MPTS Medical Practitioners Tribunal Service

PUBLIC RECORD

Dates: 21/10/2024 - 08/11/2024
05/12/2024
24/03/2025 - 04/04/2025
07/05/2025
15/05/2025
19/05/2025 - 23/05/2025

Medical Practitioner's name:	Mr Karl HATTOTUWA
GMC reference number:	4131274
Primary medical qualification:	MB BS 1982 University of Colombo

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

Summary of outcome
No warning

Tribunal:

Legally Qualified Chair	Mr Christopher Harper
Lay Tribunal Member:	Mr Vince Cullen
Medical Tribunal Member:	Dr Julius Parker

Tribunal Clerk:	Mr Laurence Millea Mr Francis Ekengwu 21/10/2024 Ms Hinna Safdar 28/10/2024

Attendance and Representation:

Medical Practitioner:	Present, not represented
GMC Representative:	Mr Ian Brook, 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 - 07/05/2025

Background

1. Mr Hattotuwa qualified in 1982 University of Colombo, Sri Lanka. At the time of the events Mr Hattotuwa was practising as a Consultant Obstetrician & Gynaecologist at Bedford Hospital, where he practised since September 2012. He also had practising privileges at the Manor Private Hospital.

2. The allegation that has led to Mr Hattotuwa's hearing can be summarised that, between 12 May 2014 and 4 February 2021, Mr Hattotuwa failed to provide adequate clinical care to 14 patients. It is alleged that Mr Hattotuwa's failings related variously to supervision, record keeping, advice, informed consent, seeking advice from colleagues, treatment and communication. It is further alleged that in 2018, Mr Hattotuwa was dishonest when completing a funding request form for a procedure.

3. The initial concerns were raised with the GMC on 17 January 2019 by Patient H.

The Outcome of Applications Made during the Facts Stage

4. The Tribunal granted Mr Hattotuwa's application, made pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to admit evidence in the form of an expert witness report by Mr X. The Tribunal's full decision on the application is included at Annex A.

5. The Tribunal granted an application made on behalf of the GMC, pursuant to Rule 17(6) of the Rules to amend the Allegation. The Tribunal's full decision on the application is included at Annex B.

The Allegation and the Doctor's Response

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

Patient A

1. On 12 May 2014 you directly supervised Dr B in carrying out a right salpingectomy procedure and:

a. despite a pre-operative ultrasound scan having shown an ectopic pregnancy in Patient A's right fallopian tube ('the Right Tube'), you failed to:

i. discontinue the procedure prior to the removal of Patient A's left fallopian tube ('the Left Tube') so that an ultrasound scan could be arranged to confirm the side of the ectopic pregnancy; **Admitted and found proved.**

ii. arrange a post-operative repeat scan, to evaluate the Right Tube; **To be determined.**

b. you failed to maintain adequate clinical records, in that you did not record the justification for removal of the Left Tube; **To be determined.**

c. (in the alternative to paragraph 1b) you failed to ensure that Dr B made adequate clinical records, including the justification for removal of the Left Tube. **To be determined.**

Patient C

2. On 27 October 2014 you performed a diagnostic laparoscopy on Patient C and failed to maintain adequate clinical records, in that within the operating record, you:

a. recorded the words 'green top entry', but did not explain what this meant; To be determined.

b. did not record:

i. how the abdomen was entered, insufflated and laparoscoped; To be determined.

ii. the size or placement of the laparoscope; To be determined.

iii. the size, number or placement of additional ports; To be determined.

iv. closure of the skin. To be determined.

3. On 13 November 2014 during a post laparoscopic consultation with Patient C, you failed to:

a. adequately advise Patient C about:

i. the risk of:

1. further surgery; To be determined.

2. injury to other organs; To be determined.

3. the possible failure to treat Patient C's presenting symptoms; To be determined.

ii. alternative treatments; To be determined.

b. (in the alternative to paragraph 3a) maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 3a. To be determined.

4. On 27 January 2015 you performed a laparotomy on Patient C ('Patient C's Laparotomy'), and you failed to:

a. adequately obtain consent, in that you did not discuss with Patient C:

i. the reasons for Patient C's Laparotomy; To be determined.

ii. specific risks relating to:

1. the bowels, bladder, ureters and blood vessels; To be determined.

2. thrombosis; Admitted and found proved.

3. return to theatre; To be determined.

4. the failure to cure Patient C's pelvic pain; To be determined.

iii. the possible need for:

1. another procedure to repair any damage; To be determined.

2. blood transfusions; To be determined.

b. (in the alternative to paragraph 4a) maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 4a; To be determined.

c. respond adequately to post operative complications, in that following Patient C's blood loss, you did not:

i. seek advice or guidance from the anaesthetist with whom you had just completed Patient C's Laparotomy; To be determined.

ii. institute the hospital's major haemorrhage protocol; To be determined.

iii. either:

1. arrange for Patient C to be transferred in an ambulance with paramedic facilities; or To be determined.

2. accompany Patient C in the ambulance; To be determined.

iv. adequately consider concerns raised by the ambulance staff that they were not paramedics; To be determined.

v. arrange for Patient C to be directly transferred to the Emergency Department at Bedford Hospital, rather than the ward; To be determined.

d. maintain adequate clinical records, in that within the operating record you did not record:

i. the date of Patient C's Laparotomy; To be determined.

ii. the dose and route of post operative local anaesthetic; To be determined.

iii. the approach to closure of the skin; To be determined.

iv. any description of estimated blood loss. To be determined.

Patient D

5. On 10 March 2015 you performed a myomectomy procedure on Patient D and you failed to maintain adequate clinical records, in that, within the consent form, you did not record:

a. adequate detail in relation to the intended benefits; To be determined.

b. the risk of:

i. injury to the bowel, bladder and ureters; To be determined.

ii. return to theatre. To be determined.

6. On 17 March 2015, you performed a re-suturing of wound procedure on Patient D and you failed to maintain adequate clinical records, in that within the consent form, you did not record the risk of:

a. thrombosis from the anaesthetic; To be determined.

b. return to theatre. To be determined.

Patient E

7. On 16 February 2016 you inappropriately performed an elective total abdominal hysterectomy and bilateral salpingo-oophorectomy procedure on Patient E:

   a. despite knowing the laparoscopy findings of bilateral tubo ovarian abscesses ('the Abcesses'); To be determined.

   b. when you should only have drained the Abcesses and not completed the hysterectomy; To be determined.

   c. at a private hospital, which you knew lacked sufficient facilities and/or resources for the likely complexity and difficulty of the procedure. To be determined.

Patient F

8. On 14 December 2016 you carried out a right salpingo-oophorectomy procedure on Patient F and you failed to:

   a. convert the procedure to an open laparotomy, to allow removal of the left ovary; To be determined.

   b. call one or more colorectal surgeons to assist in the dissection; To be determined.

   c. maintain adequate clinical records, in that in the operating sheet, you did not record:

      i. your reasons for placing a drain; To be determined.

      ii. that:

         1. the operation had been difficult; To be determined.

         2. there was the potential for complications to arise post operatively; To be determined.

d. (in the alternative to paragraph 8c) ensure adequate clinical records had been made by the junior doctor in attendance, in your role as clinical supervisor. To be determined.

Patient G

9. On 30 July 2018 you performed a hysteroscopy and polypectomy procedure on Patient G and you:

a. inappropriately removed part of Patient G's small-bowel; To be determined.

b. failed to recognise during the procedure that you had:

i. perforated Patient G's uterus; To be determined.

ii. removed part of Patient G's small bowel; Admitted and found proved

c. failed to adequately respond to intra-operative complications, in that despite a significant uterine perforation you did not:

i. stop the procedure; To be determined.

ii. perform a diagnostic laparoscopy to investigate further. To be determined.

Patient H

10. On 28 September 2018 you consulted with Patient H in relation to mixed urinary incontinence, and you failed to:

a. discuss options for treatment other than surgery, including alterations to Patient H's lifestyle; To be determined.

b. discuss alternative treatment options if surgery was required, including abdominal sacrocolpopexy; To be determined.

c. arrange appropriate investigations of Patient H's symptoms by way of:

i. bladder diary; To be determined.

ii. preoperative urodynamics; To be determined.

d. (in the alternative to paragraph 10a-10b) maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 10a-10b. To be determined.

11. On 19 November 2018, you carried out a vaginal hysterectomy on Patient H and you failed to:

a. obtain informed consent from Patient H, in that you did not adequately discuss:

i. the intended benefits of the procedure; To be determined.

ii. the risk of:

1. injury to bowel, bladder and ureters; To be determined.

2. return to theatre; To be determined.

3. failure to achieve goals; To be determined.

4. recurrence of the prolapse; To be determined.

5. alteration to sexual function; To be determined.

b. (in the alternative to paragraph 11a) maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 11a;

c. record, within the operative note for the procedure:

i. ~~the scarring from previous fenton's procedures~~; Deleted under Rule 17(6)

ii. ~~the use of bladder buttress sutures~~; Deleted under Rule 17(6)

iii. the type of suture used; To be determined.

iv. clear post-operative instructions in relation to pack and catheter retention and removal. To be determined.

12. On or around 23 November 2018 you consulted with Patient H and failed to maintain adequate clinical records, in that you did not record the consultation. To be determined.

Patient I

13. On 5 October 2018 you consulted with Patient I in relation to a total abdominal hysterectomy and bilateral salpingo oophorectomy procedure and you:

    a. failed to obtain informed consent, in that you did not discuss:

        i. the intended benefits of the procedure; To be determined.

        ii. the risks of:

            1. injury to bowel, bladder, blood vessels and ureters; To be determined.

            2. return to theatre; To be determined.

        iii. that a blood transfusion may be required; To be determined.

        iv. the type of any other procedure that may be required; To be determined.

    b. (in the alternative to paragraph 13a) failed to maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 13a; To be determined.

    c. falsely stated within an individual funding request general form for the procedure ('the Funding Form') that Patient I had previously had a Mirena IUS and GnRH treatment. To be determined.

14. You knew when completing the Funding Form that Patient I had not previously had:

        i. a Mirena IUS; To be determined.

        ii. GnRH treatment. To be determined.

15. Your actions as described at paragraph 13c were dishonest by reason of paragraph 14. To be determined.

16. On or around 14 December 2018, following Patient I's CT scans on 23 November 2018 and 13 December 2018, you:

    a. inappropriately advised that Patient I's catheter could be removed despite the CT Scan of 13 December 2018 demonstrating an ongoing injury to the bladder; To be determined.

    b. failed to put in place further review by way of:

        i. ongoing catheterisation for a further four weeks; To be determined.

        ii. a repeat CT urogram; To be determined.

        iii. review in clinic. To be determined.

Patient J

17. On 28 November 2018 you performed an outpatient hysteroscopy and biopsy on Patient J and you failed to adequately heed to Patient J's request to stop the procedure due to the level of pain she was experiencing. To be determined.

Patient K

18. On 2 January 2019 you carried out a laparoscopic ovarian cystectomy procedure on Patient K and:

    a. you inappropriately completely transected the sigmoid colon; To be determined.

    b. after recognising that you had caused an intraoperative bowel injury:

        i. you inappropriately carried out a laparotomy by way of pfannenstiel incision instead of by way of midline approach; To be determined.

ii. (in the alternative to paragraph 18bi) you failed to wait for a surgeon to attend before conversion to the laparotomy; To be determined.

c. you failed to recognise that you had completely transected the sigmoid colon; To be determined.

d. you failed to maintain adequate intra-operative records, in that within the operative record you did not record:

i. any detail:

1. as to how the injury to Patient K's sigmoid colon and bladder occurred; To be determined.

2. about your laparoscopic entry to the abdomen; To be determined.

ii. any information about the:

1. type of laparotomy you undertook; To be determined.

2. site and size of the bladder injury; To be determined.

3. the bladder injury's relationship to the urethra or ureteric orifices. To be determined.

Patient L

19. On 13 June 2019 you carried out:

a. a pfannenstiel laparotomy procedure on Patient L and you failed to:

i. perform the procedure adequately because you:

1. perforated the bowel by way of a one centimetre complete enterotomy; To be determined.

2. contused the bowel; To be determined.

3. tore a hole in the sigmoid mesentery; To be determined.

4. did not identify the injuries to Patient L's sigmoid and proceeded to close Patient L's abdomen; To be determined.

ii. maintain adequate clinical records, in that within the operative record, you did not record:

1. any information on sutures used to close Patient L's vagina, rectus sheath or skin; To be determined.

2. a description of the volume and concentration of local anaesthetic applied to the skin; To be determined.

3. why Patient L's left ovary had been removed; To be determined.

b. a secondary laparotomy on Patient L, and you failed to maintain adequate clinical records, in that within the operative record, you wrongly assigned bleeding points to the right and left. To be determined.

Patient M

20. On or around 6 January 2020 you reviewed a biopsy report dated 27 December 2019 in respect of Patient M ('the Biopsy Report'), and you failed to check the relevant colposcopy opinion and cytology result. To be determined.

21. On or around 27 July 2020 you investigated and concluded a Datix report into the management of Patient M's care following the Biopsy Report ('the Datix Report'):

a. which was inappropriate due to your involvement in Patient M's care on or around 6 January 2020; To be determined.

b. and you failed to communicate the outcome of the Datix Report to Dr N. To be determined.

Patient O

22. On 11 September 2020 you consulted with Patient O following the still birth of her daughter, and you failed to:

    a. prepare adequately for the meeting; To be determined.

    b. adequately communicate with Patient O, in that on one or more occasion, you said to Patient O:

        i. that her papers had ended up on your desk; To be determined.

        ii. "I've never met you before, what do you want to know?";

    or words to to that effect. To be determined.

Patient P

23. On 4 February 2021 you consulted with Patient P following an ultrasound scan, and you failed to:

    a. recommend further assessment by cardiotocograph; To be determined.

    b. reassess Patient P for induction of labour; To be determined.

    c. either:

        i. offer Patient P induction of labour within 24 hours; or To be determined.

        ii. discuss Patient P's case with a colleague who had a special interest in management of twin pregnancies, or with a fetal medicine consultant. To be determined.

The Admitted Facts

6. At the outset of these proceedings, Mr Hattotuwa 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

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

- Patient J, in person, who also provided a written witness statement dated 19 April;
- Patient C, in person, who also provided a written witness statement dated 16 June 2020 and supplemental statement dated 22 May 2024;
- Dr N, Obstetrics and Gynaecology Consultant and Oncology Lead at Bedford Hospital, in person, who also provided a written witness statement dated 6 May 2024;
- Patient O, in person, who also provided a written witness statement dated 30 April 2024;
- Ms R, matron on call at Bedford Hospital at the time of events, in person, who also provided a written witness statement dated 24 April 2024
- Ms S, Patient O's community midwife, in person, who also provided a written witness statement dated 7 May 2024;
- Patient H, in person, who also provided a written witness statement dated 23 February 2020 and supplemental statement dated 15 May 2024;
- Patient I, in person, who also provided a written witness statement dated 21 May 2020 and supplemental statement dated 21 May 2024;

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

- Patient E, who provided a written witness statement dated 4 May 2020;
- Patient J's husband, who provided a written witness statement dated 26 April 2024;

9. Mr Hattotuwa did not provide a written witness statement but did provide a Rule 7 response letter, undated, and also gave oral evidence at the hearing.

10. The Tribunal received evidence from the following witnesses on Mr Hattotuwa's behalf:

- Mr T, in person, who also provided written supervisor's reports dated 2 September 2021 and 17 March 2022.

11. Both Mr U and Mr Hattotuwa provided the Tribunal with written submissions in respect of the facts stage.

Expert Witness Evidence

12. The Tribunal also received evidence from three expert witnesses.

13. Mr V was called on behalf of the GMC and provided an expert report dated 11 August 2021, and two supplementary expert reports dated 17 August 2022 and 30 August 2022. Mr V also gave oral evidence at the hearing in person (via Microsoft teams). Mr V's specialist field is Gynaecology and Gynaecological Oncology.

14. Dr W was called on behalf of the GMC and provided an expert report dated 30 August 2022. Dr W also gave oral evidence at the hearing in person (via Microsoft teams). Dr W is a Consultant in Obstetrics and Gynaecology and her evidence was directed at assisting the Tribunal in understanding the care provided by Mr Hattotuwa to Patient P.

15. Mr X prepared an expert report for the GMC dated 10 September 2020, which was submitted to the Tribunal following an application by Mr Hattotuwa (see Annex A). Mr X did not give oral evidence at the hearing. Mr X is a Consultant in Obstetrics and Gynaecology and his report was prepared at an earlier stage of these proceedings.

Documentary Evidence

16. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to: Patient medical records; various correspondence in relation to patients; NICE Guideline (NG123) – Urinary incontinence and pelvic organ prolapse in women: management; timeline of events; appraisal and supervisor reports for Mr Hattotuwa; colleague and patient feedback for Mr Hattotuwa.

The Tribunal's Approach

17. 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. Mr Hattotuwa 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.

18. In relation to the allegations of dishonesty, the Tribunal had regard to the guidance in the case of *Ivey v Genting Casinos (UK) Limited [2017] UKSC 67:*

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

The Tribunal's Analysis of the Evidence and Findings

19. 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.

Patient A

1. On 12 May 2014 you directly supervised Dr B in carrying out a right salpingectomy procedure and:

a. despite a pre-operative ultrasound scan having shown an ectopic pregnancy in Patient A's right fallopian tube ('the Right Tube'), you failed to:

i. discontinue the procedure prior to the removal of Patient A's left fallopian tube ('the Left Tube') so that an ultrasound scan could be arranged to confirm the side of the ectopic pregnancy;

20. The Tribunal noted that Mr Hattotuwa admitted this sub-paragraph of the Allegation and said that he removed the Left Tube, having commenced the procedure and observed the ectopic pregnancy in the Left Tube rather than the Right Tube.

21. Accordingly, it found this paragraph of the Allegation admitted and found proved.

ii. arrange a post-operative repeat scan, to evaluate the Right Tube;

22. The Tribunal considered the account of Mr Hattotuwa in respect of this paragraph. He stated that immediately following the procedure he had spoken face to face with a Consultant, Miss Y, who was the Lead for the Early Pregnancy Assessment Unit. He had informed her of his findings and asked her to review the scan, with the expectation that she would see if there was an error in reporting with a "left/right" confusion. Miss Y had then arranged a repeat scan, which occurred on 13 May 2014, the following day. Mr Hattotuwa submitted that this allegation had been put forward without the knowledge or experience as to how "the Medical Fraternity communicate and work".

23. In his expert report, Mr V stated that he would have expected Mr Hattotuwa to put in place a further ultrasound scan (when he did the post-operative review the following morning) to evaluate the remaining tube.

24. During his oral evidence, it was put to Mr V that Mr Hattotuwa had discussed the situation with Miss Y, who had arranged a further scan. However, he maintained his opinion that Mr Hattotuwa was responsible for arranging the further scan and stated that the post-operative note did not suggest that Mr Hattotuwa had made any such follow-up arrangements.

25. The Tribunal noted that the further ultrasound scan had occurred the following day and the results were documented by Miss Y.

26. Whilst there was no supporting documentary evidence that Mr Hattotuwa had discussed the matter with Miss Y, it found no reason not to accept his account that such a conversation had occurred.

27. Whilst Mr Hattotuwa had not booked or carried out the post-operative repeat scan himself, the Tribunal was satisfied that he had liaised with Miss Y as part of his follow-up and requested her to review the original scan, relying on her expertise to decide the correct course of action. It noted that Mr Hattotuwa made no reference to a further scan in his notes on 13 May 2014, but concluded that did not undermine his account of a conversation as a result of which another professional took responsibility for that aspect of care.

28. The Tribunal was of the opinion that follow-up on the part of Mr Hattotuwa resulted in a further scan, and that the GMC had not sufficiently proved that his actions amounted to a "failure" in this respect.

29. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

b. you failed to maintain adequate clinical records, in that you did not record the justification for removal of the Left Tube; To be determined.

30. The Tribunal noted that there was no allegation in respect of the correctness of Mr Hattotuwa's decision to remove the Left Tube, but that it was alleged that the justification for that decision had not been adequately recorded.

31. Mr Hattotuwa denied this allegation on the basis that he did not write the records, which were written by a Senior Registrar who was a senior trainee and had undergone his "Intermediate Training" such that they would have been considered competent. Mr Hattotuwa accepted that he was therefore "relaxed and did not go over the documentation with a fine tooth comb." In his oral evidence Mr Hattotuwa accepted that more detail should probably have been recorded. He also gave evidence of a team discussion which he accepted should have been documented.

32. The submission made on behalf of the GMC was that the documentation made it insufficiently clear why the decision to remove the other tube was taken and did not describe the justification for the removal of the left tube when the ultrasound had shown an ectopic pregnancy in the right. The opinion of Mr V was that this decision was not adequately justified in the operative record which stated "left ruptured ectopic" but included no comments regarding the rationale for removing the left tube given the discrepancy with the ultrasound scan which showed this to be on the right.

33. In reaching its decision, the Tribunal noted that Mr V's expert report stated that "the procedure by the ST5 was adequately carried out on the wrong tube". It appears that Mr V had reported on the basis that it was his understanding that the left tube had been removed in error. The Tribunal noted that was not the state of the evidence by the time of the hearing, nor reflected in the Allegation. He also asserted that Patient A had been left infertile as a result. This was incorrect as Patient A went on to conceive and deliver a child.

34. The Tribunal concluded that although limited, the inclusion of "left ruptured ectopic" was the justification for the decision, in limited terms, and was the explanation given to Patient A the following day.

35. The Tribunal did not receive evidence as to what further detail was required and why. It found that whilst more information may have been preferable, this did not amount to a failure to "record the justification for removal of the Left Tube".

36. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

c. (in the alternative to paragraph 1b) you failed to ensure that Dr B made adequate clinical records, including the justification for removal of the Left Tube. To be determined.

37. Having determined that a justification for removal of the Left Tube was included on the operative note, the Tribunal found this paragraph of the Allegation not proved.

Patient C

2. On 27 October 2014 you performed a diagnostic laparoscopy on Patient C and failed to maintain adequate clinical records, in that within the operating record, you:
a. recorded the words 'green top entry', but did not explain what this meant;

38. The opinion of Mr V, as submitted on behalf of the GMC, was that there are two different meanings or interpretations of 'green top entry' and that the operating record should have indicated which of these was used.

39. The position of Mr Hattotuwa was that his inclusion of "Palmer's test done" within the operating record made clear which of the two meanings was applicable and that this was in the abdominal space, which would be understood by fellow Gynaecologists.

40. This was put to Mr V during his oral evidence, where he was asked:

> "is there anything on that page that reduces the range of possible types of entry from the green top guidance such that there could only be one left?"

and to which he replied:

> "…there is a line, third the third line down says "Palmer's test done". So that it would suggest that he used a sharp needle entry. But it doesn't tell us where the sharp needle entry was done, whether it was done at the umbilicus in Palmer's point, or

somewhere else, but it would suggest that on that occasion of that op sheet, it was a Veres needle entry into the abdomen.[sic]"

41. Mr V went on to confirm that someone with his specialisation interpreting the document would probably understand what that meant looking at that particular example but that his personal opinion was that good accepted practice would be to use a description of the type of entry into the abdominal pelvic cavity.

