PUBLIC RECORD

Dr Thampi has lodged an appeal against decisions of this Tribunal. She remains free to practise unrestricted while the appeal is considered.

Dates: 13/09/2024 - 09/10/2024; 03/03/2025 - 05/03/2025; 07/04/2025 - 11/04/2025; 15/04/2025; 23/04/2025 - 09/05/2025; 12/06/2025

Medical Practitioner's name: Dr Premila THAMPI

GMC reference number: 4261917

Primary medical qualification: MB BS 1987 University of Madras

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

Summary of outcome

Suspension, 3 weeks

Tribunal:

Legally Qualified Chair:	Mrs Tehniat Watson
Lay Tribunal Member:	Ms Liz Daughters
Medical Tribunal Member:	Dr Nagarajah Theva

Tribunal Clerk:	Miss Emma Saunders Mr Andrew Ormsby (03/03/2025 - 05/03/2025) Ms Hinna Safdar (12/06/2025)

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Ms Lydia Barnfather, Counsel, instructed by Clyde & Co LLP
GMC Representative:	Mr Simon Jackson, KC

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 02/05/2025

Background

1. Dr Thampi qualified in 1987 at the University of Madras in India. She worked in obstetrics and gynaecology and paediatrics during her time practising as a junior doctor in India and completed a Postgraduate Diploma in obstetrics and gynaecology. Dr Thampi moved to the UK in May 1991 and became a Member of the Royal College of Obstetricians and Gynaecologists (RCOG) in 1996. She was granted full registration with the GMC in 1996 and was entered on the specialist register for obstetrics and gynaecology in March 2007. Dr Thampi had worked and completed further training in the UAE between January 1998 and August 2001. At the time of the events in question, Dr Thampi was practising as a Consultant in Obstetrics and Gynaecology at the Milton Keynes University Hospital NHS Foundation Trust ('the Trust'). After undertaking a number of locum Consultant roles in Southampton and Maidstone, Dr Thampi had obtained this substantive post at Milton Keynes University Hospital ('the Hospital') in February 2010, and she worked there until 2020. From January 2021 Dr Thampi has been working as a locum Consultant Obstetrician and Gynaecologist at East Surrey Hospital, Surrey and Sussex Healthcare NHS Trust.

2. The allegations that have led to Dr Thampi's hearing relate to her conduct during her time at the Hospital. It is alleged by the General Medical Council (GMC) that, on dates from XXX October 2016 to XXX August 2018, Dr Thampi failed to provide good clinical care to Patients A, B and C, in respect of the delivery of their babies. It is also alleged by the GMC that, on 26 October 2018, Dr Thampi made an inappropriate comment to a colleague during an appraisal process.

3. The initial concerns were raised with the GMC by the Trust on 14 February 2020, which was further to a local investigation by the Trust under the NHS's Maintaining High

Professional Standards process. On 30 May 2022 the GMC wrote to Dr Thampi to inform her of the allegations against her. Dr Thampi provided a response to the allegations on 13 January 2023. On 8 March 2023 the GMC wrote to Dr Thampi to advise her that her case had been referred to a Medical Practitioners Tribunal hearing.

The Outcome of Applications made during the Facts Stage

4. At the outset of the hearing the Tribunal raised the question of anonymity with the parties. It was agreed with the parties that patients, and their relatives, must be anonymised during the hearing to ensure their confidentiality.

5. The Tribunal granted the GMC's application, made on 13 September 2024 and pursuant to Rule 17(6) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), for amendment of paragraph 4 and withdrawal of paragraphs 1(f) and 1(g) of the Allegation. The Tribunal's full decision on the application is included at Annex A.

6. The Tribunal granted the GMC's application, made on 17 September 2024 and pursuant to Rule 17(6) of the Rules, for withdrawal of paragraphs 3(a)(i)(1) to (3), 3(iv), and 3(e)(ii) to (iv) of the Allegation. Mr Jackson, Counsel on behalf of the GMC, also asked for the removal of the words *"receive and"* from paragraph 5(a)(i) and the Tribunal also proposed that the word *"you"* should be inserted at paragraph 3(d) of the Allegation. The Tribunal's full decision on the application is included at Annex B.

7. On 19 September 2024 the Tribunal agreed that a witness called on its behalf as the result of a preliminary application, Ms R, would be permitted to give evidence by video link. In respect of Rules 34(13) and (14) of the Rules, the Tribunal considered that the decision to hear the evidence by video link was in the interests of justice and ensured that the hearing could proceed without delay.

8. On 20 September 2024 the Tribunal raised, of its own volition, the possibility of amendment of the Allegation and invited submissions from the parties on this point. The Tribunal determined to make amendments to paragraphs 5(a)(ii) and 5(c)(i) and (ii) of the Allegation pursuant to Rule 17(6) of the Rules. The Tribunal's full decision on the application is included at Annex C.

9. On 26 September 2024 the Tribunal agreed, in accordance with Rules 34(13) and (14) of the Rules, for Dr M to give evidence by video link. It agreed that this was the most practical way to continue and considered it was in the interests of justice to do so.

10. On 1 October 2024 the Tribunal was hearing evidence from a witness. An issue arose as to whether Mr Jackson should be permitted to continue asking questions of the witness regarding Syntocinon. As there was disagreement between the parties, the Tribunal made a decision on this issue and did not permit Mr Jackson to continue with this line of questioning. The Tribunal's full decision on the application is included at Annex D.

11. On 3 October 2024 the Tribunal granted Dr Thampi's application, made pursuant to Rule 17(2)(g) of the Rules, in relation to paragraphs 3(a)(i)(4), 3(e)(i), and 5(a)(ii) of the Allegation. The Tribunal refused the GMC's application, made pursuant to Rule 17(6) of the Rules, for amendment of paragraph 5(a)(ii) of the Allegation. The Tribunal's full decision on the application is included at Annex E.

12. On 7 October 2024 the Tribunal was hearing oral evidence from Dr Thampi. An issue arose during Mr Jackson's cross-examination as to whether he should be permitted to continue asking questions of Dr Thampi about consent in respect of Patient A with reference to two guidance documents. The Tribunal determined the questions to be relevant and, in light of the time afforded to Dr Thampi to read the documents in full, it considered that allowing the questions on the additional documents to be fair. As such, the Tribunal permitted Mr Jackson to continue with this line of questioning. The Tribunal's full decision on the application is included at Annex F.

13. On 7 October 2024 the Tribunal was invited to consider the question of the two research articles that Mr Jackson was seeking to put to Dr Thampi in oral evidence, pursuant to Rule 34(1) of the Rules. The Tribunal determined that the admission of the two articles at this stage would not be fair and it also did not consider them to be relevant. As such, the Tribunal determined that it would put the contents of the articles out of its mind in the continuation of the case, and in its consideration of all the evidence when making its decision on the facts. The Tribunal's full decision on the application is included at Annex G.

14. On 9 October 2024 the Tribunal determined to adjourn the hearing part heard at that stage. The Tribunal had been due to sit until 11 October 2024, but a witness was unavailable due to clinical commitments given the change in timetabling that had occurred during the course of the hearing. The Tribunal's full decision in respect of adjournment is included at Annex H.

The Allegation and the Doctor's Response

15. The Allegation made against Dr Thampi is as follows:

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

Patient A

1. On or around [XXX] October 2016 you were involved in delivering Patient A of her baby and you failed to:

a. inform Patient A that there was an increased chance of failure of operative vaginal delivery due to:

i. her body mass index;
To be determined

ii. her inability to push as effectively because of her neuromuscular condition;
To be determined

b. adequately consider and/or facilitate a discussion with Patient A about the alternative options for her delivery, given the increased chance of failure of operative vaginal delivery with a vacuum device;
To be determined

c. act on and/or take account of Patient A's views, when she told you:

i. on one or more occasions, she wanted a caesarean section;
To be determined

ii. on one or more occasion, that she did not want an instrumental delivery or words to that effect;
To be determined

d. obtain informed consent for forceps delivery in that you:

i. did not discuss with Patient A the risks and benefits of instrumental delivery;
To be determined

ii. did not discuss with Patient A the risks and benefits of caesarean section;
To be determined

iii. pressurised Patient A into agreeing to a forceps delivery;
To be determined

e. appropriately respond to the lack of progress in Patient A's delivery by not:

i. abandoning the vacuum delivery after three pulls;
To be determined

ii. immediately offering Patient A:

1. the option of transfer to theatre;
To be determined

2. repeat examination following anaesthesia;
To be determined

3. a caesarean section, given that Patient A had explicitly told you she did not want a forceps delivery;
To be determined

~~f. review Patient A in person before she was discharged;~~
Withdrawn

~~g. ensure that postnatal review was offered to Patient A as an outpatient;~~
Withdrawn

h. communicate appropriately with:

i. Patient A in that you stated one or more of the following:

1. "no you can't have a c-section" or words to that effect, without a discussion about risks and benefits;
To be determined

2. "it is now after six o'clock and I could have gone home and let a registrar deliver your baby, but I haven't so you need to let me do this" or words to that effect;
To be determined

3. "you need to let me do this as I don't know what is going to happen to your baby" or words to that effect;
To be determined

ii. Ms F, in that you asked Ms F for consent to a forceps delivery when Patient A had capacity to give consent.
To be determined

2. On or around [XXX] October 2016 you were delivering Patient A of her baby and the degree of force you used to conduct the instrumental delivery was inappropriate.
To be determined

Patient B

3. On or around [XXX] June 2018, you were involved in delivering Patient B of her baby and:

a. you failed to;

~~i. obtain informed consent in that you did not:~~

~~1. facilitate an appropriate discussion about potential complications in labour;~~
Withdrawn

~~2. discuss the options available to Patient B;~~
Withdrawn

~~3. discuss the risks and benefits of all options available to Patient B;~~
Withdrawn

~~4. confirm Patient B's final choice;~~
Deleted after a successful Rule 17(2)(g) application

ii. recognise and/or respond to the complications which developed during Patient B's delivery by:

1. abandoning the operative vaginal delivery;
To be determined

2. recommending a caesarean section in line with RCOG guidance in place at the time;
To be determined

iii. discuss with Patient B, prior to attempting instrumental delivery, the chance of an episiotomy being indicated during Patient B's delivery;
To be determined

~~iv. complete an operative summary of Patient B's delivery;~~
Withdrawn

b. you undertook an excessive number of pulls of Patient B's baby's head using a Kiwi vacuum;
To be determined

c. you inappropriately applied forceps to Patient B's baby's head and then proceeded to carry out an excessive number of additional pulls after you had carried out the pulls described at paragraph 3b;
To be determined

d. you inappropriately disregarded Midwife G's repeated reminders about the number of pulls you had carried out, and her request for you to cease the instrumental delivery;
Amended under Rule 17(6)
To be determined

~~e. your management plan for Patient B was not adequate or appropriate with regards to the risk of post-partum haemorrhage, in that you did not record:~~

~~i. blood loss at delivery;~~
Deleted after a successful Rule 17(2)(g) application

~~ii. use of an hourly urometer;~~
Withdrawn

~~iii. when to check the patient's haemoglobin count by blood test;~~
Withdrawn

~~iv. the duration and frequency of postnatal observations.~~
Withdrawn

4. You inappropriately introduced Midwife G on the labour ward a few weeks after Patient B had delivered her baby as "the midwife who had Datix me by saying the baby was battered, bruised and injured after my delivery", or words to that effect.
Amended under Rule 17(6)
To be determined

Patient C

5. Between 11 and 12 August 2018 you were the on-call consultant and you were telephoned for advice and assistance by Dr D, during the labour and/or delivery of Patient C's baby, and you:

a. declined to:

i. ~~receive and~~ review the cardiotocography ('CTG') that Dr D had expressed concerns about during a call she made to you at around 2:05am ('Call 1'), by text message when Dr D offered to send an anonymised picture of it to you;
Amended under Rule 17(6)
To be determined

~~ii. and failed to attend in person when specifically requested to do so, by Dr D, when she rang you on a second occasion at or around 02:30am ('Call 2');~~
Deleted after a successful Rule 17(2)(g) application

b. failed to:

i. attend in person to review Patient C's CTG in person following Call 1;
To be determined

ii. attend in person prior to delivery to review Patient C and agree a treatment plan;
To be determined

iii. explain your rationale for recommending treatment of Patient C with antibiotics to Dr D in Call 2;
To be determined

c. told Dr D not to deliver Patient C's baby by caesarean section in spite of the fact that you had ~~not~~ failed to personally review~~ed~~:
Amended under Rule 17(6)

i. Patient C;
To be determined

ii. the CTG(s).
To be determined

Additional

6. On or around 26 October 2018, you inappropriately told Mr H during an appraisal process, that he should not write there had not been anything specific learnt by him because the "white people won't like it", or words to that effect.
To be determined

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

Witness Evidence

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

- Dr J, a Specialty Registrar in Obstetrics and Gynaecology at the Trust at the time of events. Her witness statement was dated 24 May 2023, and she gave evidence in person on 13 September 2024.
- Ms K, scrub nurse at the Trust. Her witness statement was dated 8 February 2024, and she gave evidence via video link on 16 September 2024;
- Patient A. Her witness statement was dated 2 August 2023, and she gave evidence in person on 17 and 18 September 2024;
- Ms F, Patient A's mother. Her witness statement was dated 7 August 2023, and she gave evidence in person on 18 September 2024;
- Patient B. Her witness statement was dated 18 June 2023, and she gave evidence in person on 19 September 2024;
- Mr I, partner of Patient B. His witness statement was dated 18 June 2023, and he gave evidence in person on 20 September 2024;
- XXX (Dr D in the Allegation), Obstetrics and Gynaecology Registrar. Her witness statements were dated 25 February 2021 and 21 April 2022, and she gave evidence via video link on 23 September 2024;
- XXX (Mr H in the Allegation), a Consultant colleague who works at the Trust. His witness statement was dated 3 July 2023, and he gave evidence via video link on 25 September 2024;
- Ms L, midwife at the Trust. Her witness statements were dated 16 August 2023 and 28 February 2024, and she gave evidence via video link from 25 to 27 September 2024;
- XXX (Midwife G in the Allegation), a band 6 midwife on the labour ward at the Trust at the time of events. Her witness statements were dated 3 June 2023 and 14 August 2023, and she gave evidence via video link on 27 September 2024 and 1 October 2024.

17. The Tribunal also received evidence on behalf of the GMC from Ms O, who was the Senior Midwife/ Labour ward Coordinator at the Trust at the time. This was in the form of a witness statement dated 10 July 2023 and she was not called to give oral evidence.

18. On 19 September 2024 Mr Jackson confirmed that the GMC was not seeking to rely on the witness statement of Dr N, who is Medical Director at the Trust and was Dr Thampi's

Responsible Officer while she was employed at the Trust. This followed confirmation from Dr N that an operative note, which Dr Thampi had said she authored, was authored by her. This operative note took the form of an online pro forma document that Dr Thampi completed at the time using drop down menus on the eCare system. It was a new process that had just come in as of May/June 2018. Mr Jackson asked for the Tribunal to disregard the statement of Dr N, which the Tribunal stated it would.

19. As the result of a preliminary hearing, the Tribunal called Ms R, Senior Midwife and labour ward co-ordinator at the Trust, to give evidence before the Tribunal. Her witness statement was dated 3 July 2023, and she gave evidence via video link on 24 September 2024.

20. Dr Thampi provided her own witness statement dated 14 August 2024 and also gave oral evidence at the hearing on 4, 7 and 8 October 2024.

21. In respect of the evidence of Dr M, Senior Clinical Fellow and Specialty Doctor in Obstetrics and Gynaecology, the GMC did not originally intend to produce his evidence. A redacted version of Dr M's witness statement was included in the material relied upon by Dr Thampi and (as facilitated by the GMC) Dr M gave evidence via video link on 26 September 2024. An unredacted copy of Dr M's witness statement dated 7 August 2023 was provided to the Tribunal by the GMC on 16 September 2024.

Expert Witness Evidence

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

23. Dr Q, Consultant in Obstetrics and Gynaecology, provided expert evidence on behalf of the GMC. Her clinical obstetric interests include High Risk Obstetrics and Maternal Medicine. She provided an expert report dated 6 July 2020 and supplementary expert reports dated 22 September 2020, 2 September 2021, 30 December 2021, 14 September 2022, 29 August 2023, 6 March 2024, and 15 September 2024. Dr Q gave oral evidence to the Tribunal in person on 30 September 2024 and 1 October 2024 and via video link on 2 October 2024.

24. Dr S, Consultant Obstetrician and Specialist in Maternal & Fetal Medicine, provided expert evidence on behalf of Dr Thampi. He provided an expert report dated 24 August 2024 and gave oral evidence to the Tribunal in person on 3 to 5 March 2025.

25. Dr Q and Dr S provided evidence to assist the Tribunal in understanding the professional standards to be expected of a Consultant Obstetrician and Gynaecologist.

26. They provided a joint expert report dated 11 September 2024 in which they provided clarification on their positions in respect of the Allegation.

Documentary Evidence

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

- Various medical records in respect of Patients A to C;
- Photographs of Patient A's baby dated XXX October 2016;
- Patient B's perioperative plan dated XXX June 2018;
- Photographs of Patient B and baby dated XXX and XXX June 2018;
- Patient experience documents from Patients A and B;
- Transcripts of local investigation meetings with Dr D, Dr J, Mr H, Ms O, and Ms L;
- Undated complaint letter from Patient A to the Trust;
- Transcript of meeting between Patient A and the Trust dated 1 November 2018;
- Witness statement dated 23 June 2020 of Patient A's mother for the claim against the Trust;
- Dr Thampi's Curriculum Vitae;
- Dr Thampi's appraisal feedback documents for the 2017/2018 and 2018/2019 periods;
- A feedback email that Dr Thampi had received from Mr H;
- A number of positive testimonials on behalf of Dr Thampi;
- RCOG: *'Obtaining Valid Consent - Clinical Governance Advice No. 6'* (January 2015);
- RCOG 'Assisted Vaginal Birth: Green-top Guideline No. 26 April 2020' guidance document;
- GMC: *'Consent: patients and doctors making decisions together'* (2008);
- Various correspondence from June to August 2023 between the GMC and Ms L about her witness statement;
- Instructions from the Kiwi Complete Vacuum Delivery System with PalmPump; and
- Articles: 'Second Stage of Labor Cesarean Section Maternal and Fetal Outcomes', 'Obstetrics Outcomes in Women Undergoing Second-Stage Cesarean Section: A Cross-Sectional Study', and 'Caesarean delivery in the second stage of labour'.

The Tribunal's Approach

28. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Thampi 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.

29. The Legally Qualified Chair (LQC) referred to the case of *Byrne v GMC* [2021] EWHC 2237 (Admin), that there is only one standard of proof and that is proof that the fact in issue more probably occurred than not. Neither the seriousness of the Allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied. The LQC referred to the summarising comments of Mr Justice Morris in *Byrne*, that:

> *"(1) There is only one civil standard of proof in all civil cases, and that is proof that the fact in issue more probably occurred than not.*
> *(2) There is no heightened civil standard of proof in particular classes of case. In particular, it is not correct that the more serious the nature of the allegation made, the higher the standard of proof required.*
> *(3) The inherent probability or improbability of an event is a matter which can be taken into account when weighing the probabilities and in deciding whether the event occurred. Where an event is inherently improbable, it may take better evidence to persuade the judge that it has happened. This goes to the quality of evidence.*
> *(4) However it does not follow, as a rule of law, that the more serious the allegation, the less likely it is to have occurred. So whilst the court may take account of inherent probabilities, there is no logical or necessary connection between seriousness and probability. Thus, it is not the case that "the more serious the allegation the more cogent the evidence need to prove it."*

30. The LQC stated that, if, having weighed all of the evidence, the Tribunal considers that the case is evenly balanced, the GMC will not have discharged its burden and will not have proved its case.

31. The LQC stated that, where the allegations refer to a failure on the part of Dr Thampi, the Tribunal must consider if there was a duty established in that regard. Dr Thampi is only obliged to meet the allegations levelled against her, no other ones. The LQC referred to the cases of *Roomi, R (on the application of) v GMC* [2009] EWHC 2188 (Admin), *El-Baroudy v GMC* [2013] EWHC 2894 Admin, and *Chauhan v GMC* [2009] EWHC 2093 (Admin).

32. Tribunals can only make factual findings against a doctor which are based on an interpretation of events that has previously been disclosed to them and in respect of which they have been provided with adequate opportunity to investigate, call evidence and make submissions.

33. The LQC stated that the Tribunal has heard that Dr Thampi is of good character, and it has had sight of testimonials within the hearing documentation. The LQC stated that Dr Thampi's good character must be taken into account by the Tribunal in assessing her credibility and the likelihood of her having done what has been alleged in terms of propensity. Her good character is not a defence to the Allegation, it is simply one factor to take into account when considering all of the evidence in the case. The LQC stated that the weight to assign to Dr Thampi's good character is a matter for the Tribunal. However, the significance of such evidence ought not to be overstated and should not detract from the primary focus on the evidence relevant to the alleged wrongdoing (*Martin v Solicitors Regulation Authority* [2020] EWHC 3525 (Admin)).

34. In terms of how to approach the evidence of the assessment of credibility and reliability, the LQC referred to the case of *Byrne*, in that the credibility of witnesses must take account of the unreliability of memory and should be considered and tested by reference to objective facts, in particular as shown in contemporaneous documents. Where possible, factual findings should be based on objective facts as shown by contemporaneous documents. The LQC stated that, when considering documents, the Tribunal should consider when they were made, by whom, and for what purpose.

35. The LQC reminded the Tribunal that it should not assess witness' credibility exclusively on their demeanour when giving evidence. The Tribunal should consider all of the evidence before coming to a conclusion as to the credibility of a witness. The LQC stated that it is open to the Tribunal not to rule out the totality of a witness' evidence based on credibility; it can be divisible. Inconsistencies in the evidence of the complainant or a witness is not an automatic indicator of a lack of credibility. The LQC stated that it is one factor to be weighed in the balance which may or may not be of significance.

36. In relation to expert witnesses, the LQC stated that they are there to assist the Tribunal on particular aspects which may be outside of its experience and knowledge. The LQC stated that it was important that the Tribunal sees the expert evidence in its proper perspective, which is as part of the evidence as a whole to assist it with regard to any particular aspect of the Allegation to which it relates. The LQC stated that the Tribunal should give the expert evidence careful consideration and attach as much weight to it as it considers

appropriate. The Tribunal does not have to accept it, although if any aspect is not accepted then it should give reasons.

37. The LQC stated that the Tribunal must reach a decision on the facts based on the evidence before it. It can draw reasonable inferences on what it has heard but it must not speculate. When drawing inferences, the Tribunal must be able to safely exclude as less than probable any other possible explanation. There must be evidence that justifies the inference being drawn (*Soni v GMC* [2015] EWHC 364 (Admin)).

The Tribunal's Analysis of the Evidence and Findings

38. The Tribunal noted that references to 'operative vaginal delivery', 'instrumental vaginal delivery' and 'assisted vaginal delivery' all refer to the same procedure. This is when a ventouse and/or forceps are used to assist with the delivery of a baby. Within Dr Q's reports she stated that a Kiwi ventouse device is a single use *'vacuum'* device. The current RCOG e-learning module explains ventouse cups in this way:

> *"Ventouse cups are either soft or rigid instruments depending on the material from which they are made… Both the metal and silastic cups require a pump to create the necessary vacuum. The kiwi cup was introduced as an alternative. This is a fully disposable product in which the suction is created manually without the need for a separate pump. Both an OP and standard cup are available."*

39. Dr Q stated that many labour units now just use the Kiwi OP cup and refer to it when they discuss *'Kiwi vacuum'.* Throughout the Tribunal's determination there may be reference to 'Kiwi', 'ventouse', and 'vacuum', which all relate to the same device.

40. Dr Q also stated that there is more than one design of forceps used in modern obstetric practice. Neville-Barnes forceps are a type of forceps, and this was the type used by Dr Thampi, and are commonly used in units throughout the UK.

Patient A

41. Patient A was admitted to the Hospital at 19:10 on XXX October 2016 at 41 weeks and 3 days' gestation with spontaneous rupture of membranes (SROM) and irregular contractions. This was Patient A's first pregnancy. Patient A's baby was born on XXX October 2016 at 19:22.

42. Patient A stated that she first met Dr Thampi at the Trust on XXX October 2016 at around 08.30/09:00, after she had been transferred to the labour ward and when Dr Thampi introduced herself and reviewed Patient A. The notes indicate that Dr Thampi did the ward round with Dr J and an anaesthetist. Patient A was using Entonox for pain relief. Dr Thampi noted Patient A's progress regarding dilation and a plan was formed to continue monitoring and assess the natural progress of labour.

43. Patient A's mother, Ms F, was present with Patient A throughout her time in hospital, apart from short periods to go to the bathroom or get refreshments from the vending machines. Ms F also acted as Patient A's birthing partner and Patient A's ex-partner was also present later on that day.

44. Dr Thampi conducted a vaginal examination ('VE') around 10:10. Patient A was requesting further pain relief. Dr Thampi noted that the CTG was normal and Patient A was having contractions every two to three minutes. Patient A had a birth plan, including a typed document with relevant bullet points that she had written herself.

45. Ms L, the midwife, was also present with Patient A at various points on this day, including during the delivery of Patient A's baby. Ms L conducted a VE at 14:39, Syntocinon was increased to 24 ml/hour, and the findings were relayed to Dr Thampi. Ms L conducted another VE at 15:55, the findings of which were relayed to Dr Thampi.

46. At approximately 16:15 Dr Thampi was informed by the midwife that Patient A had a raised temperature of 37.6°C and a pulse of 108 bpm. Dr Thampi advised for continued IV fluids and for the administration of IV antibiotics due to the infection risk, because it had been more than 24 hours since Patient A experienced SROM. The plan was then for Dr Thampi to conduct a further VE at 18:30 and the midwifery team continued to monitor Patient A.

47. Ms R was not present for the delivery itself but had been in the delivery room prior to the delivery. Dr Thampi stated that Patient A and her mother had been verbally abusive towards her during the delivery. She stated that, following the advice of Ms R, she filed a Datix report about this.

48. Two days after Patient A's baby was born, Patient A stated that Dr Thampi came to see her. Patient A stated that she cut Dr Thampi off immediately and told her she was going to make a complaint and asked her to leave. Another staff member reviewed Patient A before she was discharged. Patient A was discharged from hospital on XXX October 2016.

49. Patient A wrote a formal complaint letter to the Trust 18 months after the delivery. She said that the delay was due to the mental trauma that revisiting the delivery caused her. Staff from the Trust came to Patient A's home on 1 November 2018 to discuss her experience with her.

The Tribunal examined all of the relevant evidence in order to determine the factual chain of events before addressing each paragraph of the Allegation to assess alleged failures/inappropriate conduct.

50. The Tribunal first considered Dr J's evidence which was focused on her complaint against Dr Thampi in not being allowed to pursue her plan to take Patient A for a trial of instruments delivery in theatre and having her plan 'undermined' by Dr Thampi. Dr J was unable to assist with any discussions between Dr Thampi and Patient A about instrumental delivery as she confirmed that she had left the room as soon as Dr Thampi had 'disregarded' her management plan.

51. The Tribunal considered that Dr J did not have a strong recollection of the events as she could not remember any significant features about Patient A's case, such as her presentation, or Patient A being accompanied by her mother. Dr J was adamant that, at around 17:00, Patient A was screaming in pain and struggling with the delivery which was not supported by the contemporaneous medical records which indicated that an epidural has been sited earlier in the day. She made no comment on the reported shouting and swearing from Patient A or her mother. Dr J stated that, at around 17:00, Patient A *"had accepted to be taken into theatre and to be made numb"* and *"was happy to go to theatre"* and that she had discussed the risks and benefits with her. In Dr J's oral evidence, she also confirmed that she would only use forceps as that was her practice and she had made that decision. This was at complete odds with Patient A's recollection of events. Patient A was of the view that, whilst she remembers someone at the door mentioning a trial by instruments in theatre, she did not agree to this nor were any details or risks and benefits discussed with her. The Tribunal noted that the medical records indicated that Patient A was fully dilatated at 17:45 and time had been allowed by Dr Thampi to allow the baby's head to descend. Patient A was also pushing (even involuntarily) until close to 18:26. The Tribunal noted that there was no contemporaneous medical record supporting Dr J's account, and her version of events did not fit the clinical picture as Patient A was only 7cms dilated at 17:00 and so not ready for delivery in any event. Further, and as evidenced by the medical notes, the plan for Patient A had been a natural vaginal delivery until close to 17:45 when matters were reviewed by Dr Thampi and the non-reassuring feature noted on the CTG.

52. The Tribunal noted that a significant period of time had passed since the index events relating to Patient A. Further, that there had been two years and five months before Dr J was interviewed by the Trust. It did not consider Dr J's evidence to assist in respect of the matters before it.

53. Patient A was also not clear in respect of her memory of such a potential interaction with Dr J. She could not remember if the Registrar who had come to see her was a male or female but later in evidence, she stated that a man had come into the entrance way of the door to ask if she would have an instrumental delivery. She said that, thereafter, she had asked Ms L why she would need an instrumental delivery as she was not even fully dilatated at that point. At one point in her oral evidence, Patient A stated that it was Dr Thampi who had come into the doorway when she was 7cm dilated and asked her if she would have an instrumental delivery. The Tribunal noted that none of these accounts were recorded in the medical notes, not by Dr J or by Ms L.

54. The Tribunal also noted that on 1 November 2018, in the investigation meeting with the Trust, which was closer in time to the index events than Patient A's GMC witness statement, Patient A was claiming to have had a conversation, at the point when she was 7cm dilated, where she said that Dr Thampi said to her *"Will you let me give you an instrumental delivery"* and Patient A replied *"No, I don't want one. If you think I need an instrumental delivery, I want a c-section… you can put me to sleep, I'll have a c-section".* Patient A stated that Dr Thampi said, *"You can't be put to sleep, you know that because you can't have a general".* Patient A stated that this was incorrect and that she had had general anaesthetic before. In her witness statement and her oral evidence, Patient A stated that this summary of the meeting was not accurate and that she had not said that she wanted to be put to sleep. She stated that this was not the case as she had an epidural in by then. It was put to Patient A that she was mistaken and that she had in fact used those words. She accepted that she was possibly mistaken.

55. The Tribunal continued to consider Patient A's evidence.

56. Within Patient A's GMC witness statement dated 2 August 2023, she stated:

> *"At around 17.45, Dr Thampi attended to review my progress. She explained she was going to conduct another VE… Dr Thampi explained I was fully dilated and asked if she could come and give me an instrumental delivery. I told Dr Thampi, "I don't want that, if you think I need an instrumental delivery I want a caesarean section." Dr Thampi just said that we "could talk about it later" and left the room.*

Dr Thampi next came to the delivery room shortly before 18.30. She explained that I was fully dilated and that she was going to give me an instrumental delivery… She just marched into the room to ask me if I was ready for an instrumental delivery and then marched back out again.

Dr Thampi didn't explain what an instrumental delivery would involve, or what the instruments to be used were. I knew about the use of suction and a ventouse, and I verbalised to Dr Thampi that I was against the use of forceps. Dr Thampi didn't explain any alternative options to an instrumental delivery.

…

At no point during any consultation did Dr Thampi offer the option of a CS. Dr Thampi just said, "no, you can't have a c-section" when I mentioned it. She didn't give me any explanation as to why I couldn't have a CS. I didn't ask why and I remember thinking at time that she was on a bit of a warpath, so I was reluctant to ask. I didn't want to keep pushing back as I was making her angry by refusing to have an instrumental delivery. I could tell Dr Thampi was angry by her demeanour, how abrupt she was being with me and her poor bedside manner. She was giving me no explanation as to anything, she just kept waltzing in and out of the room."

57. In her oral evidence, Patient A stated that she had made it clear earlier in the day to Dr Thampi, before she was even fully dilated, that she did not want the use of forceps. Additionally, however, Patient A also accepted that forceps were not on the radar and that it was not even suggested that she may need them, in reference to earlier in the day. She stated that prior to the delivery day, she had *"probably"* told her midwifery and antenatal team about her objection to forceps also.

58. The Tribunal considered Ms F's testimony and noted that whilst she took the same view as Patient A, that Ms Thampi had wanted to give Patient A an instrumental delivery when she was 7cms dilated which Patient A did not want, she accepted that she may be mistaken about the timings and that Patient A may have expressed her reluctance to Ms L as opposed to Dr Thampi.

59. In its overall assessment of Patient A, the Tribunal considered that Patient A, a first-time mother in 2016, had a traumatic birth and a difficult lead up to the birth. It was completely understandable that her memory would be impacted by the trauma she felt and her recollections over the years. It sought to make allowance for this. The Tribunal was also mindful that Patient A would have had repeated discussions over the years, of the events, with multiple persons including her mother, Ms F.

60. Overall, the Tribunal considered Patient A to be an honest witness and that she had assisted and tried to recollect events as far as she could. It considered that Patient A was however mistaken about the order and detail of some events which it considered was understandable given the traumatic setting of her circumstances and the passage of time.

61. The Tribunal considered Ms L's evidence.

62. Within Ms L's GMC witness statement dated 16 August 2023, she stated that Dr Thampi had written in Patient A's medical notes that she was aware of the birth plan. Ms L stated that Patient A's birth plan detailed that Patient A did not want a forceps delivery.

