to ensure that no party can gain an unfair advantage by manipulating the hearing process".

He referred the Tribunal to paragraph 26 which sets out that:

"Justice demands determinations be made on the basis of evidence, and generally the MPT will be best able to deliver justice where it has access to all of the available evidence…;"

He reminded the Tribunal of the considerations listed in paragraph 28 and submitted that there has been a lack of compliance and a number of extensions.

451. Mr Donoghue reminded the Tribunal that the GMC's case and Rule 7 bundle was served on Dr Gentry on 26 May 2022 and there was a response by Dr Gentry by 6 January 2023, some eight months thereafter. The GMC bundle of evidence was sent to Dr Gentry in October 2023, 12 months ago. He submitted XXX reasons were relied upon by Dr Gentry following a postponement of the first hearing listing. Mr Donoghue submitted Dr Gentry was required to serve any evidence upon which she relied by 28 June 2024 and it was confirmed Dr Gentry was XXX to engage at that time. He submitted it is not clear why it has taken so long for documents to have been provided. It is an understandable submission that expert Mr L cannot finalise his report until he has seen Dr Gentry's statement but, he submitted, there is a lack of cogent evidence as to why these delays have been occasioned.

452. Mr Donoghue submitted there will be an adverse impact on the hearing generally if the evidence is admitted. The GMC will need time for its expert Dr I to consider Mr L's report before the GMC could fairly or properly be expected to embark upon the opening of its case and calling evidence. He submitted, based on Dr I's availability, it would lead at the very least, to the loss of one if not two days of the case. He went on to submit that it should be noted that ordinarily, the GMC would have the benefit of a joint expert meeting before finalising the allegations and opening the case hence the reason for the case management hearings and directions which are to ensure that when the case comes to the substantive Tribunal, the issues are clearly identified and the case is ready to proceed.

453. He submitted that Rule 34 makes plain that the threshold of fairness must be crossed for evidence to be admissible.

Legal Advice

454. The Tribunal reminded itself of Rule 34(1) of the Rules which states that:

> *'34(1) The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'*

455. It also reminded itself of the questions for consideration in deciding whether or not to exclude evidence namely:

a. Has a party failed to comply with a rule or direction pertaining to the evidence in question? (The MPT should then consider the factors in paragraph 12 above);
b. Does the party have a reasonable excuse for that failing?
c. Has the party deliberately sought to disrupt the proceedings by the manner or timing of the production of the evidence?
d. What issue in the case does the evidence go to?
e. Will the other party be prevented from (or be significantly disadvantaged in) addressing the material issues raised by the evidence in question?

456. Finally it reminded itself that the admissibility of evidence is at the discretion of the Tribunal and it should have regard to the interest of fairness and consider the balance of prejudice to each party. The decision should also be considered through the lens of the overarching objective. However, excluding evidence is a draconian step which should only be taken where absolutely necessary.

Tribunal's Decision

457. The Tribunal accepted the LQC's advice and considered the submissions made by the GMC and Dr Gentry.

458. The Tribunal considered that fairness to Dr Gentry and the GMC were both of importance. It considered Dr Gentry's witness statement, her exhibits and the report of her expert witness were of paramount relevance to the hearing.

459. It noted that Dr Gentry's XXX were accepted as good reason which prevented her from meeting deadlines in the past. The Tribunal found the same reasons prevented her from

complying with the case management directions which expired on 14 October 2024. However, the Tribunal took the view that no cogent reason was submitted to explain why Dr Gentry had not communicated to the GMC any status update from the 14 October 2024 until the day of the substantive hearing listing.

460. The Tribunal found the late evidence was likely to provide useful context to the case and the matters which it needed to consider. These were therefore relevant documents that should be admitted into evidence. It accepted that Mr L needs to be fully informed of Dr Gentry's case to provide his statement on which Dr Gentry would need to rely.

461. The Tribunal considered in detail the impact of admitting the evidence against fairness to the GMC in the light of the time needed for agreements between the expert witnesses of both parties, the GMC's need to review of its case in the light of same, the availability of witnesses and the disruption to the witness timetable. The Tribunal was provided with, and noted, a proposed timetable with witness availabilities which would possibly extend the substantive hearing by 2 -3 days. It determined that the fairness and need for the Tribunal to receive and consider Dr Gentry's account and her response to the allegations outweighed the delays and inconvenience of not admitting it.