42. The Tribunal considered that the purpose of the record was to make it unambiguous to the next clinician what had been done. If the only inference from reference to a Palmer's Test is that particular type of entry then this would be apparent even though the detail was sparse and it may have been best practice to include further detail.

43. The Tribunal determined that Mr Hattotuwa had therefore not failed to maintain adequate clinical records by recording the words 'green top entry' without specifically explaining what this meant.

44. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

b. did not record:
i. how the abdomen was entered, insufflated and laparoscoped;

ii. the size or placement of the laparoscope;

iii. the size, number or placement of additional ports;

45. The evidence of Mr Hattotuwa was that the guidance on green top entry sets out the two types of laparoscopic entry and that the Veress needle technique, which is preferred by Gynaecologists, is described in greater detail, inclusive of where the incision should be made and ports placed. He stated that he has only used the Palmer's Point (Mid Clavicular, left Hypochondrial entry) once in 37 years of Practice as a Gynaecologist and that if he was using the Open Hasson Technique he would document as such.

46. It was Mr Hattotuwa's view that if complications arose or if notes need to be reviewed by another Gynaecologist, they would understand the language used and what is stated as "Green Top Entry" and what a "Hasson Technique" is.

47. Mr Hattotuwa accepted that it is perhaps good practice to record the size and placement of ports but stated that the standard is a 3-port technique, with one 10mm port in the umbilicus and two 5mm ports laterally. He submitted that in the extremely rare circumstance that a fourth port was used, he would definitely document that.

48. Mr Hattotuwa also referred the Tribunal to the expert report of Mr X, which did not make any criticisms of his surgical management or notes.

49. Mr U submitted that as Mr V categorised these missing details as significant, and the standard of record keeping as seriously below the requisite standard, it is axiomatic that they should be recorded and that there was a duty on Mr Hattotuwa to do so.

50. However, Mr V did not provide any substantive commentary on the need to record these details, and that he had conceded that it would likely be clear from the notes as to which form of entry "green top" referred.

51. In light of the evidence and submissions of Mr Hattotuwa on this matter, the Tribunal determined that the records in this case, where a standard approach with no unusual steps was taken, were sparse but not inadequate.

52. Accordingly, the Tribunal found 2(b)(i), (ii) and (iii) of the Allegation not proved.

iv. closure of the skin.

53. Mr V's evidence was that anyone subsequently treating the patient would need to know the type of suture used so that they would know if they needed to be removed.

54. Mr Hattotuwa's position was that he does not refer to closure of the skin when using sutures which will dissolve (vicryl sutures, which do so after a maximum of 14 days) as they do not need removing, and that if a suture needed to be removed it would be documented as such. He explained that there is no step to be taken by any subsequent treating clinician if the sutures will dissolve, so no note is required.

55. The Tribunal noted that, in other clinical records available to it, Mr Hattotuwa had recorded the use of other types of sutures which would require removal, in line with his stated approach.

56. Whilst the Tribunal acknowledged that it may have been helpful or best practice to do so, the requirement to record this approach to skin closure was not definitively made out and therefore Mr Hattotuwa had not failed to maintain adequate clinical records in this regard.

57. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

3. On 13 November 2014 during a post laparoscopic consultation with Patient C, you failed to:
a. adequately advise Patient C about:
i. the risk of:
1. further surgery;
2. injury to other organs;
3. the possible failure to treat Patient C's presenting symptoms;

58. The Tribunal considered Patient C's written witness statement, dated 16 June 2020, which focused mostly on what went wrong during her treatment. The consultation of 13 November 2014 was raised in her supplemental witness statement of 22 May 2024, where she states:

> *"From what I can remember he said I needed a laparotomy as this was the only thing that would relieve me of the pain. No other options were discussed. I don't recall him discussing any risks or benefits and he seemed very keen for me to have the surgery."*

59. The Tribunal noted that this written account of events was produced some ten years after the events, and that Patient C reported that she has been diagnosed with some cognitive impairment since that time. However, it considered her a credible, and largely reliable, witness who was describing her genuine recollection of events.

60. The medical records, letter from Mr Hattotuwa to Patient C's GP, dated the day of the consultation, and the handwritten notes do not mention the discussion of risks. While there is a consent form for the procedure of 27 October 2014 which references damage to organs and that additional procedures may become necessary, there was no such evidence for this consultation. The Tribunal considered that this earlier evidence of risks being discussed did not undermine Patient C's account of the consultation of 13 November 2014.

61. In his expert report, Mr V pointed out that there is no detail of the benefits, risks, outcomes or alternative treatments, which should have been discussed at that consultation,

as that was the opportunity for Mr Hattotuwa to tell Patient C his working diagnosis, the treatment options, the risks and benefits of those and the alternatives. That consultation should have described the risks of further surgery, injury risks to other organs and the risks of failure to treat her presenting symptoms. Mr V also opined that this consultation would have been the optimum time to start the consent process for the proposed procedure of laparotomy and removal of the ovaries.

62. The consent form for the laparotomy on 27 January 2015 was completed on the day of admission and the evidence of Mr V was that the day of the procedure was not the appropriate time to discuss risks, albeit he accepted that the consenting process is wider than that specific conversation and completion of a consent form.

63. Mr Hattotuwa's evidence was that he would have stated that the procedure might not work, and that this consultation and discussion were part of a broader or generalised consent process from earlier on. He did not give any evidence of having discussed those risks in any detail at that meeting where he booked in the laparotomy, and there was no documentary evidence to support that these matters were discussed at all.

64. The Tribunal was not provided evidence of any other discussion about the risks and benefits of this specific procedure until the day of the surgery, and accepted the expert opinion of Mr V that this consultation was the time to discuss the relevant risk and benefits. Whilst acknowledging that consent can be an ongoing process, the Tribunal accepted that discussions of benefits and risks should be discussed and documented for each procedure, and so Mr Hattotuwa did have a duty to discuss and document these aspects.

65. In light of the evidence of Patient C, the expert opinion of Mr V and the absence of any documentary evidence to demonstrate that these matters were discussed, the Tribunal found 3(a)(i)1, 2 & 3 of the Allegation proved.

ii. alternative treatments;

66. The Tribunal was provided no evidence that Mr Hattotuwa discussed how to manage Patient C's condition if she did not have surgery, namely the conservative treatment of pain. Mr Hattotuwa submitted that in his professional experience, there is no alternate treatment for Ovarian Entrapment Syndrome.

67. The Tribunal acknowledged that the consequence of this opinion was that there were only two options; that Patient C could undergo the surgery or not. It considered that there was no evidence that this was discussed nor the outcome or options were she not to undergo the surgery.

68. As the Tribunal considered Patient C to be a reliable witness and in the absence of any other evidence to undermine her account that no alternative was discussed, the Tribunal found this paragraph of the Allegation proved.

b. (in the alternative to paragraph 3a) maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 3a.

69. Having found paragraph 3(a) proved in its entirety, the Tribunal therefore found this paragraph of the Allegation not proved.

4. On 27 January 2015 you performed a laparotomy on Patient C ('Patient C's Laparotomy'), and you failed to:
a. adequately obtain consent, in that you did not discuss with Patient C:
i. the reasons for Patient C's Laparotomy;

70. In considering these paragraphs of the Allegation, the Tribunal was mindful of Mr V's expert report, which states:

> *"In my opinion the consent process fell seriously below the standard expected of a reasonably competent Consultant Gynaecologist because: The patient was not offered alternative treatment options and there appears to have been no discussion about the risks and benefits of surgery. The consent form does not detail the reasons for the surgery which should have read "to cure pelvic pain". It fails to mention specific risks to the bowels, bladder, ureters, blood vessels. There should be a specific mention of thrombosis, and the risks of return to theatre which are significant but infrequent risks and should be included for all patients being consented for a major surgical procedure. The consent doesn't document failure to achieve goals, in this case to cure the patient's pelvic pain. There is no mention of the need for another procedure to repair any damage or the need for blood transfusions."*

71. In relation to the reasons for Patient C's laparotomy the Tribunal considered the documentary evidence and sequence of events.

72. Patient C knew that the purpose of the surgery was to free her from her pelvic pain. She acknowledged this during her evidence and did not claim she was unaware of the purpose. Further, the consent form for her laparoscopy on 27 October 2014 referenced looking for the source of her pain and the potential need for subsequent surgery.

73. Whilst this was not specifically referenced on the consent form for this procedure, the Tribunal was mindful that consent is an ongoing process and that the Patient was aware of and understood the reason for the surgery at the time of events, following on from her presenting to Mr Hattotuwa with pain and undergoing previous consultations and procedures in relation to this issue.

74. The Tribunal therefore found this paragraph of the Allegation not proved.

ii. specific risks relating to:
1. the bowels, bladder, ureters and blood vessels;

75. The Tribunal noted that the consent form does make reference to 'damage to organs' but does not state which specific organs, and that the opinion of Mr V was that these should have been specifically referenced.

76. Mr Hattotuwa stated that he was of the opinion that those are the only organs in that area and so it is covered implicitly by reference to damage to organs.

77. In considering whether the general reference to organs was sufficient to obtain informed consent, the Tribunal noted that Mr V did not elaborate on why those specific organs should be named. However, it was of the opinion that a patient might not necessarily be aware of which organs could be damaged or, importantly, what the consequences of damage to them might be, noting that this patient went on to have continence and bowel problems.

78. Patient C's account was that she was not provided with this information and the Tribunal was provided no evidence to contradict this version of events, with Mr Hattotuwa himself indicating that it was implicit in refence to organs generally.

79. The Tribunal noted that the consent form states that the risk of bleeding was discussed which at least implies discussion of the risk of damage to blood vessels.

80. In light of all the above, the Tribunal determined that Mr Hattotuwa did have a duty to relate these specific risks to Patient C and for bowels, bladder and ureters had failed to do so.

81. Accordingly, it found this paragraph of the Allegation proved.

3. return to theatre;

82. Patient C's evidence was that a return to theatre was definitely not mentioned in relation to this procedure.

83. The consent form for the procedure makes reference to additional procedures which may become necessary during the treatment, but does not specifically reference return to theatre.

84. The Tribunal concluded that, on balance, Mr Hattotuwa did not mention the risk of a return to theatre and went on to consider whether he had a duty to do so.

85. The Tribunal assessed whether complications leading potentially to more surgery was implicit. In doing so it noted that Mr V did not elaborate on why this specific detail was necessary, other than in his opinion. In his evidence in relation to Patient L Mr V stated that the risk of a return to theatre was not high but was significant and should have been recorded, although did not elaborate on why this comment needs to be included as distinct from the risk that there may be complications or that the operation may be unsuccessful in what it seeks to achieve.

86. The Tribunal concluded that the GMC had not sufficiently demonstrated that Mr Hattotuwa had a duty to discuss and record this particular detail of the wider risk of failure or complication.

87. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

4. the failure to cure Patient C's pelvic pain;

88. The Tribunal considered the accounts of Patient C and Mr Hattotuwa. Patient C stated that she does not recall this being specifically discussed, and Mr Hattotuwa's evidence was

that he informed her that he could not guarantee the procedure would be completely successful, as was his standard practice.

89. The Tribunal accepted that Mr Hattotuwa's standard practice was to inform patients that he couldn't guarantee complete success, and that he most likely had stated this to Patient C. However, the extent or detail of that discussion was not clear as there was no record made. The Tribunal considered that in these general terms, this did not amount to adequate discussion of the specific risk of the failure to cure Patient C's pelvic pain. There was no suggestion that the likelihood of that risk had been discussed.

90. Accordingly, the Tribunal found this paragraph of the Allegation proved.

iii. the possible need for:
1. another procedure to repair any damage;

91. The Tribunal noted that Patient C did not refer to this specific matter in her evidence and that Mr V's criticism was based on the medical records, where it was not mentioned.

92. Mr Hattotuwa did not elaborate on this paragraph of the Allegation, save for denying it.

93. The Tribunal noted that the consent form does reference "additional procedures which may become necessary during the treatment" but considered that this related to procedures resulting from unexpected issues during the procedure rather than a separate procedure after the end of the first, so did not address the Allegation.

94. The Tribunal concluded that, on the balance of probabilities, this was not discussed. The Tribunal did not have evidence before it about the importance of this particular piece of information, save for Mr V's assertion that it should be discussed. The Tribunal considered that the risk of a surgery to repair any damage subsequently found was implicit in consent to a first surgery and, it was more likely than not that any patient consenting to surgery would understand that. It was provided no evidence that Mr Hattotuwa had a duty specifically to raise this risk.

95. The Tribunal concluded that the GMC had not demonstrated that Mr Hattotuwa had such a duty and therefore found this paragraph of the Allegation not proved.

2. blood transfusions;

96. The evidence of Patient C was that she had brought up the issue of blood loss to Mr Hattotuwa and he was dismissive of it. The Tribunal considered that she had good reason to recall this aspect given a past incident during which she had suffered significant blood loss and this had caused her to raise those concerns. The medical records make clear that she raised this at the time, adding a note to the pre-operative assessment questionnaire that she had experienced blood loss during her hysterectomy. In her written witness statement she recalls:

> *"I signed a consent form for the initial laparotomy and in my pre-operative assessment I wrote about my previous bleeding issues. I recall that I verbally asked the nurse how much blood they kept on site. The nurse advised me they kept two units and I remember laughing and said I might need more."*

97. The Tribunal noted that the 'blood transfusion' box on the consent form had not been ticked, there was no reference to her bleeding and there was no written record of a discussion of bleeding or the need for a transfusion. Mr Hattotuwa did not assert that he had raised the matter of a blood transfusion with her at that time.

98. The Tribunal considered that whilst the only written record of Patient C's previous blood loss was made by her, and she appears to have led the conversation about the risk of bleeding, the matter was raised at the time.

99. The Tribunal was satisfied that in these circumstances, Patient C knew she was at significant risk of bleeding and would potentially require a blood transfusion, albeit she raised the matter. As such, the Tribunal was satisfied that her consent was adequately obtained as it pertained to the risk of blood transfusions.

100. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

b. (in the alternative to paragraph 4a) maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 4a;

101. Having found that Mr Hattotuwa failed to record the discussion of paragraph 4(a)(iii)(2), it found this paragraph proved in respect of that sub-paragraph of the Allegation.

c. respond adequately to post operative complications, in that following Patient C's blood loss, you did not:

i. seek advice or guidance from the anaesthetist with whom you had just completed Patient C's Laparotomy;

102. The Tribunal considered Mr Hattotuwa's version of events, as set out in his Rule 7 response letter. His account was that he had specifically contacted the anaesthetist who had provided anaesthesia for Patient C's surgery for advice but they declined to come and see Patient C and advised that she should be taken to Bedford Hospital.

103. Whilst this was not documented or recorded, in the absence of any evidence to the contrary the Tribunal accepted Mr Hattotuwa's version of events and considered that he was honestly relaying what had occurred.

104. On the basis that Mr Hattotuwa had contacted the anaesthetist for advice and guidance and was simply told to transfer the patient, the Tribunal found this paragraph of the Allegation not proved.

ii. institute the hospital's major haemorrhage protocol;

105. During cross-examination, Mr Hattotuwa stated that his understanding is that, according to BMI Healthcare, there is a haemorrhage protocol but that he did not know what it contained.

106. However, Mr Hattotuwa described how he made a series of decisions which he considered to be most appropriate under the circumstances. The Tribunal was not provided with a copy of the hospital's major haemorrhage protocol and so was unable to ascertain whether some or all of Mr Hattotuwa's actions were in line with that protocol.

107. Whilst Mr V was critical of the actions taken by Mr Hattotuwa, he offered no specific detail in relation to the institution of the hospital's major haemorrhage protocol.

108. Given that the Tribunal was not provided a copy of the relevant protocol, nor material evidence that it existed and was in place at the time of events, it concluded that it could not find that Mr Hattotuwa failed to respond adequately to post operative complications by not instituting it.

109. Accordingly, it found this paragraph of the Allegation not proved.

iii. either:

1. arrange for Patient C to be transferred in an ambulance with paramedic facilities; or

2. accompany Patient C in the ambulance;

110. In considering these paragraphs of the Allegation, the Tribunal noted the fact that neither (1) or (2) above occurred. Arrangements were made for an ambulance to attend but this was crewed by two technicians and no paramedic. Mr Hattotuwa drove his own car to Bedford Hospital and was there for the arrival of the ambulance.

111. The Tribunal was provided with a letter from the Duty Locality Officer of the East of England Ambulance Service to the Executive Director of The Manor Hospital, dated 28 January 2015. This letter set out the account of events from the Ambulance Service's perspective. That letter states that the crew asked if the (Manor) Hospital were sending an escort with the patient and they declined and gave the crew a bag of Hartman's fluid for the journey. The crew advised unnamed hospital staff that they were not paramedics and so could not administer the fluid to the patient. The crew then asked for paramedic back up but this was declined by the Ambulance Service, who stated that Manor Hospital was the health care facility responsible for the patient. It states that the crew then asked Manor Hospital for an escort again but they declined and that "the Surgeon" told the crew he would meet them at Bedford Hospital and then drove away in his car.

112. The Tribunal considered that whilst reference to "the Surgeon" indicates that Mr Hattotuwa was present during some or all of the conversations and requests, but the letter does not detail his specific participation in those.

113. There is no information available to the Tribunal about how the information in the letter was obtained. It amounts to anonymous, multiple hearsay and arises in circumstances where different people present at the scene sought to justify their own conduct. The Tribunal therefore concluded it was unable to place significant weight on the fine detail of the statement, although it constitutes an official document such that the Tribunal accepted it had been created in good faith. The Tribunal also noted that the letter contradicted a BMI Healthcare incident description which stated that "the Consultant followed in his car to meet

them there". There is no evidence available from anyone involved in the conversations other than Mr Hattotuwa.

114. In his evidence, Mr Hattotuwa stated that the ambulance crew did not inform him that they were not paramedics or that they were reluctant to transfer the patient. He stated that he was aware that they were asking the nurse to accompany them and that he thought that they had probably escalated the request to a manager on call but it was declined. However, he was not aware of the second request for an escort. Mr Hattotuwa's evidence was that the paramedic crew did not advise him that they were not paramedics and would not be able to administer the patient the Hartman's fluid, which he believed was given to them by the nurses.

115. The Tribunal concluded that whilst there was evidence of Mr Hattotuwa being present at the time and location of these conversations generally, there was no evidence to contradict his version of events or which indicated that he had either known that the ambulance crew were not paramedics or that there had been a second request for an escort. The Tribunal also noted that at the time of these conversations, Mr Hattotuwa was in the process of coordinating the transfer of Patient C to the ward at Bedford Hospital. It concludes that coordination was important and likely to be the focus of Mr Hattotuwa's attention. The Tribunal had insufficient evidence available to conclude that Mr Hattotuwa himself was involved in any more of the conversation than he says he was, and notes that other professionals were discussing matters with each other while he performed his own function.

116. The Tribunal was of the opinion that even if he had known that the crew were not paramedics, it was not clear it can be said he had the authority or responsibility to require a paramedic attend, noting that the ambulance crew itself had requested paramedics from the Ambulance Service and were declined.

117. In respect of Mr Hattotuwa not accompanying Patient C in the ambulance, the Tribunal accepted his account that he was not aware of a second request. In his oral evidence, Mr Hattotuwa stated that he only had basic life support training and it was not clear to the Tribunal what Mr Hattotuwa could have added to the ambulance crew that would not have been provided by nurses from the Manor Hospital, had they not refused to provide an escort. It also notes that Mr Hattotuwa had a role in receiving the patient, and coordinating matters at Bedford, which he would have been less well-placed to do from the ambulance.

118. On the basis that Mr Hattotuwa was not aware of the ambulance crew's concerns and that it was not clear what his responsibilities or authority were in the situation, the Tribunal found paragraphs 4(c)(iii)(1) & (2) of the Allegation not proved.

iv. adequately consider concerns raised by the ambulance staff that they were not paramedics;

119. For the reasons set out above, namely that Mr Hattotuwa was not made aware that the ambulance crew were not paramedics and that the Tribunal was not satisfied that the responsibility lay with him in any event, the Tribunal found this paragraph of the Allegation not proved.

v. arrange for Patient C to be directly transferred to the Emergency Department at Bedford Hospital, rather than the ward;

120. Mr Hattotuwa's account was that his main concern was to get Patient C to theatre as quickly as possible in order to address the complications and bleeding. He called up the ward at Bedford Hospital and the theatre to let them know he was bringing a patient straight to the ward, speaking to the on-call registrar and an on-call anaesthetist. When Patient C arrived, everybody was on standby and Mr Hattotuwa had asked for a trolley to be brought to the ward. He stated that in his opinion, this approach was the best way to deal with Patient C urgently and was more appropriate than queuing in A&E and waiting to be triaged by a nurse.

121. The Tribunal was of the opinion that the approach Mr Hattotuwa took whereby he phoned ahead and made arrangements for Patient C to go straight to surgery were taken with the best interests of Patient C in mind. Mr Hattotuwa did not just send Patient C to the ward but coordinated logistics beforehand, arrived at the ward before the ambulance and took responsibility for Patient C's care upon her arrival.

122. The Tribunal was mindful of the evidence of Mr V, who, whilst critical of the response to the post-operative complications, deferred to an anaesthetic or accident and emergency consultant expert to confirm or refute his opinion. No such expert opinion was provided. Further, the Tribunal received no analysis as to why resuscitation of Patient C would not have been possible on the ward or in theatre/surgery, which was one of Mr V's main criticisms of the transfer directly to the ward.

123. Additionally, the Tribunal was provided no evidence that Mr Hattotuwa's approach caused any adverse effect on services and patient care being delivered at Bedford Hospital.

124. Accordingly, the Tribunal determined that Mr Hattotuwa had not failed to respond adequately to post-operative complications in this regard and found this paragraph of the Allegation not proved.

d. maintain adequate clinical records, in that within the operating record you did not record:
i. the date of Patient C's Laparotomy;

125. The Tribunal first considered the date of Patient C's laparotomy, as the initial operating note was not dated but a later duplicate had the date included. The Tribunal concluded that the date had been added by another person at an unknown time as it was not on the original note and was in different handwriting. It determined that whether or not this had been added later at Mr Hattotuwa's request, he had failed to record the date.

126. In respect of this paragraph, Mr Hattotuwa accepted that the information should have been included but that he probably failed to record the information due to tiredness after the events leading up to that point.

127. Accordingly, the Tribunal found this paragraph of the Allegation proved.

ii. the dose and route of post operative local anaesthetic;

128. Mr Hattotuwa's evidence was that he did not record this information but that it is for the anaesthetist to record. He stated that Mr V was 'nitpicking' and that this was not his responsibility.

129. Mr V's report states that he is critical of the quality of Mr Hattotuwa's written record but does not elaborate on the need or duty for the surgeon to record the dose and route of post operative local anaesthetic.

130. The Tribunal did not have evidence on which it could find that this was in fact Mr Hattotuwa's responsibility and that he therefore failed to record this information.

131. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

iii. the approach to closure of the skin;

132. As per its findings in relation to paragraph 2(b)(iv) of the Allegation, the Tribunal accepted Mr Hattotuwa's evidence that he records sutures where they are not dissolvable and require further action, and that whilst it would be best practice to record all sutures, his approach does not amount to a failure to record.

133. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

iv. any description of estimated blood loss.

134. Mr Hattotuwa's evidence was that the estimated blood loss is documented elsewhere and so he did not record this. The Tribunal could find no document to support that.

135. The Tribunal accepted that Mr Hattotuwa had not recorded this information. The Tribunal was provided no evidence as to why estimated blood loss was a feature of such importance that not recording it amounts to a failure to maintain adequate records. No basis for that expectation formed part of the evidence.

136. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

Patient D

5. On 10 March 2015 you performed a myomectomy procedure on Patient D and you failed to maintain adequate clinical records, in that, within the consent form, you did not record:

a. adequate detail in relation to the intended benefits;

137. The Tribunal noted that the consent form stated "remove fibroids" and that Mr V is critical of this in so far as that it did not record adequate detail in relation to the intended benefits of Patient D's myomectomy, which should have stated "remove fibroid uterus to improve pregnancy outcomes".

138. In his submissions, Mr Hattotuwa referred to the proposed wording of Mr V and stated that "it would render the patient infertile as there would be no uterus in which the baby could grow". He also submitted that the expert opinion of Mr X was that consent was completely adequate in this instance.

139. The Tribunal noted a letter from Mr Hattotuwa to Patient D's GP dated 1 August 2014 which set out discussions that had taken place with Patient D in relation to the myomectomy, her fibroids and the potential complications for future pregnancies. On this basis, the Tribunal was satisfied that Patient D would have been aware what the purpose and intended benefit of removing the fibroids would be and that Mr V's opinion was holding Mr Hattotuwa to a higher standard than was necessary.

140. The Tribunal therefore concluded that there was not a failure by Mr Hattotuwa to record adequate detail in relation to the intended benefits and accordingly found this paragraph of the Allegation not proved.

b. the risk of:
i. injury to the bowel, bladder and ureters;

141. As per its findings for paragraph 3(a)(i)(2), the Tribunal accepted the opinion of Mr V that the specific organs at risk of injury should be included.

142. The Tribunal noted that there was no reference to damage to organs, even in a broad sense, and that whilst a patient undergoing surgery is likely to know that there is some risk of something going wrong, this should have been specifically discussed and recorded.

143. Accordingly, the Tribunal found this paragraph of the Allegation proved.

ii. return to theatre.

144. As per its determination in relation to paragraph 4(a)(ii)(3), the Tribunal considered whether complications leading potentially to more surgery was implicit. In doing so it noted that Mr V did not elaborate on why this was necessary and was not provided any analysis of why this was required. In his expert report Mr V stated that the risk of a return to theatre was significant but infrequent and should have been recorded, although did not elaborate on why this comment needs be to be included as distinct from the risk that there may be complications or that the operation may be unsuccessful in what it seeks to achieve.

145. The Tribunal concluded that the GMC had not sufficiently demonstrated that Mr Hattotuwa had a duty to discuss and record this, and had failed to do so.

146. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

6. On 17 March 2015, you performed a re-suturing of wound procedure on Patient D and you failed to maintain adequate clinical records, in that within the consent form, you did not record the risk of:

a. thrombosis from the anaesthetic;

147. In his expert report, Mr V stated that, in his opinion, the risk of thrombosis should have been included in the 'serious or frequent risks' box. Mr Hattotuwa's Rule 7 response letter states that this risk would have been covered by the anaesthetist and in his written submissions Mr Hattotuwa stated that the procedure time is less than 30 minutes and that these patients do not require thromboprophylaxis or Flowtron boots, especially if they do not have a prolonged hospital stay.

148. The Tribunal considered that not all serious or frequent risks are recorded on every consent form and was of the opinion that Mr Hattotuwa made a reasoned decision not to include this for a shorter surgery. In the absence of evidence to counter that logic and explanation, which the Tribunal considered credible, it determined that the burden of proof had not been discharged.

149. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

b. return to theatre.

150. For the same reason as set out in relation to paragraph 5(b)(ii), the Tribunal determined that this did not amount to a failure. In addition, it accepted the justification put forward by Mr Hattotuwa that the risk of re-suturing a wound was so limited that it did not need to be included.

151. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

Patient E

7. On 16 February 2016 you inappropriately performed an elective total abdominal hysterectomy and bilateral salpingo-oophorectomy procedure on Patient E:

a. despite knowing the laparoscopy findings of bilateral tubo ovarian abscesses ('the Abcesses');

b. when you should only have drained the Abcesses and not completed the hysterectomy;

152. The opinion of Mr V was that, faced with bilateral tubo ovarian abscesses, Mr Hattotuwa should have drained the tubo ovarian masses only and not completed the hysterectomy to allow for ongoing treatment with antibiotics, and that this would make any future surgery less complex.

153. Mr Hattotuwa's Rule 7 response letter states that he believed it was appropriate to undertake the hysterectomy as there was no active infection and the abscesses were sterile due to the recent course of antibiotics, and that it was also the most appropriate procedure for the removal of the abscesses. During his oral evidence, Mr Hattotuwa stated that in his experience, only draining the abscesses and not completing the hysterectomy would have resulted in a second surgery which would then be more difficult due to the additional scar tissue created.

154. The Tribunal accepted there was a genuine disagreement between Mr V and Mr Hattotuwa as to whether future surgery was made more or less complex by the approach proposed in the Allegation. Both views were explained in a credible way.

155. Given the difference of opinion between Mr V and Mr Hattotuwa, the Tribunal also considered the expert report of Mr X. Mr X stated that "Appropriate surgery was undertaken for the tubo-ovarian abscesses." and that "An open pelvic clearance was the most appropriate procedure under the circumstances."

156. Mr X's comments indicate a degree of support for the alternative approach carried out by Mr Hattotuwa and whilst his evidence was not cross-examined or tested, the Tribunal attributed it sufficient weight to support Mr Hattotuwa's approach, in the absence of specific evidence from Mr V as to why this was the wrong approach.

157. The Tribunal therefore determined that there was insufficient evidence to demonstrate that Mr Hattotuwa performed the procedure inappropriately, and found paragraphs 7(a) and 7(b) not proved.

c. at a private hospital, which you knew lacked sufficient facilities and/or resources for the likely complexity and difficulty of the procedure.

158. Mr V's opinion was that, based on Patient E's past history and the laparoscopic findings in the pelvis, there was a significant risk that any surgery she underwent was going to be complex, difficult and might require input from other specialities e.g. a colorectal surgeon. In Mr V's opinion any responsible body of gynaecologists would have undertaken this type of surgery in an NHS facility and not at a private hospital.

159. Mr V stated that in a private facility there is unlikely to be the equivalent support to that available within the NHS if assistance from other specialities were needed, unless it was large private facility with Level 2/3 care. However, the Tribunal noted that Mr V was not able to specify the difference between facilities at a private unit and within an NHS environment, nor did he know what facilities the Manor Hospital offered or had available.

160. Mr Hattotuwa's evidence was that if a different speciality Consultant was required or if he required assistance it was easily obtained from Bedford Hospital about one mile away. This was based on his many years working at the Manor where many of his colleagues had requested help.

161. The Tribunal concluded that it had received no evidence which demonstrated that there was a lack of suitable facilities at the Manor Hospital, or that assistance from Bedford Hospital was not available as stated by Mr Hattotuwa. Mr V's views on the matter were expressed without that information and so the Tribunal placed limited weight on this aspect of his evidence.

162. The Tribunal noted the submission of Mr U that Mr Hattotuwa's Rule 7 response letter suggested that he did not think that the procedure would be complicated, whereas his evidence at this hearing was that he believed that the procedure would be difficult, as reflected in a post operative letter to Patient E's GP. The Tribunal considered that this was contemporaneous evidence that Mr Hattotuwa had anticipated that the procedure might be difficult and had considered this in deciding to conduct the procedure at Manor Hospital, and that his Rule 7 letter was drafted with his previous legal representative, so gave more weight to his evidence now than its content.

163. In any event, the Tribunal determined that the GMC had not sufficiently demonstrated that the Manor Hospital, which had access to facilities and surgical support, lacked appropriate facilities and that Mr Hattotuwa therefore knew that the procedure should not have been conducted there.

164. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

Patient F

8. On 14 December 2016 you carried out a right salpingo-oophorectomy procedure on Patient F and you failed to:

a. convert the procedure to an open laparotomy, to allow removal of the left ovary;

165. Mr V's opinion was that the correspondence from consultant colleagues prior to the procedure outlined that the intention was to perform the procedure laparoscopically. This correspondence was copied to Patient F. The consent form outlined a laparoscopic procedure with laparotomy in brackets. Therefore, it was his opinion that Patient F was informed that the procedure was going to be keyhole and not open unless there were any intraoperative difficulties. However, the abnormal ovary seen on imaging was on the left side and the operating sheet stated that it was difficult to do this laparoscopically because of adhesions. Although Mr Hattotuwa started dissection of the left ovary, he abandoned this because of the adhesions. In view of the Patient F's cancer diagnosis and need to exclude occult malignancy in the left ovary, the procedure should have been converted to an open laparotomy to allow removal of the left ovary on that date. It was his opinion therefore that the procedure was not adequately carried out.

166. In his oral evidence, Mr Hattotuwa stated that he did not remember the link to malignancy at the time of the procedure, but that he had made a judgement on how to proceed based on the circumstances and his experience.

167. Mr U submitted as the operation note states that it was not possible to visualise the left ovary, therefore, malignancy could not have been ruled out, nor a diagnosis made of a cyst, and neither was documented. Mr Hattotuwa's submission was that Mr U's interpretation of the note and procedure was incorrect.

168. Mr Hattotuwa's submissions were that the purpose of the surgery was removal of the cyst. There was no indication of malignancy which would warrant the removal of the ovary at that time and that even if there had been, he would not have removed the ovary but re-referred Patient F to the Multi-Disciplinary Team ('MDT') to decide if chemotherapy was indicated. Then, if the ovary still needed to be removed, Patient F would be referred to a Tertiary Cancer Centre.

169. The Tribunal considered that the documentary evidence indicated that the purpose of the procedure was to treat Patient F's cyst, with the consent form stating the intended benefit as "treat cyst". The patient had been treated for neck cancer previously.

170. The Tribunal was not provided any evidence that there was cancer present in the ovary, but there was some evidence that this was something that had been contemplated by the specialist cancer team involved in Patient F's care.

171. The GMC case was that as Mr Hattotuwa was dealing with suspected malignancy he should have converted to an open laparotomy in order to address this. However, the Tribunal concluded this was not borne out by the evidence, which demonstrated that the purpose of the procedure was to remove Patient F's cyst, and the decision to do so was taken in the knowledge and context of her previous cancer.

172. The Tribunal was of the opinion that it had not been provided sufficient evidence as to why Mr Hattotuwa's actions, in not converting to an open laparotomy to remove the left ovary, amounted to a failure in the circumstances, given the purpose of the procedure and in light of Mr Hattotuwa's assessment of Patient F's condition at the time.

173. Therefore, the Tribunal found this paragraph of the Allegation not proved.

b. call one or more colorectal surgeons to assist in the dissection;

174. Given that the Tribunal found that Mr Hattotuwa had not failed to convert to an open laparotomy to allow removal of the left ovary, it follows that he therefore did not fail to call one or more colorectal surgeons, as they would not be required for the procedure he was conducting.

175. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

c. maintain adequate clinical records, in that in the operating sheet, you did not record:

176. In considering these paragraphs of the Allegation, the Tribunal bore in mind Mr V's opinion on the record keeping which was that Mr Hattotuwa:

> "did not record the reasons for placing a drain or that the operation had been difficult and or had the potential for complications to arise post operatively. This is seriously

below the standard expected of a reasonably competent Consultant Gynaecologist because GMC guidance requires doctors to document their work in a clear legible and accurate way. This is especially important if other professionals might be required to care for and manage complications arising from a surgical procedure."

177. Mr Hattotuwa's position is that he did not dictate the operation record as he was supervising/guiding a junior colleague, and was therefore not aware of its contents. His Rule 7 response letter states that he believes that the note does record the reasons why the operation was difficult and that whilst it does not record the reasons why a drain was placed or the potential for post-operative complications, he believes that both would have been obvious in light of the operation record.

i. your reasons for placing a drain;

178. The Tribunal considered that Mr V had not provided analysis or explained the duty to record the reason for placing a drain, noting that there was an instruction post-operatively that it needed to be removed the following day and there was no evidence that this was a concern or related to post-operative complications.

179. The Tribunal concluded that on this basis, the GMC had not demonstrated the need for further detail, and that there was sufficient information about the drain and what follow-up was required.

180. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

ii. that:
1. the operation had been difficult;

181. The Tribunal considered that the purpose of the surgery was to remove a cyst, but that the surgeon was unable to visualise the cyst/ovary and determined that it was "not safe" to continue, recording such in the notes. The Tribunal was of the opinion that this was clearly a difficult operation given that they deemed the situation risky enough not to proceed, and that whilst the records do not explicitly state that the "operation had been difficult", this was apparent and a logical inference from what was recorded. The Tribunal accepted the submission of Mr Hattotuwa that it would be obvious to anyone reading the notes that the operation had been difficult.

182. The Tribunal therefore found this paragraph of the Allegation not proved.

2. there was the potential for complications to arise post operatively;

183. Mr V's opinion was that following the surgery, there was evidence of urine leaking out of the drain and the fact that Mr Hattotuwa ordered a CT scan the next morning suggests that he was concerned about intraoperative injury to the bladder, and therefore his clinical annotations are deficient.

184. However, the Tribunal considered that there was no supporting evidence for the conclusion that Mr Hattotuwa had concerns at the time of completing his operating sheet. The Tribunal considered it entirely reasonable that Patient F presented with these symptoms post-operatively and Mr Hattotuwa responded and arranged the scan in response.

185. It was not clear to the Tribunal what post-operative complications should have been included, save for including hypothetical complications. It noted that the consent form dealt with the generic, mostly intra-operative risks which could have post-operative impacts. The procedure was abandoned and there were no identified issues or complications, and the Tribunal noted that the surgeon had completed the 'post-operative instructions' sections setting out the follow-up and what needed to happen.

186. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

d. (in the alternative to paragraph 8c) ensure adequate clinical records had been made by the junior doctor in attendance, in your role as clinical supervisor.

187. Given the Tribunal's findings in respect of paragraph 8(c) it found this paragraph not proved. However, it noted that Mr Hattotuwa was not the person who wrote the notes and it had not been provided evidence that he was supervising the surgeon in an official capacity though he was the senior clinician in attendance. Therefore, had the record keeping been found to be below standard, the Tribunal would have found this paragraph not proved on that basis.

Patient G

9. On 30 July 2018 you performed a hysteroscopy and polypectomy procedure on Patient G and you:

a. inappropriately removed part of Patient G's small-bowel;.

188. The Tribunal noted that Mr Hattotuwa admitted that he removed part of Patient G's small bowel, but denied that this was inappropriate, on the basis that he had not realised he was doing so at the time.

189. In drafting his report, Mr V appears to have believed Mr Hattotuwa was conducting the procedure under direct observation. In fact, Mr Hattotuwa gave an account of using an older "blind" method on which Mr V was examined.

190. Mr V's opinion was that a surgeon would usually know that they had perforated the uterus during a blind procedure, as the instrument in the uterus, being used to take the sample (usually a curette) can be felt to "give way" during sampling. In his opinion, any responsible body of gynaecologists, would stop from further attempts to obtain intrauterine tissue, in order to prevent damage to structures surrounding the uterus.

191. The Tribunal received no evidence to suggest there had been a prolapse of bowel into the uterus. Rather, the instrument which perforated the bowel appears to have made contact with the small bowel, gathering some tissue from it.

192. Mr Hattotuwa's Rule 7 response letter states that he accepts that during the polypectomy a part of Patient G's small-bowel was removed. He believes that this was likely done whilst using polyp forceps during the attempted removal of the polyp. Mr Hattotuwa was not aware that a part of the small bowel had been removed although he did recognise that the uterus might have been inadvertently perforated. Both the inadvertent removal of small bowel and uterine perforation are recognised risks during hysteroscopy and polypectomy.

193. Mr Hattotuwa submitted that he did not and could not be expected to diagnose that he had injured the small bowel, did not recall seeing any fat and honestly believed that he had removed the polyp. In his evidence, he described how he was using the old-fashioned, blind method of polyp removal, which had involved locating it by using a hysteroscope, which was then removed, and the polyp forceps would then be inserted in the direction of where the polyp had been seen, and attempts made to remove it.

194. During his evidence, Mr Hattotuwa stated that he had suspected that he had perforated the uterus on the second occasion he inserted an instrument, but didn't confirm

that by inserting a hysteroscope to view the area. He suggested the risk of the perforation meant he could not distend the uterus with saline again to insert the hysteroscope. He asserted that he stopped the procedure as soon as he suspected the perforation and did not insert an instrument again thereafter.

195. Mr V when recalled on this point explained how there was no reason why saline solution could not be reintroduced and a second hysteroscopy performed, to confirm whether the uterus had been perforated and, in the alternative, a laparoscopy could be performed so that one could look from above.

196. Despite accepting that Mr Hattotuwa did not know that he had perforated the small bowel at the time and that this was a known risk of the surgery, it concluded that the removal of part of Patient G's small bowel was inappropriate.

197. Accordingly, it found this paragraph of the Allegation proved.

b. failed to recognise during the procedure that you had:
i. perforated Patient G's uterus;

198. On the evidence before it, the Tribunal was satisfied that Mr Hattotuwa did recognise that he had likely perforated Patient G's uterus and put in place a care plan based on that assumption. He explained why he did not insert a hysteroscope for further investigation.

199. The Operative Note records "likely uterine perforation".Mr V agreed that treatment with antibiotics without a laparotomy was an appropriate course of treatment for a uterine perforation in these circumstances, if the bowel injury was unknown at the time.

200. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

c. failed to adequately respond to intra-operative complications, in that despite a significant uterine perforation you did not:
i. stop the procedure;.

201. As set out above, the Tribunal accepted that Mr Hattotuwa initially thought that the piece of small bowel was a polyp, and he acted appropriately within that context and logic. His evidence, which the Tribunal accepted, was that on the second occasion he entered and

felt the tool give way. He stopped the procedure at that point, suspecting that he may have perforated the uterus, which was recorded in the operative note.

202. Given the reasoning for his actions and his understanding of the situation, the Tribunal found that Mr Hattotuwa did stop the procedure in response to his belief there had been a uterine perforation.

203. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

ii. perform a diagnostic laparoscopy to investigate further.

204. Mr V's original evidence was that if Mr Hattotuwa did not reinsert the hysteroscope, he should have performed a laparoscopy and looked from above to investigate what damage, if any, had been caused. He stated that the failure to do either of these, was seriously below the requisite standard.

205. Mr Hattotuwa stated that Patient G's menopausal state also meant that there was an increased risk of bleeding, although Mr V disputed this.

206. However, the Tribunal found that Mr Hattotuwa responded adequately and put in place an appropriate plan for what he believed the situation to be. Mr V also stated in his oral evidence that he believed it was reasonable not to complete a diagnostic laparoscopy once he was aware of Mr Hattotuwa's stated approach.

207. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

Patient H

10. On 28 September 2018 you consulted with Patient H in relation to mixed urinary incontinence, and you failed to:

a. discuss options for treatment other than surgery, including alterations to Patient H's lifestyle;

208. The Tribunal noted the evidence, including a letter to Patient H from Mr Hattotuwa following their conversation, that Patient H presented with both urinary incontinence and a possible bladder and bowel prolapse, the latter of which is not referenced in the Allegation.

209. In her written (supplemental) witness statement, Patient H stated that:

> "Dr Hattotuwa didn't offer any conservative treatment such as a pessary or urodynamics (these are treatment options I have since been made aware of).
>
> …
>
> There was no further discussion regarding incontinence/ constipation. Dr Hattotuwa did not want to explore the reasons/ cause as to why I was suffering with incontinence and constipation. I was so worried about it, I just wanted to 'fix' it. Dr Hattotuwa said the hysterectomy and repair would cure or solve the incontinence and this was my main driver for the appointment."

210. Mr V's opinion was that alternatives and other options, should have been discussed/arranged, and, therefore, this was a failure on the part of Mr Hattotuwa, who should have follow recommended diagnostic pathways as laid out in NICE guidance. Patient H had a mixed urinary incontinence ('UI') and the NICE guidance recommends the use of a bladder diary as the initial assessment of women with UI, which was not investigated. Before offering surgery, alternative treatments should be considered including drug treatment as an alternative to surgery, and neither these, nor alterations to lifestyle were discussed.

211. In cross-examination, Mr V conceded that if Patient H had been offered alternative treatments by other consultants that met NICE Guidance, then that would change his position.

212. Mr Hattotuwa's Rule 7 response letter stated that he did discuss treatment options with Patient H including taking no action, conservative measures in the form of pelvic floor physiotherapy or pessaries and surgery. However, there is no written record of this and in his written submissions Mr Hattotuwa states that "Patient H had in the past on at least 2 separate occasions tried alternative management hence I did not discuss."

213. Mr Hattotuwa said in evidence that in his experience the best approach was to do the surgery to address incontinence.

214. His written submissions state that one of Patient H's main concerns was difficulty of inserting and retaining a tampon and that this could not be relieved by conservative management and required surgery. He further submitted that "My training as a Generalist

Gynaecologist was to perform surgery to correct the Stress Incontinence path, which sometimes corrects the Detrusor Instability, the management of which is always medical."

215. The GP referral letter to Mr Hattotuwa and Mr Hattotuwa's letter to Patient H following the initial consultation do not make specific reference to the discussion of alternative treatments by other consultants. The Tribunal noted that there is a record of Patient H being offered a ring pessory, despite her evidence that she was not. However, this was not offered by Mr Hattotuwa and was not referenced in the GP referral letter, so the Tribunal had no evidence to suggest that Mr Hattotuwa knew this at the time.

216. The Tribunal also considered the opinion of Mr X, who stated in his report that:

> "There were no adequate or appropriate pre-operative checks carried out other than for the pelvic examination on 28 September 2018. Patient presented with a range of symptoms including those relating to prolapse, her urinary tract, pain with intercourse and lower abdominal pain not all of which could be ascribed to prolapse. It would have been appropriate to have requested a urine sample for culture to exclude any underlying infection. There was also the option of urodynamic studies, although if the main symptoms were as noted to be primarily linked to a significant vaginal prolapse then this would have been the main focus for management. In summary Mr Hattotuwa's pre-operative checks and investigations were inadequate and fell below but not seriously below the expected standard."

217. The Tribunal accepted that, in line with Mr V's opinion and the NICE guidance, Mr Hattotuwa should have discussed alternative options with Patient H and that on his own evidence he did not. Mr Hattotuwa did not provide evidence that he was aware of previous discussions and investigations which would negate this requirement, and there was no evidence of management of the incontinence going forwards.

218. The Tribunal accepted that it was Mr Hattotuwa's genuine opinion that the potential prolapse was the main issue and surgery was required to address this, which might also help with Patient H's incontinence. However, it concluded that incontinence was nonetheless an issue, albeit potentially a secondary issue, and that there was no specific investigation of this. There was no evidence of discussion of alternative options for treatment or of a management plan going forwards, which should have occurred. Even if Mr Hattotuwa thought surgery to repair the prolapse would, in turn, manage the incontinence issues, he had a responsibility to monitor whether that had occurred, which he did not.