63. Also, within Ms L's GMC witness statement, she stated that Patient A had expressed to her (prior to the 10:10 review) that she did not want forceps to be used when delivering her baby. Ms L stated that she encouraged Patient A to talk to Dr Thampi about her feelings and reassured her that she would be listened to. Ms L also explained that the decision is sometimes taken out of their hands if the situation becomes an emergency and forceps become the quickest way to do things. Ms L stated that she might have said *"I wouldn't give you an instrumental delivery"* in the context of *"that would be a decision for the doctors as midwives do not carry out that procedure".* Ms L also stated that she recalled that Patient A spoke with Dr Thampi about not wanting a forceps delivery. The next mention of forceps within Ms L's statement related to discussions later on at 18:26. At the point when the Kiwi was no longer working, Ms L stated that, given the time restraints, there was no time for Dr Thampi to go through the associated risks of the forceps delivery with Patient A. She stated that she felt that Patient A was still unhappy about the use of forceps and that she *"felt bad in myself as Patient A had told me directly that she didn't want forceps to be used, yet there we were".*

64. The Tribunal was concerned about the quality of the evidence that Ms L gave to the Tribunal. In an effort to be accurate, Ms L had read the medical notes before making her initial statement but had later amended earlier iterations of her statement and her account given to the Trust in her interview in 2019, from re-reading the medical notes. It seemed to the Tribunal that Ms L had, for parts of her evidence, convinced herself of an event having taken place which was not based on her actual independent memory but on the notes. Whilst at the same time, was adamant on events having taken place which were not supported by documentary evidence or the contemporaneous medical notes. In effect, it was the view of the Tribunal that she had, for parts of her evidence, rewritten over her actual memory. For instance, Ms L was adamant that Dr Thampi was made aware of Patient A's views on forceps from her having read the birth plan and also from Patient A having told her earlier in the day. It was apparent from Ms L's evidence that she held this view from her

mistaken understanding that the birth plan recorded Patient A's views and objection to the use of forceps. It did not.

65. The Tribunal considered that Ms L's subsequent evidence, to an extent, had been perpetuated by this initial mistaken belief that she had held. Even after this was clarified, Ms L seemed to remain of the view that the first time Dr Thampi would have been made aware of Patient A's views on forceps was not 18:26 but earlier and that 18:26 was only when it was first written down. Ms L was unable to give a clear account to the Tribunal as to when Patient A may have informed Dr Thampi of this. The Tribunal rejected Ms L's evidence on the issue of when Dr Thampi was informed of Patient A's view, as unreliable. Ms L did not have a recollection of any interaction between Patient A and Dr J either. It considered that there may have been an earlier discussion about forceps between Ms L and Patient A but there was no documentary evidence that Dr Thampi would have been part of that or would have been informed of it before 18:26.

66. Later in her oral evidence, Ms L disagreed with her own initial account in her written statement, which referred to Dr Thampi discussing the Kiwi with Patient A and stating that she (Dr Thampi) said that she would only use the forceps if matters dictated that it was the best way to deliver the baby. In confirming whether or not this was said by Dr Thampi, Ms L attempted to make an assessment as to whether or not it would have been reasonable to state this. When challenged, she stated, *"I'll have to put that as a no"* and *"that's the way I recalled at the time before I read what I just read…"* (referring to her statement).

67. The Tribunal was concerned with these aspects of her evidence and considered her memory and account to be unreliable. It considered that there did not need to be a wholesale rejection of her evidence, but the Tribunal could only place safe reliance on the contemporary medical notes including the ones she had recorded or where her evidence was corroborated by other reliable evidence or account.

68. Dr Thampi had limited recollection of the detail of the events and had relied on the contemporaneous medical notes. In her witness statement, she stated:

> *"I see from Patient A's statement that she suggests there was discussion with me about instrumental delivery after I had done a VE and found the patient 7cm dilated. This is incorrect. I did not undertake a VE at any point that found Patient A to be 7cm. I note that in her statement midwife* [Ms L] *indicates she did a VE at 15:55 finding the patient 7cm dilated."*

69. The Tribunal also noted the medical note entry for 17:45 recorded that, on Dr Thampi's review, the contractions were four in ten and the cervix was fully dilated. One non reassuring feature was noted, and the note stated, *"encourage pushing in 15 mins".* The notes illustrate that, at 17:50, Dr Thampi was happy to delay the pushing and allow for the descent of the PP (presenting part of the baby's head). The Tribunal considered that an instrumental delivery was not a main feature at that point. It did not accept Patient A's evidence that Dr Thampi asked her if she could give her an instrumental delivery at that point, i.e. 17:45.

70. The medical note entry stated: *"18:26 - Dr Thampi in room, instrumental delivery discussed due to sub-optimal CTG".*

71. It was Patient A's account that, when instrumental delivery was mentioned - *"I verbalised to Dr Thampi that I was against the use of forceps…"*

72. The Tribunal took the view that there was some confusion in the various recollections and placed reliance on the medical notes. It considered that, whilst Patient A may have had a conversation with Ms L earlier in the day about her view on instruments/forceps delivery, it was not something that was communicated to Dr Thampi by Patient A nor by Ms L. The Tribunal noted that, at these points earlier in the day and before 18:26, Dr Thampi would have been aware of the birth plan document dated 14 September 2016, which did not record any particular views of Patient A nor any objections to the use of instruments for an assisted delivery.

73. The Tribunal determined that the first notification to Dr Thampi about Patient A's views on instrumental delivery and, in particular forceps, was from 18:26, when Dr Thampi introduced it, as evidenced by the contemporary medical notes.

74. Having made a finding as to when Dr Thampi and Patient A first interacted regarding the instrumental delivery, it moved on to consider the factual picture of the consent and/or objection to Kiwi and forceps, if any, communicated by Patient A to Dr Thampi, and when.

75. In her written statement, Patient A had stated that Dr Thampi had not explained what an instrumental delivery would involve or what the instruments to be used were. In contrast to her written statement, Patient A accepted that both Kiwi and forceps were discussed as part of the instrumental delivery. She initially stated that she did not have a preference for either and would rather not have any and be allowed to push. She stated that she eventually agreed to the Kiwi as Dr Thampi *"would not stop going on about it being after six o'clock…"*

76. Patient A stated that she was still against the Kiwi, the forceps and the instrumental delivery and felt that Dr Thampi *"was using the idea of having to give me the forceps to get me to agree to the kiwi".* Patient A stated, *"I didn't feel that I had an option, so yes, I said that she could use the kiwi".*

77. Patient A later agreed in oral evidence that Dr Thampi had shown her the Kiwi and had held it up, which was also confirmed in evidence by Ms F. She said that Dr Thampi:

> *"said she would like, she would prefer to try with the suction cup, the Kiwi cup first, and I was saying I didn't want forceps, at all. Like, I was really against forceps. She said to me that if she pulled using the suction cup, and I was pushing, we would get the baby, the baby would be born."*

78. Patient A accepted, as her memory was jogged, that there had been a discussion about the how the Kiwi would work and that it required synchronisation, a combination of her own maternal effort in pushing and Dr Thampi pulling. Patient A further accepted that Dr Thampi had listened to her about the forceps and agreed to use the Kiwi first. She also accepted that Dr Thampi *"possibly"* stated that she would try not to use the forceps and only use them if that was the best way to deliver the baby.

79. Patient A further stated, *"Ms Thampi used the suction and then the forceps, because I had said, I didn't want a forceps delivery".* She said, *"Will you let me try with the suction, the Kiwi cup?" I felt that if I had to agree, I had to agree to that because otherwise, it would be a forceps, and I did not want a forceps. In hindsight, I wouldn't have had either because of the damage it had done to my child's head and face---"*

80. The Tribunal considered Dr Thampi's evidence.

81. In her witness statement, Dr Thampi stated that she was aware of Patient A's birth plan from the outset. She stated that the plan showed that Patient A had already had discussions about the different types of delivery where they would have been explained to her, and she would have had the opportunity to ask questions and that no issues with Kiwi or forceps were present. Dr Thampi stated that the boxes on the birth plan were ticked indicating that Patient A was agreeable to these options. Further that, Patient A had not previously raised issue with an instrumental delivery or expressed a preference for a CS and had not done so earlier in her labour either.

82. The Tribunal noted that Dr Thampi's evidence suggested that she had placed reliance on the birth plan and there being no recordings up to the point of 18:26, which indicated that

Patient A objected to forceps. It considered her evidence that, as the boxes were ticked and there had been a discussion, there was consent.

83. In referring to the birth plan completed antenatally, Dr Thampi stated that *"if it is discussed and she agrees, that means she's consenting"*. In her written statement, Dr Thampi had also stated that the use of instruments that Patient A had discussed on 14 September 2016, meant that Patient A would accept the use of Kiwi or forceps if needed.

84. The Tribunal also considered Dr Thampi's own position in stating that *"all women can change their mind at any time… and plans keep changing as well".*

85. In Dr Thampi's witness statement, she stated:

> *"I attended Patient A again, for the fourth time, at approximately 18:26. I was mindful of the suboptimal CTG, Patient A's temperature, Patient A's high BMI and the birth plan which advised a short second stage of labour. I therefore discussed the option of an assisted delivery with Patient A at this point. I advised about the use of Ventouse and also the possible use of forceps and, as would be my standard practice in this scenario, the possibility for need for episiotomy. Patient A expressed concern that forceps can damage babies,* ***but I did not interpret her comment at that point to indicate a refusal should the need arise*** *(emphasis added). I provided reassurance that forceps are one of the commonest tools for assisted birth and Patient A gave her consent to proceed with a ventouse delivery and was positioned ready for the delivery. It is suggested that I did not explain what is meant by instrumental delivery and/or reasons for proposing such an approach. I do not believe that is correct and would not be in keeping with my usual approach at that time to provide such information. As for discussing risks of vaginal delivery in her case, again I don't recall the detail, but I believe I would have followed my usual practice to advise of the risks including the possible need to perform an episiotomy. It should also be remembered that this would have been discussed with her by others previously because she had had lots of input around her birth plan. As for discussion of CS, I do not recall there being discussion at that time - it was discussed later…"*

86. Further, within Dr Thampi's witness statement, she stated that not wanting instrumental delivery had not been indicated at any point before the late stage of labour and Patient A's birth plan gave no indication of any such objection. Dr Thampi stated that, following explanation, Patient A *had* consented to the use of the Kiwi and so Dr Thampi proceeded at 18:55 with this. After it was apparent that delivery could not be completed using Kiwi, Dr Thampi stated that she then discussed the need for forceps and Patient A did

eventually consent, albeit Patient A was not happy that these had become necessary. Dr Thampi stated that she believed that she did take into account and act on Patient A's views so far as it was clinically safe to do so. Dr Thampi stated that her advice at the time to switch to forceps was that CS at that point was high risk and not the safest course for Patient A and baby. However, Dr Thampi stated that she accepted, on reflection and in light of how Patient A says she experienced the delivery, that her communication should have been clearer, and discussion had at an earlier stage to allow Patient A more time for consideration.

87. The Tribunal considered that Dr Thampi's oral evidence to the Tribunal was largely consistent with her written account. She reiterated that, at 18:26, she had a discussion with Patient A about instrumental delivery and this was the first time that she discussed the various instruments used, the Kiwi and possible forceps. However, Dr Thampi stated that, when Patient A heard the word *"forceps"*, Patient A raised concerns that she ***"did not want forceps"*** *(emphasis added)* because she was worried that they might damage her baby. Dr Thampi stated that she explained to Patient A that forceps are commonly used on labour ward for assisted birth and reassured Patient A that it was highly unlikely to damage the baby. Dr Thampi added that Patient A said *"Okay, fine"* so she respected her wish of going with the Kiwi first.

88. The Tribunal was mindful that Dr Thampi has stated that she had limited recollection of the events and part of her evidence was based on what would be her usual practice. It considered whether Patient A would have said *"okay, fine"* to the subsequent use of forceps at that time (18:26). Dr Thampi's written statement did not record this detail either. The Tribunal noted Patient A's evidence that she had just agreed to a Kiwi as she felt she had no choice as *"otherwise"* it would have been forceps. It also considered that this was corroborated by Ms L's written statement that, in response to Dr Thampi saying, *"I will try not to use forceps and will only use them if things dictate that its best way to deliver the baby"*, Patient A responded with *"Ok, it's not forceps so it's fine"*.

89. The contemporaneous medical note by Ms L confirmed *"Kiwi Ventouse delivery with consent at 18:26"* and Patient A was prepared for a Kiwi delivery at 18:45 with the Kiwi being applied with consent at 18:55. There was no reference for any prior consent to a subsequent use of forceps.

90. Dr Thampi's own entry at 08:00 on XXX October 2016 (which she made clear was retrospective), also did not reference consent to any subsequent use of forceps at the time the Kiwi was consented to. The entry stated:

"… Suboptimal CTG… Explained to Patient A/Ms F/Partner that Patient A will need assisted birth. Explained VE findings + Ventouse + possible forceps. Expressed that forceps can damage a baby. Reassured that I might be able to assist the birth with Ventouse. Proceeded to Kiwi birth with consent as there was no descent beyond ++ station possibly due to maternal clinical/physical condition. Deferred further attempts with Kiwi Ventouse to avoid foetal risks. As Vx low in pelvis unable to offer caesarean section. Explained that I have to assist birth with forceps. Patient A agreed - proceeded to forceps…"

91. In her oral evidence, Dr Thampi told the Tribunal:

"When I started with the ventouse, given the fact that this lady didn't have any contraindications for a normal delivery, I wouldn't have expected it to fail, but when the head reached the perineum and I was feeling the resistance, at that point in time, I felt possibly I am not able to proceed with the perineal phase of the ventouse because of her clinical condition, and that is when first I realised that it could be because of that, possibly, I do not know, is it because of that? Likely, that is all I can say."

92. In response to a Tribunal question, Dr Thampi further explained: *"She consented for - she was happy when I told forceps will not damage the baby and she said, "You can go ahead with the delivery". I explained to her that we might be able to deliver with the ventouse, possibly forceps".* Dr Thampi was asked if it was at this point that Patient A reluctantly consented or if it was later. Dr Thampi replied to say *"Later, she reluctantly consented".* However, later in her evidence, Dr Thampi stated that she did have consent to both at 18:26 but accepted that Patient A continued to express reluctance even after she was consented.

93. The Tribunal considered that, for the most part, Dr Thampi's evidence was clear and consistent with her written evidence. Dr Thampi came across as an honest and experienced consultant who had given credible evidence of her limited recollection or what would be her usual practice. It considered however that in respect of the issue of Patient A's objection / consent at 18:26 (their first discussion on the topic) to forceps, should the need arise, Dr Thampi's evidence was not clear and was contradictory.

94. The Tribunal was also mindful of Dr Thampi's view that Patient A's discussion and ticking of boxes within the birth plan could be taken as consent to possible use of Kiwi or forceps at a later point. The Tribunal did not agree with Dr Thampi that discussion within the birth plan, which would have been completed by a midwife, and if agreed to by the patient, would indicate consent to a possible future use of Kiwi or forceps. In any event, Dr Thampi had also acknowledged that a patient could change their mind at any point. The Tribunal

noted the expert opinion on this. Dr Q had stated that: *"It wouldn't be normal for us to rely on a discussion with a midwife for a complex obstetric patient".* Dr Q also stated that if it had been documented or discussed before that *"I think our professional duty is to check that we're clear about what the patient has or has not consented to in that moment in time".* Dr S agreed in his evidence that a birth plan does not restrict the patient, and the patient is entitled to change their mind about their plans.

95. The Tribunal noted the RCOG *'Obtaining Valid Consent - Clinical Governance Advice No. 6'* (January 2015) document, including that:

> *"Where possible, women should be informed during the antenatal period about predictable problems that may occur in labour. It is important for carers of women in labour to be aware that the woman may not recall such previously presented information during labour. If a procedure is planned, she should receive a full explanation as if she had not previously had the relevant information."*

96. Dr Thampi's own evidence also acknowledged that Patient A stated that she did not want forceps from the point when forceps were first mentioned by her.

97. The Tribunal considered that whilst Dr Thampi may have said to Patient A that she would only use forceps if that was the best way to deliver the baby, Patient A had not given Dr Thampi the 'go ahead'/consent at 18:26/18:28 to the subsequent or possible use of forceps should the need arise. Looking at all of the evidence, it did not accept Dr Thampi's account as plausible i.e. where Dr Thampi stated that she did not consider Patient A's concern about the damage that forceps could cause, as an indication for a refusal to the use of forceps, should the need arise. Dr Thampi had accepted that Patient A had voiced that she did not want forceps from the point they were mentioned. Rather, it considered that Dr Thampi had a confident belief that she would be able to deliver with the Kiwi only and would be able to avoid the need for use of forceps.

98. The Tribunal did not accept Patient A's initial view that Dr Thampi was threatening use of forceps to get her to agree to a Kiwi. It also accepted that Patient A had consented to the use of a Kiwi at 18:28.

99. The Tribunal, however, made a finding that at 18:26 or 18:28 Patient A had not provided her consent to any subsequent use of forceps should the need arise and had communicated her opposition to the use of forceps to Dr Thampi.

100. The Tribunal continued to consider the specific paragraphs of the Allegation.

Paragraphs 1(a)(i) and (ii)

101. The Tribunal considered whether, on or around XXX October 2016, Dr Thampi was involved in delivering Patient A of her baby and she failed to:

> *a. inform Patient A that there was an increased chance of failure of operative vaginal delivery due to:*
>
> > *i. her body mass index;*
> >
> > *ii. her inability to push as effectively because of her neuromuscular condition.*

102. It is recorded within the medical records that Patient A had a body mass index (BMI) of XXX. Patient A also had a neuromuscular condition - XXX). Dr Q would, within her first expert report, refer to an explanation of this condition as XXX

103. Within Patient A's GMC witness statement dated 2 August 2023, she stated:

> *"The GMC have asked if Dr Thampi explained the risks of vaginal delivery to me, specifically any risk associated with baby's heartbeat, my high temperature, my* [XXX]*, my high BMI, or the fact that my birthing plan suggested that I should avoid long labour. At no point during any consultation did Dr Thampi mention any of these associated risks. All Dr Thampi said to me in this regard was, "I've read all your notes"."*

104. During Patient A's oral evidence to the Tribunal, she stated that no one in the midwifery team had said anything to her about her weight or her muscular condition complicating labour itself and reducing her chances of a normal vaginal delivery. Patient A said that she would not have been offended had it been mentioned. Patient A confirmed that her BMI was not discussed at 18:26 when Dr Thampi was talking about the instrumental delivery.

105. Within Ms F's GMC witness statement dated 7 August 2023, she stated that, at none of Dr Thampi's encounters with them, did Dr Thampi explain any risk of vaginal delivery specifically relevant to Patient A. Ms F stated that she understood that these individual risks were outlined in Patient A's birth plan but that, at no point, did Dr Thampi draw reference to any specific risks.

106. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she accepted that she did not specifically inform Patient A of an increased risk of failure of operative vaginal delivery due to her BMI and neuromuscular condition but that she did not agree that this represented a failure in the circumstances. In respect of BMI, Dr Thampi stated that, whilst this was potentially a factor, she had examined Patient A and the baby's position such that she felt confident that the baby could be delivered vaginally. In relation to the neuromuscular condition, Dr Thampi accepted that it was potentially a factor but that she *"understood there had been extensive exploration of this in the planning for her birth prior to my involvement".* Dr Thampi stated that this had included the involvement of the neuromuscular team at University College London Hospitals (UCLH) NHS Foundation Trust and that the plan was for vaginal delivery. Dr Thampi stated that, if there had been significant concerns about Patient A's inability to push, she would have been advised of an elective CS, and that there was documentation that a long labour should be avoided.

107. Further, within her statement, Dr Thampi stated that she believed that when operative vaginal delivery became indicated, she did advise Patient A of the relevant risks involved; this is her usual practice. Dr Thampi stated that the plan that was discussed was for Patient A to push and, if necessary, for instrumental delivery to be performed. Dr Thampi stated that, from her assessment, this could safely be achieved in the delivery room without recourse to being transferred to theatre. Dr Thampi stated that she felt confident that Patient A could deliver vaginally via an assisted delivery and considered this to be a less risky option versus a CS given Patient A's risk factors. Dr Thampi stated that she did not feel at the time that Patient A's BMI and neuromuscular condition were factors of such significance that she needed to discuss them with Patient A.

108. During Dr Thampi's oral evidence to the Tribunal, she was asked whether, at any stage, she thought it was more likely that an instrumental delivery was going to fail due to the high BMI. Dr Thampi stated that *"Obstetricians do not say that"* and that in her practice (and that of her colleagues) you would not say that because of the BMI, vaginal or assisted birth could not happen. Dr Thampi stated that it was a factor that was taken into consideration as with a bigger woman you needed to avoid an emergency situation if you could. It was put to Dr Thampi that Dr Q had expressed the view that it was incumbent on a consultant to spell out to a patient the increased chance of a failure of an operative vaginal delivery, based on a BMI. Dr Thampi stated that it was not. She stated that it was a sensitive issue for everyone and so it was not something that they would normally go and say, *"Just because you have a raised BMI you will have a risk of operative vaginal delivery and that failing"*. Dr Thampi did however state that she had explained the variable factors that may affect the likelihood of the failed Kiwi.

109. The Tribunal noted paragraph 5.2 of the RCOG *' Where should operative delivery take place?'*:

> *"Operative vaginal births that have a higher risk of failure should be considered a trial and conducted in a place where immediate recourse to caesarean section can be undertaken."*

110. Dr Thampi indicated that the RCOG use the term *'"consider"* and that this is to alert the obstetrician. If there is something called *"offer"*, it is different. She stated:

> *"So, the use of "consider" means we're alerted and when we perform instrumental deliveries on the labour ward, usually the obstetric theatre is not far off from the labour ward. So there is immediately close to caesarean section should there be any concerns."*

111. Dr Thampi commented on guidance changing over time and agreed that nowadays there *"is more of a dialogue upfront…"* She also stated that she did not have any statistics to quote in respect of an operational / assisted vaginal delivery in women over a certain BMI. She stated that, in respect of the XXX, she had been guided by the *"expert opinion from St Thomas's team"* regarding the XXX and there being no contraindications to a natural or assisted vaginal delivery.

112. Dr Thampi confirmed that she was not aware of any local guidelines within the Trust that indicated that women over a certain BMI should be informed of an increased chance of a failure of an operative vaginal delivery.

113. Further, during Dr Thampi's oral evidence, she reiterated her position as above. It was put to her in cross-examination that Dr Q had said that an honest and open discussion should be had with the patient in light of her risk factors. Dr Thampi stated that she did not go to women who have a raised BMI and have a discussion to say that there is a risk of increased operative birth or that the patient could have a second stage CS. Dr Thampi stated that it was not her practice to say this and that this practice was learnt from her peers. In respect of Dr Q's opinion that she needed to be proactive, Dr Thampi stated that she did not know what was meant by *"proactive"* but that she really would not go and tell women, who are already sensitive about their raised BMI, these points. Dr Thampi stated that there was a note from the UCLH team that Patient A could have an assisted birth, that these discussions about labour can happen antenatally, and she had looked at the birth plan. In respect of a need to have an honest conversation, Dr Thampi stated that there was no need for an honest conversation that might alarm Patient A. Dr Thampi stated that her discussion would be

according to the clinical situation, based on what the patient's birth plan was and Dr Thampi's recommended plan of action.

114. The Tribunal had regard to a letter dated 25 April 2016 entitled *'Anaesthetic Management of Patients with* [XXX]*'* and a letter dated 7 July 2016 from UCLH which were within Patient A's medical records. The July letter was written to Patient A, and she was seeing the neuromuscular team there due to her XXX.

115. Within the letter, it stated:

> *"There is no real contraindication for you having a normal delivery, or even an assisted delivery if needed, however we would suggest avoiding a prolonged labour where possible due to the risk of you experiencing severe* [XXX]*. If you were to try for a normal delivery then we would suggest that your analgesic options should include epidural and Entonox and that you are able to move around to reduce the risk of stiffness which may hamper positioning for delivery.*
>
> *If you need to have an assisted delivery, the main area for concern would be prolonged positioning and the risk of increasing your stiffness.*
>
> *With regards to caesarean section, we would again suggest epidural anaesthesia to reduce the risks of* [XXX]*. We have provided you with an anaesthetic plan which contains further information about this. The overall considerations should be that you are able to move around, to be kept warm and if analgesics are required to avoid painful intramuscular injections by opting for epidural with the addition of Entonox if needed.*
> …
> *If the team looking after you during labour have any questions they can contact us for advice if required."*

116. The Tribunal had regard to Dr Q's expert report dated 6 July 2020. She stated:

> *"Patient A was known to have a neuromuscular condition. It also appears that she spoke with Dr Thampi in labour to advise that she did not want to be delivered using forceps (see the note made by* [Ms L] *on* [XXX] *October 2016 at 18:55…). The RCOG guidance includes information about when an operative vaginal delivery is more likely to fail (see Section 5.2); factors associated with a higher rate of failure include maternal body mass index over 30.*

It also seems reasonable to consider that Patient A may not have been able to push as effectively because of her neuromuscular condition.

Therefore, it is my opinion that these factors should have been discussed with Patient A before starting a Kiwi vacuum delivery; if she refused consent for forceps, best practice would have been to consider transfer to theatre, reassessment after appropriate regional anaesthesia and possible trial of vacuum, to be abandoned in the event of inadequate progress.

It was not unreasonable to consider the use of instruments and operative vaginal delivery. However, it was foreseeable that the vacuum device could fail and that recourse to CS after that could be required.

Dr Thampi's failure to consider this sequence of events and discuss available options as described above represented practice which fell seriously below the expected standard."

117. Dr Q provided the Tribunal with the RCOG Green-top Guideline No.26 [2011], including reference to Section 5.2 which includes:

"Operative vaginal births that have a higher risk of failure should be considered a trial and conducted in a place where immediate recourse to caesarean section can be undertaken.

Higher rates of failure are associated with:

- ***maternal body mass index over 30** (emphasis added)*
- *estimated fetal weight over 4000 g or clinically big baby*
- *occipito-posterior position*
- *mid-cavity delivery or when 1/5th of the head palpable per abdomen.*

…

Fetal injuries have been attributed to delay between a failed operative vaginal delivery and a caesarean section. Therefore, operative deliveries that are anticipated to have a higher rate of failure should be considered a trial and conducted in a place where immediate recourse to caesarean section can be undertaken."

118. The Tribunal had regard to Dr S's expert report dated 24 August 2024. He stated:

"… there is no record of Dr Thampi having a discussion with Patient A as to the potential benefit of forceps over Ventouse due to her raised BMI and her neuromuscular condition which would have been a good practice point."

119. Within the Joint Experts Report dated 11 September 2024, Dr Q stated that she agreed with the allegation and Dr S set out that he did not agree with it. In respect of paragraph 1(a)(i) of the Allegation, it stated:

"Areas of agreement (if any):
If accepted, this would not fall seriously below standard.

Areas of disagreement (if any):

[Dr S]*: It is not routine to inform patients that instrumental delivery may fail due to BMI; rather, it should be based on the clinical features of descent and operator experience.*

[Dr Q]*: while this patient had several individual and significant factors in her medical history,* [Dr Q] *accepts that most consultants would not mention this factor specifically, even though the RCOG guidance includes it as a risk factor."*

120. During Dr Q's oral evidence to the Tribunal, it was put to her under cross-examination that what was alleged at paragraph 1(a)(i) of the Allegation was derived from her report that women with a high BMI are less likely to deliver vaginally and through an operative delivery. Dr Q was asked whether she thought it was mandated for a consultant to say this on the labour ward. She said that she did not think that she had said that it was mandated, but that she did think it was important for Patient A because of the overall context of her clinical history. Dr Q was asked whether she was saying that Dr Thampi should have raised this point with her at the time that she was discussing the instrumental delivery with Patient A. Dr Q said *"Yes, as to the success of that"*.

121. In a continuation of Dr Q's evidence, she had stated in her reports that it was mandated for the consultant to tell Patient A that there was an increased chance that the operative delivery would not work due to her neuromuscular condition. Dr Q stated that the information available to her about the neuromuscular condition was that the muscles can contract and stay contracted for a long time. She stated that this would seem to be a concern if they were expecting descent down the birth canal past the perineal muscles. Dr Q stated that she did think it was relevant and part of the overall assessment of risk. She stated that

the use of the word *"mandated"* was probably for the Tribunal to decide how significant it is. Dr Q stated that, for Patient A, she thought it was part of her risk profile.

122. It was also put to Dr Q whether she was saying that Dr Thampi was mandated to tell Patient A that the operative vaginal delivery was likely to fail. Dr Q stated that, if she assessed that information against what a reasonably competent consultant would do within what is required for informed consent, a discussion of risks and benefits and *"therefore if facilitating informed consent is mandated, then that discussion is mandated".*

123. In oral evidence Dr S was asked how he would deal with a patient, against the background of BMI and XXX. He stated that he would have familiarised himself with Patient A's notes prior to the ward round and asked how she was. He stated that he would have had a very general type of conversation as there was nothing at that time that needed to be addressed. He stated that the plan was already there in terms of Patient A keeping hydrated, making sure she had bed socks and was keeping warm. It was put to Dr S whether the correspondence from the UCLH team, which stated that there were no contraindications to a vaginal birth, would absolve a consultant from considering BMI and XXX as risk factors. Dr S stated that this would be the same for any woman on the labour ward and that every woman was at risk of needing an instrumental birth or a CS.

124. During Tribunal questions, Dr S was asked if his evidence was that it was accepted that there was a higher risk of instrumental delivery but that this did not necessarily lead to a duty to inform - that the consultant needed to look at the wider clinical picture. Dr S stated that he would not necessarily walk into someone's room who he had met for the first time and say, *"These are the things that could happen to you because you have a raised BMI"* but they were for the clinician to bear in mind. For example, at the point that delivery becomes relevant or imminent, the patient may be more likely to develop a temperature or have difficulty in wound healing and therefore he would prescribe antibiotics. He stated that these things are contradictions and not risk factors.

125. The Tribunal had regard to the evidence before it. It noted that Dr Thampi had readily accepted that she did not know much about XXX, she had never delivered a baby where the mother had this condition, and she had sight of the letter from UCLH setting out that there was no contraindication to a vaginal or operative vaginal delivery. The letter indicated that the main area for concern for an assisted delivery would be prolonged positioning and the risk of stiffness increasing.

126. The Tribunal noted Patient A's medical records and its finding that at 18:26 Dr Thampi discussed the instrumental delivery including the possible use of forceps. Prior to this point,

Dr Thampi had been working towards a vaginal delivery, and the Tribunal could appreciate that in-line with Dr S's opinion there was no obligation or mandate upon Dr Thampi, to inform Patient A earlier in the day on XXX October 2016, that there was an increased chance of failure if she had an operative vaginal delivery, due to her BMI and XXX, as an operative vaginal delivery was not clinically indicated then.

127. The Tribunal reminded itself that the reasons for the plan to change from a natural delivery to an assisted delivery with instruments, was due to the time that had been passed since Patient A's spontaneous rupture of membranes, the concerns about potential infection, and one non reassuring feature on the CTG. At this time, Dr Thampi was and had been aware of Patient A's BMI and XXX. Additionally, and importantly, the Tribunal noted that at 18:26 onwards to when the Kiwi was applied, Patient A had not consented to any subsequent use of forceps and had communicated her objection to its use to Dr Thampi.

128. The Tribunal noted the RCOG Green-top Guideline No.26, that:

> *" Higher rates of failure are associated with:*
> - *maternal body mass index over 30."*

129. The Tribunal also noted from the experts and Dr Thampi that a successful Kiwi delivery requires a combination of maternal effort, as well as effort from the medical practitioner using it. Dr Thampi did not know the specifics of the impact of XXX but was aware of the risks of muscles stiffening from it. In light of these factors, the Tribunal preferred the view of Dr Q on this issue, in that it was foreseeable that the operative vaginal delivery could fail. The attempt to deliver with a Kiwi did in fact fail albeit it may have been due to XXX, or Patient A being exhausted, impacting on her ability to push effectively. Nevertheless, the Tribunal considered that the increased chance of failure was present for Patient A. The Tribunal accepted Dr Q's view of the practice of a reasonably competent consultant in terms of there being a duty to inform in the context of informed consent. It was of the view, based on the evidence before it, that there was a duty upon Dr Thampi to have raised these matters with Patient A to ensure that Patient A had all the facts before her.

130. In addition to the RCOG guidance, the Tribunal also had regard to the GMC guidance applicable in 2016: *'Consent: patients and doctors making decisions together'* (2008), including the following paragraphs:

> *"2. Whatever the context in which medical decisions are made, you must work in partnership with your patients to ensure good care. In so doing,* ***you must*** *(emphasis added):*

a. listen to patients and respect their views about their health
b. discuss with patients what their diagnosis, prognosis, treatment and care involve
c. share with patients the information they want or need in order to make decisions
d. maximise patients' opportunities, and their ability, to make decisions for themselves
e. respect patients' decisions.

3. For a relationship between doctor and patient to be effective, it should be a partnership based on openness, trust and good communication. Each person has a role to play in making decisions about treatment or care.