462. In the circumstances, the Tribunal determined that Dr Gentry's witness-statement, her exhibits and Mr L's expert report were relevant and that it would be fair to admit this evidence using its powers under Rule 34(1).

ANNEX B – 20/12/2024

Adjournment determination

463. On the morning of 20 December 2024 the Tribunal received information from both parties that the previous evening the GMC's instructing solicitor received a bundle containing medical notes relating to Patient A that had not previously been brought to the attention of either the GMC or Dr Gentry.

464. Both parties were of the view that the bundle of notes that had just come to their collective attention were clearly relevant to Patient A and included detailed and substantial handwritten notes written by Dr Gentry.

465. Both parties stated that they had not been able to take instruction regarding the said notes. Mr Wilson in particular stated that he had not discussed the matter of the recently received notes with Dr Gentry. They also stated that no expert witnesses had examined the recently received bundle of notes.

466. Mr Wilson initially raised the possibility of the hearing adjourning for the day in order for the bundle of notes to be considered and received by the Tribunal and expert witnesses. He stated that parties might possibly reconsider their positions in light of any expert evidence that might be given after expert witnesses receive the said bundle.

467. Mr Wilson stated that until both the Tribunal and Dr Gentry has had an opportunity of going through these notes, the Tribunal cannot start the evidence of Mr L until he has had a chance of considering these notes and considering whether the said bundle of notes affects any opinion that he has made.

468. Mr Wilson stated that the most appropriate way of proceeding might be to '*pause for now*' so that he could discuss the newly received bundle of notes with Dr Gentry. He stated that it might be unfair for Dr Gentry to undergo further cross-examination until the issue the newly received notes be '*bottomed out*'.

469. However, after discussion with Dr Gentry, Mr Wilson subsequently stated that his client would prefer the hearing to continue rather than adjourn.

470. Mr Donoghue on behalf of the GMC stated that, whilst he agreed that everyone was keen to make progress in this case, that could not be done at the expense of '*things being done properly*' and '*for the sake of one half-day*' asked that the hearing adjourn until January.

The Relevant Legal Principles

471. The Tribunal had regard to Rule 29(2) of the Rules:

> *'(2) Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit.'*

472. The Tribunal also had regard to the principles to be applied arising out of the decisions in *General Medical Council v Adeogba* [2016] EWCA Civ 162, [2016] 1 WLR 3867 and *Sanusi v General Medical Council* [2019] EWCA Civ 1172; [2019] 1 WLR 6273.

The Tribunal's Decision

473. In reaching its decision, the Tribunal considered the impact to Dr Gentry of proceeding, and whether there would be any unfairness in doing so.

474. The Tribunal considered that new material had been received that was not yet in the hand of the Tribunal.

475. It noted that both parties had stated that new bundle of notes was going to be pertinent to at least one the allegations.

476. The Tribunal considered how to proceed in the fairest and most appropriate way.

477. The Tribunal concluded that a *'clean stop'* at this stage would help resolve the matter and allow the hearing to resume in January 2025 with any possible issue raised by the late receipt of the said bundle of notes having been resolved.

478. The Tribunal considered that it would be procedurally difficult for Dr Gentry to have to continue to give evidence until she was able to see these documents. It considered that it was possible that the hearing might have to possibly revisit matters were it to continue hearing witness evidence before it had examined the new evidence.

479. The Tribunal noted that it as in the public interest for the hearing to proceed in a reasonable time. However, it concluded that adjourning would only result in the loss of half a day and that to continue might result in further time lost were evidential issues to be revisited have having examined the new received bundle of notes.

480. The Tribunal acknowledged Dr Gentry's wish to continue but concluded that that there was a strong risk of a lengthier delay and of not reaching a clear picture were the hearing to proceed with witness evidence with a possible outstanding evidential issue.

481. Therefore, Tribunal was of the view that an adjournment would assist it in reaching the correct decision in relation to the Allegation.

482. Accordingly, the Tribunal determined to adjourn the hearing early on 20 December 2024 and to continue with witness evidence when it reconvened on 13 January 2025.