219. Accordingly, the Tribunal found this paragraph of the Allegation proved.

b. discuss alternative treatment options if surgery was required, including abdominal sacrocolpopexy;

220. The opinion of Mr V was that Patient H should have been given all the options for treatment, regardless of Mr Hattotuwa's preference. He opined she should have been given the risks of each approach and allowed to make the decision based on risks and benefits. When asked if he would offer a sacrocolpopexy he advised that this may have offered some clinical benefit.

221. Mr Hattotuwa's Rule 7 response letter, evidence and submission set out that he discussed what he believed was the most appropriate surgical treatment option which was a surgical repair of Patient H's prolapse, namely an anterior colporrhaphy and a posterior colpoperineorrhaphy. He also explained to Patient H that if during the procedure there was further uterine descent, a vaginal hysterectomy and repair should be performed. Patient H then requested that a hysterectomy be performed regardless of whether there was any further uterine descent. In his oral evidence, Mr Hattotuwa stated that he did not perform abdominal sacrocolpopexy procedures, which were not undertaken at Bedford Hospital.

222. The opinion of Mr X was that:

> "The procedure was appropriate given the clinical picture.
>
> …
>
> Vaginal hysterectomy and anterior and posterior repairs was certainly one reasonable option for treatment of the prolapse as described. The records indicate that other than for the anterior and posterior vaginal wall repairs Patient H preferred that a vaginal hysterectomy be performed at the same time. This was appropriate if it was safe to do so. "

223. The Tribunal was satisfied that, on the evidence, Mr Hattotuwa did discuss alternative treatment options if surgery were required, namely an anterior colporrhaphy and a posterior colpoperineorrhaphy with the possibility of a vaginal hysterectomy and repair. It was not provided sufficient evidence as to why a sacrocolpopexy needed specifically to be discussed

as an alternative option or why not doing so amounted to a failure on Mr Hattotuwa's part. The Tribunal also noted that as part of these discussions, Patient H requested a hysterectomy in any event.

224. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

c. arrange appropriate investigations of Patient H's symptoms by way of:
i. bladder diary;

ii. preoperative urodynamics;

225. For the reasons set out in respect of paragraph 10(a) and in light of the evidence, including that of Mr Hattotuwa, that he did not arrange these investigations, the Tribunal found this paragraph of the Allegation proved.

d. (in the alternative to paragraph 10a-10b) maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 10a-10b. To be determined.

226. In light of its findings at paragraphs 10(a) to (c) set out above, the Tribunal found this paragraph of the Allegation not proved.

11. On 19 November 2018, you carried out a vaginal hysterectomy on Patient H and you failed to:
a. obtain informed consent from Patient H, in that you did not adequately discuss:
i. the intended benefits of the procedure;

227. Mr V's evidence was that the intended benefit should have been described along the lines of "to cure prolapse and urinary symptoms".

228. Patient H states that she thought the procedure was to cure her incontinence and feeling of a bulge [prolapse].

229. The consent form includes the intended benefits as "remove uterus & cervix & repair prolapse"

230. The Tribunal was satisfied that on the evidence, there were detailed conversations with Patient H about her symptoms and the purpose of the surgery, including the intended benefits.

231. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

ii. the risk of:
1. injury to bowel, bladder and ureters;

232. Mr V's evidence was that there was reference to a risk of damage being caused but not to which organs or the risk of a return to theatre.

233. Patient H's evidence was that the consenting process, which occurred on the day of the procedure, was rushed and lasted no more than five minutes. The only specific risk she remembers being mentioned was the recurrence of her prolapse, which she interpreted to mean when she was much older.

234. Mr Hattotuwa accepted that he does not go through those specifics as he believes it is obvious and does not see the value in it, so the Tribunal was satisfied that, on the evidence before it, these were not discussed.

235. While the Tribunal accepted that consent is an ongoing process, for the reasons set out in its determination on paragraph 4(a)(ii)(1) of the Allegation, it concluded that details were not discussed or documented and should have been.

236. Accordingly, the Tribunal found this paragraph of the Allegation proved.

2. return to theatre;

237. For the same reasons as set out in respect of paragraph 4(a)(ii)(3) of the Allegation, the tribunal determined that there was not sufficient evidence to demonstrate that there was a requirement for Mr Hattotuwa to specifically discuss or record this.

238. Whilst the Tribunal did not reject the evidence of Mr V that this would be good practice, it concluded that this did not represent a duty or failure to obtain consent.

239. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

3. failure to achieve goals;

240. Mr Hattotuwa stated in oral evidence that his general practice is to inform patients that he "cannot recreate what God created" which he takes to communicate that he "may not cure your symptoms or achieve what I'm trying to set out [to do]".

241. The Tribunal was of the view that this alone and without further explanation did not amount to an appropriate discussion of the risks of surgery not achieving its intended goals and accepted that there was a responsibility to provide more detail to allow patients to make informed choices about their surgery on the basis of specific risks.

242. The Tribunal found this paragraph of the Allegation proved.

4. recurrence of the prolapse;.

243. Given the evidence of Patient H, the Tribunal concluded that there was discussion about how the prolapse could reoccur. It accepted her account that the discussion was rushed, and it is unclear what details were discussed, for example the timescale on which recurrence of the prolapse might be expected.

244. However, it was clear that the concept was discussed and there was insufficient evidence for the Tribunal to find that Mr Hattotuwa had failed to discuss this adequately.

245. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

5. alteration to sexual function;

246. The Tribunal heard no evidence that this matter was discussed, including from Mr Hattotuwa. Pain during intercourse was one of the reasons Patient H came to see Mr Hattotuwa but there is no evidence that he discussed alteration to sexual function with her.

247. Accordingly, the Tribunal found this paragraph of the Allegation proved.

b. (in the alternative to paragraph 11a) maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 11a;

248. Having determined that there was a duty in respect of paragraph 11(a)(ii)(4) and that there were not adequate records to support that this discussion occurred, the Tribunal found this paragraph proved in respect of paragraph 11(a)(ii)(4).

c. record, within the operative note for the procedure:
iii. the type of suture used;

249. For the same reasons as set out in respect of paragraph 2(b)(iv) of the Allegation, the Tribunal determined that whilst it may be best practice, it is not a requirement to note the type of suture used when it is dissolvable and no further action is required. It again noted Mr Hattotuwa's position that he would record the use of nylon sutures because they would need removing in the future.

250. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

iv. clear post-operative instructions in relation to pack and catheter retention and removal.

251. In his written submissions, Mr Hattotuwa stated that "I have stated "Keep Pack & Catheter" as it is my practice to review the next day before removing them"

252. Mr V's opinion was that the note is unclear regarding retention and removal and Mr X's opinion is also that the instruction was unclear.

253. However, the Tribunal considered that the note states to keep the pack and catheter as he would be reviewing the next morning, and whilst this is not explicitly stated what he wrote is consistent with his approach and the meaning that can be extrapolated is clear enough. If, on review, an alternative course were to be taken, it should be recorded at that stage.

254. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

12. On or around 23 November 2018 you consulted with Patient H and failed to maintain adequate clinical records, in that you did not record the consultation.

255. Mr Hattotuwa's opinion was that this was not really a consultation but rather was a courtesy call and therefore did not need to be recorded.

256. According to Mr Hattotuwa, having been told of some issues with opening her bowels, he advised Patient H to have an enema, but not a manual evacuation, and also mentioned being looked at by a bowel specialist.

257. The Tribunal concluded that this was therefore a discussion about a therapeutic treatment and further investigation/follow-up and should have been documented. Regardless of Mr Hattotuwa's original intention in seeing patient H, this became, in effect, a consultation with clinical discussion and advice regarding further interventions.

258. Accordingly, the Tribunal found this paragraph of the Allegation proved.

Patient I

13. On 5 October 2018 you consulted with Patient I in relation to a total abdominal hysterectomy and bilateral salpingo oophorectomy procedure and you:

a. failed to obtain informed consent, in that you did not discuss:

i. the intended benefits of the procedure;

259. The Tribunal considered that there was significant correspondence between Mr Hattotuwa, Patient I and Patient I's GP in relation to this procedure. That correspondence demonstrates that Patient I was referred due to heavy menstrual bleeding and clotting which was suspected might be endometriosis. Patient I wanted and was pushing for a hysterectomy but Mr Hattotuwa was initially reluctant because she was relatively young.

260. With assistance from her GP, Patient I informed Mr Hattotuwa that she did not want any more children and that her husband had had a vasectomy and the procedure went ahead.

261. In those circumstances, the Tribunal considered that there was documentary evidence that Patient I did know the intended benefits of the procedure, that other options were discussed and that she elected for an abdominal hysterectomy and bilateral salpingo oophorectomy procedure. The Tribunal was satisfied that this correspondence demonstrated informed consent on the part of Patient I in respect of the intended benefits of the procedure.

262. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

ii. the risks of:
1. injury to bowel, bladder, blood vessels and ureters;

263. For the same reasons as set out in respect of paragraphs 4(a)(ii)(1) and 5(b)(i) of the Allegation, the Tribunal determined that Mr Hattotuwa did not discuss these specific risks but had a duty to do so.

264. Accordingly, the Tribunal found this paragraph of the Allegation proved.

2. return to theatre;

265. As set out for the previous paragraphs relating to the risk of return to theatre, above, the Tribunal determined that while discussion of this risk would be best practice, it was not a duty and although Mr Hattotuwa did not discuss or record this, that did not amount to a failure.

266. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

iii. that a blood transfusion may be required;.

267. Mr U's submission was that Mr Hattotuwa did not tick the 'blood transfusion' box on the consent form, whereas Mr Hattotuwa stated that he had ticked it but had gone outside the box, effectively double-ticking the adjacent box by accident.

268. Patient I's evidence was that the process was quick and Mr Hattotuwa referred her to the forms, and that she could not remember if he referenced blood transfusions. In her supplemental witness statement she says "No other risks other than those on the consent form were discussed."

269. The Tribunal, on inspecting the form, accepted that there did appear to be a double-tick, where Mr Hattotuwa had put a tick which fell outside of the 'blood transfusion' box, as well as a tick in the 'other procedure' box beneath it. Additionally, Mr Hattotuwa wrote "bleeding" in the 'serious or frequently occurring risks' section of the consent form, which logically could result in a blood transfusion.

270. The Tribunal was therefore satisfied that some discussion of the risk of blood transfusion had been documented and, whilst it was not clear as to the extent of this conversation, the GMC had not provided sufficient evidence to demonstrate a failure to discuss this risk.

271. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

iv. the type of any other procedure that may be required;

272. The Tribunal noted that Mr Hattotuwa did tick the 'other procedure' box on the consent form and considered that this indicated that there was some discussion, although it could not identify any evidence of further detail.

273. The Tribunal noted that the various correspondence referenced at paragraph 13(a)(i) did indicate some discussion of alternative surgeries. It also noted Mr V's evidence that the form should have included something along the lines of "to repair damage".

274. Given that Mr Hattotuwa did tick the box on the consent form, the Tribunal considered this evidence that the matter was discussed at least to some extent and determined that the GMC had not demonstrated a failure to discuss this risk.

275. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

b. (in the alternative to paragraph 13a) failed to maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 13a;

276. Having found that Mr Hattotuwa made no specific note or written comment as to the risk discussed in relation to paragraph 13(a)(iv), the tribunal determined that Mr Hattotuwa had failed to maintain adequate clinical records in this regard and found this paragraph of the Allegation proved in respect of paragraph 13(a)(iv).

c. falsely stated within an individual funding request general form for the procedure ('the Funding Form') that Patient I had previously had a Mirena IUS and GnRH treatment.

277. The Tribunal noted that it was not in dispute that Patient I had not had a Mirena IUS, and that Mr Hattotuwa had stated that within the Funding Form that Patient I had previously had both Mirena IUS and GnRH treatment.

278. Mr V's evidence was that the GP records show that Patient I had also not had GnRH treatment, but the Tribunal was not provided with a copy of these records. Mr Hattotuwa accepted that fact in his Rule 7 response letter and throughout proceedings, and on the basis that this was not challenged the Tribunal accepted this to be correct.

279. Additionally, in an email from Patient I to BMI Healthcare, dated 4 January 2019, Patient I states that:

> "He also said that I had tried previous methods such as zoladex injections, I interjected him at this point and confirmed I hadn't in fact had these injections and maybe he hadn't read my file correctly or got me muddled with another patient."

280. The Tribunal determined that Mr Hattotuwa had stated within the Funding Form that Patient I had previously had a Mirena IUS and GnRH treatment, and that this was false as it was incorrect.

281. Accordingly, the Tribunal found this paragraph of the Allegation proved.

14. You knew when completing the Funding Form that Patient I had not previously had:
i. a Mirena IUS;

ii. GnRH treatment.

282. Mr Hattotuwa's evidence was that at the time of filling in the form he forgot and simply made an error, filling it in incorrectly. He said that he did not have his notes available when he filled out the form, "*may have done two or three forms and got confused"* and that post-operatively he offered her Mirena and contraceptives.

283. In correspondence to her GP on 20 October 2017 (for a clinic on 13 October), Mr Hattotuwa referred to Patient I as having "*declined to have a Mirena IUS inserted at time of her hysteroscopy*".

284. The Tribunal therefore concluded that Mr Hattotuwa had, in October 2017, known Patient I had not had a Mirena IUS. There was no other reference to Mirena until the events of the Allegation in late 2018. Mr Hattotuwa suggests he forgot, or confused this patient with another.

285. In the email of 4 January 2019, Patient I says she corrected the suggestion she had previously had GnRH treatment. The Tribunal noted that this email described a conversation after the procedure, and the completion of the funding form. It lends support to the suggestion that Mr Hattotuwa had an ongoing, but incorrect, belief that Patient I had received GnRH treatment. The Tribunal accepts that. It is not required, at this stage, to assess whether that was reasonable, but accepts it was genuine.

286. Mr Hattotuwa stated that he believed the application for funding was declined because of Patient I's age, andMr V concurred.

287. The Tribunal noted that in a letter to Mr Hattotuwa from the NHS declining to fund the procedure it states that:

> "Patient does not meet criteria and is such young age which the consultant has raised as reluctance to do the surgery."

288. The Tribunal noted that Mr Hattotuwa's own advice would make it less likely to be approved. It considered that this was incongruous with him seeking to mislead in order to gain funding for an operation. Since he gave accurate information leading to the refusal of the funding application, the Tribunal accepted the assertions which made it more likely to be approved were a mistake.

289. In reaching its decision the Tribunal was also mindful of the evidence and its findings in relation to Mr Hattotuwa's record keeping and document management. There is evidence that he does not always focus on accurate completion of forms, especially when he is busy. The Tribunal has observed Mr Hattotuwa's handling of documents during the hearing, and notes he sometimes struggles to find the right ones, although in this case there were a number of versions of very large files.

290. The Tribunal determined that whilst he had information available to him to allow him to complete the Funding Form accurately, he failed to access or recollect that information when he completed the form. Therefore he did not know at the time of completing the Funding Form that Patient I had not previously had a Mirena IUS or GnRH treatment.

291. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

15. Your actions as described at paragraph 13c were dishonest by reason of paragraph 14.

292. Based on his subjective knowledge at time, Mr Hattotuwa cannot be found to have been objectively dishonest as he was mistaken or confused as to this patient's details and treatment history. His actions in response to his subjective knowledge were not dishonest by objective standards. He completed the forms correctly based on his incorrect understanding of the position at the time of completion.

293. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

16. On or around 14 December 2018, following Patient I's CT scans on 23 November 2018 and 13 December 2018, you:

a. inappropriately advised that Patient I's catheter could be removed despite the CT Scan of 13 December 2018 demonstrating an ongoing injury to the bladder;

294. Mr Hattotuwa's account of events was that during the entire process he had discussions with both Dr Z (Radiologist) and Mr AA (Consultant Urologist), that Mr AA advised him to keep the catheter in for two weeks but that he kept it in for three weeks based on his experience and training. He stated that following the repeat CT Urogram on 11 December 2018 he was uncertain what to do and contacted Mr AA again who told him "to get the bloody thing out". Mr Hattotuwa stated that he only followed the advice of a Consultant Urologist and never took any decision on his own.

295. Based on the two CT scan reports, Mr V's opinion was that any body of responsible gynaecologists would have put in place further review by way of ongoing catheterisation for a further 4 weeks, followed by a repeat CT urogram and review in clinic to ensure that Patient I had recovered from surgery. In his opinion, Mr Hattotuwa cannot have correctly read the CT report of the 13 December 2018 or communicated the findings to the Consultant Urologist, Mr AA. Whilst conceding that he is not a urologist and that an expert urology opinion might assist in this regard, Mr V was of the opinion that the urologist if advised of the findings of the CT scan from the 13 December 2018 would not have advised removal of the catheter and would have recommended ongoing urinary drainage with a catheter.

296. During cross-examination, Mr V said that "if you had explained the CT Scan report to the Consultant Urologist, and requested an opinion and that was to remove catheter and TWOC, my criticism would be removed."

297. The Tribunal noted that the Radiologist's Report from Dr Z following the second CT scan, dated 13 December 2018, stated that Patient I should be catheterised for at least a further two to three weeks.

298. Mr Hattotuwa's account of his discussion with Mr AA was that he told Mr AA the findings of the report "more or less" but could not remember if he read out the radiologist's recommendation for a further 2 or 3 weeks of catheterisation. Mr Hattotuwa also commented that "radiologists say this sort of thing all the time and we ignore them".

299. Whilst the Tribunal accepted that Mr Hattotuwa had discussed the matter with Mr AA, it was apparent from his evidence that he could not recall what information he had provided him from the radiologist's report, that he had not provided Mr AA a copy or read him the report in full, and that he could not state whether he had communicated the recommendation to retain the catheter for a further two or three weeks. Additionally, there was no documentary evidence as to why Mr Hattotuwa ignored the advice of the radiologist's report addressed to him, save for that he had discussed it with Mr AA who told him to remove it.

300. The Tribunal determined that, on the balance of probabilities, based largely on Mr Hattotuwa's evidence, Mr AA gave that advice to Mr Hattotuwa on the basis of a partial account of the radiologist's report and without being informed of the recommendation to keep the catheter in for a further two or three weeks.

301. The Tribunal was of the opinion that whilst Mr Hattotuwa spoke to a specialist and followed their advice, as he is entitled to do, he did not give enough information for that specialist to make an informed decision. The Tribunal was satisfied that Mr Hattotuwa had a duty to do so, if he intended to take a different course based on that alternative advice, and that his subsequent action in advising that Patient I's catheter could be removed was inappropriate.

302. Accordingly, the Tribunal found this paragraph of the Allegation proved.

b. failed to put in place further review by way of:
i. ongoing catheterisation for a further four weeks;

ii. a repeat CT urogram;

iii. review in clinic.

303. Given Mr Hattotuwa's inappropriate decision at paragraph 16(a), the Tribunal considered that there was not a subsequent failure on the part of Mr Hattotuwa to arrange the alternative treatment path of ongoing catheterisation for a further four weeks, a repeat CT urogram and review in clinic. In light of the decision to remove the catheter, the Tribunal was not provided evidence of a free-standing duty to take these follow-up steps, which would have been appropriate had the catheter been left in.

304. Accordingly, the Tribunal found these paragraphs of the Allegation not proved.

Patient J

17. On 28 November 2018 you performed an outpatient hysteroscopy and biopsy on Patient J and you failed to adequately heed to Patient J's request to stop the procedure due to the level of pain she was experiencing.

305. Patient J's written witness statement included the following:

> "At this appointment, Dr Hattotuwa performed a hysteroscopy. Dr Hattotuwa did not offer or give me any local anaesthetic for the biopsy and I suffered intense pain. I asked Dr Hattotuwa to stop the procedure as I could not continue with the level of pain, but he continued."

and Patient J's husband's written witness statement includes:

> "Dr Hattotuwa then pulled out a long, metal probe which had a camera and a little pair of snippets that take the biopsy. It looked quite archaic. Dr Hattotuwa then inserted this into my wife. My wife has a very high pain threshold and doesn't complain about anything, even when she had our three children, which I was present for. She doesn't need painkillers or asks for them, she is quite tolerant to pain. My wife said to Dr Hattotuwa, 'this really hurts, this really hurts'. Dr Hattotuwa continued with the procedure and my wife then actually swore at him. She doesn't swear very often, and I found this really surprising considering that she worked at the hospital. The exact words she said were, 'get that fucking thing out of me' and that she couldn't continue with the pain. She shouted this at Dr Hattotuwa. If someone stabbed you, you'd shout in response

as the pain was that intense. This was out of character for my wife as she doesn't do that. As she was working in the hospital and working with those professionals, she wouldn't normally shout and swear at a fellow professional. It was clear that Dr Hattotuwa heard my wife, obviously because he was that close to her doing the procedure on her. There was no doubt that he heard, everyone in the room would have heard. Dr Hattotuwa paused for a moment and then continued. This caused more intense pain for my wife and she told Dr Hattotuwa to just take the probe out, but by then he'd managed to get the sample. I was asked by the GMC how many times my wife told Dr Hattotuwa to stop the procedure. During the procedure my wife was telling Dr Hattotuwa that it was painful, but not obviously shouting and swearing apart from one time."

306. In his written submissions, Mr Hattotuwa stated:

"Both the HCA/CSW and the qualified nurse would have stopped me from proceeding if what Patient J (and her husband) said is true

…

I can categorically state that NO patient has ever sworn at me - If such an incident occurred, I will be extremely troubled, traumatised and remember the patient and incident.

…

I have spoken to both the nurses present on the day. They state that they too would remember such an incident."

307. The Tribunal noted that there were no witness statements or evidence from the two nurses present.

308. The Tribunal considered the discrepancy between Patient J's account (and that of her husband) that she did not receive any anaesthetic and Mr Hattotuwa's account that she did.

309. Mr Hattotuwa stated that he administered the local anaesthetic using two vials, which was how Mr V said that he would do it, and was reflected in a letter to Patient J from the Chief Executive of Bedford Hospital following her raising a complaint about the event.

310. The Tribunal concluded that there was evidence that some anaesthesia was used, and accepted that Patient J could be mistaken about that aspect as she was in pain at the time and could not see what was happening.

311. The Tribunal went on to consider Patient J's evidence. Her complaint was made two years later, allowing time for her memory to have changed, developed, be less clear or for detail to have been lost. During cross-examination she states that the reason she raised the complaint was because she became aware of other women who said they had been hurt by procedures Mr Hattotuwa had done and that he needed an update on his practice to prevent this. She also stated that she had the procedure twice more and it was nothing like that. The Tribunal noted that there was documentary evidence that she did have at least one further procedure which was too painful and had to stop. Patient J was also critical of the nurse present, who she stated would have noticed yet did not intervene ("was not my advocate"). In her oral evidence, Patient J confirmed that she only told Mr Hattotuwa to stop once before he did, although not immediately.