5. If patients have capacity to make decisions for themselves, a basic model applies:
a. The doctor and patient make an assessment of the patient's condition, taking into account the patient's medical history, views, experience and knowledge.
b. The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.
c. The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one. They also have the right to accept or refuse an option for a reason that may seem irrational to the doctor, or for no reason at all.
d. If the patient asks for a treatment that the doctor considers would not be of overall benefit to them, the doctor should discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment would not be of overall benefit to the patient, they do not have to provide the treatment. But they should explain their reasons to the patient, and explain any other options that are available, including the option to seek a second opinion.

28. Clear, accurate information about the risks of any proposed investigation or treatment, presented in a way patients can understand, can help them make informed decisions. The amount of information about risk that you should share with patients will depend on the individual patient and what they want or need to know. Your discussions with patients should focus on their individual situation and the risk to them.

29. In order to have effective discussions with patients about risk, you must identify the adverse outcomes that may result from the proposed options. This includes the potential outcome of taking no action. Risks can take a number of forms, but will usually be:

a. side effects
b. complications
c. failure of an intervention to achieve the desired aim.

Risks can vary from common but minor side effects, to rare but serious adverse outcomes possibly resulting in permanent disability or death.

30. In assessing the risk to an individual patient, you must consider the nature of the patient's condition, their general health and other circumstances. These are variable factors that may affect the likelihood of adverse outcomes occurring."

131. The Tribunal also considered the RCOG *'Obtaining Valid Consent - Clinical Governance Advice No. 6'* (January 2015) document, including that:

"Consent is a process during which the professional provides adequate and accurate information concerning a procedure to a patient that allows them to reach a considered decision.

The key principles for consent to be valid are:

- *The patient must have capacity to make an informed decision:*
  - *considered competent to give consent*
  - *able to understand information provided*
  - *can communicate their decision.*
- *Consent must be provided voluntarily:*
  - *In most cases the decision to provide or withhold consent should be by the patient themselves.*
  - *The patient should not be coerced or influenced by carers, family or friends.*

- *The patient should be fully informed of the following by carers with enough time allowed to reflect and ask questions:*
  - *benefits and risks of the intended procedure*
  - *alternative management strategies*
  - *implications of not undergoing the proposed treatment.*

…

Where possible, prior consent to treat any problem that could reasonably be expected to arise should be obtained and documentation of any procedures to which the patient would object or would prefer to give further thought before proceeding should take place."

132. In all the circumstances, the Tribunal found, on the balance of probabilities, that it was incumbent on Dr Thampi to inform Patient A that there was an increased chance of failure of operative vaginal delivery (which includes the Kiwi) due to her BMI and her XXX. It took the view that this duty arose around 18:26 on XXX October 2016 when instrumental delivery became clinically indicated. In not informing Patient A of this, Dr Thampi did fail to act in the way that is alleged. Accordingly, the Tribunal found paragraphs 1(a)(i) and (ii) of the Allegation proved.

Paragraph 1(b)

133. The Tribunal considered whether, on or around XXX October 2016, Dr Thampi was involved in delivering Patient A of her baby and she failed to:

b. adequately consider and/or facilitate a discussion with Patient A about the alternative options for her delivery, given the increased chance of failure of operative vaginal delivery with a vacuum device.

134. The Tribunal bore in mind that it did consider that there was an increased chance of failure of an operative vaginal delivery with a Kiwi for Patient A. It also noted its finding that, at 18:28, Patient A had only consented to a Kiwi and there was no consent given for a subsequent forceps delivery and that she had communicated her objection to its use to Dr Thampi.

135. The Tribunal considered Dr Thampi's evidence of what she had discussed with Patient A at the point when the original plan for a natural delivery was no longer clinically indicated.

136. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she did not accept that she failed to adequately consider or facilitate discussion of the alternative

options for delivery. She stated that, in the first instance, the option of a natural vaginal birth was Patient A's preference, and she was aware that this had been considered and agreed in the process of drawing up Patient A's birth plan as evidenced in the medical records. Dr Thampi stated that she was content with this from a clinical perspective and allowed time for the birth to progress whilst Patient A was monitored. She stated that, when it became necessary to intervene, she did consider the options for delivery. Dr Thampi stated that she had reference to Patient A's birth plan which recorded no objections to the use of Kiwi or forceps. She stated that she was confident that the baby could be delivered by operative vaginal delivery. Dr Thampi stated that she had considered Patient A's high BMI and the position of the baby's head when considering the option of a CS. She stated that she did not consider a CS to be clinically advisable. Dr Thampi stated that it was agreed with Patient A to use the Kiwi first after which she recommended that it was necessary to change to forceps due to Patient A's clinical condition. Dr Thampi stated that, although this was not Patient A's preference, Patient A consented to the same after she explained why she considered it clinically necessary.

137. In Dr Thampi's oral evidence to the Tribunal, she stated that, from the notes, she understood that she had discussed with Patient A about the use of the Kiwi. She stated that it was her usual practice to discuss the Kiwi and possible forceps if needed and the routine use of episiotomy if it was a forceps birth. It was put to Dr Thampi as to whether it was incumbent upon her to offer, as an alternative to instrumental, a CS at this point. Dr Thampi stated that it was not her usual practice to do this as the head was in a favourable position and, as per her professional judgement, she was reasonably confident that they would deliver the baby vaginally. She stated that the discussion of the assisted delivery would include Kiwi and possible forceps because the head was down enough to consider an assisted vaginal birth.

138. Whilst mindful that any factual findings were the remit of this Tribunal, it had regard to Dr Q's expert report dated 6 July 2020. She stated:

> *"Dr Thampi did not inform Patient A that there was an increased chance of failure of vacuum delivery and to consider the available options for delivery if such a failure occurred. This practice fell seriously below the standard expected when explaining treatment options available and likely complications.*
> ...
> *It is also my opinion that Dr Thampi did not offer Patient A delivery by caesarean section, despite clinical indications; this fell far short of the standard required in GMC guidance on obtaining consent."*

139. The Tribunal had regard to Dr S's expert report dated 24 August 2024. He stated:

"The evidence bundle provided indicates that Dr Thampi did perform counselling for instrumental delivery, and she has documented this in the delivery records details. In response to the allegations above, Dr Thampi has clearly written that a forceps delivery might be required to assist with the birth due to her clinical condition.

As evidenced by the medical records and Dr Thampi's statement, up until the point of decision to deliver there had been no expressed objection to forceps or the need for instrumental delivery consistent with birth plan.

There was no record by the midwife or Dr Thampi that Patient A had expressed a wish to decline or avoid forceps prior to the decision for instrumental delivery and Dr Thampi had read Patient A's birth plan and birth preferences, neither of which stated a wish that forceps were not to be used.

140. The Tribunal reminded itself however that it was assessing whether, in light of its earlier finding that there was an increased chance of an operative vaginal delivery failing, which included use of a Kiwi, discussion of alternative options to an instrumental delivery were mandated on Dr Thampi's part.

141. During Dr Q's oral evidence to the Tribunal, the Tribunal asked Dr Q about the next steps in a situation where a natural delivery is no longer considered to be safe. Dr Q's evidence was that it would be good practice to go for an instrumental delivery and there is then a discussion with the patient. The Tribunal asked whether, at this point, a CS needs to be mentioned as well or whether the discussion of instrumental delivery would be sufficient. Dr Q stated that, if the CTG is suboptimal or there is the possibility of infection then you would want to expedite delivery of the baby. Dr Q stated that, in terms of informed consent, mention of all available options should be included but that she would usually refer to CS by saying *"I don't think caesarean section is the best or fastest or safest way at the minute".* It was put to Dr Q whether it was incumbent on the obstetrician to mention CS at this point. Dr Q stated that, in terms of the reasonably competent consultant, it depended. She referred to Patient A, with the XXX and the high BMI. Dr Q stated that she thought it was incumbent within that conversation to discuss all options and *"the pros and cons".* She stated that she thought, within what the RCOG suggests and what informed consent requires, that mentioning a brief discussion of why what may or may not be an option is incumbent.

142. In oral evidence, Dr S was referred to Patient A's medical records where Dr Thampi came to review Patient A at 17:45. Contractions were four in ten minutes and the cervix was fully dilated. It was put to Dr S that, at this point, they had not reached the point of no return.

Dr S agreed with this. It was put to Dr S that there would have been the option of not continuing with the instrumental delivery and looking at the alternatives. Dr S stated *"yes"* and that if the discussion was had and Patient A had declined any offer of instrumental delivery, then the only option left would either be unassisted vaginal delivery or, if unable to, then CS would be required. Dr S was asked by the Tribunal whether this point would be before the application of the Kiwi, and he agreed that it was.

143. During Dr S's oral evidence to the Tribunal, he explained:

> *"When you assess somebody, before you have a conversation about which instruments you think you're going to use, you should, as an experienced operator, know whether you think the odd risk of failure – whether there is a risk of failure present. In other words, again, making the decision. This is why registrars are known to take patients more readily to theatre, because they do not have the experience and they feel more unsure as to whether they can facilitate a safe delivery with either the ventouse or the forceps. Therefore they will rely on that slight comfort zone of being in theatres, so that if they are unable to deliver the baby with instruments, then they can resort to caesarean section. As consultants, we've been doing it longer, we have a much clearer idea in our own heads as to whether we think a delivery can be facilitated in the room with the use of instruments. I would say that my practice would be that once we've tried the instruments and there has been no – if, which only rarely happens, thankfully – there's been no sign of delivery, we have to say the instruments are not working, we will have to go to theatre for a caesarean section. My usual practice would be to discuss caesarean section only after instrumental delivery has failed."*

144. Dr S was asked by the Tribunal if that conversation would be different if a patient was reluctant to the use of forceps. He stated that it was a matter of judgment and that if a patient has said, *"I'll accept ventouse, but I won't accept forceps",* then you would have to explain very clearly that, *"This means we have to facilitate delivery with the ventouse, therefore you're going to have to be able to push with me and we're going to have to make sure that you give us every bit of effort, otherwise, we're going to be left in a situation where we're going to end up potentially with a very difficult or protracted delivery that may end up as a caesarean section."*

145. Dr S further agreed that the benefit of such early discussion could mean that that the entirety of the instrumental delivery is done away with and there is an elective CS.

146. Dr S did however also state that, if the consultant thought that there was agreement to the plan for forceps (if they became necessary) as part of the instrumental delivery, then it would not be mandated to discuss the option of CS.

147. The Tribunal had regard to the evidence before it. It considered that, in light of the increased risk of failure of an instrumental delivery with Kiwi and in light of Patient A's opposition to the use of forceps communicated to Dr Thampi at 18:26, Dr Thampi ought to have considered and facilitated a discussion of the alternative options with Patient A. The Tribunal considered that this necessitated a discussion about an elective CS as an alternative to the instrumental delivery. The Tribunal accepted that, before the development of the non-reassuring feature of the CTG, a CS was not indicated as the plan had been for an induction of labour and natural delivery. It considered that, when the CTG concern developed, a CS may not have been the best route as an alternative option, due to its own associated risks but it was still a valid alternative option that was available and ought to have been offered to Patient A in light of the chance of the Kiwi failing due to her XXX and BMI, and Patient A's opposition to the use of forceps communicated to Dr Thampi at 18:26. This did not happen. The Tribunal considered that a discussion, before the start of the instrumental procedure, would have addressed risk factors for each alternative option and would have impacted Patient A's choices in light of her clinical picture and would have been in compliance with the GMC consent guidance of 2008. The Tribunal referred to the GMC and RCOG guidance on consent, including paragraph 30 of the GMC's consent guidance, as quoted above.

148. The Tribunal was of the view, based on the evidence before it, that there was a duty upon Dr Thampi which she did not fulfil, to adequately consider and/or facilitate a discussion with Patient A about the alternative option for delivery, given the increased chance of failure of operative vaginal delivery with a vacuum device.

149. In all the circumstances, the Tribunal found, on the balance of probabilities, that Dr Thampi did fail to act in the way that is alleged. Accordingly, the Tribunal found paragraph 1(b) of the Allegation proved.

<u>Paragraphs 1(c)(i) and (ii)</u>

150. The Tribunal considered whether, on or around XXX October 2016, Dr Thampi was involved in delivering Patient A of her baby and she failed to:

c. act on and/or take account of Patient A's views, when she told [her]:

i. on one or more occasions, she wanted a caesarean section;

ii. on one or more occasion, that she did not want an instrumental delivery or words to that effect.

Paragraphs 1(d)(i) to (iii)

151. The Tribunal also considered whether, on or around XXX October 2016, Dr Thampi was involved in delivering Patient A of her baby and she failed to:

d. obtain informed consent for forceps delivery in that [she]:

i. did not discuss with Patient A the risks and benefits of instrumental delivery;

ii. did not discuss with Patient A the risks and benefits of caesarean section;

iii. pressurised Patient A into agreeing to a forceps delivery.

152. The Tribunal considered paragraphs 1 (c) and 1(d) together.

153. It reminded itself that, in Patient A's GMC witness statement dated 2 August 2023, she had stated:

"At around 17.45, Dr Thampi attended to review my progress. She explained she was going to conduct another VE… Dr Thampi explained I was fully dilated and asked if she could come and give me an instrumental delivery. I told Dr Thampi, "I don't want that, if you think I need an instrumental delivery I want a caesarean section." Dr Thampi just said that we "could talk about it later" and left the room.

…..

At no point during any consultation did Dr Thampi offer the option of a CS. Dr Thampi just said, "no, you can't have a c-section" when I mentioned it. She didn't give me any explanation as to why I couldn't have a CS. I didn't ask why and I remember thinking at time that she was on a bit of a warpath, so I was reluctant to ask."

154. Dr Thampi in her witness statement stated:

"It is also said by the patient and/or her mum that there was discussion of instrumental delivery with the patient saying she did not want that and instead wanted a Caesarean section (c-section) and discussion about general anaesthetic. Again, I have no recollection of any such conversation, and I do not think it is correct.

At this point we were giving patient A further time for descent of the baby's head before starting to push. I would not be having a discussion about instrumental or c-section delivery at that point and I would not be discussing general anaesthetic with the patients in any event, as this is a matter for the anaesthetist, not me."

155. The Tribunal had already found from its earlier assessment of the evidence, that, on balance, Dr Thampi first mentioned instrumental delivery with Patient A at 18:26 and not 17:45. From the medical evidence, it accepted that there had been no advance plan or an indication for an elective CS. The contemporaneous medical records also did not mention any discussion between Dr Thampi and Patient A about a CS or Patient A seeking a CS at 18:26 or 18:28. The Tribunal considered both accounts and determined that Patient A had not asked Dr Thampi for a CS at 17:45 when she states Dr Thampi responded with *"we could talk about it later".* It found that Patient had asked Dr Thampi for a CS, but it was in the context of the Kiwi failing and when consent to forceps was being sought at approximately 18:55.

156. This paragraph of the Allegation alleged a failure on Dr Thampi's part to *"act on and /or take account of"* Patient A's views in respect of wanting a CS and not wanting an instrumental delivery. It also considered the evidence in respect of the discussions Dr Thampi had with Patient A on both issues.

157. In her witness statement, Dr Thampi also stated that, when she had advised Patient A about the use of Kiwi, she also mentioned the possible use of forceps, which the Tribunal accepted. Further, that Patient A had consented to the use of Kiwi and so Dr Thampi proceeded with that. Dr Thampi had explained in her statement:

"At approximately 18:55 the Kiwi cup was applied I attempted to deliver the baby using the Kiwi for approximately 15 minutes. Unfortunately, whilst descent was achieved, the head did not descend enough to complete the birth using the Kiwi cup probably because of Patient A's clinical condition. I could feel her muscles contracting preventing me from being able to apply enough traction with the Kiwi cup."

158. Dr Thampi continued:

"Once it was apparent that delivery could not be facilitated solely by the use of ventouse, I discussed further with Patient A the use of forceps and the need for an episiotomy. Patient A said she did not want a forceps delivery but only when, in my clinical judgment, it was too late to safely change to a Caesarean section. I tried to avoid using forceps by initially using the Kiwi cup. However, Patient A's clinical condition, the CTG and the position of the baby's head meant that I considered that

the use of forceps was the most reasonable option in Patient A's and the baby's best interests.

… Given the situation regarding how low the baby's head was and my concerns about the baby's wellbeing, it was my clinical judgement that a Caesarean section was more likely to cause harm than using the forceps to facilitate delivery of the head. I explained this to Patient A.

It is alleged that there was no discussion or explanation, but that is not correct. I would always explain to a patient the reasons for recommending Caesarean section or why the risks involved indicated against it. I would aim to get across clearly what the reasoning is for the advice. I believe I would have explained the head was too low for this to be a safe option; that there was concern for baby; that mum had a temperature and the need for us to deliver and that I was confident I could deliver the baby vaginally and genuinely felt a c-section would involve a higher risk to mum and baby than a forceps delivery."

159. Dr Thampi's oral evidence was consistent with her written. She detailed for the Tribunal that:

"I have explained to her - the head came down with the ventouse, but I am experiencing some resistance in the pelvic floor and I will not be able to continue and complete the delivery with the ventouse cup. In my professional judgment, it would be advisable to change the instrument to the forceps… at that time, she [Patient A] said, "I do not want forceps" and I explained to her again and at that point I told the head is low down, I should be able to complete the delivery with the forceps and, despite her hesitation, she gave consent."

160. The Tribunal further considered the contemporaneous medical note entry for 18:55 stating that Patient A and her mother did not want forceps to be used. The notes, as written by Ms L, stated that "*this was already stated earlier in an earlier discussion with Ms Thampi".* The Tribunal took this to mean, at 18:26 / 18:28. As at 19:14 the note stated that Patient A had finally agreed to the forceps being applied as she felt she had no choice and that she had not been listened to. It was recorded that the forceps were applied at 19:15.

161. Within Patient A's GMC witness statement dated 2 August 2023, she stated:

"Dr Thampi next came to the delivery room shortly before 18.30… I verbalised to Dr Thampi that I was against the use of forceps… Dr Thampi began the delivery using

the Kiwi suction device… Dr Thampi then asked if she could use forceps to try and deliver my baby. I declined… Dr Thampi then explained, in reference to the forceps, that, "you need to let me do this as I don't know what is going to happen to your baby." It was due to this comment I felt forced into consenting to the use of forceps. I just said, "do whatever you want, you're going to do whatever you want anyway."… I was getting louder throughout as I repeatedly declined the use of forceps, and I didn't feel like Dr Thampi was listening to me."

162. In her evidence, Patient A reiterated this and explained that *"Eventually I became so frustrated I swore at Dr Thampi. I don't think I was abusive when I swore at Dr Thampi, I was just scared and was trying to get her to stop her doing something to me that I clearly didn't want her to do to me".*

163. In oral evidence Dr Thampi stated that Patient A did *"did eventually agree, which is evidenced in my notes to say that she agreed consent, despite the initial hesitation, after an honest and open communication with her regarding forceps and explaining to her that the forceps is not a tool which could damage her baby, she agreed, and she gave consent".*

164. Dr Thampi further stated: *"I discussed with her about the forceps and I know at that time, I know the environment wasn't conducive at that time. She was reluctant and then she said and I had to explain it again. The eventual agreement is evidenced that she gave consent despite her initial and repeated hesitations. I have documented in the notes, "Proceeded to forceps delivery after consent"."*

165. Patient A had confirmed to the Tribunal that she had not wanted an instrumental delivery. Her preference was to have a natural delivery. She said that she had not understood the need for an instrumental delivery even to the day she was giving evidence. She remained adamant in her oral evidence that the CTG feature had not been mentioned to her. The Tribunal considered that it was not plausible or probable that Dr Thampi had not informed Patient A about the one non-reassuring feature on the CTG trace before introducing the need for an instrumental delivery. It noted that Ms L had recorded in the medical notes *"Ms Thampi in room - Instrumental delivery discussed due to suboptimal trace"*, and Dr Thampi's note made the next morning included reference *to "explained to [Patient A]/partner that she will need assisted birth".* It further noted that Patient A had taken a copy of her medical notes soon after the index events and, in her subsequent discussion with the hospital staff, would have at least enquired about the clinical need arising for an instrumental delivery. It considered that it was more likely than not that Patient A had forgotten that she had been informed about the CTG finding by Dr Thampi.

166. Within Dr Thampi's witness statement dated 14 August 2024, and in respect of CS, she stated that if Patient A had indicated that she wanted a CS at that point she would have discussed this with her and would likely have agreed. However, it was only in the late stage of delivery after the failure of the Kiwi with Patient A fully dilated and the baby's head low, that Patient A said she wanted a CS/did not want forceps. Dr Thampi stated that, whilst she accepted that she did not act on Patient A's view to switch to a CS, she felt at the time that she did take account of Patient A's views and did try to clearly explain why she felt that a late change of plan to a CS was high-risk and the forceps delivery was the safer option to which Patient A did then consent.

167. Whilst Patient A remained adamant initially in her oral evidence that Dr Thampi had not explained the risks of the option of CS to her once the Kiwi had failed, she did accept later in her evidence that Dr Thampi had told her that she could not have a CS as it was too risky, too late and that the baby's head was too low.

168. In her oral evidence Patient A stated that she did eventually agree to the forceps as she felt she had no other choice. She stated that she thought her baby was going to die.

169. The Tribunal noted Ms L's evidence in her statement. She stated that, in respect of Dr Thampi seeking Patient A's consent for the use of forceps, Patient A had said words to the effect of, *"whether I say yes or no, you're going to do whatever you want anyway"*. Ms L stated that, from her observation, Patient A appeared to feel helpless.

170. Ms L's account did corroborate the account of Patient A. She stated that, once the forceps were applied, Patient A started shouting at Dr Thampi *"I hate you", "you haven't listened".* Ms L stated that she got the impression that it was all to do with Patient A not wanting a forceps delivery and feeling that Dr Thampi had not listened to her or had considered what she did and did not want. Ms L stated that Ms F was also very unhappy during the delivery.

171. Dr Thampi stated that it was her advice that a forceps delivery was in the best interests of Patient A and her baby. Dr Thampi stated that she knew that forceps were not Patient A's preferred choice, but she did not believe that she pressurised Patient A into this but gave Patient A her clinical advice based on prior experience. This would have included an explanation as to why she did not consider a CS to be suitable. Dr Thampi reiterated her comments that, given how Patient A expressed she experienced this delivery, she fell short with regard to the clarity of her communication. Dr Thampi stated that Patient A gave consent after she advised what she considered the best course of action to be clinically. Dr Thampi

stated that, on reflection, she should have done more to ensure that Patient A understood the necessity for the use of forceps at this point in the birth.

172. In oral evidence it was suggested to Dr Thampi that when it gets to the 'sharp end' there was less time, and decisions often need to be made quickly. Dr Thampi stated that labour was an evolving process, and decisions need to be made quickly. Further, that the more information that the patient had early, would avoid the 'pinch point' of the Kiwi failing and forceps being the way forward. Dr Thampi stated that it does become very difficult for women in the last stages of labour and that this was why discussions are had antenatally and all through labour. She stated that there had been instances when consultants are called into the room to hear *"This lady does not want forceps" and* then the drip is stopped, and they offer them straight CS. Dr Thampi was asked whether she treated this previous birth plan as being consent to those procedures that were ticked. Dr Thampi stated yes. That it showed they had discussed it, and any concerns would be written down at that point. Dr Thampi, however, also acknowledged that plans do change and that all women can change their mind at any time.

173. The Tribunal had regard to Dr Q's expert report dated 6 July 2020. She stated:

> "[If it were accepted that Patient A told Dr Thampi that she did not want an instrumental delivery and wanted a CS]
> *If it is accepted that these are Patient A's comments, it will be necessary to determine if Dr Thampi explained the risks and benefits of instrumental delivery and caesarean section (CS).*
> *This would be expected practice to demonstrate facilitation of the process of informed consent, as set out in contemporaneous GMC guidance.*
> *If there was an important issue which meant birth by CS was less safe than instrumental, this should be part of that discussion.*
> *The patient's choice at the end of that discussion should then be confirmed.*
> *If it is shown that Dr Thampi declined to offer Patient A a CS without such a discussion, her practice at that point would have fallen seriously below the expected standard.*
> [If it is accepted that Patient A told Dr Thampi that she wanted a CS]
> *If these comments are accepted, it is clear that Patient A wanted to delivery her baby by CS.*
> *As above, this should be noted and the options available discussed regarding risks and benefits, to clarify that Patient A had the necessary information available to make an informed decision. To not offer such discussion would fail to take account of contemporaneous GMC guidance about taking consent and would represent practice which fell seriously below the expected standard.*

…

If it is accepted that Patient A was pressurised into ultimately agreeing to a forceps delivery and it is accepted that she had stated clearly on more than one occasion beforehand that she did not want a forceps delivery, this would be practice which had not followed the principles of informed consent facilitation and would fall seriously below the expected standard."

174. The Tribunal had regard to Dr S's expert report dated 24 August 2024. He stated:

"It is important for the clinician to explain the rationale behind their clinical decisions and ensure that all members of the team providing care are aware of the intended plan for delivery.

The clinical records indicate that the use of either Ventouse or forceps had not been raised as an issue in labour that prior to the decision to perform an instrumental delivery, nor had there been a discussion about performing a Caesarean section.

At the point that Patient A was fully dilated, Dr Thampi has stated that she had concerns about the fetal well-being and the emerging clinical picture of infection as evidenced by the raised temperature.

Her clinical experience and judgement was that delivery would be feasible and appropriate to be performed by an instrumental vaginal delivery, rather than by Caesarean section which was likely to be difficult given that Patient A was fully dilated and had a raised BMI.

Her decision to counsel Patient A about instrumental vaginal delivery was in keeping with the practice of a reasonable body of Obstetricians."

175. Within the Joint Experts Report dated 11 September 2024, in respect of paragraph 1(c)(i) of the Allegation, Dr Q stated that she agreed with the allegation and Dr S stated that he did not agree with it. Within the report it stated:

"Areas of disagreement (if any):

Relates to point 1(b) above about how appropriate/feasible a Caesarean section would have been at the point that Dr Thampi changed instruments from Ventouse to forceps."

176. Dr Q further opined:

> *"If it is accepted that Patient A was pressurised into ultimately agreeing to a forceps delivery and it is accepted that she had stated clearly on more than one occasion beforehand that she did not want a forceps delivery, this would be practice which had not followed the principles of informed consent facilitation and would fall seriously below the expected standard.*
> *…*
> *I have not been able to identify a discussion between Patient A and Dr Thampi which included summaries of risks of ventouse delivery, forceps delivery and the alternative risks of CS.*
>
> *There was opportunity to complete this discussion when Dr Thampi first met Patient A while there was no urgency about delivery of the fetus.*
> *…*
> *In the absence of a summary note to outline such a discussion and in the context of Patient A's clearly expressed wish to not have an instrumental delivery, I must conclude that Dr Thampi's practice in the area of obtaining informed consent for a forceps delivery fell seriously below the expected standard."*

177. Within Dr Q's report she also included a document entitled *'RCOG Consent Advice No. 11'* [July 2010], which stated at point 6 that:

> *"What the procedure is likely to involve, the benefits and risks of any available alternative treatments, including no treatment*
>
> *Delivery of the baby (or babies) vaginally by means of forceps or a vacuum device. A clinical assessment is performed before the instrument is applied. The operator will choose the instrument most appropriate to the clinical circumstances and their competence.*
> *A caesarean section performed when the baby's head is low in the birth canal could be more traumatic for mother and baby than an operative vaginal delivery.*
> *It may be appropriate to explain that a competent pregnant woman may choose the no-treatment option; that is, she may decline operative vaginal delivery, even when this would be detrimental to her own health or the wellbeing of her baby."*

178. The Tribunal had regard to Dr S's expert report dated 24 August 2024. He stated:

"Dr Thampi has stated that at the time Patient A was fully dilated, given the clinical situation, she discussed the option of assisted vaginal delivery which included the use of Ventouse and also the possible use of forceps and the need for episiotomy

Dr Thampi's statement attests to the fact that she had read Patient A's notes and was aware of birth plan and prior discussions about instrumental delivery and that there had been no issues raised.

Dr Thampi is an experienced clinician and would have conducted many instrumental deliveries over many years.

She made a clinical decision based on the examination findings that delivery could be facilitated vaginally without the recourse to performing a difficult Caesarean section in advanced second stage and preventing the potential complications that can arise as a result.

…

Given the risks associated with a second stage Caesarean section on a background of concern around fetal wellbeing, it was appropriate to consider the use of forceps rather than abandoning the procedure and transferring Patient A to theatre which would have also been emotionally and physically traumatic and was not guaranteed to have improved the outcome for Patient A or her baby.

There was no documented evidence that there had been any issues raised prior to the decision to perform instrumental delivery that patient A had objected to the use of forceps or requested Caesarean section earlier in the labour.

A reasonable body of Obstetricians would have supported the decision to perform a forceps delivery instead of a complicated Caesarean section which would have been associated with multiple potential adverse effects and did not fall below an acceptable standard."

179. During Dr Q's oral evidence to the Tribunal, she stated that women do express anxiety about forceps. Dr Q was asked what is said and done to alleviate these concerns and that it can be challenging for some patients to understand the risks. Dr Q stated that it was very variable as to what patients anticipate or understand the risks may involve and how they can evolve during labour. It was put to Dr Q whether she accepted that if the obstetrician had been found to have been expressing clinical concern for foetal wellbeing or seeking to explain the urgency and need for intervention then it could be taken as coercion, but this would not in fact be the intent. Dr Q stated that it related to matters of fact and how the words were

used. She stated that if *"You need to let me do this"* was said without presenting any other options then this was not reasonable.

180. During Dr S's oral evidence to the Tribunal, he was asked whether obstetricians come across a situation where, ultimately, they get consent, albeit it might be thought of as a reluctant consent. Dr S stated that this happened every single day on the labour ward because it is a very difficult time. He stated that, although the obstetrician may perform that form of delivery multiple times in a day, some women will only have that operation performed once in their life and they have potentially never experienced it before. Dr S stated that it is, undoubtedly, a very emotionally difficult time for them, and making these sorts of decisions is going to be very difficult. Dr S stated that they try to maintain an aura of calm and try to explain to the best of their ability why something is clinically beneficial. Dr S was referred to the criticism from Dr Q that Patient A should have been offered the transfer to theatre and a re-examination and then a CS. He stated that if there had been no descent of the foetal head when the instrument (whatever instrument) had been used then it would have been appropriate at that point to remove the instrument and discuss transferring to theatre. However, in Patient A's case according to the records and the evidence there seemed to have been descent from a station of plus one down towards the perineum, and therefore it was not unreasonable to assume that the delivery could be completed albeit with a different instrument.

181. The Tribunal considered parts of the Guidance documents already mentioned, and particularly also the guidance on obtaining informed consent. It also considered the guidance referred to by Dr Q (RCOG 2011) in respect of the choice of women to opt for no treatment / decline operative vaginal delivery, even though it may be detrimental to their own health and/or wellbeing of the baby. The Tribunal also considered the following parts of the GMC: *'Consent: patients and doctors making decisions together'* (2008):

> *"7. The exchange of information between doctor and patient is central to good decision-making. How much information you share with patients will vary, depending on their individual circumstances. You should tailor your approach to discussions with patients according to:*
>
> *a their needs, wishes and priorities*
> *b their level of knowledge about, and understanding of, their condition, prognosis and the treatment options*
> *c the nature of their condition*
> *d the complexity of the treatment, and*

e the nature and level of risk associated with the investigation or treatment.

8. You should not make assumptions about:

a the information a patient might want or need
b the clinical or other factors a patient might consider significant, or
c a patient's level of knowledge or understanding of what is proposed.

9. You must give patients the information they want or need about:
…
e the potential benefits, risks and burdens, and the likelihood of success, for each option; this should include information, if available, about whether the benefits or risks are affected by which organisation or doctor is chosen to provide care."

182. The Tribunal had regard to all of the evidence before it, including the various guidance documentation and both experts' extensive evidence. It bore in mind its findings on the factual scenario and accepted aspects of both the experts' opinions. Whilst it noted Dr S's view as to the clinical decision of Dr Thampi in choosing forceps over a high risk second stage CS being supported by a reasonable body of obstetricians, it considered that this view has not taken into account Patient A's objection to forceps initially communicated to Dr Thampi from 18:26.

183. In considering whether Dr Thampi had taken into account Patient A's wishes, the Tribunal accepted that Dr Thampi had listened to Patient A's objections in respect of the forceps but only to the extent that she had tried to deliver Patient A's baby with a Kiwi. However, despite Dr Thampi's confidence in her being able to deliver the baby via the Kiwi, this was not possible.

184. The Tribunal also accepted that Dr Thampi had informed Patient A about the CTG issue, had showed Patient A the Kiwi instrument before its use, had explained its use, i.e. the combined maternal effort to push with Dr Thampi pulling on the Kiwi and had mentioned the possible use of forceps. It also accepted that Dr Thampi gave information to Patient A, when Patient A first raised this, that in her view the forceps were not likely to cause harm to a baby.

185. However, the Tribunal bore in mind its earlier finding of the increased chance of failure of a Kiwi specific to Patient A, and Patient A's opposition to forceps that Patient A had

communicated to Dr Thampi when instrumental delivery was mentioned, before the application of instruments.

186. In respect of a CS, the Tribunal considered that whilst Dr Thampi had responded to Patient A asking for a CS once the Kiwi had failed, she had not raised this as an alternative option herself with Patient A at 18:26, as part of the discussion of instrumental delivery and its stages including that it could lead to a CS which may be a higher risk second stage CS. Further, that Dr Thampi had not raised CS as part of the alternative options, as an elective CS available to Patient A, particularly in light of her views on forceps.