ANNEX C – 30/01/2025

Application for the admission of further evidence - Application on behalf of the GMC

483. On 16 January 2025, Mr Donoghue made an application for the admission of further evidence, namely an updated bundle of intrapartum notes containing medical notes pertaining to Patient A, two supplementary reports of Dr I dated 8 January 2025 and 17 January 2025 and a timeline of requests and responses for Patient A and Patient D's medical reports between the GMC and the West Hertfordshire NHS Trust (the Trust). This application was made under Rule 34(1) of the General Medical Council (GMC) (Fitness to Practise Rules) 2004 as amended ('the Rules'), which states:

> *"The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law."*

Submissions

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

484. Mr Donoghue submitted that the updated intrapartum notes are relevant as the content includes the medical notes of Patient A that were previously not available. Mr Donoghue submitted that it is unfortunate that these records were not provided earlier despite many requests by the GMC over a number of years. However, fairness requires that these records be submitted to ensure that the Tribunal can make the most informed decision possible.

485. Mr Donoghue further submitted that fairness requires these reports to be admitted in evidence as they will assist the Tribunal to reach a fair assessment of the care provided to patient A from a contemporaneous position. Mr Donoghue submitted that both elements of fairness and relevance are met as required under Rule 34. Mr Donoghue reminded the

Tribunal that Dr Gentry will have the opportunity to respond to these additional reports in her oral evidence, hence it would be advantageous to all if they are admitted.

486. Regarding Dr I's further report, Mr Donoghue submitted that should the Tribunal admit the intrapartum notes of Patient A then it will be necessary and relevant for the Tribunal to admit the supplementary statements of Dr I which give her response to and expert opinion on the medical notes received in respect of Patient A.

487. Regarding the timeline of the GMC's requests for records for Patients A and D and their relevance, Mr Donoghue reminded the Tribunal that the timeline was prepared by the GMC pursuant to the Tribunal's directions of the 20 December 2024. He submitted that this timeline shows the background of the correspondence between the GMC and the Trust and provides context for the Tribunal on the efforts made to obtain them. Mr Donoghue submitted that in fairness to Dr Gentry, the fact that the relevant medical records of Patient A have only just been provided at this late stage of the proceedings is relevant to her assertion that there are also medical notes in relation to Patient D that have not been produced and/or are missing.

488. Mr Donoghue submitted that the timeline provides the Tribunal with an understanding of why Patient A's records have only just become available at this late stage. Mr Donoghue submitted that the timeline also clarifies the confusion that arose between Patient A and another patient with similar initials, whose records were initially provided by the Trust in error.

489. Mr Donoghue was of the view that the late provision of Patient A's intrapartum notes was an exceptional situation. He submitted that the Tribunal may take the view that the notes bear no relevance to its assessment of Patient D, but he submitted that the notes are certainly relevant to Patient A. Mr Donoghue submitted that the Tribunal can only consider that issue when it has received the evidence of the timeline and the explanations it provides. He submitted that there is no unfairness by this timeline being admitted. He acknowledged that Dr Gentry does not accept some of the explanations from the Trust, but he submitted that that does not exclude the documents being admitted. Mr Donoghue stated that Dr Gentry can give evidence as part of her oral testimony on the issues she has with the explanations provided by the Trust.

On behalf of Dr Gentry

490. Mr Wilson submitted that, regarding the intrapartum notes, Dr Gentry accepts that the records are relevant to the contention that Patient A's foetus was lying transverse at the time of the insertion of the Prostin pessary. Mr Wilson accepted that the notes were made contemporaneously on the date in question. However, he submitted that the records are incomplete and had distorted the narrative.

491. Mr Wilson submitted that the intrapartum notes received did not contain any record of the notes that the attending midwife (Ms P) would have made when Dr Gentry carried out a scan and an ECV on Patient A. Neither did the notes contain any record of the partial success that Dr Gentry says she had when turning the foetus of Patient A from a transverse lie to an oblique lie.

492. Mr Wilson also informed the Tribunal that Dr Gentry is concerned not only by the lateness with which the intrapartum notes were adduced but also that it appears that they are incomplete. This is significant in relation to the critical 2 hours and 15 minutes from 15:15 to 17:30 during the events in question. These missing notes are records which would corroborate Dr Gentry's evidence.