312. The Tribunal noted the accounts of all parties and accepted that neither the nurses present or Patient J's husband stepped in to intervene. The Tribunal acknowledged that whilst the nurse should have acted as advocate in such a situation, Mr Hattotuwa was still the senior practitioner undertaking the procedure. The Tribunal concluded that the nurse not intervening did not provide a defence, nor did it undermine Patient J's account of her pain or request to stop the procedure. The Tribunal did accept that the lack of intervention from the nurse/s and Patient J's husband suggested a relatively short timespan between the indications of more intense pain, the request to stop and the end of the procedure.

313. Although Patient J's complaint was raised two years after the procedure, it was a single, short series of events for her to remember, leaving less room for confusion. The Tribunal considered Patient J to be a credible witness who was giving an honest account of her recollection and found no evidence to suggest that she and her husband were deliberately seeking to misrepresent or falsify their accounts. Their consistent evidence was that Patient J asked explicitly for the procedure to cease but Mr Hattotuwa did not immediately comply.

314. The Tribunal did not accept, as Mr Hattotuwa suggested, that being sworn at would constitute such an unusual event that he would recall the procedure in detail. Mr V's evidence was that he was unsure if he would remember that language, but would be more

likely to remember the consultation going badly, but the Tribunal did not attribute significant weight to his view in reaching its determination.

315. The Tribunal determined that on the balance of probabilities, Patient J did ask for the procedure to cease and that Mr Hattotuwa continued when he should have stopped. The accounts of Patient J and her husband indicate that Mr Hattotuwa did briefly pause, then continued and by the time Patient J then told him to just take the probe out, he had completed the procedure.

316. As Mr Hattotuwa could not recall the procedure, he was unable to assist the Tribunal in determining how long he continued for, but it was the Tribunal's opinion, based on the evidence, that the request to stop happened towards the natural end of the procedure.

317. Whilst it appears that Mr Hattotuwa continued relatively briefly to complete the procedure, the Tribunal concluded that he did fail adequately to heed Patient J's request to stop when he should have done so.

318. Accordingly, the Tribunal found this paragraph of the Allegation proved.

Patient K

18. On 2 January 2019 you carried out a laparoscopic ovarian cystectomy procedure on Patient K and:

a. you inappropriately completely transected the sigmoid colon;

319. The Tribunal considered the documentary evidence in respect of this allegation, namely the surgical note of the surgeon, Mr BB, dated 2 January 2019. That note includes the text "*Finding - complete transection of proximal sigmoid colon and limited faecal contamination*".

320. Mr V's evidence on this was that a full transection must have occurred i.e. the bowel was completely cut across. When questioned on the significance of "limited faecal contamination" he said the level of contamination would depend on the amount of faeces in the bowel and was not an indication of the extent of the injury.

321. Mr Hattotuwa's written submissions reflected his oral evidence, stating that:

> "The Sigmoid colon has a diameter of approximately 6cm. A laparoscopic scissor blade effective cutting end is approximately 1cm. Therefore to Completely Transect the Sigmoid Colon, one has to repeatedly and blindly continue cutting both front and back of a "tube" A prolonged malicious act with complete disregard."

322. Mr Hattotuwa suggested that as the Consultant Colorectal Surgeon called to perform the repair, Mr BB, is Turkish, that he must have used the inappropriate terminology of 'transection' when he meant 'enterotomy'. He submitted that an example of confused terminology was "Oophorectomy" and "Ovariectomy" which he states means the same in England, as per Mr V's evidence, but in Sri Lanka, Mr Hattotuwa's country of origin, means two different things: Oophorectomy is the removal of a normal ovary; Ovariectomy is the removal of an abnormal ovary.

323. The Tribunal did not receive evidence from Mr BB to assist with the interpretation of his notes, and had to rely on the interpretations of Mr Hattotuwa and Mr V.

324. The Tribunal was of the opinion that Mr Hattotuwa's example of inconsistent terminology did not assist in relation to Mr BB's use of the term "complete transection".

325. The Tribunal considered that Mr Hattotuwa's assertion that he could not have unintentionally transected the bowel owing to the small size of the scissors in relation to the diameter of the colon was unsupported evidence. The Tribunal did not have evidence as to the size of the scissors, the diameter or size of the wound or the number of cuts required to transect it in this case and Mr Hattotuwa's evidence relied on generalised estimates.

326. Mr Hattotuwa suggested that the correct interpretation was that he conducted an enterotomy- a hole- which caused some more minor damage to the bowel and that Mr BB fully transected in order to repair it. Mr V's opinion was that this did not accord with the description on the surgical note, and the Tribunal was also of that opinion.

327. The Tribunal did not consider that there was any compelling evidence that Mr BB had not described what he found and concluded that the language had a clear meaning.

328. Accordingly, the Tribunal found this paragraph of the Allegation proved.

b. after recognising that you had caused an intraoperative bowel injury:

i. you inappropriately carried out a laparotomy by way of pfannenstiel incision instead of by way of midline approach;

329. Mr V's opinion was that any responsible body of gynaecologists would be aware that after a significant bowel injury, a laparotomy should be conducted through a midline approach. Failing that, Mr Hattotuwa could have waited for the surgeon to attend before conversion to the laparotomy which would have ensured Patient K would have had only one scar line.

330. Mr Hattotuwa's evidence was that as an experienced gynaecologist his inclination is to default to undertaking a laparotomy by way of pfannenstiel incision instead of by way of midline approach, as patients do not want a scar on their midline. He stated that maybe he should have opened her up and down and accepted the criticism.

331. Mr Hattotuwa stated that he did not want to delay the laparotomy and that by going in and clamping the bowel he prevented more significant faecal contamination.

332. The criticism of Mr Hattotuwa was that he should have been competent to undertake a midline approach and that his actions resulted in a double scar by adding a horizontal part to the scarring (as the midline approach was subsequently also undertaken).

333. The Tribunal accepted the expert opinion on this matter, particularly given that Mr Hattotuwa now recognises that he should perhaps have taken the midline approach, though he did not think that in the moment. The Tribunal was of the opinion that this demonstrated that he did not properly consider the treatment path and that his actions were inappropriate.

334. Accordingly, the Tribunal found this paragraph of the Allegation proved.

ii. (in the alternative to paragraph 18bi) you failed to wait for a surgeon to attend before conversion to the laparotomy;

335. The Tribunal noted that this paragraph was charged in the alternative, and that Mr Hattotuwa chose to proceed with the laparotomy without waiting for the surgeon to attend in order to clamp the injury and prevent further faecal contamination.

336. The Tribunal therefore found this paragraph of the Allegation not proved.

c. you failed to recognise that you had completely transected the sigmoid colon;

337. The Tribunal found that Mr Hattotuwa did completely transect Patient K's colon, and whilst he recognised an injury to the bowel at the time, he still holds the opinion that he did not fully transect the bowel.

338. Accordingly, the Tribunal found this paragraph of the Allegation proved.

d. you failed to maintain adequate intra-operative records, in that within the operative record you did not record:
i. any detail:
1. as to how the injury to Patient K's sigmoid colon and bladder occurred;

339. Mr Hattotuwa recorded that he was attempting to dissect a 5cm cyst off the bowel, which the Tribunal considered to be an accurate, though limited, note of how the injury occurred. The criticism from Mr V relates to the legibility of the notes but the Tribunal was of the opinion that they were sufficiently understandable.

340. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

2. about your laparoscopic entry to the abdomen;.

341. Mr V's opinion was that "there is no detail in the operative sheet about his laparoscopic entry to the abdomen and no information about the type of laparotomy he undertook".

342. Mr Hattotuwa put to Mr V in cross-examination that he had recorded "Visiport entry" and that this was sufficient, to which Mr V replied that if you are recording laparoscopy correctly you need to record where you place the ports, as there are different positions on the abdomen, and describe how you insufflated the abdomen as there are lots of options. He stated that this needs to be recorded as it affects complications that can arise subsequently.

343. Whilst accepting the opinion of Mr V that further detail would be good practice, it noted that the wording of the allegation states that Mr Hattotuwa did not record "any" detail about his laparoscopic entry to the abdomen. The Tribunal notes that the information was

limited but accepts that other professionals could draw appropriate conclusions from what is recorded.

344. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

ii. any information about the:
1. type of laparotomy you undertook

345. Mr V did not provide any detail on why Mr Hattotuwa needed to specify that he undertook a pfannenstiel incision in the circumstances of this case. It noted that Mr Hattotuwa recorded that he had moved to a laparotomy and handed over to another surgeon, who recorded the operation as a whole, including a diagram of the entry scars.

346. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

2. site and size of the bladder injury;

347. The Tribunal was of the opinion that Mr Hattotuwa's note, which recorded "bladder dome" as the site, whilst minimal, did indicate the site of the injury and that a surgeon reading the note would understand that the bladder dome is on the top of the bladder.

348. Mr Hattotuwa's evidence was that he had not recorded the size of the bladder injury as it was just a 'nick', but the Tribunal accepted Mr V's opinion that this should have been recorded and that Mr Hattotuwa had not recorded any information about it.

349. Accordingly, the Tribunal found this paragraph of the Allegation not proved in respect of the site of the injury and proved in respect of the size of the injury.

3. the bladder injury's relationship to the urethra or ureteric orifices.

350. As set out above, the Tribunal accepted that by recording "dome" it would be apparent where the injury site was. The Tribunal concluded that it followed from this that a surgeon would know that the dome was on the top of the bladder, and therefore the injury would not have a relationship to the urethra or ureteric orifices.

351. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

Patient L

19. On 13 June 2019 you carried out:
a. a pfannenstiel laparotomy procedure on Patient L and you failed to:
i. perform the procedure adequately because you:
1. perforated the bowel by way of a one centimetre complete enterotomy;

352. Mr Hattotuwa's account was that there was no damage present when he closed Patient L after checking for any damage, as per his operation note, but the patient was returned to theatre due to an intra-abdominal bleed and at the conclusion of that surgery he noticed the bowel damage and called a colleague, Mr Wild, to fix the issue.

353. Mr Hattotuwa suggested that the injury could have been caused by a suction device used to remove the blood following the initial procedure. Although there was no documentary evidence to support this suggestion, when it was put to Mr V he responded that it would depend on the type of sucker, that mostly they were guarded and that whilst it could cause such an injury if used injudiciously he had never seen this in practice.

354. The Tribunal considered whether to accept that Mr Hattotuwa inspected the bowel on first closing and was correct in identifying that there was no damage, or whether there was damage at that point but he simply missed it.

355. The operation note states that the bowel was inspected and there was no injury so in the Tribunal's opinion Mr Hattotuwa clearly did not see an injury at that time. The Tribunal accepted that had Mr Hattotuwa observed such an injury he would not have completed the operation without addressing it, as he did once it later became apparent.

356. It was not clear to the Tribunal how easy it would be to miss such an injury as it did not receive any evidence on this.

357. The Tribunal noted the possibility of the suction device having caused the injury, but attributed it little weight in reaching its determination. The Tribunal did note that a site of bleeding was found during the second operation, which appears to have been the source of the intra-abdominal bleed. The bleed itself does not, therefore, provide evidence that the bowel injury was present at the conclusion of the first surgery. Ultimately, the Tribunal determined that there was a lack of positive evidence on which it could find that Mr Hattotuwa had missed the injury on inspection.

358. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

2. contused the bowel;

3. tore a hole in the sigmoid mesentery;

4. did not identify the injuries to Patient L's sigmoid and proceeded to close Patient L's abdomen;

359. Having found paragraph 19(a)(i)(1) of the Allegation not proved, it therefore follows that paragraphs 19(a)(i)(2), (3) and (4) are not proved.

ii. maintain adequate clinical records, in that within the operative record, you did not record:
1. any information on sutures used to close Patient L's vagina, rectus sheath or skin;

360. The Tribunal's previous findings were that, whilst it would be good practice, Mr Hattotuwa did not have a duty to record the use of dissolvable sutures, unless any further action in relation to them was required.

361. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

2. a description of the volume and concentration of local anaesthetic applied to the skin;

362. The Tribunal noted that, whilst Mr Hattotuwa did not produce the operation notes, he conceded that he was supervising his colleague who was conducting the surgery, and so was responsible for them.

363. The Tribunal noted that whilst Mr Hattotuwa had not recorded this information, it had been documented elsewhere, so if there had been any issues relating to it the anaesthetist records could be reviewed. The Tribunal was not presented with any evidence as to why Mr Hattotuwa had a free-standing duty to repeat this record.

364. As per its reasoning in relation to paragraph 4(d)(ii) of the Allegation, the Tribunal determined that Mr Hattotuwa did not have a duty to record this information and therefore had not failed to do so.

365. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

3. why Patient L's left ovary had been removed;

366. Mr Hattotuwa's evidence was that the operation note deals with this as it says "ovary adherent to uterus" at the top line.

367. Mr V's evidence was that the operation was not consented for, that there is no description as to why the ovary was removed and that in his opinion the absence of reasons as to why the ovary was removed fell seriously below the standard expected.

368. The Tribunal rejected Mr V's conclusion on the basis that Mr Hattotuwa did include that the ovary was adherent to the uterus, and was of the opinion this was an adequate explanation for future clinicians, albeit it did not provide much detail.

369. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

b. a secondary laparotomy on Patient L, and you failed to maintain adequate clinical records, in that within the operative record, you wrongly assigned bleeding points to the right and left.

370. The Tribunal accepted the evidence, as set out in a local investigation of the incident, that the operative record wrongly assigned bleeding points to the right and left.

371. Mr Hattotuwa's evidence was that he had gone in to assist a new consultant with the operation as a 'favour', that he was not on call and that the operative note was not, therefore, his responsibility.

372. The Tribunal was of the opinion that Mr Hattotuwa still had some responsibility when attending the operation, but that he cannot be held responsible for his colleague's notes being accurate in this instance.

373. The Tribunal was not provided evidence that he had such a responsibility to check or correct his colleague's work, which states that the record was dictated by "Mary" on the form.

374. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

Patient M

20. On or around 6 January 2020 you reviewed a biopsy report dated 27 December 2019 in respect of Patient M ('the Biopsy Report'), and you failed to check the relevant colposcopy opinion and cytology result.

375. There was considerable dispute about whether Mr Hattotuwa had responsibility for the colposcopy conducted on Patient M. He did not perform the procedure and was on a "hot week" in another department at the time, although the clinic was in his name. The Tribunal accepted that he had no direct involvement in the colposcopy.

376. The Tribunal accepted the evidence, as conceded by Mr Hattotuwa, that he had reviewed the biopsy report, circling "FILE" and "LETTER", writing "KH COLP FILING CAB" and dating the document "6/1/20". The Tribunal treats this as his first involvement in the care of this patient. That document contained a reference to "high-grade dyskaryosis" and also to "CIN 1" [low-grade]. The Tribunal was therefore of the view that it was apparent on the face of that document that there was a discrepancy.

377. In his written submissions Mr Hattotuwa stated that in January 2020, which was prior to the merger with Luton & Dunstable Hospital, there was no protocol or guideline at Bedford Hospital Colposcopy department that if there was a discrepancy between, cytology, colposcopy findings and histology such a case would need to be brought and to an MDT meeting. This requirement was brought in subsequently.

378. The Tribunal was provided no evidence or allegation in relation to arranging an MDT or a duty to do so, noting that the allegation relates specifically to a failure to check the relevant colposcopy opinion and cytology result.

379. Whilst the results were not in relation to a case or patient Mr Hattotuwa was otherwise involved with, he was the professional who received and reviewed the biopsy report and was therefore responsible for the case at that point in time.

380. The Tribunal noted that Mr V's evidence was that had the discrepancy been checked and the matter referred to an MDT, that would have likely resulted in the same response, namely advice to repeat the colposcopy in six months.

381. The Tribunal therefore determined that Mr Hattotuwa had a duty to check the relevant colposcopy opinion and cytology result and had failed to do so.

382. Accordingly, the Tribunal found this paragraph of the Allegation proved.

21. On or around 27 July 2020 you investigated and concluded a Datix report into the management of Patient M's care following the Biopsy Report ('the Datix Report'):

a. which was inappropriate due to your involvement in Patient M's care on or around 6 January 2020;

383. The Tribunal considered the evidence of Mr V, who stated in his expert report that:

> "From what I have reviewed in the bundle, it is my opinion that it was Mr Hattotuwa's failure in January 2020 to put in place appropriate management that was the subject of the Datix of 27.07.2020 and, if this is the case, then it was in my opinion inappropriate for him to have closed the Datix off. He should have handed over the investigative part of the datix completion to another consultant."

384. The Tribunal noted that there was undoubtedly ambiguity about who was responsible globally for the care of Patient M and that Mr Hattotuwa's involvement was administrative due to his review of a document on 6 January 2020. Prior to this he had not been involved in the patient's care.

385. Mr Hattotuwa states that the Datix report was allocated to him, that he was surprised to receive it and that he did not realise that he could hand it off to another colleague. The Tribunal accepted that Mr Hattotuwa's evidence and reasoning was genuine, and that as he saw the Datix as a learning exercise, rather than a process assigning blame, he did not consider at the time that it would be inappropriate for him to complete.

386. The Tribunal considered that Mr Hattotuwa's actions and approach at the time, whilst genuine, were naïve and that it was not appropriate for Mr Hattotuwa, effectively, to review his own work and to draw conclusions about other people's work.

387. Accordingly, the Tribunal found this paragraph of the Allegation proved.

b. and you failed to communicate the outcome of the Datix Report to Dr N.

388. The Tribunal noted that it did not have the original Datix as submitted by Mr Hattotuwa. The copy available had subsequently been amended.

In his witness statement and oral evidence, Dr N suggested that he only found out about the Datix when Public Health England made contact in 2021.

389. Mr Hattotuwa submitted that the claim that he never told Dr N is false, that he shared the office with him and that he told him across the desk and subsequently again in the corridor, "when it got heated".

390. The Tribunal also noted that there was evidence that Dr N knew about the Datix Report prior to when he stated in his witness statement. It appeared that Dr N found out within, at most, three months of the Datix Report although it remains unclear who informed him about it, because he was sent a message on 15 October 2020 containing the words "*Hi [Dr N]as requested- Datix has been reopened for further investigation*". The Tribunal considered that he was not being deliberately misleading and accepted Dr N's evidence that he found out from someone other than Mr Hattotuwa which resulted in an argument or heated discussion, as described.

391. In considering whether Mr Hattotuwa had a duty to inform Dr N, the Tribunal noted Mr V's opinion that

> "In my opinion the failure to communicate with medical colleagues, [Dr N]… following completion of the Datix dated 27.07.2020 fell seriously below the standard expected of a reasonably competent Consultant Obstetrician and Gynaecologist because GMC Good Medical Practice requires collaborative working with colleagues to maintain and improve patient care and the outcome from the Datix should have been sent to [Dr N]…"

392. The tribunal accepted the opinion of Mr V in this regard and noted that in order for the Datix to function as a learning tool or exercise, those colleagues involved need to be made aware of its existence and findings.

393. Accordingly, the Tribunal found this paragraph of the Allegation proved.

Patient O

22. On 11 September 2020 you consulted with Patient O following the still birth of her daughter, and you failed to:

a. prepare adequately for the meeting;

394. The Tribunal considered the varying accounts of what occurred at the meeting.

395. Patient O's recollection was that the meeting felt rushed, partly due to Mr Hattotuwa's comments, that he did not lead the meeting and that he was not answering her specific questions.

396. Mr Hattotuwa's general description was that he had been asked by a colleague to conduct a debrief/follow up appointment for a patient whose care he had not been involved with and who had suffered a stillbirth. Mr Hattotuwa was clear that he had read the notes prior to the meeting and that in the circumstances his approach was to let the patient lead the conversation and to answer any questions they had.

397. The Tribunal is of the view that the primary purpose of the meeting was to discuss the cause of the stillbirth. That is reflected in Patient O's witness statement:

> *"I thought the meeting was to discuss what had happened with [baby] and why she had died. The meeting did not achieve anything*
>
> *I said something like "What happened? Why did she die?""*

398. The Tribunal was also of the view that it was inevitable Patient O would want to receive information about the risk in future pregnancies and the steps that could be put in place to mitigate them.

399. The Tribunal noted a number of topics covered in that meeting:

- The cause of the stillbirth, which Mr Hattotuwa said was an abruption about which there was no warning, and nothing in the subsequent blood analysis, or post-mortem to indicate an alternative cause. There seems to have been some dispute in the meeting about this, arising from Patient O's conversation at the time with a paediatric doctor, and a note that had been crossed out.

- Whether a Caesarean section could be provided in any future pregnancy. Mr Hattotuwa said that it could.
- Whether it could be performed at 37 weeks' gestation, which Patient O proposed, and he said was against policy.

400. The two midwives present provided slightly different perspectives to each other but both commented that Mr Hattotuwa could have been more comforting. They largely reflect the same account of the content of the meeting.

401. Mr Hattotuwa was therefore able to discuss the test results, the cause of death to the extent that it was known, steps that could be put in place in future pregnancies, and his view on why a proposed early Caesarean could not be endorsed at that stage.

402. The Tribunal considered that the only evidence that the GMC had provided to demonstrate that Mr Hattotuwa had not prepared for the meeting was the account of Patient O and her observations and criticisms of Mr Hattotuwa. She drew the conclusion that Mr Hattotuwa had not prepared because he had given answers she did not think were personal to her, and which appeared to conflict with a conversation she had with another doctor at the time of the stillbirth.

403. The Tribunal took the view that the evidence showed Mr Hattotuwa did not provide answers Patient O had hoped for, and that he appears not to have provided comfort to her as may be expected.

404. Ultimately, the Tribunal was of the view there was no direct evidence that Mr Hattotuwa had not prepared for the meeting. It appeared that the meeting did not go how either Mr Hattotuwa or Patient O had expected and that Mr Hattotuwa's manner did not assist, but the Tribunal was not satisfied that the GMC had discharged its burden to show he was unprepared.

405. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

b. adequately communicate with Patient O, in that on one or more occasion, you said to Patient O:

i. that her papers had ended up on your desk;

406. In his oral evidence Mr Hattotuwa confirmed that he probably did say something to the effect of the wording alleged and explained that he had never met the patient before and that this was true.

407. The Tribunal was of the opinion that any reasonable person hearing that would interpret such a comment as dismissive, and suggestive of his having been thrust into the meeting. The Tribunal took the view that the comment will have contributed to Patient O's distress throughout the meeting, and her perception that it did not achieve anything for her.

408. The Tribunal concluded that, while he had not meant to offend or upset Patient O with this comment, it was insufficiently empathetic, worded badly, and that Mr Hattotuwa had therefore failed to communicate adequately with Patient O.

409. Accordingly, the Tribunal found this paragraph of the Allegation proved.

ii. "I've never met you before, what do you want to know?";
or words to that effect.

410. In her written witness statement Ms S, one of the midwives present stated that:

> "Dr Hattotuwa said something along the lines of, 'Why are you here?' and 'What is it you want to talk about?' which came as a surprise to because I think [Patient O] was hoping Dr Hattotuwa would lead the conversation."

411. Mr Hattotuwa's Rule 7 response letter states that he "would have used phrases such as "I'm sorry to meet you under these circumstances" and "how can I help you"".

412. In his oral evidence, Mr Hattotuwa stated that he did not say "I have never met you before, what do you want to know?" as this was "not my style of talking" and in his written submissions he stated that "I did ask "How can I help you?""