187. The Tribunal also considered that Dr Thampi had *responded* to Patient A once the Kiwi failed and informed her that it was too late for a CS due to the head of the baby being low but had not detailed the specific risks and any benefits to both baby and mother, as Dr Thampi had outlined for the Tribunal which included fracture to a baby's skull in pushing the head back up into the birth canal and harm that could be caused to the mother's anatomy. These detailed risks were not mentioned by Patient A in her evidence as being communicated to her, nor detailed within the medical notes or Dr Thampi's written statement as having been communicated to Patient A. Whilst having *responded* to Patient A mentioning a CS, the Tribunal took the view that Dr Thampi had not presented Patient A with a choice /option for a CS at this point when the Kiwi had failed.

188. The Tribunal accepted that it would have been a high-risk option but one that Patient A should have been informed of in order to take the decision for herself, in light of the risks being explained to her and in light of her opposition to forceps. It considered that detailed discussion of the specific risks from a second stage CS may not have been conducive at a time when matters were already fraught, and time was of the essence, but ought to have taken place, preferably at an earlier point before the application of any instruments to enable an informed choice to be made on the options. The Tribunal bore in mind the RCOG 2015 guidance which states that *"Care must be taken when obtaining consent from women who are in labour. This applies particularly if they are in pain or under the influence of narcotic analgesics. Women who are pain-free in labour as a result of effective epidural anaesthesia can consent normally".* It noted that Patient A may not have been able to process such information at the crucial time when the Kiwi had failed in order to decide between agreeing to forceps or choosing the riskier option of a CS. It considered that, if presented with fuller information on risks and benefits and options available, whether earlier at 18:26 or even when the Kiwi had failed, Patient A may not have chosen the higher risk option in any event but in line with the RCOG *'Obtaining Valid Consent - Clinical Governance Advice No. 6'* (January 2015) document, she ought to have been given the opportunity to make that decision herself, particularly as the Tribunal found, she was opposed to the use of forceps

from the outset and remained reluctant to consent to the course that had been suggested by Dr Thampi.

189. The Tribunal appreciated that a hostile environment developed between Dr Thampi and Patient A/Ms F as the matters progressed, specifically as the relationship deteriorated from around the time of the Kiwi failing and the use of forceps, which will be explored further in terms of the communication at paragraph 1(h) of the Allegation. Verbal abuse is not acceptable or appropriate and the Tribunal appreciated that it would have been difficult to engage with Patient A and Ms F at certain points. However, the Tribunal was also clear that Patient A had clearly articulated, at 18:26, that she did not want forceps when things would have been comparatively calmer, at that point, when no instruments had been applied.

190. It was the Tribunal's view that Dr Thampi ought to have discussed the full risks and benefits of an instrumental delivery and in the event of the Kiwi failing, the need for a CS, which may or may not have been a high-risk option, as it would depend on the descent of the baby's head. This ought to have been discussed in light of Patient A's opposition to the use of forceps. It did not accept Dr Thampi's evidence in respect of not speaking to patients about "*unnecessary intervention when there is no need to"* or where it is not yet clinically indicated.

191. The Tribunal considered that, despite the information and explanations given by Dr Thampi to Patient A as above, she had not acted on nor taken into account Patient A's views that she did not want an instrumental delivery. Dr Thampi had not offered Patient A the choice of a CS either at 18:26 or when the Kiwi had failed, despite her indication to Dr Thampi that she did not want the use of forceps. The Tribunal considered all the evidence and determined that the sum effect of this was that Patient A was ultimately forced down the path and thus pressurised into, having to reluctantly accept, the use of forceps as the only route to deliver her baby. In all the circumstances, the Tribunal found that Dr Thampi had failed to obtain informed consent. Accordingly, it found the entirety of paragraph 1(c) and 1(d) of the Allegation proved.

<u>Paragraph 1(e)(i)</u>

192. The Tribunal considered whether, on or around XXX October 2016, Dr Thampi was involved in delivering Patient A of her baby and she failed to:

e. appropriately respond to the lack of progress in Patient A's delivery by not:

i. abandoning the vacuum delivery after three pulls;

193. Within Patient A's medical records it stated, that at 18:28 Patient A was *"for kiwi ventouse delivery with consent".* She was prepared for Kiwi delivery at 18:45 and it was applied at 18:55. It was recorded that forceps were applied at 19:15, and then that the baby's head was out *"after four pulls on kiwi + forceps delivery of live male infant"*.

194. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she accepted that she did not abandon the vacuum delivery after three pulls, however she did not believe that that was inappropriate in this case. Dr Thampi stated that she abandoned the Kiwi delivery after four pulls and changed to forceps. Dr Thampi stated that, whilst there was descent of the baby's head, she was not able to achieve sufficient traction with the Kiwi to complete the delivery as she could feel Patient A's muscles contract/spasm. Dr Thampi stated that, in her clinical judgement, it was safe to attempt a fourth pull before changing plan, especially where Patient A had indicated that forceps were not her preference but also as CS was likely to be associated with increased risks. Dr Thampi stated that she was aware of the RCOG Green-top Guideline No.26 [2011] in relation to when to abandon operative delivery and sequential use of instruments. She stated that she felt that she took these guidelines into account whilst exercising her clinical judgment as to the safest approach for delivery.
Dr Thampi stated that she also took into account the training she had received from Professor T, as later reflected in the updated Green-top Guideline No.26 [2020]. Dr Thampi stated that she had received training from Professor T that three pulls in the descent phase and three in the perineal phase is acceptable as long as there was descent observed during the pulls.

195. The Tribunal had regard to Dr Q's expert report dated 6 July 2020. Within this she referred to the RCOG Green-top Guideline No.26 [2011], including Section 5.4 entitled *'When should operative vaginal delivery be abandoned?'.* This includes that:

> *"Operative vaginal delivery should be abandoned where there is no evidence of progressive descent with moderate traction during each contraction or where delivery is not imminent following three contractions of a correctly applied instrument by an experienced operator.*
> *…*
> *The bulk of malpractice litigation results from failure to abandon the procedure at the appropriate time, particularly the failure to eschew prolonged, repeated or excessive traction efforts in the presence of poor progress."*

196. Within Dr Q's report, she stated that:

> *"The RCOG guidance is clear about when to abandon the operative vaginal delivery and about the use of sequential instruments.*

Dr Thampi noted that "it might not be feasible" to perform a CS.
Dr Thampi delivered Patient A's baby subsequently using 2 pulls.
This suggests that the fetal head was not so far down the birth canal as to not consider the option of CS.

It is my opinion that Dr Thampi did not recognise and respond to the lack of progress when attempting a Kiwi vacuum delivery and respond in line with RCOG guidance.
…
Conversion to a CS was indicated after 3 pulls with the Kiwi vacuum without adequate progress, as outlined in the RCOG.
Dr Thampi's failure to offer to convert the mode of delivery to CS at this point fell seriously below the RCOG guidance; the information contained in her note does not justify or explain why Patient A could not have been transferred to theatre for appropriate analgesia, repeat examination and CS."

197. During Dr Q's oral evidence to the Tribunal, she stated that she was taught that with three pulls delivery should be imminent (i.e. something visible whether the Kiwi cup or the baby's head) and the RCOG guidance from the time would seem to support this as well. Dr Q stated that she appreciated that Professor T talks about extra pulls once the head is on the perineum, but again that is very low down and visible, and even with rotational vacuum, the current RCOG position for the simulation training is that occiput-posterior (OP) vacuum should be the same as an occiput-anterior (OA), and it does not say you are allowed extra pulls for rotation. Dr Q was asked, if the baby is not visible at that point, what are the options after three pulls on the Kiwi. She stated that it depended whether the operator thinks they have progressive descent and/or rotation if that was what you set out to do. Dr Q stated that if the operator thought delivery could be achieved with one more pull then consideration of this with the mother should follow (and an explanation of what would come next including the possible application of forceps). Dr Q stated that if the descent or rotation had been minimal and the head was still quite high up within the birth canal then interrupting the procedure and moving away from instrumental delivery to CS was the next step.

198. The Tribunal noted that OP position is where the baby's head is down but is facing the mother's front instead of her back. OA position is where the baby's head is down, and the front of the baby is facing towards the mother's back.

199. Further in Dr Q's oral evidence, it was put to her that the RCOG guidance were guidelines and not tramlines or rules. Dr Q stated that they were labelled as *'guidelines'* and that they were what is used in everyday practice as a benchmark for assessing practice. Dr Q did not accept that the guidance was 'guidelines' rather than 'tramlines'. She stated that it

depended on the specific circumstances and the reason for deviation from that guidance. She stated that she did not think she could make a broad comment of agreement. Dr Q was asked what the role of clinical discretion had in the application of these guidelines. She stated that she could only speak to her experience of how her peers and colleagues had used those guidelines over the years. She stated that, largely speaking, there is discretion in *"very, very extenuating circumstances"*. She stated that she was not clear that she had seen evidence of such variance and widely extenuating circumstances in this case. It was put to Dr Q that the guidelines were not intended to dictate to consultants or to indicate an exclusive course of management. Dr Q stated that she accepted that she probably disagreed with Dr S on this point, but she returned to her comments as to how she sees them used in everyday practice with reasonably competent consultant colleagues. Dr Q had clarified to the Tribunal that she meant the colleagues she had worked with.

200. Dr Q was referred to the RCOG Green-top Guideline No.26 [2011], including that:

> *"The Royal College of Obstetricians and Gynaecologists produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of clinical data presented by the patient and the diagnostic and treatment options available within the appropriate health services.*
>
> *This means that RCOG Guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken."*

201. It was put to Dr Q that there was a distinction between local protocols and these guidelines, which are specifically not intended to be prescriptive directions defining a single course of management. Dr Q was asked whether she disagreed with this. Dr Q stated that she did not think that was what she said. She said that, when she sees the guidelines being applied and interpreted by her competent consultant colleagues, that they would abide by those recommendations.

202. Dr Q was also asked about the teaching of Professor T in terms of the Kiwi and whether his recommendation of three pulls for descent to the perineum and three pulls to

get it over the perineum had been adopted by the RCOG within its updated guidelines. Dr Q stated that it was certainly included. She stated that it was not a specific recommendation but that it was included within the 2020 guidelines. Dr Q was asked whether she considered this *"three plus three pulls"* approach when arriving at her original opinion in July 2020. She stated that she did consider it, but she considered the evidence of the practice she saw with reasonably competent consultants and based her conclusions upon that. Dr Q was asked whether there was any reason why, within any of her eight reports, there is no mention of this point. Dr Q stated that there was no particular reason. She stated that she asked the RCOG library archive to provide her with the contemporaneous guidance and based her conclusions around that. She stated, when asked, that the 2020 guidelines were part of her consideration but not within her written report.

203. Dr Q was referred to the instructions from the Kiwi Complete Vacuum Delivery System with PalmPump. In the instructions it stated:

> *"Abandonment of a vacuum delivery should be considered 1) if no descent (progress) of the head occurs after 2 tractions, 2) if delivery is not achieved or imminent after 4 tractions, or 3) if the vacuum cup detaches ("pops-off") twice."*

204. It was put to Dr Q that there is reference within the instructions to a fourth traction. Dr Q was asked whether she was saying that this was to be entirely disregarded. Dr Q stated that she did not think that was what she had said. She stated that "2*) if delivery is not achieved or imminent after 4 tractions"* did appear to contradict the RCOG comment. Dr Q stated that she thought it needed to be re-evaluated after three if delivery is going to be imminent with the next out (the fourth one). She stated that she did not think that she had said that was not within accepted practice.

205. Dr Q was referred to the RCOG Green-top Guideline No.26 [April 2020], including that:

> *"Where available, the operator should be aware of the manufacturer's recommendations for the chosen instrument."*

When questioned further on this, Dr Q agreed that the instructions from the Kiwi Complete Vacuum Delivery System with PalmPump could be borne in mind.

206. During Dr S's oral evidence to the Tribunal, he stated that the RCOG guidelines were based upon expert opinion and relevant evidence in clinical literature, to be able to come to a set of suggestions and advice. He stated that they are only guidelines. Dr S stated that, in terms of practicality and practical procedures, a lot of what will be learnt through training is

going to be influenced by what is taught by peers and seniors. He stated that the guideline is there as a recommendation for things that you should try and avoid or where it seems appropriate to say that discretion is required. Dr S stated that he had always taken the advice about the number of pulls to be a salutatory warning to people, lest they pull on a Kiwi or forceps seven, eight, ten times, without seeing any actual progress or actual descent of the foetal head. He stated that, in Patient A's case, there was descent of the foetal head with the Kiwi, albeit not to the point of actual delivery.

207. Dr S was referred to the relevant documents as Dr Q had been, including the April 2020 version of the RCOG Green-top Guideline No.26. It was put to Dr S that Dr Q had, effectively, said that any more than three pulls on the Kiwi was excessive. Dr S stated that the *"guideline and your own experience"* gives you that ability to stay within the boundaries of reasonable practice by making a clinical assessment of whether there has been descent. He stated that it would have been unreasonable for anybody to have continued after two pulls of a Kiwi if no descent is obtained. At that point you would have to go back and reevaluate your clinical assessment of the situation. Dr S stated that, where there has been progressive descent, it is appropriate to carry on and, indeed, the actual clinical information on the Kiwi does say that four pulls can be used. Dr S stated that there was scope for being able to use more than three pulls on the Kiwi as long as there is continued descent and the operator's assessment that delivery could be facilitated safely vaginally, rather than having to resort to CS or other methods. Dr S was asked whether Dr Q's opinion on this point fairly reflected the range of opinion within the profession at the time or if it was an overly narrow approach. He stated that it was too narrow because the guidelines did provide for that bit of discretion as to how to facilitate the delivery.

208. The Tribunal considered that in the contemporaneous medical notes for XXX October 2016, Dr Thampi wrote that at 17:45 the baby was OA at spines +1. The note further referred to *"PP not descending well with pulls"* which indicated some descent albeit limited. In the handwritten medical note that Dr Thampi made at 08:00 the next day, it was not clear from the handwriting whether the note stated *"++"* equating to +2 or whether the note stated +1. The context of this note was reference to insufficient descent, due to which further attempts on the Kiwi had to be deferred. The record also indicated that the vertex was low in pelvis due to which Dr Thampi was *"unable to offer CS".*

209. The Tribunal referred to Dr Thampi's operative note which would appear to have been made soon after the birth the same evening on XXX October 2016 at 20:40, which stated:

"Pt wasn't keen on forceps. However, as vertex +2 station + more than 15 minutes after ventouse application, explained to Patient A that …need to assist birth with forceps due to clinical condition and suboptimal ctg. Agreed for forceps birth after explaining that it might not be feasible CS as Vx in perinium…"

210. It considered that the references within the notes were consistent with a picture of there being some descent from +1 station and the vertex being low in the pelvis / perineum. It noted that the baby had been borne with two further pulls of the forceps. Having considered all these factors, it determined that the reference to the note made on at 8am on XXX October 2016 was *"++"*, i.e. +2.

211. The Tribunal took account of what both Dr Q and Dr S opined as to the nature and application of the RCOG Green-top Guideline No.26, as well as the operating instructions for the Kiwi. It considered Dr Q's evidence on this issue did not come across as consistent or balanced, or reflective of all the varying factors. It preferred Dr S's evidence in this regard.

212. The Tribunal was of the view that there was a broader interpretation of the guidelines, which was acceptable, to permit a fourth pull on the Kiwi as long as there was progressive descent. This was within the instructions from the manufacturer, based on training Dr Thampi had undertaken with Professor T, and was considered appropriate by Dr S. The Tribunal had determined that there had been descent of the head to +2 station, as recorded by Dr Thampi. It therefore determined that Dr Thampi had not failed to appropriately respond to the lack of progress in Patient A's delivery by not abandoning the vacuum delivery after three pulls. Dr Thampi switched to using forceps after the fourth pull was not successful as she needed more traction, and the baby was delivered after two pulls of the forceps. The Tribunal did not find a failure on part of Dr Thampi in not abandoning the Kiwi vacuum delivery after three pulls.

213. Accordingly, the Tribunal found paragraph 1(e)(i) of the Allegation not proved.

<u>Paragraphs 1(e)(ii)(1) and (3)</u>

214. In considering this allegation, the Tribunal bore in mind paragraph 1(e)(i) and considered that the reference to "lack of progress" was that the baby had not been delivered by Kiwi.

215. The Tribunal considered whether, on or around XXX October 2016, Dr Thampi was involved in delivering Patient A of her baby and she failed to:

e. appropriately respond to the lack of progress in Patient A's delivery by not:

…

ii. immediately offering Patient A:

1. the option of transfer to theatre;

…

3. a caesarean section, given that Patient A had explicitly told [Dr Thampi] she did not want a forceps delivery.

216. Within the typed amendments to the transcript of Ms L's investigation meeting at the Trust on 19 March 2019, she stated:

"Q - At that stage, was it possible for a caesarean section to be performed?
A - As there had been a failed attempt at Kiwi delivery, Patient A could have been taken to Theatre for trial of forceps; if the forceps failed, we could have transferred to doing a caesarean section… However, [Dr Thampi] was the only one who could make this judgement as she had hands on.
…
A - … [Dr Thampi] tried again but the baby did not come, the forceps delivery, in a labour ward room, should have been a simple lift out.
I remember that it had been taking too long and that more force was being applied. I remember thinking whether I should have spoken out about transferring Patient A to Theatre."

217. Within Ms L's GMC witness statement dated 16 August 2023, she stated that:

"At 18.29 Patient A prepared for delivery. As the delivery progressed, Dr Thampi was unable to deliver the baby using the ventouse. Dr Thampi decided forceps were required. I turned to Dr Thampi and, as I didn't want to challenge her too loudly, asked, "are we doing this in the room?" I believe Dr Thampi would have understood that I was asking whether we should transfer Patient A to theatre. If second stage of labour prolonged, we may need go to theatre for a trial of forceps, especially with cases where the ventouse delivery has failed. Dr Thampi just said, "yes, yes, yes, it's fine." I thought, 'Well. Okay. She's the one with hands on the baby. If we're doing it in the room, it should just be a simple lift out with the forceps.' The only time we would use forceps is if it was a simple lift out case. As the consultant, Dr Thampi knows what the protocols should be and when we should move to theatre, so I didn't challenge her. Additionally, there was a Band 7 Labour Ward Coordinator, [Ms U] *in the room and*

the Band 7 Labour Ward Coordinator, [Ms R] *was also in and out of the room prior to delivery. Both Band 7's knew what was happening with Patient A."*

218. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she did not accept these allegations. In respect of paragraph 1(e)(ii)(1) of the Allegation, Dr Thampi stated that, whilst she accepted that she did not offer Patient A transfer to theatre, she did not accept that this was a failure on her part. Dr Thampi stated that she was aware that women with a high BMI are at an increased risk of failed assisted birth. Dr Thampi stated that, following a thorough assessment, she was confident in her ability to achieve a successful delivery in the room. Dr Thampi stated that she is accountable for every birth she performs and that she always works to the best of her professional and clinical judgement. She stated that she has a duty of care to ensure the safety of the mother and the baby and, in exercising this duty, she draws on her extensive experience, competency, professionalism and clinical knowledge. Dr Thampi stated that, although it was necessary to change to forceps, she was confident that the delivery could be achieved in the room. The baby's head was low, and she did not consider it wise to delay. There was also the benefit of the midwifery support available on the labour ward than in theatre. Dr Thampi stated that she should have explained in greater detail.

219. In respect of paragraph 1(e)(ii)(3) of the Allegation, Dr Thampi stated that she accepted that she did not offer a CS. She stated that she considered that the risks of a CS were too high at this stage. The baby's head was too low and Patient A's BMI was very high. Dr Thampi stated that she discussed this with Patient A, and she believed it was at this time that Patient A made comments about her 'doing it anyway' or words to that effect. Dr Thampi stated that this was not true, but it was her strong clinical advice in the best interests of Patient A and her baby. Dr Thampi stated that Patient A consented to the delivery by forceps on this basis. Dr Thampi stated that she would have had no reason to, and would not, carry out a procedure that a patient did not consent, and she did not do so in this case. Dr Thampi stated that, given the findings at the time, she advised that a forceps delivery was in the best interests of Patient A's and her baby because it carried less risk than a CS.

220. The Tribunal bore in mind its earlier findings in respect of Dr Thampi's response to Patient A about CS when the Kiwi had failed. Dr Thampi told the Tribunal that when the head is low, it is difficult to perform a CS because of the increased risk of injury to the mother. Further, that when a baby's head has crossed a wider diameter, pushing the head back can cause fractures to the skull of the baby. Dr Thampi was asked what her assessment of the risks of CS were to Patient A before she applied the forceps. Dr Thampi stated that she was mindful that Patient A wanted to have a vaginal birth and about the requirement to avoid prolonged positioning. Dr Thampi stated that the baby's head was really low down and taking

Patient A back to theatre and trying to push the head up was certainly going to risk a skull fracture. She stated that there was also a risk of damage to the side of the pelvis for Patient A or the uterus, as well as a higher risk of bleeding and of pre-term delivery in the second pregnancy. Dr Thampi stated that, taking all of the factors into consideration, she felt that it was safe to perform a sequential instrumental procedure.

221. Dr Thampi was referred to the RCOG Green-top Guideline No.26 [2011], including Section 5.2 entitled *'Where should operative vaginal delivery take place?'*:

> *"Operative vaginal births that have a higher risk of failure should be considered a trial and conducted in a place where immediate recourse to caesarean section can be undertaken.*
>
> *Higher rates of failure are associated with:*
> - *maternal body mass index over 30 …"*

222. Dr Thampi stated that the RCOG use the term *"consider"* and that is to alert the obstetrician. She stated that they are alerted and when they perform instrumental deliveries on the labour ward, usually the obstetric theatre is not far off from the labour ward so that its immediately close to CS should there be any concerns.

223. The Tribunal had regard to Dr Q's expert report dated 6 July 2020. This included:

> *"… Conversion to a CS was indicated after 3 pulls with the Kiwi vacuum without adequate progress, as outlined in the RCOG.*
> *Dr Thampi's failure to offer to convert the mode of delivery to CS at this point fell seriously below the RCOG guidance; the information contained in her note does not justify or explain why Patient A could not have been transferred to theatre for appropriate analgesia, repeat examination and CS."*

224. Within Dr Q's expert report dated 6 March 2024, she considered:

> *"Did Dr Thampi adequately recognise and respond to the difficulties in progressing delivery of Patient A's baby?*
>
> *As in my previous reports, Dr Thampi did not recognise and respond to such delays in that she failed to recognise and respond to lack of progress during vacuum delivery and abandon that vacuum delivery and she failed to offer delivery by CS after a failed vacuum delivery."*

225. Within the Joint Experts Report dated 11 September 2024, Dr Q stated that she agreed with the allegations and Dr S stated that he did not agree with them. Within the report it stated:

> *"Areas of disagreement (if any):*
>
> [Dr Q] *is of the opinion that at the point of vacuum delivery was not successful, Patient A should have been counselled about the option of transfer to theatre.* [Dr S] *is of the opinion that the clinical scenario warranted expeditious delivery and that forceps after the Ventouse was the most clinically appropriate/feasible method."*

226. The Tribunal reminded itself of Dr Q's evidence options after three pulls on the Kiwi - if the baby's head is not visible. She stated that it depended whether the operator thinks they have progressive descent and/or rotation. Dr Q stated that if the operator thought delivery could be achieved with one more pull then consideration of this with the mother should follow (and an explanation of what would come next including the possible application of forceps). Dr Q stated that if the descent or rotation had been minimal and the head was still quite high up within the birth canal then interrupting the procedure and moving away from instrumental delivery to CS was the next step. Dr Q was asked whether this decision should take account of the patient's wishes. She stated that she felt it had to, and that this was what informed consent links to.

227. The Tribunal also had regard to its earlier considerations and findings at 1(c) and 1(d).

228. The Tribunal noted that a CS cannot be undertaken in the labour room and that the patient must be moved to theatre for this to be done. The Tribunal did not understand there to be a difference between what is alleged at paragraphs 1(e)(ii)(1) and (3) of the Allegation; it was essentially the same point. It also bore in mind the relevant evidence and its evaluations within paragraph 1(d) of the Allegation.

229. The Tribunal had particular regard to the expert evidence and the GMC consent guidance (2008) and the RCOG *'Obtaining Valid Consent - Clinical Governance Advice No. 6'* (January 2015) in terms of this matter. Dr Q's position is that there needs to be this offer of the option of a transfer to theatre and a CS as at the time the Kiwi failed. The Tribunal noted that Dr Q's premise for this was if the baby's head had not progressively descended - in this case, the Tribunal accepted, had descended.

230. In response to Tribunal questions, Dr Thampi referred to the point in time where the Kiwi had failed and the baby needed to be delivered, as an *"unanticipated emergency".* This was not mentioned in her written statement or earlier in her oral evidence. Dr Thampi explained further that the head was low, and she was unable to proceed with the Kiwi. When challenged about the use of this term, Dr Thampi said *"…the question was asked to me with regards to the guidance and I was just trying to say, yes, at that point in time, it was an unexpected emergency with regards to the consent guidance".* However, the Tribunal also noted the experts' oral evidence on the higher risk second stage CS. In her oral evidence Dr Q told the Tribunal that *"… there's a variance in opinion between different people here that caesarean section in second stage should be avoided at all costs and it's a horrendous operation. That's not what I see happening in real life. My position is that it should have been discussed with the pros and cons of risk…"* Dr S's evidence was that they are used as a *"last resort"* when no other option is available. The Tribunal did not accept that this was an *"unanticipated emergency"* as it considered that there was an increased chance of failure due to Patient A's BMI and XXX and that this was foreseeable. In any event, it noted and acknowledged that Dr Thampi had clarified in evidence that the Kiwi failing was an *"unanticipated emergency"* for her.

231. The Tribunal had accepted that the baby's head had descended to +2 station after the attempts made on the Kiwi. It also appreciated that the baby was in fact successfully delivered with the use of a forceps. It had accepted that Dr Thampi had informed her that the baby's head was too low for a CS, and that it was risky. It considered Dr Thampi's clear evidence that she would not have *recommended* the transfer to theatre/CS due to the risks, Dr Thampi had also acknowledged that Patient A had mentioned CS when it was *"too late".* Having considered the evidence, the Tribunal found that, in line with this view, Dr Thampi did tell Patient A that she could not have a CS, and that it was *"too late".*

232. In any event, The Tribunal did not consider that the high-risk nature of the CS procedure at this point, would negate the duty to make the *offer* of this procedure to Patient A alongside providing information and explanation of the risks and any benefits. Particularly so, in light of Patient A's opposition and continued reluctance to the use of forceps. It found Dr Q's evidence to be persuasive in this regard that the patient should be informed of all of the options, even if they are detrimental. It considered this to be an essential element of Patient A's ability to make an informed decision and give informed consent, albeit in a fractious and time critical environment.

233. It considered that the paragraphs of the Allegation that had been found proved essentially painted a picture that Dr Thampi ought to have recognised the increased chance of the instrumental delivery with a Kiwi failing and ought to have informed Patient A about

that in light of her views on the use of forceps. Dr Thampi ought to have had an earlier discussion with Patient A, before the start of any procedure to consider the alternative option of an elective CS. Further, Dr Thampi ought to have recognised and informed Patient A that any failure to deliver with a Kiwi (where the baby's head had descended low) was likely to lead to the stark choice of a higher-risk CS or a forceps delivery.

234. The Tribunal determined, on the balance of probabilities, that Dr Thampi failed to appropriately respond to the lack of progress in Patient A's delivery by not immediately *offering* Patient A a CS, given that Patient A had explicitly told you she did not want a forceps delivery. The Tribunal reiterated its comments, to ensure clarity of the position going forward, that these were essentially the same point. Accordingly, the Tribunal found paragraphs 1(e)(ii)(1) and (3) of the Allegation proved.

Paragraph 1(e)(ii)(2)

235. The Tribunal considered whether, on or around XXX October 2016, Dr Thampi was involved in delivering Patient A of her baby and she failed to:

> *e. appropriately respond to the lack of progress in Patient A's delivery by not:*
>
> *…*
> *ii. immediately offering Patient A:*
> *…*
> *2. repeat examination following anaesthesia;*

236. The Tribunal had regard to all of the evidence, including that set out above.

237. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she did not accept this allegation. Dr Thampi stated that Patient A already had a functioning epidural in place. Dr Thampi stated that she did carry out another examination; she would not have been able to proceed with the forceps delivery without examining Patient A.

238. The Tribunal had regard to Dr Q's expert report dated 6 July 2020, including that:

> *"Conversion to a CS was indicated after 3 pulls with the Kiwi vacuum without adequate progress, as outlined in the RCOG.*
> *Dr Thampi's failure to offer to convert the mode of delivery to CS at this point fell seriously below the RCOG guidance; the information contained in her note does not justify or explain why Patient A could not have been transferred to theatre for appropriate analgesia, repeat examination and CS."*

239. Within the Joint Experts Report dated 11 September 2024, Dr Q stated that she agreed with the allegation and Dr S stated that he did not agree with it. Referring to Dr Thampi, Dr S stated that "*She made a clinical decision based on the examination findings that delivery could be facilitated vaginally without recourse to performing a difficult CS in advanced second stage and preventing the potential complications that can arise as a result".*

240. The Tribunal took account of Dr Thampi's statement in that the epidural was already in place from earlier in the day and that, practically, she would have repeated the examination and would not have been able to proceed with the use of the forceps otherwise.

241. The Tribunal was of the view that the GMC has not provided it with any rationale as to the specifics of the examination and as to why Dr Thampi had failed to appropriately respond to the lack of progress in Patient A's delivery by not immediately offering Patient A a repeat examination following anaesthesia. As such, the Tribunal determined that the GMC has not discharged its burden and found paragraph 1(e)(ii)(2) of the Allegation not proved.

Paragraphs 1(h)(i)(1) to (3)

242. The Tribunal considered whether, on or around XXX October 2016, Dr Thampi was involved in delivering Patient A of her baby and she failed to:

h. communicate appropriately with:

i. Patient A in that [Dr Thampi] stated one or more of the following:

1. "no you can't have a c-section" or words to that effect, without a discussion about risks and benefits;

2. "it is now after six o'clock and I could have gone home and let a registrar deliver your baby, but I haven't so you need to let me do this" or words to that effect;

3. "you need to let me do this as I don't know what is going to happen to your baby" or words to that effect;

1(h)(i)(1)

243. The Tribunal reminded itself of the relevant evidence in this regard which it had considered when making its finding on paragraphs 1(e)(ii)(1) and (3) and also documented earlier in this determination. Within Dr Thampi's witness statement dated 14 August 2024,

she stated that she did not accept this allegation. She stated that she had no recollection of saying this comment and it would not be the sort of thing she would say. Dr Thampi stated that it was very difficult as it was so long ago and she did not remember in detail, so all she could say is if she did express herself such that this was the impression given then she could only apologise for that. Dr Thampi stated that her usual practice when suggesting that a certain course of treatment is not recommended would have been to explain why it was not recommended. Dr Thampi stated that Patient A had a high BMI and by the time Patient A informed her that she would prefer a CS to a forceps delivery, the baby's head was too low. Dr Thampi stated that she advised Patient A of the reasoning behind her clinical advice.

244. Within Patient A's GMC witness statement dated 2 August 2023, she stated: "*At no point during any consultation did Dr Thampi offer the option of a CS. Dr Thampi just said, "no, you can't have a c-section" when I mentioned it".*

245. The Tribunal noted that Dr Thampi had accepted that she did not recommend a CS as she considered the risks to be too high and the use of forceps to be safe. Patient A had also accepted that there had been some information given by Thampi as to the low head of the baby and the high risk of the CS. On balance, it had found that in light of Dr Thampi's views, and her not offering (found proved by the Tribunal) and in not recommending a CS to Patient A, Dr Thampi did say to Patient A that it was *"too late"* for a CS and that she could not have a CS.

246. It noted Dr Q's view as per her report dated 6 March 2024. She stated:

> *"There are occasions where CS is associated with more risk to the mother and baby than vaginal birth, including instrumental vaginal birth. However, it is for the doctor involved to explain these risks, within a discussion about risks and benefits, to facilitate informed choice, rather than to refuse an option without any explanation or discussion.*
>
> *If Patient A's comments are accepted, Dr Thampi's comments at this point, understood to be unaccompanied by such a discussion, would represent practice which fell seriously below the expected standard."*

247. The Tribunal had regard to Dr S's expert report dated 24 August 2024. He referred to various sections in the GMC's *Good Medical Practice* (GMP), which describe the necessary attributes of a doctor when communicating with patients. Dr S stated that it was imperative that Dr Thampi communicate with Patient A to explain her rationale for the clinical decisions she was making.

248. In all the circumstances, the Tribunal determined that, on the balance of probabilities, whilst having given some information and explanation to Patient A re the risks of a CS, Dr Thampi did fail to communicate appropriately with Patient A in that she stated *"no you can't have a c-section"* or words to that effect, without a detailed discussion about risks and benefits and without enabling or allowing Patient A to choose this option, in light of her views on forceps, which linked to the failure in obtaining informed consent. Accordingly, the Tribunal found paragraph 1(h)(i)(1) of the Allegation proved.