493. Mr Wilson stated that the explanation given by the Trust and the GMC for the both the late receipt and the absence of significant parts of the intrapartum notes was unacceptable. He submitted that it would be highly unusual for any midwife who has care for a patient on a labour ward not to document what was going on for 2 hours and 15 minutes. He challenged both the late receipt and the missing parts and suggested that the Tribunal should view the same with caution.

494. Mr Wilson informed the Tribunal that fortunately, Dr Gentry was able to find a contemporaneous statement from Ms P dated 3 February 2017 in which she confirms that Dr Gentry did carry out an External Cephalic Version (ECV), that it was partially successful in that it turned the foetus from transverse lie to an oblique lie. Mr Wilson submitted that this occurred prior to the insertion of the Prostin. Dr Gentry does not object to the admission of the intrapartum notes, as received provided the statement of Ms P was admitted also, Mr Wilson submitted that, without the statement of Ms P, Dr Gentry would be put at a disadvantage and the Tribunal would not be properly informed as to the events as Dr Gentry says they occurred.

495. Turning to the timeline of the medical records, Mr Wilson submitted that Dr Gentry does not object to that being admitted into evidence. Firstly, because the timeline has been produced pursuant to a direction by the Tribunal. Secondly, because the repeated requests for the records by the GMC to the Trust will need to be taken into account when the Tribunal is considering the allegation.

496. Regarding the first supplementary report of Dr I dated 8 January 2025, Dr Gentry does not object to this report being admitted as further evidence for the same reason that she does not object to the intrapartum notes being admitted. As far as the second supplementary report of Dr I is concerned, Dr Gentry considers it would be relevant because Dr I would have the opportunity to consider the supplementary statements of Dr Gentry and the documents exhibited therein. She will also have the opportunity to review the evidence and her opinion on the position of the foetus at the time when the Prostin was inserted.

497. Mr Wilson reminded the Tribunal that both Dr I's supplementary reports come after the close of the GMC's case. However, Dr Gentry has no objection to the GMC relying on Dr I's first and further supplementary report.

Legal Advice

498. The Tribunal reminded itself of Rule 34(1) of the Rules which states that:

> *'34(1) The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'*

499. It also reminded itself of the relevant factors for consideration namely, the relevance of the material to the case and, the fairness of admitting or disallowing the evidence to both parties. It also reminded itself of questions for consideration in deciding whether or not to exclude evidence namely:

> a. Has a party failed to comply with a rule or direction pertaining to the evidence in question?
> b. Does the party have a reasonable excuse for that failing?
> c. Has the party deliberately sought to disrupt the proceedings by the manner or timing of the production of the evidence?
> d. What issue in the case does the evidence go to?

e. Will the other party be significantly disadvantaged or prevented from addressing the material issues raised by the evidence in question?

500. Finally it reminded itself that the admissibility of evidence is at the discretion of the Tribunal, and it should have regard to fairness and balance any prejudice to each party. The decision should also be considered through the lens of the overarching objective of the Tribunal. However, bearing in mind that excluding evidence is a draconian step which should only be taken where absolutely necessary.

Tribunal's Decision

501. The Tribunal had regard to Rule 34(1) of the Rules, as quoted above, and the submissions made by both parties

The Intrapartum notes

502. The Tribunal first considered whether these documents were relevant. It noted that both parties agreed that the notes were relevant in that they gave evidence of contentious issues regarding Patient A. The Tribunal concluded that the notes were made contemporaneously and addressed pertinent issues in the case.

503. Having regard to fairness, the Tribunal considered Dr Gentry's assertion that further crucial parts of the medical records of Patient A were missing. However, the Tribunal did not find any unequivocal evidence that such notes did exist. The Tribunal was careful not to stray into speculation. It noted that as there was evidence from other sources, the possible incompleteness of the notes did not prejudice determination of the facts and that the intrapartum notes as received, were admissible.

504. The Tribunal was satisfied that the GMC had made reasonable efforts to obtain all available notes. The Tribunal will give the appropriate weight to these notes when considering its findings of the allegation.

505. The Tribunal noted that had the 'missing' intrapartum notes been provided at the outset of the case, they would likely have been adduced as part of the GMC's case. It found that it was the timing of receipt of the notes and not the contents that made the application necessary.

506. The Tribunal finds that it is fair to both parties and in the interests of justice for the notes to be admitted in reaching an informed determination on the allegations. The Tribunal therefore admits the intrapartum notes into evidence.