413. The Tribunal was satisfied that on the basis of the evidence, Mr Hattotuwa did say something to the effect of "I've never met you before, what do you want to know?".

414. The Tribunal accepted that an appropriate approach to the meeting might be to allow Patient O to ask questions of Mr Hattotuwa. That was not the approach Patient O or Ms S had expected, and it caused upset.

415. However, the Tribunal considered that such an approach was reasonable, and the wording was not objectionable. While Patient O was genuinely upset by it, Mr Hattotuwa did not fail to communicate adequately by the use of these words.

416. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

Patient P

23. On 4 February 2021 you consulted with Patient P following an ultrasound scan, and you failed to:

a. recommend further assessment by cardiotocograph;.

417. The Tribunal considered the expert opinion and expertise of Dr W in respect of Patient P. Mr Hattotuwa challenged Dr W' standing as an expert witness and highlighted his belief that he was equally qualified to express opinions about appropriate care.

418. The Tribunal took the view that Dr W was a properly qualified expert. It subjected her evidence to scrutiny, and weighed it against Mr Hattotuwa's in reaching its decisions. It noted that at times Dr W appeared to rely more on her experience as a practitioner than on written or formal policies and guidance. The Tribunal considered that there were some elements of Dr W' evidence that were specific to her working environment and did not translate directly to Mr Hattotuwa's.

419. Mr Hattotuwa's evidence was that a further assessment by cardiotocograph ('CTG') was not indicated and would not have been useful in this situation, given that the Doppler (ultrasound) was fine and that Patient P was not having any reduced foetal movement. His evidence was that in this circumstances, the CTG would not be helpful and would be normal.

420. In his evidence, Mr Hattotuwa also raised the difficulty of arranging a quick referral, and that he thought Dr W' was basing her opinion on what she would have had access to in Northern Ireland, where the services appeared more integrated.

421. By the end of Dr W' oral evidence, the Tribunal was of the impression that her opinion was that a CTG assessment should have been undertaken out of an abundance of caution and for supplemental information rather than there being any specific or determinative reason why one was required in this case. Her assessment appeared to be that a high-risk

(twin monozygotic) pregnancy with a sudden change in the disparity of growth rates between the babies should have led to more assessment. She accepted the disparity in weight between the foetuses did not reach the threshold to trigger immediate intervention, but she criticised Mr Hattotuwa's reaction to it, suggesting that he should have been more alert and cautious.

422. The evidence shows that Mr Hattotuwa arranged for Patient P to come in for an early delivery at the soonest time he was able, on Sunday 7 February, around 72 hours later, and advised her to return if there was any reduced foetal movement. Mr Hattotuwa attempted to admit her earlier but the ward manager told him that they could not do so any sooner.

423. Patient P was admitted on 07 February 2021, as planned, and there is a handwritten entry (author unknown) which states: "Reports no FMs today last felt some movements on Friday." Sadly, scans confirmed that neither twin's heartbeat was present; and both had died in utero.

424. The Tribunal considered that Mr Hattotuwa was conscious of the increased risks and did take action, noting that this was in the context of growth plotting charts not being designed for twin pregnancies. He arranged for her to have an early delivery and there is evidence that he sought to arrange this as soon as he was reasonably able to.

425. The Tribunal concluded that Dr W was unable to demonstrate a mandatory or defined treatment pathway in the circumstances, but sought to assist the Tribunal with how she would approach the situation, in her experience and in her judgement.

426. The Tribunal accepted that view, but did not find that Dr W had provided a clear explanation as to why the CTG was a necessary, rather than desirable, step in the circumstances of this case.

427. The Tribunal determined that there was insufficient evidence satisfactorily to demonstrate that there was a failure to recommend further assessment by cardiotocograph.

428. Accordingly, the Tribunal found this paragraph of the Allegation not proved

b. reassess Patient P for induction of labour;

429. The Tribunal accepted Mr Hattotuwa's evidence that he took steps to induce labour at the earliest opportunity that he was able to do so and could be agreed by colleagues, as set out above.

430. Dr W criticism of this was that he should have, effectively, overridden the views of the ward manager, but it was not clear to the Tribunal that this was an option available to him in the circumstances, or that the state of the pregnancy as it was then known, required that.

431. The Tribunal notes that there was no suggestion of reduced foetal movements at that stage. While Mr Hattotuwa did not document that movements were normal at the time, the Tribunal accepts that he would have recorded were they abnormal, or absent.

432. Accordingly, the Tribunal found this paragraph of the Allegation not proved

c. either:
i. offer Patient P induction of labour within 24 hours; or

433. For the same reasons as set out for paragraphs 23(a) & (b), as set out above, the Tribunal found this paragraph of the Allegation not proved.

ii. discuss Patient P's case with a colleague who had a special interest in management of twin pregnancies, or with a fetal medicine consultant.

434. The Tribunal considered that Dr W evidence indicated that Northern Ireland operates somewhat differently, as she stated that she always has someone she can get hold of and work collaboratively with. Mr Hattotuwa's evidence was that he did not have such support immediately available, partly due to Covid and the pressures at the hospital/department, and also more generally. He stated that he would have had to arrange something the following day and it was unclear whether a colleague with such a speciality would have been available over the weekend in any event.

435. The Tribunal considered that, on basic principles, if a practitioner is uncertain about something it is best to have a discussion, and that in this instance that would not have interfered with the plan already in place. However, the Tribunal was not provided with any evidence, save for the judgement of Dr W, that Mr Hattotuwa was required to or should have done so. It noted the particular circumstances of a normal Doppler, the advice given to return

if there were reduced foetal movements, and that the patient was coming back in three days for an induction.

436. The Tribunal therefore determined that the GMC had not demonstrated that this was a failure on Mr Hattotuwa's part, and found this paragraph of the Allegation not proved.

The Tribunal's Overall Determination on the Facts

437. The Tribunal has determined the facts as follows:

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

Patient A

1. On 12 May 2014 you directly supervised Dr B in carrying out a right salpingectomy procedure and:

    a. despite a pre-operative ultrasound scan having shown an ectopic pregnancy in Patient A's right fallopian tube ('the Right Tube'), you failed to:

        i. discontinue the procedure prior to the removal of Patient A's left fallopian tube ('the Left Tube') so that an ultrasound scan could be arranged to confirm the side of the ectopic pregnancy; **Admitted and found proved.**

        ii. arrange a post-operative repeat scan, to evaluate the Right Tube; **Not proved**

    b. you failed to maintain adequate clinical records, in that you did not record the justification for removal of the Left Tube; **Not proved**

    c. (in the alternative to paragraph 1b) you failed to ensure that Dr B made adequate clinical records, including the justification for removal of the Left Tube. **Not proved**

Patient C

2. On 27 October 2014 you performed a diagnostic laparoscopy on Patient C and failed to maintain adequate clinical records, in that within the operating record, you:

   a. recorded the words 'green top entry', but did not explain what this meant; Not proved

   b. did not record:

      i. how the abdomen was entered, insufflated and laparoscoped; Not proved

      ii. the size or placement of the laparoscope; Not proved

      iii. the size, number or placement of additional ports; Not proved

      iv. closure of the skin. Not proved

3. On 13 November 2014 during a post laparoscopic consultation with Patient C, you failed to:

   a. adequately advise Patient C about:

      i. the risk of:

         1. further surgery; Determined and found proved

         2. injury to other organs; Determined and found proved

         3. the possible failure to treat Patient C's presenting symptoms; Determined and found proved

      ii. alternative treatments; Determined and found proved

   b. (in the alternative to paragraph 3a) maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 3a. Not proved

4. On 27 January 2015 you performed a laparotomy on Patient C ('Patient C's Laparotomy'), and you failed to:

   a. adequately obtain consent, in that you did not discuss with Patient C:

i. the reasons for Patient C's Laparotomy; **Not proved**

ii. specific risks relating to:

1. the bowels, bladder, ureters and blood vessels; **Determined and found proved**

2. thrombosis; **Admitted and found proved.**

3. return to theatre; **Not proved**

4. the failure to cure Patient C's pelvic pain; **Determined and found proved**

iii. the possible need for:

1. another procedure to repair any damage; **Not proved**

2. blood transfusions; **Not proved**

b. (in the alternative to paragraph 4a) maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 4a; **Determined and found proved in respect of 4(a)(iii)(2)**

c. respond adequately to post operative complications, in that following Patient C's blood loss, you did not:

i. seek advice or guidance from the anaesthetist with whom you had just completed Patient C's Laparotomy; **Not proved**

ii. institute the hospital's major haemorrhage protocol; **Not proved**

iii. either:

1. arrange for Patient C to be transferred in an ambulance with paramedic facilities; or **Not proved**

2. accompany Patient C in the ambulance; **Not proved**

iv. adequately consider concerns raised by the ambulance staff that they were not paramedics; **Not proved**

v. arrange for Patient C to be directly transferred to the Emergency Department at Bedford Hospital, rather than the ward; **Not proved**

d. maintain adequate clinical records, in that within the operating record you did not record:

i. the date of Patient C's Laparotomy; **Determined and found proved**

ii. the dose and route of post operative local anaesthetic; **Not proved**

iii. the approach to closure of the skin; **Not proved**

iv. any description of estimated blood loss. **Not proved**

Patient D

5. On 10 March 2015 you performed a myomectomy procedure on Patient D and you failed to maintain adequate clinical records, in that, within the consent form, you did not record:

a. adequate detail in relation to the intended benefits; **Not proved**

b. the risk of:

i. injury to the bowel, bladder and ureters; **Determined and found proved**

ii. return to theatre. **Not proved**

6. On 17 March 2015, you performed a re-suturing of wound procedure on Patient D and you failed to maintain adequate clinical records, in that within the consent form, you did not record the risk of:

c. thrombosis from the anaesthetic; **Not proved**

d. return to theatre. **Not proved**

Patient E

7. On 16 February 2016 you inappropriately performed an elective total abdominal hysterectomy and bilateral salpingo-oophorectomy procedure on Patient E:

   a. despite knowing the laparoscopy findings of bilateral tubo ovarian abscesses ('the Abcesses'); Not proved

   b. when you should only have drained the Abcesses and not completed the hysterectomy; Not proved

   c. at a private hospital, which you knew lacked sufficient facilities and/or resources for the likely complexity and difficulty of the procedure. Not proved

Patient F

8. On 14 December 2016 you carried out a right salpingo-oophorectomy procedure on Patient F and you failed to:

   a. convert the procedure to an open laparotomy, to allow removal of the left ovary; Not proved

   b. call one or more colorectal surgeons to assist in the dissection; Not proved

   c. maintain adequate clinical records, in that in the operating sheet, you did not record:

      i. your reasons for placing a drain; Not proved

      ii. that:

         1. the operation had been difficult; Not proved

         2. there was the potential for complications to arise post operatively; Not proved

   d. (in the alternative to paragraph 8c) ensure adequate clinical records had been made by the junior doctor in attendance, in your role as clinical supervisor. Not proved

Patient G

9. On 30 July 2018 you performed a hysteroscopy and polypectomy procedure on Patient G and you:

   a. inappropriately removed part of Patient G's small-bowel; Determined and found proved

   b. failed to recognise during the procedure that you had:

      i. perforated Patient G's uterus; Not proved

      ii. removed part of Patient G's small bowel; Admitted and found proved

   c. failed to adequately respond to intra-operative complications, in that despite a significant uterine perforation you did not:

      i. stop the procedure; Not proved

      ii. perform a diagnostic laparoscopy to investigate further. Not proved

Patient H

10. On 28 September 2018 you consulted with Patient H in relation to mixed urinary incontinence, and you failed to:

   a. discuss options for treatment other than surgery, including alterations to Patient H's lifestyle; Determined and found proved

   b. discuss alternative treatment options if surgery was required, including abdominal sacrocolpopexy; Not proved

   c. arrange appropriate investigations of Patient H's symptoms by way of:

      i. bladder diary; Determined and found proved

      ii. preoperative urodynamics; Determined and found proved

   d. (in the alternative to paragraph 10a-10b) maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 10a-10b. Not proved

11. On 19 November 2018, you carried out a vaginal hysterectomy on Patient H and you failed to:

    a. obtain informed consent from Patient H, in that you did not adequately discuss:

        i. the intended benefits of the procedure; **Not proved**

        ii. the risk of:

            1. injury to bowel, bladder and ureters; **Determined and found proved**

            2. return to theatre; **Not proved**

            3. failure to achieve goals; **Determined and found proved**

            4. recurrence of the prolapse; **Not proved**

            5. alteration to sexual function; **Determined and found proved**

    b. (in the alternative to paragraph 11a) maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 11a; **Determined and found proved in respect of paragraph 11(a)(ii)(4)**

    c. record, within the operative note for the procedure:

        i. ~~the scarring from previous fenton's procedures~~; **Deleted under Rule 17(6)**

        ii. ~~the use of bladder buttress sutures~~; **Deleted under Rule 17(6)**

        iii. the type of suture used; **Not proved**

        iv. clear post-operative instructions in relation to pack and catheter retention and removal. **Not proved**

12. On or around 23 November 2018 you consulted with Patient H and failed to maintain adequate clinical records, in that you did not record the consultation. **Determined and found proved**

Patient I

13. On 5 October 2018 you consulted with Patient I in relation to a total abdominal hysterectomy and bilateral salpingo oophorectomy procedure and you:

    a. failed to obtain informed consent, in that you did not discuss:

        i. the intended benefits of the procedure; **Not proved**

        ii. the risks of:

            1. injury to bowel, bladder, blood vessels and ureters; **Determined and found proved**

            2. return to theatre; **Not proved**

        iii. that a blood transfusion may be required; **Not proved**

        iv. the type of any other procedure that may be required; **Not proved**

    b. (in the alternative to paragraph 13a) failed to maintain adequate clinical records, in that you did not record having discussed the matters described in paragraph 13a; **Determined and found proved in respect of** paragraph 13(a)(iv)

    c. falsely stated within an individual funding request general form for the procedure ('the Funding Form') that Patient I had previously had a Mirena IUS and GnRH treatment. **Determined and found proved**

14. You knew when completing the Funding Form that Patient I had not previously had:

        i. a Mirena IUS; **Not proved**

        ii. GnRH treatment. **Not proved**

15. Your actions as described at paragraph 13c were dishonest by reason of paragraph 14. **Not proved**

16. On or around 14 December 2018, following Patient I's CT scans on 23 November 2018 and 13 December 2018, you:

    a. inappropriately advised that Patient I's catheter could be removed despite the CT Scan of 13 December 2018 demonstrating an ongoing injury to the bladder; **Determined and found proved**

    b. failed to put in place further review by way of:

        i. ongoing catheterisation for a further four weeks; **Not proved**

        ii. a repeat CT urogram; **Not proved**

        iii. review in clinic. **Not proved**

Patient J

17. On 28 November 2018 you performed an outpatient hysteroscopy and biopsy on Patient J and you failed to adequately heed to Patient J's request to stop the procedure due to the level of pain she was experiencing. **Determined and found proved**

Patient K

18. On 2 January 2019 you carried out a laparoscopic ovarian cystectomy procedure on Patient K and:

    a. you inappropriately completely transected the sigmoid colon; **Determined and found proved**

    b. after recognising that you had caused an intraoperative bowel injury:

        i. you inappropriately carried out a laparotomy by way of pfannenstiel incision instead of by way of midline approach; **Determined and found proved**

ii. (in the alternative to paragraph 18bi) you failed to wait for a surgeon to attend before conversion to the laparotomy; **Not proved**

c. you failed to recognise that you had completely transected the sigmoid colon; **Determined and found proved**

d. you failed to maintain adequate intra-operative records, in that within the operative record you did not record:

i. any detail:

1. as to how the injury to Patient K's sigmoid colon and bladder occurred; **Not proved**

2. about your laparoscopic entry to the abdomen; **Not proved**

ii. any information about the:

1. type of laparotomy you undertook; **Not proved**

2. site and size of the bladder injury; **Determined and found proved (in respect of size of the injury only)**

3. the bladder injury's relationship to the urethra or ureteric orifices. **Not proved**

Patient L

19. On 13 June 2019 you carried out:

a. a pfannenstiel laparotomy procedure on Patient L and you failed to:

i. perform the procedure adequately because you:

1. perforated the bowel by way of a one centimetre complete enterotomy; **Not proved**

2. contused the bowel; **Not proved**

3. tore a hole in the sigmoid mesentery; **Not proved**

4. did not identify the injuries to Patient L's sigmoid and proceeded to close Patient L's abdomen; **Not proved**

ii. maintain adequate clinical records, in that within the operative record, you did not record:

1. any information on sutures used to close Patient L's vagina, rectus sheath or skin; **Not proved**

2. a description of the volume and concentration of local anaesthetic applied to the skin; **Not proved**

3. why Patient L's left ovary had been removed; **Not proved**

b. a secondary laparotomy on Patient L, and you failed to maintain adequate clinical records, in that within the operative record, you wrongly assigned bleeding points to the right and left. **Not proved**

Patient M

20. On or around 6 January 2020 you reviewed a biopsy report dated 27 December 2019 in respect of Patient M ('the Biopsy Report'), and you failed to check the relevant colposcopy opinion and cytology result. **Determined and found proved**

21. On or around 27 July 2020 you investigated and concluded a Datix report into the management of Patient M's care following the Biopsy Report ('the Datix Report'):

a. which was inappropriate due to your involvement in Patient M's care on or around 6 January 2020; **Determined and found proved**

b. and you failed to communicate the outcome of the Datix Report to Dr N. **Determined and found proved**

Patient O

22. On 11 September 2020 you consulted with Patient O following the still birth of her daughter, and you failed to:

    a. prepare adequately for the meeting; **Not proved**

    b. adequately communicate with Patient O, in that on one or more occasion, you said to Patient O:

        i. that her papers had ended up on your desk; **Determined and found proved**

        ii. "I've never met you before, what do you want to know?"; **Not proved**

    or words to that effect.

Patient P

23. On 4 February 2021 you consulted with Patient P following an ultrasound scan, and you failed to:

    a. recommend further assessment by cardiotocograph; **Not proved**

    b. reassess Patient P for induction of labour; **Not proved**

    c. either:

        i. offer Patient P induction of labour within 24 hours; or **Not proved**

        ii. discuss Patient P's case with a colleague who had a special interest in management of twin pregnancies, or with a fetal medicine consultant. **Not proved**

Determination on Impairment - 21/05/2025

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

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, Mr Hattotuwa gave oral evidence at this stage of proceedings.

Submissions

On behalf of the GMC

3. Mr U provided written submissions, which he supplemented with oral submissions.

4. Mr U submitted that the clinical failures which the Tribunal have found proved all fell seriously below the expected standards and amount to serious misconduct. He submitted that a number of the general failures found proved, whilst less serious, also amount to serious misconduct.

5. Mr U submitted that in relation to consent matters, the GMC concede that the failures to discuss the risks relating to the bowels, bladder, ureters and blood vessels, may be viewed in the context of the reference to "other organs" in the documentation, and might be considered to be technicalities. However, the failure to discuss the potential failure to achieve goals and the alteration of sexual function do just about cross the threshold of serious misconduct.

6. Mr U submitted that the GMC accept that the Tribunal may take the view that the recording failures found do not constitute serious misconduct, bearing in mind the nature of the omissions from the record. He submitted that the false statements in the funding request form are mere errors of fact, in circumstances of the finding that Mr Hattotuwa was not acting dishonestly.

7. Mr U submitted that, in the circumstances of Mr Hattotuwa's limited involvement in the cytology result and the biopsy report, and considering all the evidence that was presented, the Tribunal may well find that those matters concerning Patient M do not amount to serious misconduct. He submitted that the inadequate communication to Patient O cannot be categorised as amounting to serious misconduct.

8. Mr U submitted that the most serious proved matters are the inappropriate removal of part of Patient G's small bowel, via a uterine perforation, and the transection of Patient K's sigmoid colon; however these matters occurred almost six and seven years ago respectively, and there has been much water under the bridge since then. He submitted that Mr Hattotuwa has been supervised as set out in the three Supervisor's Reports, since March 2021.

9. Mr U submitted that, save for the admissions made, Mr Hattotuwa has demonstrated very little insight and that at the hearing he was occasionally disparaging of Mr V, and questioned whether Dr W was an expert and any better placed than him to speak of the Patient P matters. He submitted that Mr Hattotuwa seemed to take offence that he was being questioned and challenged on any aspect of his professional abilities and competence, unlike in the Supervisor's Reports, where he is said to have been willing to accept constructive feedback, and has conducted himself with a degree of humility.

10. Mr U submitted that notwithstanding Mr Hattotuwa's poor level of insight, there is the remediation, demonstrated by his attitude towards compliance with, and conduct during, his period of supervision. He submitted that there has clearly been issues with gentler tissue handling, and "laparoscopic and hysteroscopy surgeries are not his strongest skill set, but he manages simple cases, with his supervisor's presence, comfortably.".

11. Mr U submitted that in the main, the three Supervisor's Reports speak well of Mr Hattotuwa, and his Supervisor, Mr T, is of the opinion that he is safe to return to practice, albeit that there is a reference to indirect supervision in his last Report.

12. Mr U submitted that Mr Hattotuwa has in the past acted, and, arguably, is liable in the future to act, so as to put a patient or patients at unwarranted risk of harm, in particular, if he were to perform the more complex procedures, unsupervised and that the Tribunal should therefore find that his fitness to practise is currently impaired.

<u>On behalf of Mr Hattotuwa</u>

13. Mr Hattotuwa submitted that he has been working under the supervision of Mr T since March 2021 and has improved his surgical skills in this time. He submitted that, as set out in Mr T's Supervisor's Reports, he has been trained to utilise newer equipment for open surgery, including the use of a stapler-type implement in place of knot-tying to close after

surgery. He submitted that during this period his clinical and surgical skills have been closely observed and feedback provided.

14. Mr Hattotuwa submitted that as a result of this ongoing supervision he has undergone a significant amount of one-to-one training in a practical environment, dealing with both emergency and elective surgeries and using newer techniques and equipment. He submitted that this was of more value than simply attending courses and that he has taken on board these changes to procedures within his practice.

15. Mr Hattotuwa submitted that he no longer uses the 'blind procedure' for polypectomies and so any future risk of injury to patients' small bowels is minimised. He also explained that Bedford Hospital now has better resources in place, including the appointment of a urogynaecologist, and that workload has also reduced, with shorter surgical lists involving fewer procedures in each operating session.

16. Mr Hattotuwa submitted that he used to take on difficult cases and procedures that other practitioners would not, that perhaps this was foolish, but that he did so in order to help these patients. He submitted that he would be more cautious in future and that he has nothing to prove in respect of his clinical abilities, nor a need to take on complex procedures. He submitted that he has updated his practice when providing advice to patients, thoroughly records this, and has not received any complaints. He has also received no complaints from GPs in relation to responding to their advice and guidance requests. He said he now has more detailed written consent forms that he fills in, which ensure he discusses all necessary matters with patients.

17. Mr Hattotuwa submitted that, in addition to the Supervisor Reports of Mr T, he has provided patient feedback demonstrating that patients appreciate how he communicates with them. He submitted that he was sorry that the events occurred and that patients suffered as a result.