1(h)(i)(2)

249. Within Patient A's undated complaint letter to the Trust, she stated:

> *"During the process of having my legs put into the stirrups, I was saying "I do not want the forceps to be used and I haven't pushed yet"… Miss Thampi then said something I will never forgot (sic) for the rest of my days - "Patient A what you need to understand and appreciate is that I am a Consultant, and it is after six o'clock and I could have gone home and left one of my Registrar's to delivery this baby!"… I felt Miss Thampi was pressuring me into something I did not want by implying that if I didn't agree I would be left to receive a substandard level of care."*

250. Within Patient A's GMC witness statement dated 2 August 2023, she stated:

> *"It was agreed that I be left to progress for another 15 minutes. Shortly after Dr Thampi had left the room the other staff present, including my midwife* [Ms L]*, said words to the effect of, "nothing could make me give you instrumental delivery." I understand* [Ms L] *was expressing her concerns with Dr Thampi's plan by her words.* [Ms L] *explained that women usually get 1 hour to progress, but that Dr Thampi was only giving me 15 minutes. I got the impression that it was after 18.00 and Dr Thampi just wanted to go home.*
>
> *…*
>
> *Surely, Dr Thampi returned to deliver my baby around 18.45. She made a comment to the effect of, "I could have gone home and let my registrar deliver your baby." She kept saying, "it's after 18.00, I could have gone home, you need to let me do this." "This" meaning an instrumental delivery. She was implying that I would receive a substandard level of care from her registrar, and instead, she had stayed so I had consultant care. She actually said, "I'm a consultant". I think these comments were made coercively to try and scare me into letting her do the instrumental delivery so*

that I wouldn't have been left in the hands of the registrar, who she made out to be incompetent to deliver me safely."

251. During Patient A's oral evidence to the Tribunal, Patient A said that Dr Thampi told her over and over again: *"It was after six o'clock. I'm a consultant. I could have gone home, and I want to give you an instrumental delivery." I kept asking, "But why?" Even* [Ms L] *had said to me, "I do (sic) know why, [Patient A]". I had* [Ms L] *here, in my ear, telling me, even she didn't know why, and said "Don't listen to her anymore. Listen to me"."*

252. The Tribunal noted that within Ms F's witness statement dated 23 June 2020 in respect of Patient A's claim against the Trust, she stated:

"When Miss Thampi came back into the room, she said that Patient A would now need to have an instrumental delivery. She didn't give any explanation as to why the instrumental delivery was required, just that it was necessary. [Ms L] *didn't say anything during this discussion or try to intervene. Miss Thampi said that she was a consultant and that Patient A needed to listen to her. She said that it was now after 6pm and she could have gone home and left a junior to deliver the baby."*

253. Dr Thampi maintained that she had no recollection of saying this comment and it would be out of character for her to speak to her patients like this. She stated that she would not have been going home at six o'clock in any event, she was contractually obliged to be on site until 7pm and that her usually practice generally is to stay late sometimes to catch up with her admin work but if she is too tired then she will leave at 7pm. Hence why she stated she did not think she would be saying this. She stated that, if she had made such a comment, she would have expected the midwife to note it very clearly and to have reported it.

254. The Tribunal had regard to all the evidence before it, including that set out above.

255. It noted that Dr Thampi had remained on shift for a couple of hours beyond six o'clock as part of her rota and Patient A had stated that Dr Thampi was dealing with her after that and left late as Dr Thampi was in the room with her until *"gone 9pm"* suturing her. Dr J has also confirmed in her evidence that the evening handover would take place at 8pm.

256. It considered that, on balance, Patient A had been influenced by Ms L's comment that nothing would make her give Patient A an instrumental delivery. It noted that whilst Ms L's meaning was that midwives do not make these decisions, Patient A had considered this to mean that an instrumental delivery was not necessary or clinically indicated and was upset that she had not been allowed to push for longer than 6pm. It considered that Dr Thampi was

likely to have also mentioned 6pm in this context to Patient A, i.e. that she had allowed Patient A to push until at least 6pm despite the sub-optimal CTG. The Tribunal was mindful of contagion in Patient A having discussed this with Ms F, which it considered would be multiple times and had perpetuated the mistaken view as to why her delivery was progressed swiftly as an assisted delivery.

257. Considering all the evidence. the Tribunal determined, on the balance of probabilities, that Dr Thampi did not make the comment that *"it is now after six o'clock and I could have gone home and let a registrar deliver your baby, but I haven't so you need to let me do this"* or words to that effect.

258. Accordingly, Dr Thampi had not failed to communicate appropriately with Patient A and the Tribunal found paragraph 1(h)(i)(2) of the Allegation not proved.

1(h)(i)(3)

259. The Tribunal noted that in her witness statement Patient A had stated: *"Dr Thampi asked me to "start pushing" but then screamed at me to "stop pushing" because she "did not know what tissue she had stuck in the cup"."* Ms F stated that Dr Thampi was checking whether the Kiwi was on right and that she was not sure what tissue was caught inside. Dr Thampi did not have a specific recollection of this but did explain the *"pop offs"* which can happen where maternal tissue gets stuck in the Kiwi.

260. The Tribunal considered that it was at this is the point when Patient A and Ms F became verbally aggressive towards Ms Thampi which included shouting and swearing as detailed by Ms R in her evidence. Both Ms A and Ms F had accepted this conduct which they said was demonstrative of their frustrations. It considered that, on balance, it was during the approximate 15 min break between the Kiwi being stopped and forceps being applied that Ms R would have intervened to calm Ms F.

261. The Tribunal noted Dr Thampi's position that:

> *"I note both Patient A and her mother indicated in their statements that they were abusive to me and the reasons they say for this. I remember they were abusive towards me during the delivery. I particularly remember Patient A's mother. They both swore and shouted at me, and I felt that their behaviour, in particular that of Patient A's mother, potentially hindered my ability to provide the best possible treatment at times. Their behaviour towards me was significant enough that I considered it*

necessary to document it in the notes and, following the advice of labour ward coordinator [Ms R]*, file a Datix report."*

262. Within Patient A's undated complaint letter to the Trust, she stated:

"After 15 minutes or so of pulling on the Ventouse Miss Thampi stopped, turned around while still holding onto the Ventouse handle and said to the Paediatricians stood at the back of the room with the Registrar - "Well I can't get this baby out!" Miss Thampi said this while shrugging her shoulders with her hands out to her sides, Miss Thampi then said, "I don't know what to do!" Miss Thampi then turned to me and said, "Patient A I am a Consultant and I cannot get your baby out!" I replied to Miss Thampi "I told you that I didn't want a forceps delivery, I would rather have a C-Section!" Miss Thampi said "well it's too late for a C-section now, you need to let me use the forceps because I don't know what is going to happen to your baby!" I said "I didn't want forceps I told you that!"… Miss Thampi said, "Patient A I am a Consultant I cannot get your baby out, you are putting your own baby at risk by not allowing me to use the forceps"."

263. Within Patient A's GMC witness statement dated 2 August 2023, she stated:

"Dr Thampi kept taking the Kiwi cup on and off my baby's head and repositioning it. Dr Thampi looked up at me and said words to the effect of, "I can't get baby out with the Kiwi, I don't know how I'm going to get this baby out." Dr Thampi then asked if she could use forceps to try and deliver my baby. I declined… Dr Thampi then explained, in reference to the forceps, that, "you need to let me do this as I don't know what is going to happen to your baby." It was due to this comment I felt forced into consenting to the use of forceps. I just said, "do whatever you want, you're going to do whatever you want anyway..."

264. During Patient A's oral evidence to the Tribunal, she was referred to her medical records, including at 19:14, that *"[You] finally agreed for forceps to be applied, as she feels she has no choice and…she had not been listened to."* It was put to Patient A that the *"finally"* meant there had been quite a bit of discussion. Patient A stated yes. Further, that there had been the backwards and forwards of *"I didn't want forceps"* or *"I don't know how else I'm going to get this baby out".*

265. Within Ms F's witness statement dated 23 June 2020 in respect of Patient A's claim against the Trust, she stated:

"Miss Thampi then looked to the young doctor, one hand still on the handle of the ventouse and said "I don't know how we're going to get this baby out" and that she did not know what would happen. It was then that Miss Thampi said that she'd need to use forceps."

266. Dr Thampi maintained that she did not have any recollection of making this comment. She stated that, as a clinician, she would never say to a patient, *"I do not know how I'm going to get this baby out".* Dr Thampi stated that these words did not impart confidence on the mother and so she found it very strange for this term to be used. Dr Thampi was also asked if she recalled how Patient A and Ms F communicated with her. Dr Thampi stated that both were not pleasant to her. She stated that both were screaming in the room, and she was trying to synchronise her contractions with my pull. Dr Thampi stated that it might have appeared that she was shouting. She stated that, at the end of the day, she was a clinician and responsible for Patient A and the baby. Dr Thampi stated that it was not a pleasant situation on that day.

267. The Tribunal had regard to Dr Q's expert report dated 6 March 2024. She stated:

"if these comments from Patient A are accepted, they are not in keeping with guidance about discussion of options, risks and benefits and fell seriously below the expected standard."

268. The Tribunal had regard to Dr S's expert report dated 24 August 2024, as referred to above in respect of paragraph 1(h)(i)(1) of the Allegation.

269. Within the Joint Experts Report dated 11 September 2024, Dr Q stated that she agreed with the allegation (if Ms F and Patient A's statements are accepted) and Dr S stated that he did not agree with the allegation (if Dr Thampi's statement is accepted). Within the report it stated:

"Areas of agreement (if any):

It would be for tribunal to decide which version of the events is the accepted one.

Areas of disagreement (if any):

[Dr Q] *is of the opinion that if the statement was reflective of coercion, then the standard fell seriously below.* [Dr S] *is if the opinion that if expressing clinical concern*

for fetal wellbeing to explain urgency/need for an intervention, then this is not below standard."

270. The Tribunal had regard to all of the evidence before it.

271. It noted the circumstances at this time, including that a CS was high risk and Dr Thampi was seeking consent from Patient A for the use of forceps which Patient A was reluctant to agree to. Dr Thampi has set out that the baby's head was low and that she felt she could deliver the baby using forceps. The Tribunal also noted the fraught situation at this point, including that the situation was becoming hostile with raised voices and Patient A and Ms F were verbally abusive towards Dr Thampi.

272. Whilst the Tribunal appreciated that Dr Thampi says she would never say this but did not recall the incident, it took the view that it was more likely than not, within this fraught position, that Dr Thampi did make the comment alleged as she was adamant, knowing the detail of the risks associated with a CS at that point with the position of the head being as it was, that the best course of action for Patient A was for the use of the forceps. The Tribunal was clear that everyone in the room was becoming frustrated and Patient A and Ms F were shouting. It was of the view that it was more likely than not that Dr Thampi let her frustrations get the better of her and did make a comment in the terms alleged as part of her efforts in seeking Patient A's consent to the use of forceps.

273. It further considered the experts view and was persuaded by Dr Q's opinion. Whilst it appreciated the fraught situation, it did consider that the comment made was a failure to communicate appropriately and below the standard expected of a reasonably competent obstetrician.

274. In all the circumstances, the Tribunal determined that, on the balance of probabilities, Dr Thampi failed to communicate appropriately with Patient A in that she stated *"you need to let me do this as I don't know what is going to happen to your baby"* or words to that effect. Accordingly, the Tribunal found paragraph 1(h)(i)(3) of the Allegation proved.

<u>Paragraph 1(h)(ii)</u>

275. The Tribunal considered whether, on or around XXX October 2016, Dr Thampi was involved in delivering Patient A of her baby and she failed to:

h. communicate appropriately with:

...

ii. Ms F, in that [Dr Thampi] asked Ms F for consent to a forceps delivery when Patient A had capacity to give consent.

276. Within Patient A's undated complaint letter to the Trust, she stated:

"I said "I didn't want forceps I told you that!" Miss Thampi then turned to my mum and asked "mum?" My mum replied "Patient A said NO forceps, why are you not listening? Patient A has been telling you call day!" Talking over my mum Miss Thampi said, Patient A I am a Consultant. I cannot get your baby out, you are putting your own baby at risk by not allowing me to use the forceps"… I did shout and swear at this point at Miss Thampi. I said "do what the fuck you want, you're going to fucking do it anyway, you haven't listened to me all day!"

277. Within Patient A's GMC witness statement dated 2 August 2023, she stated:

"Dr Thampi then asked if she could use forceps to try and deliver my baby. I declined. Dr Thampi then turned to my mum and asked her, words to the effect of, "Mum, can I just use the forceps?" I didn't say anything, Mum said, words to the effect of, "that's not up to me. Patient A has said no, why are you asking me?"

278. During Patient A's oral evidence she maintain her accounts as above and denied that Dr Thampi could be looking to Ms F for her to give Patient A reassurance.

279. It was put to Patient A that there were a lot of people in the room and was she saying that Dr Thampi was bullying her in front of all those people. Patient A said that this was correct.

280. Within Ms F's witness statement dated 23 June 2020 in respect of Patient A's claim against the Trust, she stated:

"The discussion then went around in circles with Miss Thampi pressurising Patient A to have an instrumental delivery and Patient A kept saying no. Miss Thampi then said to me, mum you need to make the decision on Patient A's behalf. The impression I got was that Miss Thampi didn't like Patient A's answer so was looking at me to override Patient A's refusal. I said that Patient A had been telling her all day that she didn't want an instrumental delivery. I said that it as Patient A's choice. Miss Thampi was clearly not now happy with me either."

281. In her oral evidence, Ms F told the Tribunal that she had thought that she was being asked to overrule Patient A's consent.

282. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she did not accept this allegation. She stated that she would not have done this as Ms F was not her patient. Dr Thampi stated that, when delivering babies, she will answer questions if asked by a patient's companion but would otherwise focus on her patient who had mental capacity. In her oral evidence, Dr Thampi stated that with reference to the notes, that the atmosphere was not conducive in the room and so she was probably asking the mother (Ms F) to explain the need for the forceps to her daughter (Patient A).

283. The Tribunal noted Dr S's comments in oral evidence where he stated that it was commonplace that, in an emotionally charged situation such as labour or the delivery of a baby, the words used and the manner in which they are communicated can be misconstrued and lead to misunderstandings.

284. The Tribunal had regard to all of the evidence before it. It noted that there were quite a few people present in the labour room and that no one else had reported this issue about asking someone other than the Patient for consent. It did not consider it plausible that Dr Thampi would have sought consent from Ms F, even in trying to progress the delivery due to its time critical factor. It considered that its finding on paragraph (h)(i)(3) of the Allegation bolstered its view that Dr Thampi was seeking to persuade Patient A as to the use of forceps and in that vein had sought assistance from Ms F as opposed to Ms F's consent.

285. The Tribunal determined, on the balance of probabilities, that Patient A and Ms F misinterpreted what Dr Thampi was saying to them. The Tribunal appreciated that the atmosphere in the labour ward room was fraught at this point and accepted Dr S's view about communications being misconstrued and could lead to misunderstandings.

286. Accordingly, the Tribunal found paragraph 1(h)(ii) of the Allegation not proved.

Paragraph 2

287. The Tribunal considered whether, on or around XXX October 2016, Dr Thampi was delivering Patient A of her baby and the degree of force she used to conduct the instrumental delivery was inappropriate.

288. During the hearing, the GMC confirmed that it was proceeding with this paragraph of the Allegation on the initial basis outlined in Dr Q's report, however noted the view within

the joint expert report that pictures of injuries are not always indicative of excessive force. Mr Jackson also confirmed that the subsequent view of Dr Q that the allegation of excessive force was based on the summative and cumulative force from the number of pulls that had taken place, was also not being pursued.

289. Within Ms F's witness statement dated 23 June 2020 in respect of Patient A's claim against the Trust, she stated:

> *"When Miss Thampi started pulling on the ventouse I have never seen anything like it. She was almost swinging on it. I remember thinking oh my god, she's going to do some serious damage. My heart was in my mouth but I couldn't say anything. I could not complain to Miss Thampi at this time in front of Patient A and even if I had, it was quite clear that she was not about to listen to me. I would say that Miss Thampi used an excessive amount of force. [XXX (Patient A's ex partner)] was on one side of Patient A and I was on the other. We were doing our best to keep Patient A from being pulled off the bed. Patient A was now well over the 'split' in the bottom of the bed and it took both of us pushing against her thighs to keep her from being dragged off of the bed, such is the force that Miss Thampi was using to pull on the baby. Even now this horrifies me."*

290. During Ms F's oral evidence to the Tribunal, she confirmed that she had never seen a Kiwi delivery before and did not know what is and what is not excessive force. Ms F stated *"That's what it appeared to me… but, like I said, I've never seen one. I just thought you pulled them out".* Ms F was also asked about the stirrups that Patient A had her legs in. She stated that Patient A had said to her that her leg was not in the stirrup. Ms F stated that, at one point, Patient A's foot became dislodged, and that the stirrup swung around, and she thought that it hit Dr Thampi, who was 'quite cross' about it. Whilst Patient A, who had given evidence before Ms F, had not volunteered this information in her oral evidence, the Tribunal noted that her written account that she had been concerned about her leg falling out of the stirrups.

291. Within Ms L's GMC witness statement dated 16 August 2023, she stated that:

> *"For me as a midwife, the delivery felt traumatic being beside Patient A, I can't begin to imagine what it was like for her. I was next to Patient A and could see and feel Patient A's bottom shifting forwards in response to the pull of the forceps. I thought, 'this is a hard pull, a really hard pull'. "*

292. Within Ms L's oral evidence, she was asked whether she could recall Patient A repeatedly saying that her leg was not secured in the stirrup. Ms L stated that Patient A's leg was probably a bit loose but that this was as a result of the pulling of the patient. She stated that if the leg had come out of the stirrup she would have gone around there and put it back in. Ms L had no memory of Patient A's repeated complaint at the time about her leg not being in position.

293. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she did not accept this allegation relating the inappropriate degree of force and that she did not believe that she used an inappropriate amount of force to deliver Patient A's baby. She stated that the delivery was more difficult than it might have been with other patients due to Patient A's XXX. This meant Patient A found it difficult to push to assist when Dr Thampi pulled with the Kiwi. Dr Thampi stated that it is not possible to apply excessive force otherwise the Kiwi will simply pull off. She stated that it would also pull off if the angle of traction was not perpendicular with the position of the Kiwi cup. Dr Thampi stated that, after it was apparent that delivery would not be achieved with the use of the Kiwi alone, she changed to forceps and delivered Patient A's baby with two steady pulls. Dr Thampi stated that she recalled that Patient A was a large lady and maintaining positioning on the bed was difficult and she may well have slipped down a little with a pull. Dr Thampi stated that, unfortunately, Patient A's baby was delivered with some forceps marks, but this is not an unusual risk in forceps deliveries and the marks sustained were not, in her view, consistent with an overly forceful use of the forceps. Dr Thampi stated that she believed that the degree of force used was appropriate, necessary and safe.

294. During Dr Thampi's oral evidence she stated that she did not recall Patient A slipping down on the bed and that sometimes, if there was less contact with the patient and the bed, there might be slippage. Dr Thampi stated that sometimes the wipe-to-clean mattress can slip and if you have a large lady who does not have proper contact with the mattress then this can happen. Dr Thampi stated that she used adequate force that was necessary at the time. She stated that it could be perceived as excessive force but that the patient slipping down the bed did not equate to the force of the forceps.

295. The Tribunal had regard to Dr Q's expert report dated 29 August 2023. She stated:

> *"There is no specific measure to assess the amount of traction force used at an instrumental delivery. Some kiwi devices have a pressure gauge attached but forceps do not. Therefore, it is generally held that the traction force should not be so great that the patient (mother) is pulled down the delivery bed.*

I refer to the statement from [Ms L]*, … which includes the following comment:*
"… I was next to Patient A and could see and feel Patient A's bottom shifting forwards in response to the pull of the forceps…"

[Ms F]'s witness statement… includes the following comment:
"When Miss Thampi started pulling on the ventouse I have never seen anything like it. She was almost swinging on it. I remember thinking oh my god, she's going to do some serious damage. My heart was in my mouth but I couldn't say anything. I could not complain to Miss Thampi at this time in front of (Patient A) and even if I had, it was quite clear that she was not about to listen to me. I would say that Miss Thampi used an excessive amount of force. ([Patient A's ex-partner]) was on one side of (Patient A) and I was on the other. We were doing our best to keep (Patient A) from being pulled off the bed. (Patient A) was now well over the 'split' in the bottom of the bed and it took both of us pushing against her thighs to keep her from being dragged off the bed, such is the forces that Miss Thampi was using to pull on the baby…"

Based on these comments, one about the use of a vacuum device and one about use of forceps, the degree of force used by Dr Thampi fell seriously below the expected standard."

296. The Tribunal had regard to Dr S's expert report dated 24 August 2024. He referred to the two images of the baby of Patient A that were provided. Dr S stated that there was a scalp trauma visible from the application and use of the kiwi hand-held device and evidence of the application and use of forceps on the left side of the baby's face. Dr S stated that, if the baby's head was not in an appropriate position, the blades would not have been able to be applied or locked, nor would Dr Thampi have been able to facilitate delivery. Dr S stated that the NHS information page on instrumental delivery states that risks to the baby from forceps delivery include:

"- marks from forceps on your baby's face – these usually disappear within 48 hours.
- small cuts on your baby's face or scalp – these affect 1 in 10 babies born using assisted delivery and heal quickly."

297. Dr S stated that the mark of the left blade was slightly more anterior than ideal, suggesting that the baby's head was tilted (asynclitism), but still in a position that would be compatible with a forceps delivery. Dr S stated that, given that cuts and bruises are known to occur with the use of forceps, there was insufficient evidence to support the allegation that the degree of force used to conduct the instrumental delivery was inappropriate.

298. During Dr Q's oral evidence to the Tribunal, she was asked about her discussion with Dr S as to the photographs of Patient A's baby. Dr Q stated that their conversation related to the photographic evidence of the injuries sustained by the baby as confirming the use of excessive force or not but not beyond that. Dr Q stated that she agreed that the photographic evidence could not be taken to demonstrate beyond doubt that there was excessive force used with the forceps. However, Dr Q further stated that her concerns and report conclusions had also come from the episodes of traction there were and the fact that the mother had been moved down the bed.

299. Further, Dr Q was asked about what had to occur for there to be excessive force. Dr Q stated that it was generally held that if the patient is moved by the force used for instrumental delivery, then that is excessive force. Dr Q stated that if Patient A was pulled off the bed, and she could not find any other reason for it *"then that would suggest excessive force".* Dr Q stated that she had not been made aware of any other reason, apart from excessive force, as to why Patient A would have moved down the bed. She stated that she knew the patient was larger and had an epidural so would have been paralysed in that sense such that movement would have required significant effort. Dr Q stated that, unless Patient A slipped on a sheet underneath, she could not find a reason why it would happen otherwise. It was put to Dr Q that Patient A had given evidence that one of her legs was not secured in the stirrup and that the stirrup consequently swung around and hit Dr Thampi. Dr Q stated that this should not affect the position of Patient A's pelvis in terms of moving down the operative bed.

300. Further, Dr Q was referred to Ms F's statements. In reference to whether or not it would not have been possible for an obstetrician to have two hands on the Kiwi and was *"swinging"*, and that the Kiwi would just detach. Dr Q stated that it would detach, yes. It was put to Dr Q that it was a dangerous inference to draw that excessive force had been used on a woman who was not securely placed on the mattress and has moved down it. Dr Q was asked if this was all it took for her to allege that excessive force had been used. Dr Q questioned what else would have made the woman move. It was put to Dr Q that the patient was not secure on the bed and was shouting/screaming. In response Dr Q stated that the patient had an epidural.

301. During Dr S's oral evidence to the Tribunal, he stated that the original suggestion made by the GMC was that this paragraph of the Allegation was predicated on the injury sustained and the photographs. Dr S was asked why he agreed with Dr Q that the injuries were not indicative of inappropriate force. Dr S stated that it depended very much on what the situation was when a particular instrument has been applied. He referred to a swollen scalp that can occur with the use of a Kiwi in a prolonged, protracted labour. He also referred

to the marks that forceps can produce on a baby's face. Dr S stated that the marks did not suggest or indicate that an inappropriate amount of force was used if they were facilitated in the right way. Dr S stated that it can be quite alarming sometimes and, if the forceps compress a blood vessel or causes a blood vessel to burst, then you will see evidence of bruising. Dr S stated that the two did not correlate; the force used to complete the delivery, and the appearance of the actual baby do not necessarily relate to each other.

302. In respect of this Allegation now relying on the accounts of Ms F and Ms L, Dr S was asked what the likelihood was of applying such traction with the Kiwi that a patient moves. Dr S stated that this would be extremely unlikely. He stated that they have fail-safes such that you could not exceed a certain amount of pressure before the Kiwi either slips or comes off. Dr S stated that pulling on a Kiwi which then causes the patient to slide down the bed was unlikely to have happened as, by that point, the Kiwi cup would have already slipped or come off. In response to Dr Q's view that, whether it was Kiwi or forceps, it was generally held that if there was force such that the patient moves then this is excessive force, Dr S stated that there were a lot of reasons why, other than excessive force, a patient would move. He stated that the main one was inappropriate positioning. He stated that hospital beds are made of wipe-clean material such that you can slide, the sheets are usually very thin and will have the legs in stirrups sometimes for an instrumental delivery. Dr S stated that it was likely that you would have movement of a patient during a delivery if they have not been appropriately positioned and if the legs were not secured in the stirrups, could make the patient unstable.

303. The Tribunal had regard to all of the evidence before it, including that set out above. It was clear that the GMC was not relying on the number of pulls/cumulative force. The Tribunal was also clear that both experts agreed that the photographs of Patient A's baby were not evidence of excessive force, and that bruises and marks can occur when the Kiwi and forceps are used.

304. The Tribunal had regard to Dr Q's evidence that movement of Patient A down the bed, with reference to the evidence of Ms F and Ms L, would have amounted to excessive force. The Tribunal was clear that Dr Thampi could not have been *"swinging"* on or from the Kiwi and that these devices have a fail-safe and would detach when a certain amount of pressure is applied. It also noted the variance, that Ms F's account related to the use of the Kiwi whilst Ms L had referred to a hard pull on the forceps.

305. In respect of Patient A moving or being pulled down the bed equating to an inappropriate degree of force, the Tribunal took the view that it was understandable that Dr Thampi nor Ms L, had any recollection of this due to the passage of time. Additionally, it considered that the situation within the labour room was fraught for all in any event. Patient

A had been concerned about her leg not been secured in the stirrups which the Tribunal found was more likely than not to have been the case. It was also conscious that Ms F had never seen such a delivery before, and whilst entitled to her view as she perceived events, she was not qualified to assess the degree of force applied.

306. The Tribunal determined that, on the balance of probabilities, it was more likely than not that the movement of Patient A on the bed was due to the combination of the type of the bed, its wipe clean surface and thin sheets and Patient A's leg not being secured in the stirrup, and her consequential inappropriate positioning. The Tribunal preferred the evidence of Dr S in this regard and placed reliance on his evidence and found this to be a plausible and probable alternative explanation for what occurred.

307. The Tribunal was concerned about Dr Q's evidence before the Tribunal on this allegation; it noted that within her email to the GMC on 12 September 2024, Dr Q stated that she was still she was "*still of the opinion that excessive force was used if it was accepted that Dr Thampi used 7 episodes of traction to deliver the baby".* Further, that "*if it is accepted that Dr Thampi used 7 episodes of traction, then excessive force was used in a summative sense and fell seriously below the expected standard…"* There was no dispute that the Tribunal could see in respect of there having been four pulls with the Kiwi and two with the forceps. In oral evidence, Dr Q was asked how she arrived at the number of seven episodes of traction, and she was unable to pinpoint where this had come from. It considered that Dr Q was not able to explain reference to this and was reluctant to accept that this may be an error which the Tribunal found unhelpful. It noted that in her eighth report, Dr Q had referred to the tractions as being six in total. It considered that Dr Q's view was not fair nor balanced in this regard and her starting point seemed to be that she *"had not been made aware of any other reason, apart from excessive force, as to why Patient A would have moved down the bed",* which implied that the onus was on Dr Thampi to disprove that inappropriate/excessive force was applied. The Tribunal did not accept Dr Q's evidence on this issue.

308. The Tribunal did not find, on the balance of probabilities, that the degree of force used by Dr Thampi was inappropriate. Accordingly, the Tribunal found paragraph 2 of the Allegation not proved.

Patient B

309. Patient B presented to the Antenatal Day Assessment Unit at the Trust on XXX June 2018 with severe itching and was admitted to Ward 9. Her partner, Mr I, was present with her at the Hospital. This was Patient B's first baby.

310. The induction process was started on XXX June 2018, and Patient B was started on steroids. Patient B understood that this was to induce labour early due to her obstetric cholestasis, which is an issue with the liver. Her waters broke and she had two steroid injections on XXX June 2018. It is Patient B's recollection that she first met Dr Thampi on XXX June 2018 when she introduced herself and performed a VE on Patient B. Patient B stated that she was in a lot of pain during the VE. However, Dr Thampi has said that she did not recall seeing Patient B on XXX June, and had seen her on XXX June 20218 during antenatal ward rounds instead. Dr Thampi stated that the medical records did not reflect her undertaking a VE on Patient B on XXX June 2018.

311. Patient B was later examined again by a midwife and transferred to the labour ward where she was put onto a hormone drip. She also had an epidural. The midwife recorded discussion with the registrar, Dr M, to confirm agreement for Syntocinon infusion and this was commenced at 19:05. There is a record made by a midwife that, at 23:09, a further VE took place and a discussion of the findings with the patient and a discussion between the midwife and the registrar (which on the nightshift was Dr J). An epidural was sited at 23:36 for pain relief and the Syntocinon was increased overnight as per guidelines. It was stopped at 07:45, and the midwife records VE by the registrar at 07:44 with dilation found to be at 8cm and a plan for review at ward round for consideration of a possible CS.

312. On XXX June 2018 there was discussion about *"uneven dilation"* and the advice from the registrar was that a CS take place. Patient B was told that the registrar needed to discuss her plan with the consultant on duty, which was Dr Thampi.

313. On the ward round, recorded at 09:36, Dr Thampi performed a VE, and discussed the management plan with Patient B and her partner. Dr Thampi's plan was to recommence the Syntocinon infusion.

314. Dr Thampi saw Patient B again around 11:50 and the Syntocinon had been stepped up. Dr Thampi competed another VE and found Patient B to be fully dilated. The plan was a trial of assisted birth in theatre (plus or minus CS).

315. Patient B said that the focus of the conversation was for an instrumental delivery and there was no discussion around a move to a CS. Dr M, who had taken over from Dr J that morning, had obtained written consent from Patient B for a trial of instrumental delivery +/- a CS. Dr Thampi stated that, regardless of written consent, it was her practice to talk patients through procedures as she is doing them.

316. Patient B was in theatre at 12:30 and the epidural top up was established at 12:30. Following an examination in theatre, Dr Thampi proceeded by starting to use the Kiwi. Dr Thampi stated that she noted four pulls using the Kiwi and that some progress was made with some descent achieved but there was no rotation. Dr Thampi then trialled a delivery with forceps. Dr Thampi stated that these were easily applied and achieved good progress and noted three pulls to successfully deliver the baby. Within the room there was a whiteboard which recorded various information, and it was noted that the information on this, written by an unknown person, recorded more pulls via Kiwi and forceps than Dr Thampi has recorded in her notes.

317. Patient B gave birth to her baby at 13:01 on XXX June 2018. Patient B underwent an episiotomy and sustained a vaginal wall tear during the delivery. She had a postpartum haemorrhage, and the bleeding was controlled with uterotonic medications.

318. Patient B described that her baby was black and blue and bleeding post-delivery due to the use of the instruments. The Tribunal has been provided with photographs of Patient B and her baby showing the marks to the baby's face and scalp.

319. Patient B recalled various interactions she had had with staff and Dr Thampi post-delivery and of the pain her baby was in during this time. This included on two occasions for postnatal checkup on XXX June 2018 and 6 August 2018. Patient B and her partner had an initial meeting with the head of midwifery on 15 August 2018 and the decision was made to arrange any further appointments, if needed, with another consultant. Patient B and Mr I then attended a meeting at the Trust on 27 November 2018 to discuss their experience.

<u>Paragraphs 3(a)(ii)(1) and (2)</u>

320. The Tribunal considered whether, on or around XXX June 2018, Dr Thampi was involved in delivering Patient B of her baby and:

> *a. [Dr Thampi] failed to;*
> ...
> ii. recognise and/or respond to the complications which developed during Patient B's delivery by:
>
> 1. abandoning the operative vaginal delivery;
>
> 2. recommending a caesarean section in line with RCOG guidance in place at the time.

321. The Tribunal had regard to Dr Q's evidence in respect of this paragraph of the Allegation. It noted that Dr Q's made an initial point in her 6 July 2020 report that she required access to the intrapartum notes, including Dr Thampi's operative vaginal delivery note, to determine if the use of instruments was appropriate. It noted that, in most part, Dr Q's evidence within her reports had not taken into account the contemporaneous post operative note authored by Dr Thampi that had been supplied to Dr Q. In any event, the Tribunal sought to consider both Dr Q's written accounts and any clarifications provided in oral evidence by her and also considered both the oral and written accounts of Dr S.

322. The Tribunal had regard to Dr Thampi's operative note. She had expressed her concern about missing records from the outset. Dr Thampi had however been able to obtain and retain her operative note as printed off the eCare system on 5 November 2018 during Trust proceedings. The Tribunal was informed that Dr Thampi's legal representatives had indicated to the GMC for some time that this document existed, and it was not provided to Dr Q for quite some time. There was a lack of clarity from the Trust as to whether this was Dr Thampi's operative note but, in a letter dated 8 February 2024, Dr N confirmed the sign off times of the electronic data fields within the operative note and of Dr Thampi as the author.