Dr I's first supplementary report dated 8 January 2025

507. The Tribunal has considered whether Dr I's first supplementary report is relevant. As this report comments on the intrapartum notes received (and admitted into evidence) the Tribunal is satisfied that this report is relevant to this hearing as it assists the Tribunal with relevant expert option on the previously unseen intrapartum notes.

508. The Tribunal considered the fairness of admitting the supplementary report. The Tribunal found that the report gives both parties the opportunity to consider and address the expert opinion in full. The Tribunal considered that it would be unfair to admit the intrapartum notes into evidence but not the expert report that comments upon them. The Tribunal also noted that neither party objected to this report being admitted into evidence.

Dr I's second supplementary report dated 17 January 2025

509. As with Dr I's first supplementary report, the Tribunal found her second supplementary report to be relevant and fair for the same reasons.

510. The Tribunal has determined to admit both the first and second supplementary reports of Dr I into evidence.

The timeline

511. The Tribunal noted that Dr Gentry had stated that the Trust had failed to provide the complete intrapartum notes relating to Patient D. It reminded itself that it directed the GMC to produce this timeline in order to provide additional information to assist in its understanding of why the intrapartum notes were provided late.

512. The Tribunal found that the timeline provided, coupled with the late production of the intrapartum notes, was relevant in that it provided a better understanding of the conduct of the Trust in relation to medical record keeping and assisted the Tribunal in attaching appropriate weight to Dr Gentry's assertions about notes she said she made but have not been provided by the Trust.

513. The Tribunal considered that it is in the interest of justice and is fair to both parties, particularly to Dr Gentry, to allow the timeline to be admitted into evidence.

514. The timeline is admitted into evidence.

ANNEX D – 30/01/2025

Application for the admission of further evidence - Application on behalf of Dr Gentry

515. On 16 January 2025, Mr Wilson made an application for the admission of further evidence, namely two supplementary statements provided by Dr Gentry dated 9 January 2025 and 14 January 2025 together with exhibits, and a supplementary report provided by Mr L. Mr L's report was yet to be concluded at the time of the application; however, it was provided, and considered by the Tribunal before reaching the determination on the application. The application was made under Rule 34(1) of the General Medical Council (GMC) (Fitness to Practise Rules) 2004 as amended.

Submissions

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

516. Mr Wilson drew the Tribunal's attention to the fact that Dr Gentry had only just been provided with the intrapartum notes of Patient A for the first time in the eight years since the incident. He submitted that the notes were important and relevant and should have been produced by the GMC at the onset of the proceedings. Mr Wilson submitted that the notes are a contemporaneous record of the allegation said to have occurred on 25 January 2017 hence it is fair that Dr Gentry be allowed to make a further statement in response.

517. Mr Wilson submitted that in the first supplementary statement, Dr Gentry seeks to fill in the gaps that are missing from the intrapartum notes as disclosed. The statement seeks to put the sequence of the events that occurred on 25 January 2017 in the chronological order from Dr Gentry's perspective.

518. Regarding the second supplementary witness statement, Mr Wilson informed the Tribunal that following receipt of the intrapartum notes and upon further reflection, Dr

Gentry remembered that in the past she had come across a statement from the Midwife; Ms P on duty on 25 January 2017, which corroborated the steps and actions she maintains she took in treating Patient A. Dr Gentry recently found Ms P's statement in her email archives and wishes to put the same before the Tribunal. Mr Wilson submitted that it is fair that Dr Gentry be allowed to adduce the statement and covering email which confirms the authenticity of the statement and puts into context as to how she retrieved it. Mr Wilson submitted that the statement of Ms P is a relevant and crucial document that the Tribunal ought to attribute the greatest possible weight to. Mr Wilson submitted that the Tribunal should note that the statement was not made for or on behalf of Dr Gentry, but it was made for and to assist the investigation carried out by the Trust. He further submitted that the statement addresses the crucial issue of the position of Patient A's foetus at the time Dr Gentry inserted the Prostin. Therefore, the statement of Ms P ought to carry significant weight and ought to be admitted.