18. Mr Hattotuwa submitted that he found it extremely difficult defending himself in these proceedings and that perhaps he did not comply with the standard that is expected. However, he has an element of knowledge and experience and felt that, at times, things were not being stated or explained correctly. He stated that this was not him being arrogant and that he was not trying to put anyone down as a person or as a human being, but at times was showing an element of emotion in challenging the allegations made against him. He

submitted that his assertion thatMr V and Dr W were at times 'nitpicking' was not meant to be rude and he was merely trying to challenge what he considered to be inaccuracies in their evidence.

19. Mr Hattotuwa submitted that he has worked for the NHS for over 35 years and would like to be able to be on-call at Bedford Hospital in order to deal with issues and patients that are within his skillset. He submitted that no doctor can guarantee there will not be complications in the future and that, if he were to do so, he would not be showing insight. He submitted that he will have no hesitation to ask for a second opinion or help if required and that he is willing to put major gynaecological surgery 'on the backburner' but would like the opportunity to be able to deal with emergency cases. He submitted that he teaches doctors and midwives on how to manage these emergencies and so knows how to deal with them appropriately.

20. Mr Hattotuwa submitted that he has had no further issues or complaints and that he remains dedicated to providing patient care. He submitted that in terms of misconduct, he does not deny that he made mistakes and understands that damage to bowels, which is a known complications of surgery, is serious. He submitted that he would never intentionally cause harm to a patient and that in terms of insight, he reflects every single day after work on how the day went, what did he learn, were patients handled correctly or should something have been done differently. He submitted that his record keeping has now significantly improved and includes his name and GMC number on all his notes. He submitted that in terms of consenting, he understands that it is a process which starts the day that the patient first sees him.

The Relevant Legal Principles

21. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

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

23. The Tribunal must determine whether Mr Hattotuwa's fitness to practise is impaired today, taking into account his conduct at the time of the events and any relevant factors

since then such as whether the matters are remediable, have been remedied and whether any repetition is highly unlikely.

24. The LQC highlighted the case of *Roylance v GMC (no2) (2000) 1 AC 311* in which 'misconduct' was defined as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.'. It was also noted that the case of *Roylance* highlights the need for the misconduct to be linked to the profession of medicine and to be serious.

25. In the case *Nandi v GMC [2004] EWHC 2317 (Admin)*, it was said that serious misconduct is sometimes described as misconduct which would be considered deplorable by fellow practitioners.

26. The LQC reminded the Tribunal of the need to take into account the overarching objective which is to protect the public and which includes to:

a protect and promote the health, safety and wellbeing of the public;
b promote and maintain public confidence in the medical profession;
c promote and maintain proper professional standards and conduct for the members of the profession.

27. The LQC reminded the Tribunal that whilst there is no statutory definition of impairment, the Tribunal 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. […]'

28. The Tribunal also had regard to the case of *Cohen v GMC [2008] EWHC 581* where the court said "*it must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second it has been remedied and third that it is highly unlikely to be repeated".*

The Tribunal's Determination on Impairment

Misconduct

29. Throughout, the Tribunal accepted Mr Hattotuwa's evidence that he did not intend to cause harm to any patients. It noted that it was not alleged as part of the GMC's case that he had such an intention.

Paragraph 1(a)(i)

30. The Tribunal considered the context of the events, having heard evidence that the system then in place did not allow for intra-operative ultrasound, that there had been a group discussion between Mr Hattotuwa and his colleagues and that they had agreed that the ectopic pregnancy was in the left fallopian tube.

31. The Tribunal concluded that this was not a spur of the moment decision by Mr Hattotuwa or one taken solely by him, but a considered team decision based on the presentation of the patient at the time. It also noted that the hospital now has a portable ultrasound machine available, which now allows for an approach to be taken that could not then be.

32. The Tribunal determined that, given that Mr Hattotuwa followed the consensus opinion of other professionals involved and based on the resources available, his actions did not amount to misconduct. It noted that the involvement of others did not absolve Mr Hattotuwa of his own responsibility, but concluded that he had made a clinical decision to proceed on a logical basis for appropriate reasons.

Paragraph 3(a)(i)

33. The Tribunal found that Mr Hattotuwa failed to provide the necessary information to patient C, which was required for her to make subsequent decisions about her treatment.

34. Mr Hattotuwa's evidence was that this consultation was part of a broader consent process and in reaching its decision, the Tribunal bore in mind that there had been a consent process for a prior and subsequent procedure, albeit there were also some shortcomings found in the subsequent consenting process.

35. The evidence of Mr V was that Mr Hattotuwa should have described the risks to the patient and that this consultation was the optimum time to raise these matters. Mr Hattotuwa's letter to Patient C's GP did not mention the discussion of risks and whilst the Tribunal was provided with a consent form for a later procedure which mentions damage to organs, there are no such records in relation to this consultation.

36. The Tribunal considered that a patient is not able to make a fully-informed decision without a proper consent process. It further considered that its wider findings show a pattern of Mr Hattotuwa being somewhat lax and hasty with the consent process. It took the view that it is incumbent on a surgeon to go through the consent process carefully and that Mr Hattotuwa was the only person who could do this fully.

37. The Tribunal concluded that the failure to take the opportunity to discuss risks at this consultation, which occurred between procedures, would not amount to misconduct had the consent process more broadly been adequate and the risks discussed elsewhere. That did not occur in this case, which had the effect of the first recorded discussion of the potential risks to organs, or of failure, being on the day of the laparotomy itself.

38. The Tribunal found that, owing to the consultation and broader consent process, Mr Hattotuwa's failure to discuss the risks of injury to organs and the possible failure to treat Patient C's presenting symptoms amounted to misconduct (paragraph 3(a)(i)2 and 3).

39. In line with its finding of fact in respect of similar allegations, however, it found that the risk of further surgery was sufficiently implicit to the process that not addressing it specifically at this consultation did not amount to misconduct (Paragraph 3(a)(i)1).

Paragraph 3(a)(ii)

40. The Tribunal considered that the discussion of alternative treatments should have formed part of the consultation. It accepted that Patient C had two options, namely to undergo the surgery or not, but that Mr Hattotuwa had failed to discuss options, such as conservative treatment, were the surgery not undertaken.

41. In reaching its decision, the Tribunal bore in mind the following paragraphs of GMP:

> *17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research*
>
> *21 Clinical records should include: a relevant clinical findings b the decisions made and actions agreed, and who is making the decisions and agreeing the actions c the information given to patients d any drugs prescribed or other investigation or treatment e who is making the record and when.*

42. The Tribunal determined that this fell seriously below the standard expected and amounted to misconduct.

Paragraph 4(a)(ii)

43. The Tribunal noted that the consent form references damage to organs but not which ones, and that the evidence of Mr V was that this should specifically include which organs and the consequence(s) of any damage. The Tribunal accepted that the consent process was the responsibility of Mr Hattotuwa as he was conducting the procedure.

(1)

44. The Tribunal noted the submission of Mr U that "the adverse findings, in this regard, might be considered to be technicalities" but concluded that the details missed were important in forming a rigorous consent process.

45. The Tribunal found that this single part of the discussion in respect of risks to organs fell below the standards expected, but not seriously below, and in and of itself did not amount to misconduct. Mr Hattotuwa did mention the risks to 'other organs' but did not provide the detail that would have been good practice. It noted that a patient informed of the potential for damage to other organs did have a basis on which to ask any clarifying questions. While that did not justify failing to provide the information required, it did protect the patient from not knowing of the existence of a risk.

(2)

46. The Tribunal considered that there is, as discussed during proceedings, an overarching consent process, and that a failure to satisfactorily implement this would amount to misconduct. However, it concluded that a failure to provide a level of detail which would be best practice does not amount to misconduct when each aspect is considered individually. The Tribunal was not satisfied that it had been provided evidence that Mr Hattotuwa's individual failings in this regard fell seriously below the standards expected or fundamentally undermined the consent process.

(4)

47. The Tribunal accepted the evidence of Mr Hattotuwa that his general practice was to inform patients that he cannot guarantee complete success. However, the Tribunal did not accept that this amounted to an adequate discussion of risks as part of the consent process. It concluded that Mr Hattotuwa should have given more detail as part of a thorough consent process and had failed to do so, but that as he had raised the issue generally, his actions did not amount to misconduct.

Paragraph 4(b)

48. The Tribunal noted its findings at the fact stage that whilst the only written record of Patient C's previous blood loss was made by her, and she appears to have led the conversation about the risk of bleeding, the matter was raised at the time and that her consent was adequately obtained as it pertained to the risk of blood transfusions.

49. However, the Tribunal considered that Mr Hattotuwa, who did not seem to recognise the seriousness of the possibility for the need for a blood transfusion in this specific case, had failed to maintain adequate records of this discussion. It concluded that the failure to make such a record did not create or increase the risk of an adverse outcome for the patient and that, whilst this fell below the standards expected, it did not fall seriously below or amount to misconduct on its own.

Paragraph 4(d)(i)

50. Mr Hattotuwa did not write down the date of the laparotomy, and whilst he should have, the actual date of the procedure could have been identified by a review of the patient's overall notes, even if it had not been added later by another person to the operative record.

The Tribunal concluded that this was an oversight, that the impact was negligible, and could not be said to have the potential to impact future care. It concluded that this failure, by itself, did not amount to misconduct.

51. It also noted the submission of Mr U that the GMC accepted that the Tribunal may take the view that this recording failure did not constitute serious misconduct, bearing in mind the nature of the omission.

Paragraph 5(b)(i)

52. The Tribunal noted that this allegation was about record keeping only, and that there was no allegation or evidence that Mr Hattotuwa did not discuss the risk of injury to the bowel, bladder and ureters, even in general terms. The Tribunal also noted that in this circumstance, general reference to damage to organs was not recorded on the consent form, as was the case in other instances.

53. The Tribunal concluded that this failure to record the risk of injury to organs, whilst falling below the standards expected, did not fall seriously below such that it amounted to misconduct.

Paragraph 9(a)

54. The Tribunal concluded that whilst the procedure was not carried out as was intended and that part of Patient G's small bowel was removed, it had heard evidence that this was a known risk of the procedure from Mr X, which Mr V accepted after discussion of the method used to conduct the procedure.

55. The Tribunal noted that Mr Hattotuwa had been using a more traditional 'blind method', which remained accepted practice at the time, but which he no longer uses. His evidence was that on the second entry he felt the uterus 'give' and stopped the procedure. He conceded that he must have perforated the uterus on the first entry, extracting material he believed to be a part of the polyp but was actually bowel, and that he did not recognise this until the second entry, at which point he stopped.

56. The Tribunal heard no evidence that was specifically critical of Mr Hattotuwa's failure to realise that he had perforated the uterus on the first entry or that demonstrated that Mr Hattotuwa's actions fell seriously below the standards expected in the context of the method

being used.Mr V's evidence was that if Mr Hattotuwa had thought that he had perforated the uterus but continued the procedure anyway, that would be seriously below the standard expected. That was not the state of the factual evidence.

57. Accordingly, the Tribunal determined that Mr Hattotuwa's actions did not amount to misconduct.

Paragraph 9(b)(ii)

58. During his witness evidence, Mr V stated that he did not think Mr Hattotuwa would have thought that he had extracted small bowel tissue unless it was a particularly large sample, and that even then it might have been quite difficult because it might have looked exactly the same as a polyp sample.

59. Given its findings in respect of paragraph 9(a) and the evidence that small bowel tissue could not be identified macroscopically, the Tribunal determined that Mr Hattotuwa failing to recognise that he had removed part of the small bowel could not constitute misconduct.

Paragraphs 10(a) & (c)

60. In considering this paragraph, the Tribunal reminded itself of its findings at the facts stage, as set out at paragraph 218 of its facts determination, that:

> "The Tribunal accepted that it was Mr Hattotuwa's genuine opinion that the potential prolapse was the main issue and surgery was required to address this, which might also help with Patient H's incontinence. However, it concluded that incontinence was nonetheless an issue, albeit potentially a secondary issue, and that there was no specific investigation of this. There was no evidence of discussion of alternative options for treatment or of a management plan going forwards, which should have occurred. Even if Mr Hattotuwa thought surgery to repair the prolapse would, in turn, manage the incontinence issues, he had a responsibility to monitor whether that had occurred, which he did not."

61. The Tribunal accepted that the primary issue was in fact the prolapse, rather than incontinence issues, and that Mr Hattotuwa focused on this in the belief that this might also address some of the incontinence issues, and that these could potentially be addressed later

should the prolapse procedure fail to improve these. The Tribunal also accepted that the prolapse and the symptoms which arose from that could not have been resolved non-surgically.

62. The Tribunal was of the opinion that whilst the prolapse may have been the primary issue and a priority, it would have been preferable for Mr Hattotuwa to address Patient H's symptoms holistically and discussed alternative treatments and monitoring, even though he thought that the incontinence and urological issues would also likely improve as a consequence of the surgery.

63. The Tribunal concluded that Mr Hattotuwa had a responsibility to do more and arrange for further treatment/investigation after the surgery and that he took insufficient interest in Patient H's secondary complaint. However, it noted the steps contained in the Allegation could have followed surgery to repair the prolapse, to manage the secondary complaint. Therefore, whilst it considered that his actions fell below the standards expected, it determined that they did not fall seriously below or amounted to misconduct in failing to take those steps before recommending surgery to repair the prolapse.

Paragraph 11(a)(ii)
(1)

64. As per its findings in respect of paragraph 4(a)(ii)(1), above, the Tribunal found that this single part of the discussion in respect of risks to organs fell below the standards expected, but not seriously below, and in and of itself did not amount to misconduct. Mr Hattotuwa did mention the risks to 'other organs' but did not provide the detail that would have been good practice.

(3)

65. The Tribunal accepted the evidence of Mr Hattotuwa that his general practice was to inform patients that he "cannot recreate what God created." which he takes to communicate that he "may not cure your symptoms or achieve what I'm trying to set out [to do]". The Tribunal did not accept that the amounted to an adequate discussion of risks as part of the consent process. The Tribunal was of the opinion that this statement was too ambiguous and would not make clear to the patient what exactly this meant, for example whether the procedure might not work at all or the expected degree of its effectiveness.

66. The Tribunal concluded that Patient H had not gone into surgery with no idea of the goals of the procedure and given its finding at the fact stage that Mr Hattotuwa had discussed the risk of recurrence of the prolapse, it determined that not discussing the failure to achieve goals in more detail was not sufficient to constitute misconduct. In reaching its decision it noted the submission of Mr U that "the failure to discuss the potential failure to achieve goals and the alteration of sexual function do, arguably …just about, cross the threshold of serious misconduct."

(5)

67. The Tribunal considered that one of the reasons that Mr Hattotuwa conducted the procedure on Patient H was to address the issues she was having with sexual function due to her prolapse. It therefore concluded that some discussion of sexual function must have occurred.

68. The Tribunal was not provided any evidence as to what detail should have been discussed, for example whether there was a risk that the procedure could exacerbate her symptoms in relation to sexual function. Similarly, it was provided no evidence that Mr Hattotuwa's actions in this respect fell seriously below the standards expected.

69. Accordingly, it found that his actions did not amount to misconduct.

Paragraph 11(b)

70. The Tribunal concluded that Mr Hattotuwa had failed to record any discussion around the recurrence of the prolapse. However, it found that this was discussed and that this failure did not impact patient care.

71. Accordingly, it found that Mr Hattotuwa's actions did not fall seriously below the standards expected or amount to misconduct.

Paragraph 12

72. The Tribunal considered the context of this paragraph, whereby Mr Hattotuwa spoke to Patient H out of courtesy as he was attending the hospital for another reason, and that he did not have her notes with him.

73. However, as per its findings at the facts stage, the meeting ultimately ended up being a consultation, which therefore should have been recorded.

74. The Tribunal noted that it had not been shown any evidence to demonstrate that Patient H's care was, or could have been, impacted by the failure to record the consultation which contained a general suggestion by Mr Hattotuwa that Patient H might wish to have an enema.

75. The Tribunal also noted the submission of Mr U that the GMC "accept that the Tribunal may take the view that the recording failures… do not constitute serious misconduct, bearing in mind the nature of the omissions from the records."

76. Accordingly, the Tribunal determined that Mr Hattotuwa's actions did not fall seriously below the standards expected or amount to misconduct.

Paragraph 13(a)(ii)(1)

77. As per its findings in relation to paragraphs 4(a)(ii)(1) and 11(a)(ii)(1) above, the Tribunal determined that Mr Hattotuwa's failure to specifically discuss the risks of injury to bowel, bladder, blood vessels and ureters did not fall so seriously below the standards expected as to amount to misconduct. In reaching this decision it noted that this was another example where damage to organs (generally) was referenced on the actual consent form.

Paragraph 13(b)

78. The Tribunal found at the facts stage that there had been some discussion of other procedures that may be required, although as there was no written record, it was not clear what the detail of that discussion was.

79. The Tribunal concluded that this amounted to deficient record-keeping by Mr Hattotuwa but determined that this did not amount to misconduct, particularly given that there was no impact to the patient or the care provided by other colleagues.

Paragraph 13(c)

80. As per the Tribunal's findings at the facts stage, Mr Hattotuwa was not aware that the information he was providing on the Funding Form was false at the time that he completed it, nor was he acting dishonestly.

81. The submission of Mr U in respect of this paragraph was that "The false statements in the funding request form are neither here nor there, in circumstances of the finding that the doctor was not acting dishonestly—they are mere errors of fact."

82. The Tribunal noted that Mr Hattotuwa did not have Patient I's notes when he completed the Funding Form. It concluded that his actions were careless and demonstrated a lack of willingness to ascertain the correct information before completing the application. The Tribunal considered that this was not acceptable, as accuracy is important in this context and it would expect a doctor positively to ensure that information is correct. Nonetheless, it accepted this was a genuine error, in line with its decision at the facts stage.

83. The Tribunal considered the following paragraph of GMP to be relevant:

> ***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.*

84. Whilst it considered Mr Hattotuwa's actions to amount to a failure, it determined that they fell short of serious misconduct.

Paragraph 16(a)

85. As per its findings at the facts stage, the Tribunal determined that Mr Hattotuwa had sought the advice of an expert colleague and acted on their advice, but had failed to ensure they were aware of the full context and the radiologist's opinion. During his evidence at the impairment stage, Mr Hattotuwa stated that he had thought or assumed that Mr AA had read the full report, and the Tribunal heard evidence from him that it was not uncommon for specialists to go against or overrule the suggestions of radiologists.

86. The Tribunal considered the following paragraph of GMP when reaching its decision:

> ***35*** *You must work collaboratively with colleagues, respecting their skills and contributions.*

87. The Tribunal concluded that Mr Hattotuwa was therefore given the advice, expressed in robust terms, which he followed, without ensuring this was based on a full account of the records. The Tribunal determined that this was a failure on his part and he should have been more meticulous but that this was an isolated incident and Mr Hattotuwa had not positively sought to withhold the information.

88. The Tribunal's criticism was not that Mr Hattotuwa had followed the expert advice even though it was contrary to the radiologist's advice, but that he had not been diligent in ensuring all the relevant information was considered before the contrary advice was given.

89. Whilst the Tribunal considered this a failure, it determined that it did not amount to misconduct.

Paragraph 17

90. The Tribunal accepted the evidence that the nurses present at the time, and Patient J's husband had not intervened, and therefore concluded that this occurred towards the end of the procedure. However, it found that Mr Hattotuwa should have stopped immediately when requested to do so, but rather it appeared that he completed the procedure then stopped.

91. The Tribunal concluded that it was Mr Hattotuwa's duty to stop when requested, irrespective of others speaking up, and that stopping and explaining the situation would have been the appropriate response.

92. In reaching its decision, the Tribunal also bore in mind the following paragraph of GMP:

> ***17*** *You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.*

93. Whilst acknowledging some mitigating circumstances, the Tribunal found that Mr Hattotuwa continued with the procedure despite consent being withdrawn, and it was provided no evidence that this was necessary for the patient's safety.

94. The Tribunal therefore determined that Mr Hattotuwa's actions fell seriously below the standards expected and amounted to misconduct.

Paragraph 18(a)

95. As Mr Hattotuwa denied this paragraph of the Allegation, which he is entitled to do, the Tribunal was provided no explanation as to how or why this happened.

96. As per its determination on the facts, the Tribunal found that Mr Hattotuwa cut through a structure that he was not meant to be operating on. In his expert report,Mr V stated that:

> "In my opinion part of the performance of the procedure fell seriously below the standard expected of a reasonably competent Consultant Gynaecologist because Mr Hattotuwa did not recognise that he had cut through the sigmoid colon in its entirety. The fact that he completely transected the sigmoid colon without recognising that he was inside the sigmoid colon in my opinion shows he did not have the skill set to undertake this level of laparoscopic surgery."

97. The Tribunal determined that Mr Hattotuwa had improperly conducted the surgery and was mindful of the opinion ofMr V that there is a very clear difference between cutting into or perforating a bowel and a complete transection.

98. The Tribunal considered the following paragraphs of GMP when reaching its decision:

> *7 You must be competent in all aspects of your work, including management, research and teaching.*
>
> *14 You must recognise and work within the limits of your competence.*

99. Accordingly, it found that Mr Hattotuwa's actions fell seriously below the standards expected and amounted to misconduct.

Paragraph 18(b)(i)

100. The Tribunal considered that the height of the criticism against Mr Hattotuwa in respect of this paragraph was that Patient K ended up with two scars rather than one, as the

patient subsequently had an incision by way of a midline approach, in addition to the Pfannenstiel incision.

101. At the facts stage, Mr Hattotuwa stated that maybe he should have undertaken a midline approach and accepted the criticism, and the Tribunal determined that this demonstrated that he did not properly consider the treatment path and that his actions were inappropriate.

102. However, the Tribunal concluded that Mr Hattotuwa's actions, though ultimately inappropriate, were not reckless. He usually used this approach to reduce scarring for patients and was attempting to consider Patient K's needs at the time. He was not thinking forward as to the approach a subsequent surgeon would take and acted in line with what he thought was the best approach at the time.

103. Therefore, the Tribunal determined that his actions did not fall seriously below the standards expected or amount to misconduct.

Paragraph 18(c)

104. Having found that Mr Hattotuwa inappropriately completely transected the sigmoid colon and that this fell seriously below the standards expected, and in light of the evidence of Mr V, the Tribunal also found that Mr Hattotuwa's failure to notice that he had done so also fell seriously below the standards expected and amounted to misconduct.

Paragraph 18(d)(ii)(2)

105. The Tribunal considered Mr Hattotuwa's evidence that he had caused and repaired the bladder injury and that the specific size was not relevant to other treating practitioners.

106. Whilst not accepting that the size of the injury was entirely irrelevant, the Tribunal determined that Mr Hattotuwa's failure to record this did not fall seriously below the standards expected or amount to misconduct, in circumstances where he had repaired the damage, it was relatively small, and no further treatment was required.

Paragraph 20

107. During his evidence at the impairment stage, Mr Hattotuwa stated that he knew the latest histology finding was not concerning and was more reliable than the examination that came before it, so had relied on that and filed it in line with policy at the time. Mr V's evidence was that if he had checked the relevant colposcopy opinion and cytology result, and convened an Multi Disciplinary Team ('MDT') meeting, as is now the normal approach, he would have ended up in the same position, but with discussion and the input of colleagues.