323. To assist the Tribunal in resolving the following paragraphs of the Allegation in respect of Patient B, it was of the view that it needed to resolve a dispute between the parties as to how many pulls on the Kiwi and forceps had been made by Dr Thampi during the delivery of Patient B's baby.

324. The Tribunal noted that, whilst Patient B had signed a consent form for trial of instruments +/- CS, her preference was to have a vaginal birth. The Tribunal noted Patient B's evidence, within her GMC witness statement dated 18 June 2023, that she could feel a lot of pressure happening but could not tell how many pulls there were. Similarly, Mr I had erroneously thought that Dr Thampi had been switching between the Kiwi and forceps and stated that, in hindsight, had thought that she was struggling. He accepted in oral evidence that he did not know that rotation was trying to be achieved, he said that his view was limited from behind the screen and that he could not recall how many pulls there had been.

325. Within Patient B's medical records is a *'Perioperative Care Plan'* document in which details of the various pulls on the Kiwi and forceps are recorded. Under the *'Implants/comments'* section are handwritten notes. The pulls are recorded as:

"Kiwi applied 12:30	*Forceps applied 12:48*
1st pull 12:32	*1st pull 12:50*
2nd pull 12:36	*2nd pull 12:52*

3rd pull 12:39
4th pull 12:41
5th pull 12:43
6th pull 12:45
3rd pull 12:55
4th pull 12:59
Head out 13:00"

326. In respect of the number of pulls recorded, within Ms K's GMC witness statement dated 8 February 2024, she stated that the handwriting of the pulls appeared to be hers and that she took over the form to complete the *'implants/comments section'*.

327. Ms K stated in her written statement:

> *"In theatre, everyone will be watching the delivery, albeit with different roles…, unless they are pulled away to collect something for the surgeon. The person writing on the whiteboard is the person who records the number and timing of the pulls made during the delivery. These are always very specific times as the person writing on the whiteboard watches the clock whilst performing this task. The information is written on the whiteboard for the benefit of the entire team in theatre, including any surgeons, paediatricians, midwives and anaesthetists."*

328. Ms K stated that the information about the number of pulls would have come from a whiteboard that is completed during delivery by one of the people present. This information is then written up into the *'Perioperative Care Plan'*. She stated that the person writing on the whiteboard records the number and timing of the pulls made during the delivery. She stated that, in her experience, the number of pulls was not a subjective matter and that, although the surgeon does not announce *"I'm pulling"*, all the theatre staff must pay attention to the delivery and the whiteboard so as to know this information. Ms K stated that the GMC had asked her whether she would be able to distinguish between a 'pull' and a 'rotation' intra-operatively. She stated that common practice dictated that a surgeon should tell the theatre team when they are performing a rotation as, unless the surgeon says this, the team would not know. The Tribunal consider Ms K's evidence to be clear and helpful.

329. Within Midwife G's GMC witness statement dated 3 June 2023, she stated that she was the midwife supporting Patient B and, at delivery, was stood at Patient B's head. She stated that Patient B had had an epidural and so could not feel when to push herself, so Midwife G was feeling for her contractions and telling her when to push. Midwife G stated that the delivery was traumatic due to a combination of things. She stated that she repeatedly reminded Dr Thampi about the number of pulls that had been made. Midwife G stated that Dr Thampi just kept saying *"the baby's head is coming"* and she assumed the baby was progressing, but the number of pulls worried her. Midwife G stated:

> *"I repeatedly reminded Dr Thampi that she had made, "3 pulls, do you want me to call for assistance?" Dr Thampi just asked me, "can you feel for contractions?" I don't think Dr Thampi was listening to what I was saying in any particular regard, she just kept saying, "she will deliver vaginally, it's coming"."*

330. She stated that she was traumatised by the whole experience and went home that evening and sat a long time reflecting on what could have been done differently. Midwife G stated that she could not work out what happened, or why Dr Thampi insisted on delivering instrumentally rather than converting to a CS. A couple of days later she came to the ward to see Patient B and told her that she was going to raise a Datix about the delivery as she was concerned about what had happened.

331. Within Patient B's medical records, Midwife G had completed a retrospective entry on XXX June 2018. Within this she stated:

> *"12:41 After the fourth Kiwi pull, Miss Thampi was reminded by myself that it was the fourth pull and she acknowledged it, I asked miss Thampi if we can stop at this point, however she told Patient B and her partner that she is doing everything to deliver this baby vaginally on several occasions. (Miss Thampi was also reminded of Patient B's name on several occasions, as she called her [by a different name] throughout the instrumental procedure) Obstetric registrar* [Dr M] *also present, and they were discussing the presentation and the next action of plan.*
> *12:43 At 5th pull Miss Thampi was asked to stop Kiwi as it was 5th pull. She agreed with obstetric registrar to scrub in preperation (sic) for C-section however she continued to pull for the 6th time with Kiwi at 12:45.*
> *12:55 Miss Thampi was reminded of the 3rd attempts by Forceps and she acknowledged it. However she carried on with 5th pull with forceps delivery."*

332. Within her oral evidence, Midwife G was asked whether she made the XXX June 2018 note, being two weeks after the index events, within Patient B's medical records as she was unhappy or angry with Dr Thampi. She stated that she was not and that she had made the entry after a discussion with a supervisor. Midwife G was also asked about whether there was any possibility that the number of pulls recorded on the whiteboard was incorrect. She stated that there was no possibility and that whatever is written on the whiteboard *"it is always correct".* Midwife G was asked if she ever spoke with Dr Thampi to clarify the number of pulls that had been made. She said that she did not need clarification of the pulls and that her concern was more about the delivery itself, the outcome, how much blood the patient had lost, and it would have been good to have had a debrief.

333. The Tribunal noted that, in her Trust interview in 2019, Midwife G had referred to telling Dr Thampi that it was the third pull of the Kiwi and asking her if the head was coming. Whilst there were no such details initially within the contemporaneous note made by Midwife G on XXX June 2018, further details were added two weeks later. The Tribunal noted that, within this time, Midwife G had been told that there was no operative note from Dr Thampi herself. In adding these details within her retrospective note made two weeks later, Midwife G stated that she had reminded Dr Thampi on the fourth pull of the Kiwi and also that Dr Thampi had been reminded of the third attempt with forceps, but she had *"carried on with 5th pull on forceps delivery"*. In the Trust interview the following year, Midwife G had also added that Dr Thampi had carried on pulling for the sixth time. When challenged, she stated, *"…in my first record I put it there that I have remined her that from third pull. So I don't know what you are suggesting there"* and continued to say *"…Anyway, whether it was third or fourth I reminded Ms Thampi that she was doing…"*

334. The Tribunal noted that whilst Midwife G recorded in the entry that she made two weeks later that she had asked Dr Thampi to *"stop"* after the Kiwi pulls, The Tribunal could not find this detail within Midwife G's Trust interview or her written statement. It was not clear whether it was after the third or fourth pull that she may have asked Dr Thampi to stop or whether it was that she had just reminded Dr Thampi then about the number of pulls. In the Tribunal's view, Midwife G was not able to add clarity to this in her oral evidence.

335. Midwife G confirmed at the outset that she could recall some parts of the day not all, yet, in the Tribunal's view she was reluctant to accept where she may have misremembered. For instance, she accepted that she was not present for the time Patient B was being sutured whereas when it was suggested that Dr Thampi had carried out the suturing completely, she stated that *"some part of it was done by* [Dr M] *or he was maybe assisting".* Neither the contemporaneous nor her retrospective note recorded Midwife G's reference that Dr Thampi had agreed with Dr M to scrub in, in preparation for a CS, something which Dr M did not recall. When challenged, she said *"I do not get things wrong".*

336. The Tribunal took the view that Midwife G's evidence was unreliable at points and was concerned that Midwife G's adamance to be right, and lack of clarity and cogency, did not assist the Tribunal.

337. The Tribunal had regard to Dr Thampi's operative note, made contemporaneously. Within this it is recorded that the number of pulls on the Kiwi was four and the number of pulls on the forceps was three.

338. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she was the person who was undertaking the pulls and that she believed her notes accurately reflected the number of pulls involved. Dr Thampi stated that she did not call out to the room when she was making a pull (which she would now do as a result of this experience). She also stated that the timings given on the *'Perioperative Care Plan'* did not make sense when looking at the CTG. Dr Thampi stated that the notes recorded pulls at 12:32 and 12:36, yet it is clear from the CTG that Patient B was not pushing until 12:39 and so no pulling would be taking place by Kiwi before that point (as maternal effort is also required in conjunction with the doctor pulling on the Kiwi simultaneously).

339. The Tribunal had regard to the transcript (not verbatim) of a Trust investigation meeting with Dr M on 3 June 2019. Dr M, who was the on-call registrar this day, was asked about the six pulls using the Kiwi and four pulls using the forceps. He stated that he consented Patient B but could not recall if he was in the room when the instrumental delivery was started. As to whether there had been six pulls, Dr M stated that he could not recall. He stated that if the consultant or registrar had said it was a pull then it was but there could also be a rotation or an adjustment; these could look like a pull when they are not. Dr M stated that he did not know what Dr Thampi did. He stated that within the Trust interview, he asked to be provided with the CTG reading as this could assist with telling whether it was a pull or not, but it was not supplied to him.

340. Within Dr M's witness statement dated 7 August 2023, he stated that he would add that there can never be six pulls. He stated that, if delivery was not imminent after three pulls, you must go for a CS. Dr M stated that, during delivery, there could sometimes be miscommunication and that you may need to rotate the baby during delivery. He stated that, when rotating, no one else could see what you are doing unless they are looking directly over your shoulder. Dr M stated that during his practice he had seen some people document a pull and has had to say, *"I'm not pulling, I'm rotating"*. He stated that he had to do a reflective practice and discuss with his educational supervisor regarding the matter of rotation when someone had recorded that he had made five pulls when this was not the case. Dr M stated that Dr Thampi is a safe obstetrician, and he recalled that she was happy to perform rotational deliveries using Kiwi or forceps. Dr M stated that he did not directly observe Dr Thampi perform a rotation, that Dr Thampi delivered Patient B's baby, and that he could not remember why Dr Thampi performed the delivery instead of him.

341. Within Dr M's oral evidence to the Tribunal, he reiterated what he had set out within his statement. Dr M described a rotation and that it could look like you have stopped pulling but has one hand that is keeping the tension while the other is moved. He also referred to the possibility of the need to adjust the Kiwi to ensure it is on the right place on the baby's

head. The Tribunal found Dr M to be an honest and credible witness, wanting to assist the Tribunal where he could, and considered his account to be helpful, cogent and clear.

342. During Dr Q's oral evidence, she was referred to Dr M's evidence that pulls can be misconstrued. Dr Q stated that she accepted this.

343. The Tribunal had regard to Dr S's expert report dated 24 August 2024. He referred to the handwritten number of pulls within the *'Perioperative Care Plan'.* Dr S stated these times did not correspond to the appearances on the CTG of when it appears that pushing actually commenced. Dr S stated that the CTG clearly demonstrates that pushing did not occur until approximately 12:39, by which time, the handwritten notes suggest that the third pull had occurred. Dr Q did not agree with this, she said:

> *"I don't rely on the CTG trace to rule in or rule out conclusively contractions, because if the mother moves, there can be an artificial increase in muscle tone which is picked up. So I wouldn't usually rely on that to say a contraction has started or stopped and pushing had started or stopped. Against that, it's not clear to me if the CTG times are reconciled with the time in the room."*

344. In respect of what a midwife would feel when palpating a mother-to-be's belly and feeling for a contraction. Dr S said:

> *"All that anyone would be able to feel is if someone is pushing, all the midwife will be able to feel is perhaps the woman pushing, so they can feel the patient pushing, but there is absolutely no way, unless the baby is actually delivered, that you might feel that the abdomen suddenly goes down because what you've pulled has come out."*

345. In his oral evidence Dr S explained that, with a baby in an OP position, there is a risk of perineum muscle damage and anal sphincter damage, so more care is needed in delivering the baby and that the movement with the forceps, is slow controlled traction and little pushes where one large pull is divided into smaller pulls to avoid damage.

346. The Tribunal also considered Dr S's evidence that the purpose of the peri-operative care plan is essentially to record administrative matters such as the time the anaesthetic was administered, the *"time of knife to skin",* the time of leaving theatre and further that the information as to the 'pulls' is not reviewed or verified by the operator or surgeon.

347. The Tribunal considered all the evidence before it and the experts' opinions. It found Dr M's evidence to be clear that a rotation of the Kiwi can sometimes be misconstrued as a

'pull' and he provided an example of this happening in his practice which he has had to correct. The Tribunal noted that Midwife G had been stood towards Patient B's head and therefore would not have been able to clearly and exactly see the number of pulls that Dr Thampi made. It also noted that Patient B did not know how many pulls had taken place and considered that it would have been very difficult, if not impossible, for Patient B to have been able to discern the number of pulls taken. It considered that it would be very difficult for the initial note-taker of the pulls also, to be able to record them accurately if the operator was not calling this out to the room, as it was principally the operator of the Kiwi who would know this. The Tribunal has heard that it was not Dr Thampi's practice at that time to shout out when she was making a pull and so whoever was writing on the whiteboard would have been trying to gauge the number of pulls from Dr Thampi's actions. The Tribunal appreciated that, in the middle of a difficult delivery, Dr Thampi would have been trying to focus on what she was doing and that correction of the person writing the pulls on the board would not have been her focus.

348. The Tribunal found the evidence from Dr Thampi and Dr M to be plausible and cogent. Having considered both Dr S's and Dr Q's opinions, and reasoning, it preferred the clear, consistent and balanced explanations of Dr S and was persuaded by it. It accepted that, in line with the CTG readings, the first two recorded pulls on the *'Perioperative Care Plan'* were before Patient B started pushing and so should be discounted. It also accepted Dr S's evidence in relation to the forcep pulls for a OP baby and how a large pull can be executed into smaller slower pulls.

349. The Tribunal considered that the number of pulls recorded within Dr Thampi's post operative note represented an accurate picture of what had occurred with Patient B's delivery. It was clear from the evidence that it heard that the handwritten record of the six pulls on the Kiwi and four on the forceps as recorded within the *'Perioperative Care Plan'* was copied from a whiteboard of a note taken during the delivery. There is not a specific record of the person who wrote the pulls on the whiteboard, nor did the Tribunal know the qualifications or experience of the person who noted the pulls on the whiteboard. It appears that it would have been a Healthcare Assistant or a nurse - although this was not clear, nor was what their positioning and / or line of sight had been.

350. Ultimately, the Tribunal determined that the correct position was that there had been four pulls on the Kiwi and three pulls on the forceps. The number of pulls recorded on the *'Perioperative Care Plan'* was not a reliable or accurate picture of what had taken place, and the Tribunal instead placed reliance on Dr Thampi's operative note. It was of the view that this operative note more accurately represented the formal record of what had occurred and that it was different to the purpose of the whiteboard, which was primarily to record

administrative tasks and, importantly, to record swabs. The Tribunal was also mindful that Dr Thampi's operative note was recorded contemporaneously after the birth, and she would not have known that there would later be a complaint made about this case. All in all, the Tribunal determined that the pulls recorded contemporaneously within Dr Thampi's operative note were accurate.

351. Returning to the issues in respect of paragraph 3(a)(ii) of the Allegation, the Tribunal had regard to all of the evidence before it. It also referred to the evidence and its conclusions in respect of paragraph 1(e)(i) of the Allegation (albeit that this was in respect of Patient A), including in terms of the evidence as to when operative vaginal delivery should be abandoned. This included evidence from Dr Q as to the RCOG Green-top Guideline No.26 [2011], including Section 5.4 entitled *'When should operative vaginal delivery be abandoned?'* and evidence from Dr S who referred to the same documents, as well as the April 2020 version of the RCOG Green-top Guideline No.26, within which Professor T's teachings were published.

352. The Tribunal had regard to Dr Q's expert report dated 6 July 2020. She stated:

> *"The RCOG guidance is clear that operative vaginal delivery (in this case using a Kiwi vacuum) should have been abandoned after three contractions without adequate evidence of progress.*
>
> *If the note in the Perioperative Care Plan is accepted as accurate, Dr Thampi's practice of 6 pulls with a Kiwi lies so far outside the RCOG guidance relating to abandoning the instrumental delivery that her practice had already fallen seriously below the expected standard, even before she used forceps and 4 more pulls to deliver Patient B's baby.*
>
> *Dr Thampi's failure to abandon the delivery after three contractions without adequate evidence of progress fell seriously below the expected standard; delivery was not imminent, and I cannot think of any finding which made continuing with the operative vaginal delivery at this point to be considered as safe practice.*
> *…*
> *Based on the submitted documentation, Dr Thampi failed to recognise and respond to complications during Patient B's vacuum delivery, failed to abandon the operative vaginal delivery (vacuum) and failed to recommend delivery by CS, all in line with RCOG guidance in place at the time of delivery."*

353. The Tribunal had regard to Dr Q's expert report dated 22 September 2020. She stated that:

"It was not appropriate to apply forceps after 6 pulls using the Kiwi vacuum when delivery was not imminent; this practice fell seriously below the professional standard set out in the RCOG guidance. Instead, the vacuum delivery should have been abandoned with immediate recourse to caesarean section."

354. Within Dr M's witness statement dated 7 August 2023, he stated that he could not remember Patient B's delivery in much detail. He stated that the GMC had asked if he could recall whether Patient B preferred a vaginal birth to a CS but that he could not remember exactly why Patient B wanted a vaginal birth. Dr M stated that, as the registrar, he would normally conduct the trial of instruments with the consultant present to support him. He stated that he could not recall whether Patient B asked him if Dr Thampi could deliver the baby. Dr M stated that he could not recall witnessing any complications and did not express any concern about Dr Thampi's delivery method during the delivery. Further, Dr M was asked whether conversion to CS was ever discussed intra-delivery. He stated that he had a discussion with Patient B about this before she signed the consent form and that he could not remember if it was ever raised in theatre. Dr M stated that he could not remember if CS was ever considered or verbalised by Dr Thampi as Patient B's baby was delivered vaginally.

355. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she did not accept the allegation. She stated that she believed that she did recognise and respond appropriately to the complications which developed during the delivery. Dr Thampi stated that she was aware of the RCOG guidelines in place at the time in relation to when to abandon operative delivery and sequential use of instruments. Dr Thampi stated that she felt she took these guidelines into account whilst exercising her clinical judgement as to the safest approach for delivery and considered the training she had received from Professor T.
Dr Thampi stated that she kept the option of CS under review and was ready to implement this if she had considered it clinically necessary. She stated that the plan to transfer Patient B to theatre for a trial of instruments plus or minus CS was reached for exactly this reason.

356. Further, Dr Thampi stated that progressive descent (but not rotation) was achieved with the Kiwi and that she considered delivery could most easily and quickly be achieved for Patient B and her baby by continuing with an instrumental delivery by switching to forceps and performing an episiotomy. Dr Thampi stated that she considered this clinical decision to be in the best interests of Patient B and her baby. She stated that she kept Patient B and Mr I informed throughout the delivery.

357. During Dr Thampi's oral evidence to the Tribunal, she stated that, in her professional judgement, the head was in occiput-posterior (OP) position and in the perineum. Dr Thampi

stated that she has *"done deliveries direct OP that are forceps so I could only put my clinical experience".* Dr Thampi stated that she thought that forceps was the safest for Patient B at this point in time in her professional judgement. The Tribunal also noted Dr Thampi's evidence in relation to Patient B being severely constipated, which contributed to her experiencing resistance with the Kiwi, albeit it considered that the baby's head had descended – Midwife G had also confirmed that Dr Thampi had confirmed at the time *"the baby's head is coming".* This detail in respect of Patient B being constipated was also within Patient B's own account and corroborated by the medical records *"noted to have loaded bowels at birth".*

358. The Tribunal had regard to Dr S's expert report dated 24 August 2024. He stated that Dr Thampi had indicated that, although there had been descent with the Kiwi, rotation of the baby's head had not been achieved to an occiput-anterior (OA) position. Dr S stated that, in this scenario, the operator is faced with the decision to abandon the procedure and perform a difficult second stage CS with various risks, or to attempt to deliver the head in the OP position with forceps. Dr S stated that, since Dr Thampi had said there had been descent of the fetal head to the level of the perineum after four pulls of the Kiwi but without rotation, then it would not have been unreasonable to have attempted to use the forceps to perform the last part of the delivery of the fetal head assuming the blades locked easily, which is what was documented. Dr S stated that delivery of an OP baby using forceps was associated with higher risk of obstetric anal sphincter injury (OASI); i.e., third- and fourth-degree tears. Dr S referred to Dr Thampi's statement that the number of pulls with the forceps was with the intention to ensure that care was being taken to deliver the head as slowly and in as controlled a way as possible to reduce the risk of OASI. Dr S stated that good practice would dictate that the procedure with the Kiwi cup should have been abandoned after three pulls if there had been no, or insufficient, descent and Patient B should have been prepared for a CS, but this did not appear to be the situation.

359. During Dr S's oral evidence to the Tribunal, he reiterated his opinion that he thought that four pulls on the Kiwi with descent was within reasonable practice. He stated that, if there had been a clinical judgement by Dr Thampi that delivery could have been facilitated with the fourth pull, then it was reasonable to proceed with that. Dr S stated that four pulls on the Kiwi and three on the forceps was not, de facto, excessive.

360. The Tribunal was clear that Dr Q's criticism of Dr Thampi's actions was based on the suggestion that there had been six pulls on the Kiwi and four pulls on the forceps. It also found that there had been progressive descent as it was clear that Dr Thampi had stated during the use of the Kiwi that the baby's head was coming. It referred to its earlier findings that there had been four pulls on the Kiwi and three on the forceps. The Tribunal noted that

Dr Q's criticism also centred on the suggestion that the Kiwi should have been abandoned after the third pull (and not making a fourth pull, and with immediate recourse to CS). The Tribunal referred to the evidence it set out above as well as its conclusions in respect of paragraph 1(e)(i) of the Allegation. The Tribunal reiterated its earlier comments that there was a broader interpretation of the guidelines, which was acceptable, to permit a fourth pull on the Kiwi as long as there was progressive descent. The Tribunal was clear that, in respect of Patient B, a fourth pull where there was progressive descent, was not inappropriate and such it was permissible to continue with the operative vaginal delivery.

361. The Tribunal also considered whether it was incumbent on Dr Thampi to stop the operative vaginal delivery after four pulls on the Kiwi and consider CS at that point. It found Dr S's oral evidence, as above, to be persuasive. The Tribunal noted the risks of OASI and Dr Thampi's evidence that she took care when making the three pulls with the forceps to deliver the head as slowly and in as controlled a way as possible. The Tribunal was clear that, if there had been none or insufficient descent of the baby's head then this would have been a different matter entirely and would have been inappropriate. The Tribunal was of the view that there was descent in this case and therefore it was not incumbent on Dr Thampi to recommend CS after the fourth pull on the Kiwi.

362. The Tribunal determined that, on the balance of probabilities, it was not the case that Dr Thampi failed to recognise any complications, and it was not the case that she had failed to respond to any complications, by not abandoning the operative vaginal delivery and not recommending a CS in line with RCOG guidance in place at the time. Accordingly, the Tribunal found paragraphs 3(a)(ii)(1) and (2) of the Allegation not proved.

Paragraph 3(a)(iii)

363. The Tribunal considered whether, on or around XXX June 2018, Dr Thampi was involved in delivering Patient B of her baby and:

> *a. [she] failed to;*
>
> *...*
>
> *iii. discuss with Patient B, prior to attempting instrumental delivery, the chance of an episiotomy being indicated during Patient B's delivery.*

364. The GMC's case is that Dr Thampi could, and should, have raised the prospect of an episiotomy; and that she failed to discuss with Patient B, when time permitted, the likelihood of needing an episiotomy becoming indicated during her baby's delivery, and prior to attempting instrumental delivery.

365. The Tribunal had regard to a signed consent form dated XXX June 2018 within Patient B's medical records in respect of the proposed trial of instruments (plus or minus a CS). It is understood that Dr M completed this form with Patient B. On the form it stated that the intended benefits were *"Delivery of baby"* and the serious or frequently occurring risks included *"bleeding, injury to baby…"* and the other procedure section states *"Repair of any injury"*.

366. In oral evidence, Dr M stated that episiotomy was not specifically mentioned on the consent form as they did not have a procedure specific form at the time. He stated that he would have explained the procedure to the patient and that there was not enough space to list all the possible complications. Dr M stated that episiotomy was not something they would write on the form at that time and that *"Repair of any injury"* would cover it and further that there is now a new form where episiotomy is specifically mentioned. He stated that the consent form in Patient B's medical records was in accordance with the practice at the time.

367. Further, Dr M stated that his usual process for explaining a trial of instrumental delivery in theatre would include that he would examine the patient in theatre and see if it is feasible to apply the Kiwi on the baby's head. He stated that this might not be possible if there is swelling on the baby's head or if there was prematurity, for example. Dr M described the Kiwi procedure. He said that it is a soft instrument that is applied over the baby's head and sometimes the baby can be delivered using the Kiwi cup without the need for an episiotomy. He stated that he would explain the risks for the mother, include the possibility of damage to the vaginal mucosa with the Kiwi if it becomes stuck onto the vaginal wall. Dr M stated that he would say that, with the Kiwi, it would depend on how strongly the mother is pushing the baby and that sometimes, if the mother is not pushing, the Kiwi will not work. Dr M then referred to forceps and that he would explain that they would need to do an episiotomy, and that the possibility of a third-degree tear is high with a forceps delivery. He stated that he would explain that there is a possibility of some damage to the baby's skull and bone fractures. Dr M stated that the level of explanation would depend on how urgently the patient needed to go to theatre and how much time was available.

368. Within Mr I's GMC witness statement dated 18 June 2023, he stated:

> *"… At no point did Dr Thampi, or any other MKUH staff, explain to us that might be cut along her perineum in order to get the baby out. Our whole understanding of the delivery was to avoid any damage like that, hence our comment about the CS. A cut or tear to perineum was never in question heading into the delivery. If we knew stitching*

was in question, it is my understanding that we would have gone straight to a CS delivery."

369. During his oral evidence, it was put to Mr I that Dr Thampi had mentioned an episiotomy to him and whether he recalled Dr M having mentioned it when Patient B signed the consent form. Mr I stated that he did not recall this. Patient B, during her oral evidence, was asked whether she was told the part of the use of forceps involved an episiotomy. Patient B said that she could not recall whether this was explained to her at that point. She stated that her understanding, historically from the information she had got prior to the birth, was that there may be a need for an episiotomy, and she knew that this meant a cut. Further, Patient B was asked about Dr M and stated that she did not recall him. She stated that she recalled that she had been taken through the risks associated with the process as part of the consent form for the trial of instrumental delivery (plus or minus CS). She stated that she did not recall any part of the conversation with him but accepted that she consented to the procedure.

370. The Tribunal appreciated that Patient B and Mr I were being asked to recall conversations from many years ago. The Tribunal found both Patient B and Mr I to be honest and credible witnesses. They readily accepted where their memory was not complete due to the passage of time and provided helpful evidence as to their experience of the birth of their baby and their interactions with Dr Thampi.

371. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she believed she had mentioned the possibility/risk of episiotomy prior to theatre when discussing with the family the trial of instrumental delivery (likely around 11:50) and again in theatre shortly before undertaking it. Dr Thampi stated that, whilst she could not recall her exact words, she believed she would have explained, prior to theatre, about the baby's position; about the use of the Kiwi to try and rotate the head and bring it down, the possible change to forceps if required and also reference to the potential need for episiotomy.

372. Further, Dr Thampi stated that it is her practice during delivery to vocalise to the patient prior to performing the episiotomy. She stated that the chance of an episiotomy would normally also be discussed at the same time as discussing and obtaining formal written consent for a trial instrumental delivery; this was completed by Dr M. Dr Thampi stated that Dr M was an experienced registrar, and she would expect that the episiotomy was included in that discussion. She stated that she would not necessarily expect 'episiotomy' to be specifically listed on a written consent form where the risks of injury and the need to repair any injury were already noted.

373. The Tribunal had regard to Dr Q's expert report dated 6 March 2024. She stated:

> *"I have not found evidence that Dr Thampi mentioned the chance of episiotomy being indicated during Patient B's delivery.*
> *Dr Thampi may have felt that the chance of needing to cut an episiotomy was very low although it would still be usual practice to mention it as a possible intervention when obtaining consent for instrumental.*
> *If it is confirmed that no such discussion took place and the chance of episiotomy was not discussed at all, Dr Thampi's practice at this point fell seriously below the expected standard.*
> *…*
> *If this discussion did not occur, it is difficult to have a full and informed discussion about the potential benefit of episiotomy when the fetal head is about to deliver. Some of my peers will assert that completion of an episiotomy at this point can be held as an action which is in the best interests of the mother in terms of reducing the risk of an anal sphincter tear."*

374. Dr S provided evidence on why episiotomy was not specifically spelt out on the consent form. He stated that it was not a risk but *"it is part of the procedure. So that would also include things like catheterisation, to empty the bladder, or suturing of the episiotomy. Anything that need - I mean, it is on there about perineal tears, but that would be something that would be unexpected or out of keeping with the actual procedure. So an episiotomy is part of instrumental delivery, and is not necessarily then - in terms of how the consent form is worded - a serious or frequently occurring risk, because otherwise it would be 100% of the time in the majority of cases."*

375. In respect of whether the said consent form was normal for that time (2018), Dr S stated that it is very similar to the consent form that they use in Sheffield and that it is an NHS template for being able to discuss any procedure. Further, that many places have now moved to the RCOG recommended consent form.

376. Within Dr Q's oral evidence, she stated that there was RCOG guidance about how to consent for instrumental birth and CS and that, if she looks at the people that she witnesses who are consenting someone for a trial plus or minus CS, the episiotomy is discussed, and it is documented. Dr Q also stated that there are some doctors who believe that they can deliver a baby without an episiotomy and do not mention it but that she thought this was uncommon. Dr Thampi, within her oral evidence, confirmed that she would also consent and perform an episiotomy for all forceps deliveries. Dr Q stated that the RCOG *"position would*

be to mention it [the episiotomy] and I suppose in reasonably competent real-life practice I would hear it discussed within that conversation about instrumental birth".

377. The Tribunal noted that it was Dr M and Dr Thampi's usual practice to mention episiotomy when consenting for trial by instruments. Dr Thampi stated that she would have mentioned the risk of episiotomy prior to theatre when discussing the trial of instrumental delivery, Dr M had then undertaken and obtained formal written consent for this, and it was Dr Thampi's practice to discuss episiotomy again in theatre shortly before undertaking it. There was not a specific requirement to write down 'episiotomy' on the written consent form at that time and the consent form within the RCOG Guideline no 26 stated that the 'woman should be aware that an episiotomy may be required, particularly with forceps. Further, it noted that the process has now been changed. The Tribunal also noted that it is Dr Thampi's usual practice to carry out an episiotomy in a forceps delivery so it would not be anything outside of the norm.

378. The Tribunal appreciated that there was a lot going on at the time of the delivery of Patient B's baby and she described the environment as "chaotic". Dr Thampi stated that it was not chaotic but acknowledged that there can be a lot going on in theatre and so she appreciated why Patient B would have described the situation in that manner.

379. The Tribunal appreciated that Patient B and Mr I could not recall Dr Thampi or Dr M discussing with them the chance of an episiotomy at any point prior to the instrumental delivery. Whilst appreciating this, the Tribunal was of the view that, on the balance of probabilities, it was unlikely that an episiotomy would not have been discussed. It had regard to Dr Thampi and Dr M's usual practice and that there was no evidence that they were 'slapdash' or in any way incompetent in the way they approached discussions and consent in terms of a trial by instruments.

380. The Tribunal determined that, on the balance of probabilities, it was more likely than not, that the chance of an episiotomy being indicated during Patient B's delivery had been discussed with Patient B. Accordingly, the Tribunal found paragraph 3(a)(iii) of the Allegation not proved.

<u>Paragraph 3(b)</u>

381. The Tribunal considered whether, on or around XXX June 2018, Dr Thampi was involved in delivering Patient B of her baby and:

b. [she] undertook an excessive number of pulls of Patient B's baby's head using a Kiwi vacuum.

382. The Tribunal referred to the evidence set out above in this regard and to its conclusions as set out in relation to paragraph 3(a)(ii) of the Allegation. The Tribunal determined, in the light of those findings, that Dr Thampi had not undertaken an excessive number of pulls of Patient B's baby's head using a Kiwi. Accordingly, the Tribunal found paragraph 3(b) of the Allegation not proved.

Paragraph 3(c)

383. The Tribunal considered whether, on or around XXX June 2018, Dr Thampi was involved in delivering Patient B of her baby and:

c. [she] inappropriately applied forceps to Patient B's baby's head and then proceeded to carry out an excessive number of additional pulls after [she] had carried out the pulls described at paragraph 3b.

384. On 19 September 2024 the Tribunal asked Mr Jackson to confirm the position as to its understanding that it was the GMC's case that the inappropriateness related to the excessive pulls. Mr Jackson stated that it was the inappropriate use of forceps after six pulls which was the gravamen of paragraph 3(c) of the Allegation.