519. Regarding the treatment of Patient D, Mr Wilson stated that the GMC asserts that Dr Gentry did not make any notes because the Trust has not been able to produce them. However, Dr Gentry is adamant that she did make notes. Mr Wilson submitted that one of the issues the Tribunal will have to consider and be satisfied about is whether Dr Gentry made notes concerning her treatment of Patient D. Mr Wilson submitted that, up until the late service of the intrapartum notes of Patient A, the Tribunal was made to believe that all existing medical notes had been provided by the Trust. He submitted that the Tribunal now knows as a fact, that this position is not correct at least as far as Patient A is concerned. Therefore, reasonable inference should be drawn with regards the medical notes of Patient D. In this regard, the Tribunal needs to take into account the second supplementary witness statement and the exhibits attached to it to draw a logical conclusion.

520. Regarding the further report by Mr L, Mr Wilson submitted in retrospect, that it is relevant because Mr L's role is to assist the Tribunal in terms of the medical issues which arose and to assist the Tribunal in commenting on such records as have been disclosed. Mr Wilson submitted that firstly it would be relevant for Mr L to express a view on the updated intrapartum notes and, secondly, it would be fair for Mr L to consider and comment on what Dr Gentry says in her first and second supplementary statements.

521. It was submitted that the Tribunal would benefit from receiving Mr L's expert opinion on the intrapartum notes as a whole and any specific comment on the absence of any notes from Ms P between 15.15 and 17.30 on 25 January 2025 as noted in the intrapartum notes. Mr Wilson submitted that Mr L would also provide his opinion on the late service of the

intrapartum notes. It therefore, would be fair to allow the report to be adduced. Mr Wilson concluded that, in principle, the supplementary report of Mr L ought to be admitted into evidence.

On behalf of GMC

522. Mr Donoghue submitted that there was no dispute on the relevance of both supplementary statements of Dr Gentry. He stated that the GMC is satisfied that the statements are relevant as they deal with the intrapartum notes and supplementary report of Dr I.

523. Mr Donoghue submitted the GMC does not oppose the Tribunal from receiving the exhibited statement of Ms P given its relevance to Patient A.

524. Mr Donoghue submitted that the timeline of the provision of Ms P's exhibited statement is unfortunate but there is clearly a link between the statement and the intrapartum notes. Mr Donoghue submitted that this statement amounts to hearsay but, given the circumstances in which the provision of the intrapartum notes had arisen, the GMC adopts a fair approach in not opposing the admittance of this evidence.

525. Mr Donoghue drew the Tribunal's attention to the fact that Dr Gentry in her second supplementary statement, adopted parts of the midwife's statement and rejected others. He submitted that, the GMC's position is that by putting forward the midwife's statement, Dr Gentry is putting it forward as a document of truth and therefore she should not be allowed to cherry-pick from the statement. He submitted that if the Tribunal accepts Dr Gentry's second supplementary statement together with the exhibited statement of the Ms P, the midwife's statement should be admitted and accepted in its entirety.

526. Mr Donoghue submitted that the GMC cannot finalise a position regarding Mr L's supplementary statement without having sight of it. However, in principle it is unlikely that there will be opposition to it being adduced.

Legal Advice

527. The Tribunal adopted the same legal advice given in Annex C. In addition, the Tribunal reminded itself that hearsay evidence is defined in the civil procedural rules as "*a statement made, otherwise than by a person while giving oral evidence in proceedings, which is tendered*

as evidence of the matters stated'. Hearsay can arise when an attending witness recalls or puts before the Tribunal, an account given to them by a third party. Hearsay evidence is admissible in these proceedings, but the Tribunal must consider the weight, if any, to assign such evidence.

Tribunal's Decision

528. The Tribunal had regard to Rule 34(1) of the Rules and the submissions made by both parties

Dr Gentry's first supplementary statement dated 9 January 2025 and exhibits (extract of intrapartum notes)

529. The Tribunal considered that Dr Gentry's first supplementary statement is relevant as it comments on the intrapartum notes provided and speaks to the allegations made by the GMC in respect of Patient A. The Tribunal considered that the page from the intrapartum notes exhibited by Dr Gentry gives further and specific context to the allegation involving Patient A.

530. The Tribunal considered it fair that Dr Gentry be allowed to comment on the intrapartum notes and for the GMC to be able to cross-examine her on the first supplementary statement during her oral evidence.

531. The Tribunal has determined that Dr Gentry's first supplementary statement and the document exhibited are relevant and the admittance of same is fair to both parties. The Tribunal admits Dr Gentry's first supplementary statement together with the exhibit into evidence.