108. The Tribunal considered that Mr Hattotuwa did have a duty to cross-check results as he was the consultant who received the histology result, but that no harm came to the patient as the outcome would have been the same as had it gone to the MDT. It accepted that the histology result was likely to be more accurate than the impression that preceded it, and noted that the policy change requiring referral to the MDT came after this incident. It concluded that best practice would have been to check but that his actions were not reckless and did not amount to serious misconduct.

109. In reaching its decision, the Tribunal also noted the submission of Mr U that:

> "In the circumstances of the Dr's limited involvement in the cytology result and the biopsy report, and considering all the evidence that was presented, in respect of these matters, at the hearing, the Tribunal may well find that those matters concerning PT M… do not amount to serious misconduct, but there is a communication issue…"

Paragraph 21(a)

110. Mr Hattotuwa's evidence was that he did not realise that he could hand off the Datix and that as the coloscopy lead he was under the impression that he was responsible for signing it off. The Tribunal accepted his evidence that he was involved administratively and that he understood the purpose of the Datix to be a learning exercise, not a process of assigning blame.

111. The Tribunal found that whilst Mr Hattotuwa was genuine in his intentions, his approach was nonetheless naïve and inappropriate, and he should not have been involved in completing the Datix given his involvement with the patient.

112. The Tribunal considered that there was just one instance of this nature, with no suggestion that Mr Hattotuwa was regularly signing off or approving his own work.

Accordingly, it determined that this did not fall seriously below the standard expected or amount to misconduct.

Paragraph 21(b)

113. The Tribunal considered that whilst not informing colleagues of a Datix report does undermine its purpose somewhat, Dr N knew the outcome by October 2020 at the very latest.

114. As this was a one-off incident the Tribunal determined that this did not fall seriously below the standard expected or amount to misconduct.

Paragraph 22(b)(i)

115. In considering this paragraph, the Tribunal reminded itself of its finding at the facts stage that:

> "The Tribunal was of the opinion that any reasonable person hearing that would interpret such a comment as dismissive, and suggestive of his having been thrust into the meeting. The Tribunal took the view that the comment will have contributed to Patient O's distress throughout the meeting, and her perception that it did not achieve anything for her."

116. The Tribunal also bore in mind the following paragraph of GMP:

> ***46*** *You must be polite and considerate.*

117. The Tribunal accepted that Mr Hattotuwa did not mean to offend Patient O but concluded that his communication in this regard was insufficiently sympathetic. It noted that this occurred in the context of an inevitably highly emotional meeting, and that Patient O had already experienced issues getting results of the post-mortem, and in arranging, and rearranging, the meeting. It was of the opinion that this may have predisposed her to being more distressed, understandably, and that this may have contributed to, or exacerbated, her perception of Mr Hattotuwa's comments, which were nonetheless, inappropriate.

118. The Tribunal concluded that this was not how the meeting should have been handled, this represented one poorly worded comment. Whilst not downplaying the impact to Patient O in the circumstances, this single failing did not constitute misconduct.

Cumulative Misconduct

119. Whilst the Tribunal determined Mr Hattotuwa's actions in respect of advising of the risks to specific organs to Patients H and I, when considered individually, did not amount to serious misconduct, it went on to consider whether, in aggregate, they did.

120. The Tribunal found that Mr Hattotuwa had failed to discuss or record the specific risks in relation to Patients C (where it found misconduct), H and I and had failed to record any such discussions in respect of Patient D. It noted that for Patients H and I there was reference to the risk of damage to organs generally but not specifically or individually (in terms of which organs) and that these patients would have been subject to the same ambiguity. However, this was open to further questions or discussion by the patients.

121. The Tribunal considered that if this had been Mr Hattotuwa's consistent practice, this could be concerning in respect of his approach to consenting patients, but it had only been given evidence of these specific and seemingly isolated examples. It therefore concluded that these failures, even when considered collectively, did not amount to misconduct.

122. The Tribunal has concluded that Mr Hattotuwa's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct, specifically in relation to:

- His failure at a consultation with Patient C to discuss damage to other organs and alternative treatments;
- Completely transecting the sigmoid colon of Patient K and failing to recognise that he had done so;
- His failure to stop a procedure when told to by Patient J.

Impairment

123. The Tribunal having found that the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct, Mr Hattotuwa's fitness to practise is currently impaired.

124. The Tribunal first considered the test set out in *Grant*, above.

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

125. The Tribunal concluded that Mr Hattotuwa's failure to discuss options properly with Patient C could have resulted in harm, in the form of limiting her ability to make the best decision for herself.

126. It also concluded that whilst no physical damage was caused to Patient J, she experienced significant physical pain and the impact of that continuing pain cannot be diminished, as is the case for the emotional or psychological harm that potentially resulted. Considering actual harm in the broader sense, the Tribunal was mindful of the impact of her withdrawal of consent not being respected, and the potential fear of that happening again in the future. Patient J did not feel at the time that this was sufficiently serious to raise concerns immediately. It was her concern for the potential for harm to others that motivated her to come forward subsequently.

127. In respect of Patient K, Mr Hattotuwa caused physical, structural harm that potentially could have had far more serious consequences were the issue not identified and repaired as quickly as it was.

Has in the past and/or is liable in the future to bring the medical profession into disrepute

128. The Tribunal concluded that accidentally transecting Patient K's colon, and failing to heed Patient J's request to stop an invasive and painful procedure, was liable to bring the reputation of the profession into disrepute, noting that the reputation of the profession as a whole can suffer as a result of an individual doctor's misconduct.

Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession

129. The Tribunal considered that respecting the limitations of consent must be considered a fundamental tenet of the profession, and that Mr Hattotuwa breached this in respect of Patient J.

130. The Tribunal then went on to consider the factors set out in *Cohen*, above, namely whether the matters are remediable, have been remedied and any likelihood of repetition, including whether Mr Hattotuwa is liable in the future to breach one or more of the limbs set out in *Grant*.

Remediable

131. The Tribunal considered that Mr Hattotuwa's misconduct was remediable and represented specific, isolated, clinical failings rather than attitudinal issues or general areas of his practice. Whilst the misconduct found may reflect failures in Mr Hattotuwa's decision-making at the relevant times, this was not a case where he was acting deliberately poorly, or prioritising something other than patients' best interests, to their detriment.

132. In respect of Patient C his failures related to the discussion of risks and alternative options, which it considered was easily remediable. In regard to Patient J it considered that this was an important failing but it was possible for Mr Hattotuwa to learn from the experience and understand his obligations and the importance of consent. With regards to Patient K, the Tribunal considered that this was also remediable as it pertains to Mr Hattotuwa's skillset, competence, and understanding his own limitations and capacity.

Remedied

133. The Tribunal then considered what evidence it had before it to demonstrate that Mr Hattotuwa had remediated his misconduct. Mr Hattotuwa gave evidence at the impairment stage where he expressed regret for his failings and explained how he has been working under supervision, has altered his practice to protect against a recurrence, and how policies and procedures have also changed since the events, reducing or eliminating the risk of repetition. He explained that he had previously taken on high-risk patients when other practitioners would not, but that he would be more careful and refrain from doing so in future. He also explained how he intends to remain in NHS practice at his current location only until his retirement in a few years, and was unlikely to undertake private practice in the future.

134. The Tribunal received Supervisor's Reports from Mr T (MRCOG) Obstetric Clinical Director, Bedfordshire Hospital NHS. These reports attested to Mr Hattotuwa's willingness to learn and to develop, and that no incidents or near misses had occurred since his supervision had commenced. They set out how Mr Hattotuwa has learned new processes and techniques, has suitable skills and knowledge and shows a capacity and willingness to update his practice. The Tribunal considered this particularly relevant as it had heard evidence throughout these proceedings that he had used more traditional techniques in some circumstances.

135. The Tribunal also noted that Mr Hattotuwa's progression was apparently demonstrated by Mr T's reports, with the first report, dated September 2021, suggesting that he needed to be gentler with tissue handling, the second report, dated March 2022 stating that he should continue with gentle tissue handling and the third report, dated March 2025, making no reference to tissue handling. The Tribunal noted the relevance of this to its findings in relation to Patient K in particular.

136. The Tribunal also noted that Mr T states that Mr Hattotuwa was managing difficult procedures competently by 2025 and had gained a lot in confidence.
Mr T states that Mr Hattotuwa pays attention to clinical details and presents cases systematically in his consultations, which the Tribunal considered was relevant to its findings in respect of Patient C.

137. It is Mr T's opinion that Mr Hattotuwa is ready to practice on his own or without direct supervision. The Tribunal acknowledged that view. However, it attributed it limited weight on the basis that whilst Mr Hattotuwa has been practising on the front line and dealing with real issues under challenging circumstances, Mr T is not a clinical assessor.

138. The Tribunal also received patient feedback on behalf of Mr Hattotuwa in the form of a report dated July 2024. The Tribunal noted that there were no instances of any responses below 'satisfactory' or 'good', and that Mr Hattotuwa's listening was rated 'very good' by all patient's surveyed, which it considered to be important given that this is an issue that has come up during the course of these proceedings. Patients report that Mr Hattotuwa is good at communicating and 92% of those who completed the survey report that Mr Hattotuwa was not their usual doctor.

139. In considering the weight to attribute to this evidence, the Tribunal was mindful that Mr Hattotuwa has been working in a supervised environment, which is different to

independent practice. It also noted that there was evidence that the workload for Mr Hattotuwa has reduced since the events of the Allegation due to reduced surgical lists.

140. The Tribunal noted that whilst Mr Hattotuwa did not provide more specific documentary evidence and detail on his development of insight or detailed reflections, he was unrepresented at these proceedings and unfamiliar with the process and what would usually be expected. He did, however, elaborate on this during his oral evidence at the impairment stage and appeared more contrite, expressing remorse, regret and articulating how he has reflected on these matters, updated his practice and reduced the likelihood of repetition. It noted this appears to reflect his approach to supervision, which he appears to have embraced and learned from.

141. Mr Hattotuwa has reflected on his discussion with patients, particularly in relation to the risks of injury to organs, and how he now addresses and records this. He was clearly shocked with the finding made against him in relation to Patient J and although he denied the allegation in this respect, as he is entitled to do, he expressed very clearly how serious the Tribunal's findings are and his responsibility to maintain ongoing consent and to heed patients' requests.

142. In his submissions, Mr U commented on Mr Hattotuwa's challenging demeanour during the proceedings and questioned whether he has insight into his failings, stating that at times he was disparaging of Mr V, and questioned whether Dr W was an expert and any better placed than him to speak of the Patient P matters. The Tribunal considered that Mr Hattotuwa had a right to defend his case robustly, and noted that in relation to the Patient P allegations, none of these were found proved and Mr Hattotuwa's position was largely upheld. Similarly, in respect of some paragraphs of the Allegation, the Tribunal found Mr V's evidence to be insufficient to make findings against Mr Hattotuwa. The Tribunal concluded that he was defending himself to the best of his ability, and was found to be right in large parts of his challenge. It did not conclude that Mr Hattotuwa's approach to these proceedings demonstrated an inability to show insight, or undermined the evidence of his remediation.

143. The Tribunal also noted that the Supervisor's Reports of Mr T, the patient feedback and Mr Hattotuwa's oral evidence demonstrates he has a more modest demeanour and a willingness to accept constructive feedback, as acknowledged by Mr U in his submissions.

144. The Tribunal was not of the opinion that Mr Hattotuwa's conduct in these proceedings indicated an unwillingness to learn or develop or undermined the evidence of his insight and remediation.

Repetition

145. The Tribunal considered that Mr Hattotuwa seems to be willing to take on board other opinions and feedback, and implement them in his regular practice, reducing the likelihood of repetition.

146. Whilst Mr Hattotuwa maintains his denial in respect of Patient K, Mr T's reports demonstrate that he is now better at handling tissue gently, which was identified as an area for improvement, was addressed with a mapped and monitored route to improvement, and improved. Mr Hattotuwa has identified weak areas of his practice and has stated that he would not undertake procedures in these areas where he does not have the sufficient skillset or experience. The Tribunal considered that this reflected a degree of insight and represented a protective mechanism to reduce the risk of repetition.

147. The Tribunal also bore in mind the significant passage of time since the events, noting that there have been no concerns or recurrence since, albeit Mr Hattotuwa has been working under supervision for several years now. It appeared to the Tribunal that Mr Hattotuwa has been chastened by these events and has taken on board the lessons learned as a result of the GMC investigation. These proceedings, and the gravity of the process and facts found against him, have, in the Tribunal's view, been a salutary experience.

148. The Tribunal considered that whilst Mr Hattotuwa could have provided more specific written reflections or provided evidence of CPD courses attended, the real world demonstrations of improvement meant that there was nothing further required of him to show that he has remediated and developed insight.

149. The Tribunal concluded that in light of all the evidence, Mr Hattotuwa had remediated and was unlikely to repeat his failings. It determined that the risk of patient harm had been mitigated and that public confidence would not be undermined were a finding of impairment not made in the specific circumstances of this case. Whilst the Tribunal did find instances of professional misconduct, these were isolated cases over a long career and in and of themselves, when taken in light of Mr Hattotuwa's actions since these events, did not warrant a finding of current impairment.

150. The Tribunal has therefore determined that Mr Hattotuwa's fitness to practise is not impaired.

Determination on Warning - 23/05/2025

1. As the Tribunal determined that Mr Hattotuwa's fitness to practise was not impaired it considered whether in accordance with s35D(3) of the 1983 Act, a warning was required.

Submissions

2. On behalf of the GMC, Mr U submitted that the GMC had considered the Tribunal's determination on impairment carefully, In particular its findings as to serious misconduct, but more importantly, the section dealing with impairment, insight, remediation and repetition. It had also carefully considered the Guidance on Warnings 2024 ('the Guidance'), particularly paragraphs 32(a) - (g).

3. Mr U submitted that Mr Hattotuwa has been through the regulatory process, which the Tribunal has found to have been a salutary experience, and that in all those circumstances the GMC did not think that a warning was necessary in the public interest.

4. Mr Hattotuwa made no submissions on the matter of whether a warning should be issued.

The Tribunal's Determination on Warning

5. The decision whether to issue a warning is a matter for the Tribunal making an evaluative judgment taking account of all the circumstances of this particular case and having regard to the submissions of the parties. In deciding whether to issue a warning the Tribunal took account of the Guidance and whether a warning was necessary, appropriate and proportionate in this case.

6. The Tribunal reminded itself of the relevant paragraphs set out in the Guidance, including the purpose of warnings, the test for issuing a warning, the factors to consider, and proportionality.

7. In reaching its decision, the Tribunal took into consideration paragraph 32 of the Guidance:

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

8. As set out in its determination on impairment, the Tribunal concluded that Mr Hattotuwa has insight into his failings and, particularly, the seriousness of the findings made against him, including those aspects of the Allegation which he denied. It reiterated its finding that these proceedings and the findings made have been a salutary experience for him.

9. It was satisfied that Mr Hattotuwa's expressions of remorse and apologies were genuine and that he genuinely regretted his mistakes.

10. As per its findings at the impairment stage and the evidence before it, the Tribunal concluded that, given his insight and remediation, the behaviour was unlikely to be repeated.

11. The Tribunal noted that this is the first time concerns have been investigated regarding Mr Hattotuwa's fitness to practise and that there has been no repetition since the events.

12. The Tribunal was satisfied that Mr Hattotuwa had taken the necessary rehabilitative and corrective steps, as set out in its determination on impairment and its discussion of his remediation.

13. In reaching its decision the Tribunal noted the Supervisor's Reports provided on Mr Hattotuwa's behalf, which supported the conclusion that he has genuine insight and remorse, has remediated the misconduct found and that the likelihood of repetition is low. It also noted the positive patient feedback provided on Mr Hattotuwa's behalf.

14. The Tribunal concluded that, in light of its findings and the Guidance, it would not be appropriate to issue a warning.

15. There interim order in place is revoked with immediate effect.

16. That concludes this case.

ANNEX A – 07/05/2025

Application to admit further evidence

1. At the outset of proceedings, Mr Hattotuwa made an application, pursuant to Rule 34(1) of the GMC (Fitness to Practise) Rules 2004 as amended ('the Rules'), to admit evidence in the form of an expert witness report by Mr X.

2. Mr X's report was not included in the hearing bundle provided to the Tribunal, and he had not been scheduled or called to give evidence. Mr Hattotuwa indicated to the Tribunal that he wished to rely on the report of expert witness Mr X, and potentially to cross-examine him.

Submissions

On behalf of the GMC

3. On behalf of the GMC, Mr U, counsel, submitted that Mr X's report had been discounted from the hearing bundle and evidence due to an identified conflict of interest, as Mr X had previously been instructed in relation to a personal claim made by Patient C against Mr Hattotuwa.

4. Mr U submitted that on 23 December 2020 the GMC had emailed Mr Hattotuwa and his then legal representatives to inform him of this, and that the decision was reiterated in further correspondence dated 24 July 2024 and 8 August 2024.

5. Mr U submitted that the GMC had contacted Mr X following Mr Hattotuwa raising the matter on the first day of these proceedings and that Mr X confirmed that he was unavailable to attend as a witness during the current listing as he was currently abroad and completing on the sale of his house and that, moreover, he was also very reluctant to appear on behalf of Mr Hattotuwa.

6. Mr U submitted that it would be for the Tribunal to decide whether:

- to adjourn and grant time for Mr Hattotuwa to contact Mr X himself and to seek to instruct him to attend a future MPT hearing if he wished;

- Mr X Report should be admitted into evidence as hearsay in line with relevant case law;
- the case should continue without Mr X's involvement.

7. Mr U submitted that from a pragmatic perspective and in fairness to Mr Hattotuwa, who was unrepresented, and to the witnesses who were expecting to testify, the GMC was in agreement with the report of Mr X being admitted into evidence on behalf of Mr Hattotuwa. He submitted that if the Tribunal were minded to allow Mr X's report into evidence as hearsay evidence, the GMC would wish the Tribunal to keep in mind that the evidence would not be agreed in its entirety. He submitted that the GMC would not be in a position to cross examine Mr X on those parts of it with which it disagrees and that the Tribunal should attach far less weight to those parts of it that are inconsistent with the expert reports of Mr V and Dr W. He submitted that both Mr V and Dr W have already seen Mr X's report and provided a response, which the GMC would wish to place before the Tribunal were Mr X's report to be admitted by the Tribunal.

On behalf of Mr Hattotuwa

8. Mr Hattotuwa submitted that he wished the Tribunal to see Mr X's report and consider it alongside the expert reports of Mr V and Dr W. He submitted that Mr V took an extreme and 'nitpicky' approach to the standards expected and his conclusions, which did not reflect how a collective body of gynaecologists would actually practise. He submitted that Mr X's opinion differed to that of Mr V on some aspects of care, was more down to earth and realistic, and that allowing the submission of his report would enable the Tribunal to consider the difference of approaches taken and conclusions reached.

9. Mr Hattotuwa submitted that requesting Mr X's attendance was not a viable option given the reasons he has set out and his stated reluctance to appear on his behalf.

10. Mr Hattotuwa submitted that in respect of Mr X's involvement with the personal claim of Patient C, he had never received or responded to such a claim and was not aware of what Mr X's involvement may have been.

11. Mr Hattotuwa submitted that in the circumstances he was applying for the report of Mr X to be admitted as hearsay evidence in order that the Tribunal could review it for the reasons set out above.

Legal Principles

12. 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.'*

13. Essentially, therefore, admissibillity of evidence is at the discretion of the Tribunal and it should have regard to the interest of fairness and also consider the balance of prejudice to each party. The decision should also be considered through the lense of the overarching objective which requires the Tribunal to:

a. Protect, promote and maintain the health, safety and well-being of the public,

b. Promote and maintain public confidence in the medical profession, and

c. Promote and maintain proper professional standards and conduct for members of that profession.

14. In considering fairness, the Tribunal applied the legal principles derived from the case of *R (Bonhoeffer) v GMC [2011] EWHC 1585 (Admin),* and the case of *Thorneycroft v NMC [2014] EWHC 1566 (Admin).* The Tribunal was aware that there were two distinct stages to assessing fairness when considering hearsay evidence in regulatory proceedings: stage one being admissibility and stage two being the weight to be attached to the hearsay evidence.

The Tribunal's Decision

15. The Tribunal noted that the submission of Mr X's report as hearsay evidence was not opposed by the GMC and that it had heard no substantive reason why it could not be submitted as such.

16. The Tribunal was satisfied that the evidence was relevant for the reasons set out by Mr Hattotuwa, who submitted that he would use Mr X's report to put his case and challenge the other expert witnesses' evidence.

17. The Tribunal concluded that there would be no unfairness to the GMC were Mr X's report to be submitted, if it was attributed appropriate weight as hearsay evidence. It also noted that the report had originally been withdrawn out of fairness to Mr Hattotuwa, who wished to have the report submitted.

18. The Tribunal therefore determined to grant Mr Hattotuwa's application to admit Mr X's report as hearsay evidence.

ANNEX B – 07/05/2025

Application to amend the Allegation

1. On 30 October 2024 Mr U made an application on behalf of the GMC to amend the Allegation, pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise) Rules 2004, as amended ('the Rules'). This application was to strike through paragraphs 11(c)(i) and 11(c)(ii).

Submissions

On behalf of the GMC

2. Mr U submitted that following the witness evidence of expert witness Dr V, the GMC sought to strike through paragraphs 11(c)(i) & (ii) of the Allegation, as set out below.

> *11. On 19 November 2018, you carried out a vaginal hysterectomy on Patient H and you failed to:*
>
> …
>
> *d. record, within the operative note for the procedure:*
> *i. the scarring from previous fenton's procedures;*
> *ii. the use of bladder buttress sutures;*

3. Mr U submitted that although the scarring from previous Fenton's procedures and the use of bladder buttress sutures was not in Mr Hattotuwa's operating note, it was in Mr

Hattotuwa's subsequent letter. He submitted that the opinion of Dr V was therefore that Mr Hattotuwa's actions fell below, but not seriously below the standards expected and that on that basis, the GMC sought to withdraw these sub-paragraphs of the Allegation.

On behalf of Mr Hattotuwa

4. Mr Hattotuwa submitted that he supported the GMC's application and that those sub-paragraphs of the Allegation should be removed accordingly.

Tribunal's Decision

5. The Tribunal was mindful of paragraph 17(6) of the General Medical Council's (Fitness to Practise) Rules 2004, as amended, which states:

> *'17(6) Where, at any time, it appears to the Medical Practitioners Tribunal that—*
>
> > *(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and*
> >
> > *(b) the amendment can be made without injustice,*
>
> *it may, after hearing the parties, amend the allegation in appropriate terms.'*

6. The Tribunal noted that the basis for the application was a shift in the expert witness evidence in respect of these paragraphs. It took the view that the approach proposed by the GMC would reflect the evidence as it now stood on those points.

7. The Tribunal determined to allow the GMC's application to remove paragraphs 11(c)(i) & (ii) of the Allegation. The Tribunal found that it was fair and sensible and would cause no injustice to Dr Hattotuwa to remove the paragraph, noting that Mr Hattotuwa was in support of the application.