385. The Tribunal referred to the evidence set out above in this regard and to its conclusions as set out in relation to paragraph 3(a)(ii) of the Allegation. The Tribunal determined, in the light of those findings, that Dr Thampi had not inappropriately applied forceps to Patient B's baby's head and then proceeded to carry out an excessive number of additional pulls after [she] had carried out the pulls described at paragraph 3b. Accordingly, the Tribunal found paragraph 3(c) of the Allegation not proved.

Paragraph 3(d)

386. The Tribunal considered whether, on or around XXX June 2018, Dr Thampi was involved in delivering Patient B of her baby and:

d. [she] inappropriately disregarded Midwife G's repeated reminders about the number of pulls [she] had carried out, and her request for [Dr Thampi] to cease the instrumental delivery.

387. The Tribunal referred to the evidence set out above in this regard and to its conclusions as set out in relation to paragraph 3(a)(ii) of the Allegation, in particular its comments regarding the evidence of Midwife G (XXX). In the Tribunal's view, it was not clear if or when Midwife G had asked Dr Thampi to cease the instrumental delivery. In respect of the reminders, if concluded that Dr Thampi had carried out four pulls with the Kiwi and three with the forceps and had been concentrating on delivering the OP baby and obtained rotation. Whilst Midwife G did state herself that there was acknowledgement from Dr Thampi on one reminder, the Tribunal thought that as the consultant concentrating on the task at hand, it may have appeared that she was disregarding the reminders from Midwife G. It bore in mind Dr S's view that the clinical decision making was for Dr Thampi, as the consultant, who was the only person in a position to know the number of pulls taking place. In these circumstances, the Tribunal did not consider this to be inappropriate. Accordingly, the Tribunal found paragraph 3(d) of the Allegation not proved.

Paragraph 4

388. The Tribunal considered whether Dr Thampi inappropriately introduced Midwife G on the labour ward a few weeks after Patient B had delivered her baby as "the midwife who had Datix me by saying the baby was battered, bruised and injured after my delivery", or words to that effect.

389. Within Midwife G's GMC witness statement dated 3 June 2023, she stated that she had had concerns about the delivery of Patient B's baby and raised a Datix about it. She stated that:

> *"When I next worked with Dr Thampi at MKUH, we were stood by the whiteboard and she announced to the other staff present, "this is the midwife who Datixed me." I though[t] this was quite unprofessional. She gave the impression that nobody should be questioning her, no matter what she does. I said, "if it had to be done, it had to be done. I was concerned about mum and baby." It felt like she was telling everyone else to be wary of me and was trying to isolate me from working well with the other doctors who shouldn't trust me. Of course, I can't speak to her intention, but that was the feeling she gave me. It was unprofessional of her in any event, but we moved on and continued to talk about other patients. If she had a problem with me raising the Datix, she should have come to me personally rather than telling the other doctors."*

390. Within Midwife G's oral evidence, she stated that she remembered the comment was made when they were standing on the labour ward. Midwife G stated that it would have happened about the handover time and so she went to Dr Thampi to update her about the

patient. Midwife G stated that Dr Thampi was standing with the obstetrician team, that she introduced herself, and then Dr Thampi made the alleged comment. Midwife G stated that she was unable to say when this comment occurred but that it was her next shift working with Dr Thampi after Patient B. Midwife G stated that she thought that the comment was unprofessional and that she had felt that the Datix needed to be submitted about Patient B due to the severity of the damage to the baby.

391. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she did not accept this allegation. She stated that she did not recall saying this comment and that she did not believe it was something she would say. Dr Thampi stated that she firmly believed in being respectful of colleagues and accepted that, had this been said, it would have been disrespectful and inappropriate. Dr Thampi stated that she firmly believed in the value of the Datix process for anyone in the team to raise a concern.

392. Within Dr Thampi's oral evidence, she stated that she was a risk lead and encouraged the use of Datix. She stated that she was not a person to commentate in the manner that is alleged. Dr Thampi stated that she would not have known who reported the Datix in respect of Patient B but that she would have been told that it had been made, usually within about 72 hours, as a root cause analysis would be started. Dr Thampi stated that she would not have made this introduction about Midwife G. She stated that there would be quite a few people around, she was a risk leader, and she encourages the use of Datix. She stated that she would not act as alleged. Dr Thampi stated that, if there had been any unprofessional behaviour at the time, it would have been escalated straight to the labour ward coordinator who was there and then this would have been raised with Dr Thampi; it was not.

393. The Tribunal was clear from both Dr Thampi and Midwife G that this comment, if made, would have been said in the presence of quite a few other colleagues and no other complaints or evidence has been presented from any other person. It was also not clear if Dr Thampi would have known the identity of the person who raised the Datix at the point this comment was allegedly made. The Tribunal also has no evidence before it that Midwife G made a complaint about this at the time.

394. The Tribunal determined, on the balance of probabilities, that the GMC has not discharged its burden of proof in respect of this paragraph of the Allegation. It was possible that a comment was made but it could have been misheard, misinterpreted or misremembered, however the position was not sufficiently clear, and memory and recollections can be fallible. The Tribunal determined that the evidential burden was not discharged by the GMC in this respect. It therefore did not find that Dr Thampi inappropriately introduced Midwife G on the labour ward a few weeks after Patient B had

delivered her baby as *"the midwife who had Datix me by saying the baby was battered, bruised and injured after my delivery",* or words to that effect. Accordingly, the Tribunal found paragraph 4 of the Allegation not proved.

Patient C

395. In considering paragraph 5 of the Allegation concerning Patient C, the Tribunal examined the entirety of the evidence adduced, before making its decision on the sub paragraphs of the Allegation.

396. Dr Thampi first saw Patient C with another consultant colleague on XXX July 2018. The agreed plan was for a planned induction whilst Dr Thampi was on-call. Patient C had XXX previous pregnancies, had a BMI of XXX and was documented to have gestational diabetes.

397. Patient C was admitted to the Hospital on XXX August 2018 where she was monitored. Dr Thampi saw Patient C for a second time on XXX August 2018 at 09:50, when she performed a VE and Prostin induction of labour was commenced. She did not have face-to-face interaction with Patient C after this.

398. The delivery of Patient C's baby took place in the early hours on XXX August 2018. The Registrar on call was Dr D. Dr D was working at ST4 level at this point, and she had worked her first day at the unit on XXX August 2018. Dr Thampi was the on-call consultant (from home) during Dr D's first nights on the unit in August 2018.

399. Within Patient C's medical records there is a short timeline of some of the events of the morning of XXX August 2018, including:

> *"… 0144 - Epidural sited - bradycardia noted; CTG interpretation - pathological*
> *… 0209 - Reg in room to review and undertake VE and scan;*
> *Reg spoke with Ms Thampi (on call consultant) happy to leave Patient C for a little longer to see if the head will descend into the pelvis"*
>
> At 03:44 the plan was documented *"to commence pushing"* and Patient C's baby was delivered at 04:08 by way of kiwi delivery.

400. Dr D completed several notes in Patient C's electronic medical records. A record had a service time of 02:38 and a closed/signed off time of 18:58 when it is understood Dr D was on the subsequent night shift. The Tribunal took this to mean that the note had been started at 02:38 and completed at 18:58. Within this note it stated:

"A:
SROM 23:45
VE 4cm 00:00
Epidural sited 01:44
Bradycardia 15 minutes

Saw prolonged bradycardia on centrale and went to review at 02:00, emergency buzzer not pulled, co-ordinator
[Ms P] *not aware. At this point FH compensatory tachycardia up to 180 with prolonged deep decelerations.*
Variability 5bpm.
Abdominally 5/5 palpable, high head ? oblique lie.
VE: 4cm poorly applied cervix ROT -3 thin meconium draining. FSE reapplied. No acceleration during VE. No cord palpable.
US entirety of head in abdomen in RIF. Head presenting, no cord beneath.

Called Miss Thampi at 02:05. FH 180. Discussed case. Explained although bradycardia recovering, baby struggling to compensate/recover from bradycardia and I was concerned that it was compromised and had poor reserve to cope with labour. Whilst on phone tachycardia settled to 165bpm, vasribility no more than 5bpm. Discussed oblique lie and my concerns that it would take considerable time to deliver vaginally and that as I couldn't confirm baby wasn't hypoxic I wanted to perform CS. Abnormal CTG, head too high to FBS. Her plan is not for CS or FBS, to wait until CTG recovers. I discussed my concerns about this plan but she was adamant that the baby would deliver vaginally.
…
Fresh eyes 30 mins and reassess."

401. A record made by Dr D had a service time of 03:28 and a closed/signed off time of 19:02. Within this note it stated:

"Called to deliver Room 5 for abnormal CTG
[Ms P] *and* [Ms O] *called Miss Thampi after Fresh eyes CTG abnormal for decelerating > 50% contractions and no accelerations.*
Came after baby delivered to answer phone
Baseline 150
Variablity 5bpm
Acceleration present

Variable decelerations >50% contractions
…
Reiterated my CTG concerns that although improved, baby struggling to cope with labour and cant confirm acidotic status.
R:
Miss Thampi advised bloods and IV antibiotics
Review in 30 minutes
Advised not for CS at present as feels head will come down"

402. A record made by Dr D had a service time of 05:09 and a closed/signed off time at 05:14. Within this note it stated:

"Came in room to assess CTG as abnormal.
VE ROT -1 to IS no caput/moulding
Good maternal effort. Awaited fetal descent with pushing- 4 pushes.
When baby at IS consented verbally for kiwi delivery.
Indwelling catheter removed
Kiwi applied to flexion point
Delivery with 1 pull, rotated and intact perineum.
Baby born floppy but responded well to stimulation, pink, cried 30s after delivery FH> 100 paeds present. DCC performed. Placenta CCT
EBL 200mls
Syntometrine and synt infusion given
Good hemostasis
Cord gasses arterial 7.12"

403. The Tribunal also noted from the Obstetrics Progress note entry opened at 05:01 and signed off at 05:20 that the baby was delivered at 04:08 hours on XXX August 2018.

404. On 20 October 2018, two months thereafter, Dr D provided a written statement to the Trust in respect of Dr Thampi's actions on 11/12 August 2018. Within this statement, Dr D stated that she called Dr Thampi at 02:05 and advised her that "*the CTG was pathological and that the baby had not compensated well to the insult of the prolonged bradycardia and appears compromised"*. Dr D stated that she explained that *"there was a tachycardia of 180bpm with prolonged atypical decelerations, that the lady was not in established labour and that the baby wasn't immediately deliverable".* Dr D stated that she wanted to perform a CS. She stated that Dr Thampi told her not to do a CS and that the baby *"would deliver vaginally".* Dr D stated that she expressed her concerns to Dr Thampi and that she considered this was an unacceptably risky decision in view of the high head and Patient C not being in

established labour. Dr D stated that she offered to send Dr Thampi an anonymised picture of the CTG, but Dr Thampi declined this. Dr D stated that she told Dr Thampi that she would observe the CTG and call back in 30 minutes.

405. Further, within that statement of 20 October 2018, Dr D stated that, at the 30-minute review at 02:30, she was delivering another baby. She stated that the review of Patient C was concluded by Ms O *"who called [Dr] Thampi as the CTG remained abnormal".* Dr D stated that she was called away from this delivery once it was completed to speak to Dr Thampi on the phone. Dr D stated that she told Dr Thampi that *"the reactive tachycardia was improved but baseline was still 160 with reduced variability and no accelerations".* Dr D stated that she re-expressed her concerns that the trace was abnormal, that Patient C was not in established labour, and that she wanted to perform a CS. Dr D stated that Dr Thampi told her "*categorically not to perform a CS and that the baby 'would deliver vaginally'. She also told me to 'resuscitate the CTG with some IV antibiotics'. There were no clinical signs of sepsis".* Dr D stated that she asked Dr Thampi to attend, and that Dr Thampi refused to do so, telling her that she was 30 minutes away. Dr D stated that they began to escalate to a second consultant but, on observing the CTG, she felt that on balance it was improving, and she would keep observing it.

406. Dr D further stated within this statement that, at 03:30, the CTG deteriorated, spending prolonged periods of time away from the baseline. She stated that she assessed Patient C in the room and she *"was 9cm dilated, -1, OT at the spines".* Dr D stated that she asked Patient C to start pushing and prepared for a kiwi delivery. Dr D asked Ms O to call Dr Thampi to inform her of what Dr D was doing. Dr D stated that, once the head was at the spines and Patient C was fully dilated, she did an *"OT kiwi delivery in the room in 1 pull".* Dr D stated that she was not signed off for rotational deliveries and would usually have taken this case to theatre but did not feel that she had the time considering the state of the CTG. Dr D expressed concerns about the support and supervision she received on these night shifts as a XXX ST4 trainee, about the risky position she felt she had been placed in regarding Patient C's care, and that she felt out of her depth without support.

407. Dr D attended an investigation meeting at the Trust on 11 March 2019. A summary of the meeting was provided (not a verbatim transcript). Within this meeting, Dr D stated that Dr Thampi was aware that she was a junior registrar who had not worked by herself out of hours before and that Dr Thampi did not know her level of competence. In respect of Patient C, Dr D stated, *"I know how to assess a CTG and when a baby is at risk"*, further that the patient was not in established labour and the CTG was abnormal. She stated that the standard practice is to perform a CS and that she felt like she *"had been placed in an impossible position to be told categorically not to do this by the consultant on call".*

408. Dr D further stated within this interview that this incident was the first time she had needed support from a consultant out of hours. She stated that, on reflection, had she said, "*If you will not let me perform a CS then you need to come in otherwise, I will call another consultant"*, maybe Dr Thampi would have come in *"but I'm not sure".* She stated that she was not used to having to be so direct with a senior colleague in that *"the position and years of experience usually demand respect".* Dr D stated that she knew she had to work with Dr Thampi for the rest of the year and so felt she had to escalate the clinical concerns.

409. Dr D was asked by the interviewer about her offer to send Dr Thampi the CTG. She stated that she did do this and that some consultants liked to see a picture of the CTG trace without the patient details on it. Dr D stated that Dr Thampi *"did not want to see a picture of the CTG".*

410. Within Dr D's GMC witness statement dated 25 February 2021, she stated that she had been a junior registrar at the time in question and therefore was not expected to have the necessary experience to make advanced decisions on the labour ward. It would be expected that a consultant would make those decisions and support the registrar in carrying out tasks beyond their level of training.

411. Dr D stated that CTG scans show the heartbeat of the baby and are used to decide whether there are concerns with the baby and if action such as a CS should be carried out. She stated that this would be based on whether the heart rate was below a certain amount over a certain period; the pattern would indicate whether a CS is needed or not.

412. With regard to Patient C, Dr D stated in her written statement to the Trust, that the CTG scan showed that the fetal heart rate pattern was abnormal. She stated that, if the CTG does not improve quickly, this generally meant that the baby was distressed and needed to be delivered. Dr D stated that, if the woman is not fully dilated, then she would require a CS and she therefore felt it was unusual that Dr Thampi gave advice over the telephone to continue with a vaginal delivery, which may occur only several hours later. Dr D stated that she had felt that Dr Thampi would agree to the CS but that Dr Thampi *"declined to allow this and also to come in to support me in managing the subsequent labour when asked".* She stated that she had offered to send Dr Thampi an anonymised photograph of the CTG to view but this was also declined. She stated that she would have felt far more comfortable had Dr Thampi seen the CTG, rather than relying on a verbal description. Dr D stated that, at the time, she felt the situation that evolved that night *"had posed a risk to the unborn baby which included the possibility of hypoxic brain injury in labour"* and that she believed at the time that the case was not managed in the safest way clinically.

413. Within Dr D's GMC witness statement dated 21 April 2022, she stated that she did not remember having a conversation with Dr Thampi regarding whether she was happy with her completing the delivery of Patient C's baby without her as this was so long ago. Dr D also stated that Dr Thampi had not met her before the shift or asked her what level of competency she had, which was something she would expect to have been clarified. Dr D stated that this was an organisational issue too and that the Trust had subsequently allocated two registrars at all times instead of one and only more senior registrars (at level ST5 and above) are now allocated.

414. Within Ms O's GMC witness statement dated 10 July 2023, she stated that, as the coordinator at the time, Dr D had come to her with concerns after the call. Ms O stated that she did not remember the details of that conversation, *"only that* [Dr D] *needed a consultant to come in but Dr Thampi refused and subsequently* [Dr D] *was feeling unsupported"*. Ms O stated that she did not contact Dr Thampi or ask her to come in as she was dealing with a very busy labour ward and staff shortage at the time.

415. The Tribunal carefully considered Dr D's oral evidence. In respect of the 02:05 hours call, Dr D stated that she had wanted to do the CS, and she thought that the sending of the CTG would be to make sure Dr Thampi was fully aware of what had happened. She said that she was not comfortable with Dr Thampi's plan to review in 30 minutes. Dr D was asked whether she had been asking Dr Thampi to come in and she initially stated that, as far as she could remember and according to her statements, 'yes'. She also stated that she remembered the plan was to *"leave for 30 minutes. I remember accepting that… I did say that I wanted to do a CS".* The Tribunal noted that this was at odds with Dr D's statement made two months after the index incident, in which she stated that *she* told Dr Thampi that she would observe the CTG and call back in 30 minutes. The Tribunal took the view that this was a reference to Dr D's agreement to what Dr Thampi had advised. Dr D also accepted that, in Dr Thampi saying that Patient C would deliver her baby vaginally and that the CTG would recover, Dr Thampi was in fact seeking to be reassuring.

416. Dr D was asked about whether she was capable of interpreting a CTG trace. She stated that she had some understanding with her level of experience at the time and knew when a CTG was pathological or normal. She stated that, in certain situations where it was not in her previous experience, she would need support. It was put to Dr D that, in Patient C's medical records, there was mention of an epidural being sited at 01:44, and whether that causes a change in the trace after an epidural is sited. Dr D stated that yes it was quite common to have a bradycardia like that. The Tribunal also noted that she had previously stated in her Trust interview that she knew how to assess the CTG.

417. The Tribunal further noted Dr D's oral evidence about the second call purported to have been at 02:30. It was put to Dr D that Dr Thampi had called in around 02:30 and was told that the CTG had continued to recover. Dr D stated that she did not remember this anymore but that she had written in her statement that she was called away at this point to deliver another baby. She stated that she thought that Dr Thampi would therefore have spoken to the coordinator. Dr D further accepted that at this point the CTG was recovering, and the position was no longer in the acute phase of concern, although Dr D maintained that she thought that it was not normal. Dr D further accepted that there was no mention in Patient C's medical records to Dr D asking Dr Thampi to come in, and this being refused and further that she would not have been able to ask Dr Thampi to come in at 02:30 or any call around that time, as she was delivering the other baby at this point.

418. The Tribunal noted Dr D's evidence in respect of the reflection she made within the Trust interview, referred to above, that she should have been more direct and perhaps more explicit in her request to have asked Dr Thampi to come in. Dr D stated that it was difficult because she did not remember the words that she used at the time. She stated that she remembered Dr Thampi saying not to do the CS but that she did not remember the words that were said over the phone. Dr D stated that she would have been able to describe the CTG and offered to send the trace but that she could not remember the subtleties of the language used at the time.

419. In her oral evidence, Dr D initially stated that it would be difficult to remember at what point of the shift she had a second call with Dr Thampi. Dr D stated that, looking at the records today, i.e. when Dr D gave evidence, that it would be 03:30 as she had written the second note then, however she thought that she may also be recording the 30-minute review held earlier which she was not part of.

420. In her oral evidence and in response to a question as to whether she had asked Dr Thampi to attend at the 03:38 hour call, Dr D stated:

> *"This is what I've written at the time. I haven't documented that I've asked her to attend or that she's refused to attend. In all honesty, on my first shift on-call, I probably would find that difficult to do and it may be that I recorded a separate statement and then that's the statement that's gone through. I haven't written that in the medical records, but my recollection would be that it would be at this time that we had that discussion. But as you say, it's not in the medical records that have been documented at the time."*

421. Whilst Dr D confirmed, having considered the records, that her second call with Dr Thampi was at around 03:27 and accepted that she had not documented asking Dr Thampi to attend or documenting that refusal. Dr D's evidence alluded to a 4th call at some point after 03:27/03:28 hours where Dr D would have asked the midwife to let Dr Thampi know and be made aware that she was doing the delivery for Patient C.

422. The Tribunal noted that within the medical notes, it was noted by a midwife, that Dr D had spoken to Dr Thampi at 03:27 hours, *"Dr Thampi informed of CTG concerns and requested to speak to* [Dr D]*".* The Tribunal also noted from the medical notes that the baby's head had come down as the *"FSE clip entirely in vagina",* that Dr D was encouraging Patient C to push at 03:45 hours and that the baby was delivered at 04:08 hours.

423. The Tribunal considered Dr Thampi's evidence. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she had taken hundreds of on-call shifts in which she took countless calls from junior doctors and so it was impossible for her to recall the exact details of calls from around six years ago. Dr Thampi stated that nothing was raised with her at the time of the alleged events and that she has tried her best to respond based on the medical records and what would have been her normal practice.

424. Dr Thampi stated that her usual practice on call would be that the registrar describes the CTG and how 'mum' is doing and on that basis, she would decide whether to go in, to give advice without going in and/or suggest an approach with a call back in an agreed timeframe to check on process - further that she would set an alarm to call back. In reference to Dr D's statement that Dr Thampi was adamant that the baby would deliver vaginally, Dr Thampi stated that she did not believe she would be saying this at that time but rather advising, as recorded in the midwife's contemporaneous note, to leave Patient C a little longer to see if the head would descend. The Tribunal also noted that the records corroborated this, and Dr D had accepted Dr Thampi's advice to continue to observe the CTG and wait for a further 30 minutes.

425. In respect of the copy of the CTG that Dr D offered to send through to her by text message, Dr Thampi stated that, in line with GDPR and Trust policy at the time, she would have declined the request. She stated that she was the Information Governance lead for the department and that data protection was taken very seriously. Dr Thampi stated that it was her understanding that, even if a patient's name was anonymised, a CTG remains patient data and could even be considered patient identifiable. Dr Thampi stated that she felt she could rely on Dr D to interpret the CTG and relay this accurately to her. She stated that Dr D was an ST4 which meant that she had met specific parameters to work independently on the labour ward and there had been no issues concerning additional support being required in

respect of Dr D. In response to Dr D's indication that she would have felt more comfortable if Dr Thampi had seen the CTG, Dr Thampi stated that Dr D did not say this to her at the time. Dr Thampi stated that Dr D had described the CTG and did not indicate that she could not accurately do so. Dr Thampi also stated that she had subsequently seen the CTG in the medical records and that she believed her advice would have been the same in person as it was over the phone. Dr Thampi remained clear and consistent in her oral evidence, maintaining that the plan to wait and see if the baby's head would descend which she thought was a reasonable and appropriate plan.

426. In her oral evidence, Dr Thampi consistently maintained that her best recollection was through reading the medical records in that there was bradycardia and a compensatory rise in the baby's heartbeat which is a good sign. Dr Thampi stated that the CTG that was described to her was not a pathological CTG where she would say an urgent CS is required so she said to observe the CTG for 30 minutes and keep her informed. Dr Thampi stated that she set an alarm and called back to the unit around 02:30 to check what was happening. She stated that the message she got was that things had settled.

427. Whilst the Tribunal noted that Dr Thampi calling in for an update, at the 30-minute review past the call at 02:05 hours was not in dispute, it was clear from the review of the evidence, that there was no call between Dr Thampi and Dr D at this time - approximately 02:30 hours. There was no note of such a call and Dr Thampi's evidence was that she had no recollection of such a call either.

428. The Tribunal examined Dr Thampi's evidence in relation to Dr D's indication that she requested Dr Thampi to attend in person. Dr Thampi stated that she did not recall Dr D specifically asking her to do so. She stated that, from the information given to her in the call at or around 02:05, she did not consider that her attendance was required and did not recall Dr D specifically asking her to do so. Dr Thampi stated that, had Dr D specifically asked, she believed she would have done and would not have refused to come in. She told the Tribunal that she was renting a room near the hospital and was an eight-minute drive away. She stated in oral evidence that, in her career so far, she had never refused to attend when asked. She stated that she had been happy with the clinical scenario explained by Dr D and, had she not, then it would have been different. Dr Thampi also referred to the two processes of escalation via the labour ward coordinator that could have taken place in the event of any refusal and that she had received no contact in line with those processes. Dr Thampi told the Tribunal that it was now her practice to expressly ask whether she should come in to assess the situation to ensure trainees are comfortable with clinical situations.

429. The Tribunal further examined the evidence in respect of Dr Thampi being adamant not to deliver the baby via a CS. Dr Thampi told the Tribunal that no one can be adamant about the mode of delivery as labour is an evolving process. She stated that she would have reassured Dr D that the patient was 4cm dilated, the baby's head is high, and that it would come down. The Tribunal noted that Dr D too had accepted this. Dr Thampi stated that any ruling out of CS was only 'at present' and that it was to be kept under review. The Tribunal also noted her evidence, that she reminded Dr D to 'do the bloods' in case a CS was needed, which the Tribunal saw noted in the records also.

430. The Tribunal further considered Dr Q's and Dr S's expert opinion on the issue of whether, in the circumstances, there was a duty on Dr Thampi to attend in person to review Patient C's CTG and also to attend in person, prior to Patient C's delivery, to review and agree a treatment plan.

431. Dr Q produced a number of expert reports. Within those, she opined:

> *"a. advised/arranged adequate pre-operative checks and investigations, including reviewing any CTGs where necessary;*
> *If* [Dr D]*'s comments are accepted, she offered to send an anonymised photo of Patient C's CTG to Dr Thampi on* [XXX] *August 2018 in and around 02:05, which Dr Thampi declined.*
> *As the CTG features were of major concern to* [Dr D] *and Dr Thampi was on call from home, this offer was reasonable. Further, it is my opinion that* [Dr D]*'s description of the CTG was of significant clinical concern and Dr Thampi should have reviewed it. Dr Thampi's failure to view the CTG by message or to attend in person fell seriously below the expected standard. I cannot think of any reason for Dr Thampi to refuse* [Dr D]*'s offer. If Dr Thampi was not happy with transmission of information in this way, she should have attended in person to review the CTG herself."*

432. Further that:

> *"Dr Thampi's decisions and recommendations on* [XXX] *August 2018 in and around 02:05 did not acknowledge* [Dr D]*'s concerns about Patient C's CTG or the lie of the baby. As such, based on the information available, there is nothing to demonstrate that Dr Thampi recognised or responded to the complications (concerns) described. This failure to acknowledge significant and serious concerns is fundamentally concerning and fell seriously below the expected standard.*

It is my opinion that Dr Thampi should have attended in person, given the clinical issues raised and the patient's high parity (with associated increased risk of unstable fetal lie and haemorrhage)."

433. However, in oral examination, Dr Q told the Tribunal the following:

434. In respect of whether the Data Protection and GDPR legislation required legal obligation / justification to share private details, Dr Q confirmed that she too would have had training on this and whilst she did not have a recollection of the timeline, she accepted that the new guidance was filtering down through to Trusts and old habits of sharing had to be reviewed.

435. Dr Q further stated that, in respect of whether a consultant is obliged to attend if a specialist registrar telephones with concerns about a CTG trace of this nature, she opined in oral examination that it very much depended on the matters of fact about what was discussed in the conversation. Dr Q said that it was individualised and fact specific and would also depend on the confidence that the consultant would have on the person relaying the CTG trace and information. Having read the transcript of Dr D's oral evidence, Dr Q further opined in her own oral examination, *"If she didn't ask Dr Thampi to come, she didn't ask her to come so Dr Thampi couldn't be expected to come on that direct request".* Dr Q further revised her initial review from her report and conceded that Dr D would not have told Dr Thampi that there was an 'oblique lie' but rather she would have queried it. Reviewing the medical note, she confirmed that the head of the baby would in fact have been in the pelvis however she maintained that the CTG would still be concerning if the mother was not in labour. The Tribunal noted also that, in respect of the recording made by Dr D in respect of the 02:05 hours call with Dr Thampi, she had recorded that there had been discussion about the possible 'oblique lie' of the baby. Further, in respect of the timeframe around 03:27 hours, Dr Q confirmed that it was very likely that the patient was in established labour then.

436. Within Dr S's expert report dated 24 August 2024, he referred to The RCOG Good Practice Guideline No.8 (2009): *"Responsibility of the Consultant On-Call"*, which states, at point 4.1:

"4.1 Attendance in person
In the following situations, the consultant should attend in person, whatever the level of the trainee:
- *eclampsia*
- *maternal collapse (such as massive abruption, septic shock)*
- *caesarean section for major placenta praevia*

- *postpartum haemorrhage of more than 1.5 litres where the haemorrhage is continuing and a*
  massive obstetric haemorrhage protocol has been instigated
- *return to theatre – laparotomy*
- ***when requested**."(emphasis added)*

437. He further opined that:

> *"In a situation such as this, if a consultant disagrees with a plan made by a more junior or inexperienced Obstetrician, it would be up to that Consultant to explain their rationale for the decisions they made based on the clinical findings."*

438. Dr S further opined that it would not be good medical practice if a consultant declined or refused to attend in person when a direct request had been made - further he stated that he would expect that refusal to be recorded.

439. In his oral evidence, Dr S further confirmed that:

> *"on the description of the CTG that Dr D provided and explained that there was a bradycardia after which there was a compensatory tachycardia that was now settling, variability was again at the limit of what we would consider the lower limit of normal at 5 and then I would consider that basically, the baby had recovered from its bradycardia, given the situation of this woman being para* [XXX] *and likely to be able to labour quickly, that it was reasonable and appropriate to observe the CTG and see if there were any further changes or, if there was any further deterioration, then a plan could be made to expedite delivery."*

440. Dr S considered the advice provided by Dr Thampi as recorded by Dr D to be entirely appropriate confirming that clinical decisions based on information provided in one call can be made. He further stated:

> *"When the registrar who is in the fourth year of her training, so I would imagine reasonably competent to be able to describe the CTG, has described what happened, including the bradycardia, the compensatory tachycardia, which was now recovering, and again in the context of the clinical situation of a woman who is grand multiparous so likely to labour fairly quickly, it's appropriate to say, "Well, we will review the situation in a set period of time", whether it be 20 minutes or 30 minutes or some other agreed timeframe and say, "Well, if things do not improve or they deteriorate, then it was appropriate to then interject and expedite delivery". If, however, after the*

following review things looked like they had improved, which the records seemed to indicate, then again it seems appropriate again to say, "Well, let's review the situation again in a short period of time", and in this instance by the time four o'clock came, then the lady was already in second stage and ready to delivery soon after that."

441. Dr S further informed the Tribunal that in respect of the advice given by Dr Thampi around 03:27/03:28 hours - in respect of a CS, in that *"not at present, feels the head will come down",* Dr S again agreed with this advice stating that *"when one has more years of experience, one is able to reasonably predict what may happen in labour".*

442. In light of its review of the evidence, the Tribunal considered the specific paragraphs of the Allegation.

Paragraph 5(a)(i)

443. The Tribunal considered whether, between 11 and 12 August 2018, Dr Thampi was the on-call consultant, and she was telephoned for advice and assistance by Dr D, during the labour and/or delivery of Patient C's baby, and she:

a. declined to:

i. ~~receive and~~ review the cardiotocography ('CTG') that Dr D had expressed concerns about during a call she made to [Dr Thampi] at around 2:05am ('Call 1'), by text message when Dr D offered to send an anonymised picture of it to [Dr Thampi].

444. The Tribunal had regard to all of the evidence above. The Tribunal was clear that Dr Thampi accepted, as a matter of fact, that she declined to review the CTG at 02:05. She explained that she would have declined, in line with GDPR and Trust policy, the request from Dr D when she offered to send a copy of CTG through to her personal phone and that it as her understanding that, even with anonymisation of the patient's name, a CTG remained patient data and could even be considered patient identifiable. The Tribunal was clear that the word *"receive"* had been removed from this paragraph of the Allegation and that the concern remained about declining to *"review"* the CTG in these circumstances. The Tribunal was clear that Dr Thampi did not review the CTG by text message when offered an anonymised picture as it would have potentially been a data breach. The Tribunal has heard that Dr Thampi was content as to Dr D's explanation of the CTG over the phone.

445. In all the circumstances, the Tribunal determined that the facts as alleged in this paragraph of the Allegation were accepted by Dr Thampi and proved. However, it was mindful that no failure was alleged and, in any event, having considered all of the evidence and the experts' views, the Tribunal did not consider that there was any failing attributable to this sub-paragraph within the Allegation.

Paragraphs 5(b)(i) to (ii)

446. The Tribunal considered whether, between 11 and 12 August 2018, Dr Thampi was the on-call consultant, and she was telephoned for advice and assistance by Dr D, during the labour and/or delivery of Patient C's baby, and she:

b. failed to:

i. attend in person to review Patient C's CTG in person following Call 1;

ii. attend in person prior to delivery to review Patient C and agree a treatment plan;

447. The Tribunal understood that Call 1 is timestamped within the records as 02:05. It understood, with reference to Dr D's written statement to the Trust, that she was able to give detailed information about the CTG to Dr Thampi, including:

> *"I called the consultant on call, Miss Thampi at 02:05. I advised her that the CTG was pathological and that the baby had not compensated well to the insult of the prolonged bradycardia and appears compromised. I explained that there was a tachycardia of 180bpm with prolonged atypical decelerations…"*

448. The Tribunal has been unable to find any complaint on Dr D's part specifically to a failure for Dr Thampi not having reviewed the CTG in person. It was clear that Dr D had wanted to do a CS as at the 02:05 call and had called Dr Thampi thinking that this would be the agreed plan. The plan instead was to wait and reassess in 30 minutes, as set out above.