Dr Gentry's second supplementary statement dated 14 January 2025 and exhibits (email between the Trust and Dr Gentry and the statement of Ms P)

532. The Tribunal is satisfied that the second supplementary statement of Dr Gentry is relevant as it further addresses the intrapartum notes, exhibits the statement of Ms P and responds to the second supplementary report of Dr I.

533. The Tribunal considers that the exhibited statement of Ms P is relevant and sheds light on matters where the intrapartum notes are silent. It was contemporaneously made and

helps to provide further information that will assist the Tribunal when considering some of the allegations put forward by the GMC.

534. The Tribunal accepts that the statement of Ms P is an exhibit but determines that its contents amount to hearsay evidence. The Tribunal accepts the statement in its entirety and concluded that the appropriate weight, if any, will be given to it when the Tribunal considers its findings on facts.

535. The Tribunal concluded that it is fair to admit Dr Gentry's second supplementary statement and exhibits into evidence.

Mr L's supplementary report dated 15 January 2025

536. On 17 January 2025, the Tribunal received the supplementary report of Mr L dated 15 January 2025. The Tribunal considers that the report is relevant as it addresses points in the allegation which were not addressed before the receipt of the intrapartum notes. It also gives the Tribunal insight into his expert opinion on the content of the notes, Dr Gentry's supplemental statements and the exhibits she produces.

537. The Tribunal determine that it is fair to admit the report as it gives both parties the opportunity to consider and address the expert opinions in full.

538. The Tribunal determined that Mr L's supplementary report is admitted into evidence.

ANNEX E – 11/08/2025

Application to adjourn proceedings - XXX

539. On 11 August 2025, Dr Gentry made an application to adjourn the hearing under Rule 29(2) of the Rules, which states:

> *"Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit."*

540. The Tribunal noting that the application concerned issues, in most part relating to XXX, decided of its own volition under Rule 41(2) to hear the whole of the application in private.

> *(2) The Committee or Medial Practitioners Tribunal may determine that the public shall be excluded from the proceedings or any part of the proceedings, where they consider that the particular circumstances of the case outweigh the public interest in holding the hearing in public.*

541. Both Dr Gentry and the GMC were in agreement with the Tribunal's decision.

Submissions

Dr Gentry

542. Dr Gentry, following clarification from the chair regarding the adjournment application process, submitted that proceedings be adjourned until the next scheduled listing in December 2025. She added that she had submitted a written application detailing her request for an adjournment to the MPTS case management team.

543. Dr Gentry cited the unexpected prolonged and multiple listings of the case to date meant that she had run out of funding and lost her legal representation. She also has had to XXX.

544. XXX

545. Dr Gentry submitted that she is unable to represent herself and requires time to seek support and alternative legal representation to properly participate in the hearing. XXX.

On Behalf of the GMC

546. Ms Bucklow, Counsel submitted that the GMC was neutral on application for an adjournment.

The Tribunal's Decision

547. The Tribunal had regard to the submissions from the parties and to their current positions. The Tribunal received legal advice from the LQC which referred to Rule 29(2) of the Rules as well as the guidance in the cases of *R v Jones [2003] 1AC1 GMC V Adeogba (2016) EWCA Civ 162, (2016) 1WLR 3867 and GMC v Hayat [2018] EWCA Civ 279.*

548. The Tribunal was aware that if this hearing had not concluded by 15 August 2025, it was due to reconvene from 15 December 2025 until 19 December 2025.

549. The Tribunal considered Dr Gentry's participation in the hearing thus far and noted her desire to continue to participate in this hearing.

550. The Tribunal also had regard to Dr Gentry's written and oral submissions regarding XXX:

- XXX;
- Correspondence between the GMC and Dr Gentry's legal representation;
- Various correspondence between the GMC and Dr Gentry regarding her application for an adjournment of this listing of the hearing.

551. The Tribunal considered that Dr Gentry said she would have been able to proceed if she had sufficient legal representation as this would have XXX, but as she did not have legal representation, Dr Gentry said she was unable to properly participate in the hearing process.

552. Bearing in mind the guidance from the case law cited in the legal advice, the Tribunal acknowledged that this case involved serious concerns which needed to be dealt with expediently. It also considered if proceedings could progress in the event of Dr Gentry's absence in the light of the uncertainty around XXX.

553. The Tribunal had regard to Dr Gentry's willingness to participate in the proceedings and the reasons for her inability to do so at this stage. It also had regard to the challenges of proceeding with the case in her absence.

554. The Tribunal determined that the interests of justice and fairness to Dr Gentry outweighed the public interest of not granting Dr Gentry's application for an adjournment. The Tribunal determined that the adjournment would allow sufficient time for Dr Gentry to

find alternative legal representation, attend to XXX and participate in the remainder of the proceedings.

17 In the light of all the above, the Tribunal adjourned this case until 15 December 2025.

XXX Schedule 1 – Testimony to Coroner

1. '*She said she wanted to go home, I said why, she said she had been here for 3 days and there was no prospect and I may not be saying in exact words what she said';*

2. *'And that she wanted to go home to see if she could go into labour herself because she did not want to stay in hospital anymore'*;

3. *'I said to her that I understand that the registrar had offered you a c-section and you declined. She told me that she was not keen to have a c-section, not in those words but that she did not want to have a c-section she wanted to have a natural birth'*;

4. *'I explained to her that having the c-section was better in the sense that because the labour ward was so full so would have had her delivery, if she wanted to have a c- section, today';*

5. *'instead of going home and waiting because you don't know how long you are going to wait for, she said no she wanted to go home';*

6. when asked if your evidence is that:
    a. you offered her a c-section that could be performed that day, your response was '*yeah*';
    b. she said that she did not want it, your response was*'yeah'*

7. '*I explained to her that it was better for her to stay although she said that babies movement were normal and that she never had any problems with the movements from the time she came to triage at 38+5, that was when she came… she didn't tell me 38+6 sorry but she said when she came for reduced movements and at that time she was 38+6'*;

8. *'And even though I was telling her that that was not the right thing and it was much more easier for her and better if stayed because she would have the c-section that day because she would be classified then as an emergency because of the failed induction, that was before I examined her and she was just wanting to go home';*

9. *'Yes, so what I said to her is if you must go home against my advice she should do, and before then I said to her because of the cervix condition, the condition of her cervix she was most likely to go into labour within the next 24 to 48 hours and that if she started contracting again please she should back to triage. And I said if the baby's movements become a concern again to come straight back. I told her these things to come back and to attend the triage also if her waters went and then to come to Maternity Day Assessment unit alternate days and then if she did not deliver by Tuesday, which was my clinic at Hemel, that she should just come to the clinic and I will make sure that she delivered that day or the following day. She didn't have to have an appointment to come she can just come to the clinic.'*;

10. *'After the discussion with* [Patient D] *and she was determined to go home I then went to look for her notes I could not find her medical notes and I took the sheet of paper then to write';*

11. *'What I can say is that I do not recollect* [Patient D] *saying to me in any way at all that she wanted to have a c-section';*

12. '*You can add extra notes, continuation sheets for different reasons, for example when I came to see her I could not find the notes and I had other clinical commitments so I had no option but to start writing on a sheet of paper, I mean it is a common practise if and especially if people are busy and somebody has the notes and be writing you can write your own separately and just add it. The most important thing is to make sure that it is added*';

13. on 29 September 2017, you saw Patient D after she had delivered Baby E, and said *'So when I went there and saw it was [Patient D], Oh God I felt really horrible for her because the baby was in a bad condition, so I went to see her. My recollection was once that [Patient D] saw me she broke down crying and she did that and I went to hug her and then she was really crying and I had tears in my eyes as well because I felt…I felt for her, so I then told her I was going to see [Baby E] before I left she said to me "Miss Gentry you won't believe I came back 3 times" that is what I thought I heard …"I came back 3 times after I went home, the first time they sent me back home, I came back a second time and they sent me back again….",*

14. *That is what I believe she told me. So after that I went to see [Baby E] and then*

came back to Patient D to talk to console, to talk to her and that was when I told her the plan, there were planning to send.. I don't know what she knew before then, they were planning on sending [Baby E] to Luton and if she could give me her telephone number because they would be moving her as well so that I would see how things were going. She did give me her telephone number but I can't remember if I called her, you know, after she left. So what I have written there is based on my discussion with her because I didn't think she did not have any reason to tell me that if it did not happen..'

or words to that effect.