449. The Tribunal also noted Dr D's evidence that she would sometimes need support in respect of reading CTG's at the time. However, the Tribunal did not consider that Dr D's complaint was directly related to her interpretation of the CTG but rather her expectation of supervision with advanced obstetric skills which she said she had not experienced previously. Dr D's evidence had been that she was in fact seeking support with advance labour ward decisions. The Tribunal also noted Dr D's evidence that the level of risk she considered

existed during the early hour of the morning on XXX August 2018 was contributed to by her level of experience at the time. There was no evidence before the Tribunal however that Dr D had communicated her concerns about the management of the patient, or feeling unsupported to Dr Thampi.

450. The Tribunal appreciated that there were wider support concerns that Dr D had expressed to the Trust about her work on these on-call night shifts, such that the Trust had subsequently allocated two registrars at all times instead of one and only more senior registrars (at level ST5 and above) are now allocated to that unit.

451. The Tribunal also noted from Dr D's oral evidence that there were no indicators or training needs on her part, specifically in respect of her ability to read CTG traces.

452. The Tribunal considered that Dr D's evidence as to whether she had categorically asked Dr Thampi to attend in person whether at the call 02:05 or even at a later call, which would have been at approximately 03:27 hours. It was not clear, and in fact, Dr D's evidence was confused and confusing. Dr D's various written statements were not consistent with her oral evidence as to when she may have specifically asked Dr Thampi to attend in person or whether she had merely reflected in hindsight about directly asking her this which she accepted may have been difficult for her as Dr Thampi's junior. From the specific evidence as examined above, the Tribunal was clear that there had not been a call at 02:30 between Dr Thampi and Dr D. It seemed that Dr D may have mistaken the 03:27 call, which had taken place between her and Dr Thampi, and was recorded not just by her but also by a midwife, to have been an earlier call. The clinical picture, however, did not fit in with what Dr D stated happened in that call. Dr D stated that Patient C was not in established labour, however the medical records showed that, 18 minutes later, Patient C was encouraged to push, and Dr S and Dr Q's view was that this was likely established labour. The Tribunal noted in the records that accelerations had been present which Dr S confirmed would have been a reassuring feature. The Tribunal also noted Dr D's evidence that she was unsure whether she had merely re-recorded the outcome of the 02:05 hours call again in her medical note for Patient C that she had opened at 03:28 hours. Dr D had alluded to this in her oral evidence but seemed confused about the accuracy of the clinical picture herself.

453. Further the Tribunal did not see any recording in the medical note as to Dr Thampi being asked to attend at any point nor was there a recording in respect of Dr Thampi having refused to do so.

454. The Tribunal considered Dr D's account that she would not record such concerns in the medical notes; however, it noted that she had recorded the concerns about not being able to deliver Patient C's baby with a CS.

455. It preferred and accepted Dr Thampi's evidence that, in her career, she had never refused such a request, and that she was an eight-minute drive away. The Tribunal considered it plausible that Dr Thampi would have attended in person had she been specifically asked to do so.

456. The Tribunal considered that, whilst Dr D had tried her best to assist the Tribunal, her recollection was muddled and confused as to the timings of the calls to/from Dr Thampi and what occurred in respect of them. Dr D readily accepted that she could not recall certain events due to the passage of time which the Tribunal considered understandable. Nonetheless, it was the Tribunal's view that Dr D's written evidence was not consistent with her oral evidence, and she was also not clear as to the number of calls there had been in total between her and Dr Thampi in respect of discussing Patient C's clinical condition and what she had asked of Dr Thampi within those calls.

457. The weight of the evidence was such that the Tribunal determined that, on balance, a direct request had not been made of Dr Thampi to attend in person. It further considered Dr Q's evidence that a reasonable body of obstetric consultants would attend in person to respond to complications during delivery, when requested to do so, however it would depend on the individualised and specific circumstances. The Tribunal accepted Dr Q's and Dr S's account that, at 03:27, Patient C was likely to be in established labour and it noted Dr S's view that, whilst the CTG was abnormal, it was improving, and the accelerations were reassuring. The Tribunal also considered that Dr Thampi had also spoken to Dr D as to the evolving situation. Further, it noted that, in addition to Dr Thampi speaking to Dr D at 02:05 hours, Dr Thampi had called back for an update 30 minutes later and thereafter had also spoken to Dr D at 03:27 when as it is recorded, *"Dr Thampi asked to speak to Dr D".* The Tribunal considered that Dr Thampi had remained involved to review, support and advise as the clinical picture evolved as to the specific circumstances of Patient C.

458. The Tribunal considered that Dr Thampi's practice had been in line with the requirements of paragraph 34 of *Good Medical Practice* (2013) ('GMP'), which stated that:

> *"When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support."*

459. It considered the RCOG guidance on when attendance in person is mandated, which in this case would be apply if it was requested.

460. In light of the evidence, it determined that, on the evidence before it, a duty to attend in person in the circumstances had not been established. It was not mandated that Dr Thampi attend in person to review Patient C's following Call 1, and further, it was not mandated for her to attend in person prior to delivery to review Patient C and agree a treatment plan. The Tribunal determined that therefore in not doing so, there was no failure in the specific circumstances of this case. It therefore found paragraphs 5(b)(i) and 5(b)(ii) of the Allegation not proved.

Paragraph 5(b)(iii)

461. The Tribunal considered whether, between 11 and 12 August 2018, Dr Thampi was the on-call consultant, and she was telephoned for advice and assistance by Dr D, during the labour and/or delivery of Patient C's baby, and she:

> b. failed to:
>
> …
>
> iii. explain [her] rationale for recommending treatment of Patient C with antibiotics to Dr D in Call 2.

462. The Tribunal bore in mind its findings as above. It noted that this paragraph of the Allegation was on the basis that the alleged treatment with antibiotics took place during Call 2, which was initially purported by the GMC to be at 02:30 hours. As was already considered, the Tribunal was clear that there was an initial call at 02:05 hours and, more likely than not, there was a call at 03:27 between Dr Thampi and Dr D.

463. The Tribunal had regard to Dr D's note within Patient C's medical records that Dr Thampi had advised *"bloods and IV antibiotics".* This was within Dr D's note that she opened at 03:28 hours that morning. In her 20 October 2018 written statement to the Trust, Dr D stated that she was told by Dr Thampi to resuscitate the CTG with some IV antibiotics at some point after 02:30.

464. Dr D suggests that the CTG remained abnormal at the 30-minute review but that when she spoke to Dr Thampi at some point thereafter the "*Reactive tachycardia was improved but baseline was still 160 with reduced variability and no accelerations… she told me to rescutite (sic) the CTG with some antibiotics… there were no clinical signs of sepsis".* Dr

D reiterates in her Trust interview in 2019 that Dr Thampi did not give an explanation as to why she advised to resuscitate with some antibiotics.

465. The Tribunal noted that within the contemporaneous note of the 02:05 hours call there was no such reference to antibiotics being advised. There was reference to it however within the note that Dr D opened at 03:28 hours which was signed off at 19:02 hours and it was unclear which time period it alluded to. It was stated alongside the request for 'bloods' but it was not clear from the clinical picture why antibiotics would be needed.

466. From the medical records, the Tribunal could see that the IV fluids were administered throughout early that morning at 01:24, 02:38 and 02:39. Dr Thampi's evidence was that she would not have prescribed the antibiotics as there were no specific indications for it and that advice for the provision of IV fluids would make more sense.

467. The Tribunal noted that there was no record in the medical notes of Dr Thampi having prescribed antibiotics as opposed to advised them within Dr D's statement. There was no note either to state that, whilst Dr Thampi had advised them, they were not prescribed nor administered.

468. It further noted Dr Q's opinion. She stated that:

> *"Dr Thampi's recommendation during the second phone call (in and around 02:30) to use antibiotics also seem unfounded. The only rationale I can think of is that Dr Thampi considered that the membranes around the foetus might have been infected, a condition called chorioamnionitis. This condition does not always manifest with changes to maternal observations, but it can be the cause of a high fetal heart rate (tachycardia).* [Dr D] *noted that there were no clinical signs of sepsis; this is often the case when chorioamnionitis is suspected. Dr Thampi should have explained her rationale for recommending treatment with antibiotics to* [Dr D]*; her failure to do so represented practice which fell seriously below the expected standard in any discussion of treatment options, regardless of whether the discussion is by telephone or face to face."*

469. Dr S opined:

> *"There was no rationale in a woman without prolonged rupture of membranes and no signs of chorioamnionitis to have instructed Dr D to have commenced intravenous antibiotics to "resuscitate the fetus"."*

470. The Tribunal did not accept Dr Q's view as above - there were no reported concerns about sepsis or chorioamnionitis within Patient C's records. It did however accept the joint expert's view of October 2024 that it would not be standard practice to prescribe antibiotics in a case of suspected hypoxia.

471. Whilst Dr D also confirmed that there was no indication for antibiotics in this case, she maintained in oral evidence that she did not think this was an error as this was one of the matters that she had been worried about that night. In answer to Tribunal questions, Dr D stated, as to whether she would have queried or questioned the instruction to resuscitate with antibiotics, that she presumed she would have but did not have a memory of doing so. The Tribunal took the view that, had this taken place, Dr D would have recorded any rationale in the notes or why it was then not administered to Patient C.

472. In all the circumstances and looking at all of the evidence before it, the Tribunal determined that it is more likely than not that Dr Thampi advised IV fluids and not IV antibiotics such that the recording of *"IV antibiotics"* in the notes was an error. It considered that this was more likely due to the pressures and demands on Dr D during a busy shift that night. In light of its finding that Dr Thampi did not recommend treatment of Patient C with antibiotics, the issue of failing to explain its rationale does not arise. Accordingly, the Tribunal found paragraph 5(b)(iii) of the Allegation not proved.

Paragraphs 5(c)(i) and (ii)

473. The Tribunal considered whether, between 11 and 12 August 2018, Dr Thampi was the on-call consultant, and she was telephoned for advice and assistance by Dr D, during the labour and/or delivery of Patient C's baby, and she:

> c. told Dr D not to deliver Patient C's baby by caesarean section in spite of the fact that [she] had ~~not~~ failed to personally review~~ed~~:
>
> i. Patient C;
>
> ii. the CTG(s).

474. The Tribunal had already found paragraphs 5(b)(i) and (ii) of the Allegation not proved in that Dr Thampi had not failed any established duty to personally review Patient C or the CTG. For completeness however it considered whether Dr Thampi had in fact told Dr D not to deliver Patient C's baby by CS in this context.

475. Whilst Dr D had stated in her October 2018 statement that Dr Thampi had told her *"categorically"* not to perform a CS and that the *"baby would deliver vaginally"',* she had accepted that Dr Thampi would have been reassuring her that the head was too high and would come down, hence a CS was not indicated at that time. Dr D further agreed that a plan to wait and review in 30 minutes was agreed.

476. The Tribunal noted that the note recorded by Dr D herself post 03:28 hours was that the advice from Dr Thampi was *"Advised not for CS at present as feels head will come down".* The Tribunal considered that such advice was not a categorical 'do not deliver Patient C's baby with a CS' but rather advice that was evolving with the changing clinical picture that Dr Thampi remained involved with and had been kept under review. It also considered it significant that Dr Thampi had previously advised *"bloods"* in case a move to CS did become clinically indicated.

477. As such, the Tribunal did not consider that Dr Thampi had, in any event, categorically told Dr D not to deliver Patient C's baby by CS and, in line with its earlier findings at 5(b)(i) and 5(b)(ii), found paragraphs 5 (c)(i) and (ii) of the Allegation not proved.

Paragraph 6

478. The Tribunal considered whether, on or around 26 October 2018, Dr Thampi inappropriately told Mr H during an appraisal process, that he should not write there had not been anything specific learnt by him because the *"white people won't like it"*, or words to that effect.

479. The Tribunal noted that appraisals are a yearly process to ensure all doctors are up to date in terms of their knowledge, skills, and development. Feedback is collected from patients and colleagues as part of this process.

480. As part of Dr Thampi's role at the Hospital, she carried out a number of appraisals for several Consultant colleagues. Dr Thampi stated that she had been carrying out this function for around three to four years prior to the appraisal with Mr H without any issues that she was aware of.

481. The appraisal meeting with Mr H took place face-to-face in Dr Thampi's office on 26 October 2018. This was Mr H's first appraisal at the Trust and, as Dr Thampi was in another department and specialised in a different area of medicine, he did not remember seeing or talking to her prior to his appraisal.

482. Mr H attended an investigation meeting at the Trust on 12 March 2019. A summary of the meeting was provided (not a verbatim transcript), and this is the most contemporaneous document the Tribunal had in respect of his complaint. Within the note of the meeting, it stated that Mr H said that he *"experienced a mixture of inappropriate comments and condescending/patronising attitude"* from Dr Thampi. Mr H stated that there were follow ups during the appraisal process either by email or on the telephone and, during this, he had *"experienced the same attitude"* from Dr Thampi. He stated that, during the last few calls with Dr Thampi, he had informed her that he *"was not happy with the way she was with me"*. Mr H stated that previous colleagues who had appraised him *"were more professional and treated me as their equal"*.

483. Mr H was asked to tell the Case Investigator about the alleged inappropriate comment made by Dr Thampi. He stated that there was a section on the appraisal form about reflections following a formal complaint. Mr H stated that he had not had a formal complaint but there was an informal one in respect of communication with a patient who had been on dialysis. Within the section of the form where it asked what had been learnt, Mr H had said that there had not been anything specific. He stated that Dr Thampi said she thought he should change this: *"as I should not write there had not been any learning as the "white people won't like it"."* Mr H stated that he thought it had been an irrelevant thing to have said, and he did not say anything in response. He said he met with Appraisal Officer and informed them of his concerns about the appraisal. Mr H also stated that he had completed a survey after the appraisal but that the form said that *"if you had any concerns that they should not be included on the form, hence contacting the appraisal team"*.

484. Within Mr H's GMC witness statement dated 3 July 2023, he stated that he had not initially challenged Dr Thampi's inappropriate comments as he was surprised, and he did not *"know where it was going to go"*. Mr H stated that during the follow up telephone call sometime in November 2018 he informed Dr Thampi that he was unhappy with the appraisal and that he would raise these concerns with the team. Mr H stated that he did not remember Dr Thampi's exact response but that she *"backed off a bit and said that she was just trying to help"*. He also clarified that his meeting with the Appraisal Officer took place a few weeks after his appraisal but that he could not remember the exact date. The Tribunal remained mindful that, whilst Mr H referred to inappropriate comments, it was only concerned with a singular allegation and the Tribunal continued to examine the evidence in that regard.

485. Within Dr Thampi's witness statement dated 14 August 2024, she stated that she believed this was Mr H's first appraisal at the Trust and there were some gaps in his documentation. She stated that it was her intention to help him complete the appraisal fully,

including making sure those gaps were filled in. Dr Thampi provided her handwritten notes that she took at the time of the appraisal meeting with Mr H.

486. Dr Thampi stated that she *"certainly [did] not recall making any inappropriate or unprofessional comments"*. She stated that she *"would never wish to offend anyone"*. Dr Thampi stated that it caused her great distress for it to be implied that she had made a racist remark. She stated that, if something had been misinterpreted, she sincerely apologised.

487. Dr Thampi stated that she could not remember having said what is alleged and that she did *"not believe that this is something I would have said"*. Dr Thampi stated that she *"would never wish to cause offence or act unprofessionally in the course of an appraisal"*. She stated that she had tried to reflect back to consider whether anything she had said could have been misinterpreted or misunderstood but after all this time she could not recollect the conversation and could only say that she did not believe she would have said what is alleged.

488. Dr Thampi stated that she had previously received appreciative feedback with regard to her help of colleagues with the appraisal process. The Tribunal had regard to a thank you card and an email dated 20 January 2020 from another colleague. He stated that Dr Thampi had been his appraiser for three years and that he found her to be very helpful. The colleague stated that Dr Thampi had only been professional, that she had guided him with his e-portfolio, and that she was very approachable and always had time for him.

489. In a document from Dr N, Responsible Officer at the Trust, *"provided in response to a s35A request, 06 September 2024"*, he stated that Dr Thampi's appraisee feedback for 2018/9 had been reviewed. Dr N stated that seven appraisees had provided feedback and that it was *"likely that this represents all the doctors she appraised that year"*. Within the document it stated:

> *"Feedback left by* [Mr H]*: I would like to thank my appraiser for taking the time to guide me through the appraisal process which was new to me and different from my previous trust."*

490. During Mr H's oral evidence to the Tribunal, he was asked under cross-examination whether he had been offended or annoyed that Dr Thampi had suggested there should be reflection in respect of an informal- as opposed to a formal- complaint. Mr H stated that this was not the case and that he had been very clear that he was surprised by the comment which he thought was inappropriate. Mr H said that, as the comment was made six years ago, he could not remember the way it was expressed *"but I certainly can remember that*

comment". Mr H accepted that his complaint was that he thought Dr Thampi had been condescending and that she had the right to advise and comment on all sections of the appraisal form, but he consistently maintained that his main issue was the inappropriate comment rather than the advice itself.

491. During cross-examination, a number of issues about the appraisal form were mentioned that Dr Thampi had raised with Mr H, based on Dr Thampi's handwritten notes. It was put to Mr H that Dr Thampi had raised issues about his spelling errors with him and that she was very thorough in working through the appraisal. It was put to Mr H whether what was causing him offence was that he found Dr Thampi's thoroughness to be pedantic. Mr H stated that this was not the case. He stated that he felt that the appraisal meeting was not comfortable, the attitude was not right, and there were some inappropriate comments. He stated that he was not saying the appraisal process was flawed or that Dr Thampi had not been thorough but that it was his impression that the professionalism was lacking which led him to raise his concerns.

492. Mr H explained that nonetheless he gave Dr Thampi positive feedback about the appraisal. He stated that he followed the correct process by not writing his concerns in the feedback but contacting the appraisal team separately about it. Mr H further clarified to the Tribunal that a colleague correcting his spelling was not something that would make him put in a complaint against a colleague. He stated that it was the combination of factors, including Dr Thampi's attitude and the inappropriate comment which caused him concern. Further that it was after he had the follow up phone call with Dr Thampi, when it became clear to him that he needed to raise his concerns.

493. During Tribunal questions, Mr H further stated that he had been surprised about the alleged comment as per paragraph 6 of the Allegation. He said that he did not feel it was appropriate. He stated that he did not think it was very relevant to the issue they had been discussing and that it kind of shocked him at the time. He stated that he did find it to be inappropriate and unprofessional.

494. During her oral evidence, Dr Thampi explained that she was very shocked to read the comment she was alleged to have made. She stated that she would never behave that way to anyone and there was no reason for her to make such a remark.

495. Dr Thampi stated that her *"pedantic"* and *"patronising"* manner may have been Mr H's perception, but that she was trying to help him as there were a number of things that should have been completed on the appraisal form. Dr Thampi also recalled that Mr H had not raised

any concerns with her. Dr Thampi stated that, to the best of her knowledge, the incident did not happen.

496. The Tribunal had regard to all of the evidence in respect of this paragraph of the Allegation. It also continued to bear in mind Dr Thampi's good character.

497. The Tribunal was of the view that Mr H was clear and consistent in his oral evidence, and he had maintained that the alleged comment was made to him at the face-to-face appraisal meeting he had with Dr Thampi on 26 October 2018. Mr H was clear as to how the comment and the other issues he had about Dr Thampi's manner made him feel and when he decided to report his concerns. It also considered Dr Thampi's evidence, in which she stated she had no such recollection of making this comment and that she would not say things like this.

498. The Tribunal noted that Dr Thampi had pointed out a number of corrections to Mr H's appraisal form and that he might have had the impression that she was pedantic in her approach, such as pointing out spelling mistakes. It considered that she was genuinely trying to help Mr H in ensuring that his appraisal was of a good quality and clearly demonstrative of his reflections. However, it considered that his account about the comment was within the most contemporaneous document it had, and he remained clear and unwavering in his account when he spoke about it in his evidence.

499. The Tribunal considered Dr H to be an honest witness, relaying the events and his reaction to the Tribunal in a matter-of-fact way and consistently. It did not consider that it was likely that he would have misheard in a face-to-face meeting or fabricated the alleged comment as having been made by Dr Thampi in amongst his complaint about his perception of her attitude.

500. Whilst the Tribunal did think Dr Thampi was trying to help Mr H with his appraisal, the Tribunal concluded that it was more likely than not that Dr Thampi made the comment alleged. Nonetheless, a comment about colleagues' likely response to Mr H's reflective learning, or lack of, being related to their colour, was inappropriate in the Tribunal's view.

501. In all the circumstances, the Tribunal found, on the balance of probabilities, that Dr Thampi did act in the way alleged. Accordingly, the Tribunal found paragraph 6 of the Allegation proved.

The Tribunal's Overall Determination on the Facts

502. The Tribunal has determined the facts as follows:

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

Patient A

1. On or around [XXX] October 2016 you were involved in delivering Patient A of her baby and you failed to:

a. inform Patient A that there was an increased chance of failure of operative vaginal delivery due to:

i. her body mass index;
Determined and found proved

ii. her inability to push as effectively because of her neuromuscular condition;
Determined and found proved

b. adequately consider and/or facilitate a discussion with Patient A about the alternative options for her delivery, given the increased chance of failure of operative vaginal delivery with a vacuum device;
Determined and found proved

c. act on and/or take account of Patient A's views, when she told you:

i. on one or more occasions, she wanted a caesarean section;
Determined and found proved

ii. on one or more occasion, that she did not want an instrumental delivery or words to that effect;
Determined and found proved

d. obtain informed consent for forceps delivery in that you:

i. did not discuss with Patient A the risks and benefits of instrumental delivery;
Determined and found proved

ii. did not discuss with Patient A the risks and benefits of caesarean section;
Determined and found proved

iii. pressurised Patient A into agreeing to a forceps delivery;

Determined and found proved

e. appropriately respond to the lack of progress in Patient A's delivery by not:

i. abandoning the vacuum delivery after three pulls;
Not proved

ii. immediately offering Patient A:

1. the option of transfer to theatre;
Determined and found proved

2. repeat examination following anaesthesia;
Not proved

3. a caesarean section, given that Patient A had explicitly told you she did not want a forceps delivery;
Determined and found proved

~~f. review Patient A in person before she was discharged;~~
Withdrawn

~~g. ensure that postnatal review was offered to Patient A as an outpatient;~~
Withdrawn

h. communicate appropriately with:

i. Patient A in that you stated one or more of the following:

1. "no you can't have a c-section" or words to that effect, without a discussion about risks and benefits;
Determined and found proved

2. "it is now after six o'clock and I could have gone home and let a registrar deliver your baby, but I haven't so you need to let me do this" or words to that effect;
Not proved

3. "you need to let me do this as I don't know what is going to happen to your baby" or words to that effect;
Determined and found proved

ii. Ms F, in that you asked Ms F for consent to a forceps delivery when Patient A had capacity to give consent.
Not proved

2. On or around [XXX] October 2016 you were delivering Patient A of her baby and the degree of force you used to conduct the instrumental delivery was inappropriate.
Not proved

Patient B

3. On or around [XXX] June 2018, you were involved in delivering Patient B of her baby and:

a. you failed to;

~~i. obtain informed consent in that you did not:~~

~~1. facilitate an appropriate discussion about potential complications in labour;~~
Withdrawn

~~2. discuss the options available to Patient B;~~
Withdrawn

~~3. discuss the risks and benefits of all options available to Patient B;~~
Withdrawn

~~4. confirm Patient B's final choice;~~
Deleted after a successful Rule 17(2)(g) application

ii. recognise and/or respond to the complications which developed during Patient B's delivery by:

1. abandoning the operative vaginal delivery;
Not proved

2. recommending a caesarean section in line with RCOG guidance in place at the time;
Not proved

iii. discuss with Patient B, prior to attempting instrumental delivery, the chance of an episiotomy being indicated during Patient B's delivery;
Not proved

~~iv. complete an operative summary of Patient B's delivery;~~
Withdrawn

b. you undertook an excessive number of pulls of Patient B's baby's head using a Kiwi vacuum;
Not proved

c. you inappropriately applied forceps to Patient B's baby's head and then proceeded to carry out an excessive number of additional pulls after you had carried out the pulls described at paragraph 3b;
Not proved

d. you inappropriately disregarded Midwife G's repeated reminders about the number of pulls you had carried out, and her request for you to cease the instrumental delivery;
Amended under Rule 17(6)
Not proved

~~e. your management plan for Patient B was not adequate or appropriate with regards to the risk of post-partum haemorrhage, in that you did not record:~~

~~i. blood loss at delivery;~~
Deleted after a successful Rule 17(2)(g) application

~~ii. use of an hourly urometer;~~
Withdrawn

~~iii. when to check the patient's haemoglobin count by blood test;~~
Withdrawn

~~iv. the duration and frequency of postnatal observations.~~
Withdrawn

4. You inappropriately introduced Midwife G on the labour ward a few weeks after Patient B had delivered her baby as "the midwife who had Datix me by saying the baby was battered, bruised and injured after my delivery", or words to that effect.
Amended under Rule 17(6)
Not proved

Patient C

5. Between 11 and 12 August 2018 you were the on-call consultant and you were telephoned for advice and assistance by Dr D, during the labour and/or delivery of Patient C's baby, and you:

a. declined to:

i. ~~receive and~~ review the cardiotocography ('CTG') that Dr D had expressed concerns about during a call she made to you at around 2:05am ('Call 1'), by text message when Dr D offered to send an anonymised picture of it to you;
Amended under Rule 17(6)
Determined and found proved

~~ii. and failed to attend in person when specifically requested to do so, by Dr D, when she rang you on a second occasion at or around 02:30am ('Call 2');~~
Deleted after a successful Rule 17(2)(g) application

b. failed to:

i. attend in person to review Patient C's CTG in person following Call 1;
Not proved

ii. attend in person prior to delivery to review Patient C and agree a treatment plan;
Not proved

iii. explain your rationale for recommending treatment of Patient C with antibiotics to Dr D in Call 2;
Not proved

c. told Dr D not to deliver Patient C's baby by caesarean section in spite of the fact that you had ~~not~~ failed to personally review~~ed~~:
Amended under Rule 17(6)

i. Patient C;
Not proved

ii. the CTG(s).
Not proved

Additional

6. On or around 26 October 2018, you inappropriately told Mr H during an appraisal process, that he should not write there had not been anything specific learnt by him because the "white people won't like it", or words to that effect.
Determined and found proved

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

Determination on Impairment - 08/05/2025

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

The Evidence

504. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence as follows.

505. Dr Thampi provided a further witness statement dated 6 May 2025 and also gave oral evidence at the hearing at the impairment stage. Dr Thampi also provided an additional bundle which included a large number of testimonials, details of patient accolades received, appraisals and formal feedback received, details of her learning including Continuing Professional Development (CPD) certificates, and a Certificate of Excellence from the Trust dated 8 October 2018 for being *"Extremely approachable and a pleasure to work with".*

506. Within Dr Thampi's witness statement, she stated that she accepted and respected the findings made by this Tribunal. She stated that she apologised unreservedly to Patient A, Mr H, the GMC and the Tribunal for the instances where her actions have been found not to have met the expected standards. Dr Thampi stated that she has practised Obstetrics and Gynaecology for over 30 years and it has always been her intention to treat her patients to the best of her ability and to treat her colleagues with respect. Dr Thampi stated that it caused her great distress and regret that on occasions she has failed to do so.

507. With regard to Patient A, Dr Thampi stated that she appreciated the effects that a traumatic birth can have on a mother and baby. Dr Thampi stated that she was very sorry that Patient A had the birthing experience that she did. Dr Thampi stated that she had reflected on this deeply and that it was undoubtedly a tense and difficult delivery and one she would always remember. Dr Thampi stated that she had found it upsetting to hear Patient A's evidence and would never wish for any patient to feel the way that Patient A does about her birthing experience. Dr Thampi stated that she was very sorry and hoped that Patient A feels some closure from these proceedings and that Patient A and her child are happy and healthy.

508. Dr Thampi referred to the personal impact on her. She referred to the various clinical duties she has undertaken, including leadership and educational responsibilities throughout her career. Dr Thampi stated that the roles she has held reflect her deep commitment not only to clinical care but also to safety, governance, training and the advancement of standards in obstetrics. Dr Thampi stated that she had found the events culminating in these proceedings to have had a profound impact on her life - personally, professionally and emotionally. She stated that she has struggled with confidence and a deep sense of instability in her professional life. Dr Thampi referred to her current role at Surrey and Sussex Healthcare NHS Trust ('SASH'), including that she has not been involved in any issues since she began working there in January 2021 and that she was committed to ensuring no such issues will occur again. She stated that she was grateful that several colleagues had offered her their support.

509. In terms of reflection, Dr Thampi stated that she has listened to the concerns raised and learnt from them. She stated that she is willing to accept when she is wrong and how she can improve. Dr Thampi stated that these proceedings had encouraged her to reflect on her practice and consider areas for improvement. She stated that it was apparent to her that the Tribunal's findings have at their foundation a problem with adequate communication, including in the context of informed consent.

510. With regard to Patient A, Dr Thampi stated that she did not seek to dispute the errors made but wanted to reassure the Tribunal that they were genuine errors and not born out of complacency or disregard for her patient's wellbeing. Dr Thampi stated that she appreciated that, while obstetrics can be fast paced and stressful, communication must remain of a high standard. She stated that she deeply regretted that her actions did not meet the standard of communication and respect for patient autonomy that every woman deserves in her care. Dr Thampi stated that she now more fully appreciates how critical it is not only to share clinical information clearly and thoroughly, but also to ensure that patients feel heard, respected, and involved in decisions about their own care, particularly in high stress and time pressured situations. She stated that, to ensure this did not happen again, she had actively sought out further training and education including attending courses focused on shared decision making and informed consent. She referred to the guidance she has read, the courses/training on communication and consent undertaken, and the changes she has made to her day-to-day practice. Dr Thampi stated that she now ensures she explicitly informs patients with a raised BMI that there is a higher risk of failure with operative vaginal birth. She stated that she clearly explains the rationale for conducting the procedure in theatre and involves the patient fully in deciding whether they are comfortable with attempting delivery in the room or prefer theatre-based care. Dr Thampi stated that she was now much more

conscious of creating space, even in time pressured scenarios, to ensure patients feel informed, respected and central to the decisions being made.

511. In respect of Mr H, Dr Thampi stated that she did not recall making such a comment and was taken aback when it was brought to her attention. She stated that she accepted the Tribunal's findings and respected the process by which the conclusion was reached. Dr Thampi stated that she agreed that such a comment is inappropriate and offered an unreserved apology. Dr Thampi stated that she has worked in the NHS with colleagues and patients from all backgrounds and has always taken pride in upholding values of respect, equality and professionalism. She stated that she did not mean to cause any offence and she was sorry if she did so. Dr Thampi stated that she had reflected on the issue and sought to maintain sensitivity in her communication with colleagues. She stated that she had attended training to strengthen her understanding of how language, unconscious bias and cultural dynamics can affect perceptions. Dr Thampi stated that the experience had made her more vigilant about how her words are received and the importance of creating a safe, respectful environment in all professional interactions.

512. Within Dr Thampi's oral evidence to the Tribunal, she reiterated her unreserved apology and spoke to the written statement she had produced. Dr Thampi stated that the whole Tribunal process had been a defining moment in her life, she has become more aware of how she communicates, and she has been reading the findings and reflecting very deeply. Dr Thampi stated that, since the concerns were raised, she would come home from work every day and think about whether her actions had been correct. She stated that she had been trying to build up her confidence again with the support of her colleagues. Dr Thampi reiterated that she had spent significant hours reflecting on this case and how she can improve her skills especially with regard to communication and obtaining valid consent in time pressured situations. Dr Thampi stated that, going forward, she sees herself as a doctor who ensures patient autonomy, speaks with more clarity, who listens more deeply, and who does not compromise on patient care. She stated that she had learnt a lot. In respect of Patient A, Dr Thampi stated that she had thought that she could deliver the baby successfully with the Kiwi and should have discussed CS prior to the use of instruments. She accepted that all choices should have been discussed with Patient A including that the Kiwi may fail and then she would have to use forceps and, if not, then a CS. She stated that her current practice on ward rounds in either the labour or antenatal wards, would be that for every woman booked in for induction of labour she will speak with them, explain the whole process of induction, offer them choices and explain the associated risks, and specifically ask them if they have any reservations with a procedure. She stated that she takes the extra time to explain to patients all of the possibilities of what can happen upfront so that they have

enough time to revisit their preferences. In respect of XXX, Dr Thampi stated that she is not a maternal medicine expert but she had sought to read lots of literature on it since the events.

513. In addition, the Tribunal received testimonial evidence from the following witnesses on Dr Thampi's behalf:

- Ms V, Delivery Suite Ward Manager at SASH. Her testimonial was dated 10 September 2024 and she gave evidence via video link on 6 May 2025;

  Ms V stated that her experience of working with Dr Thampi has always been a positive one. She stated that Dr Thampi is extremely hard working, conscientious and "*often goes out of her way to ensure appropriate care is given"*. Ms V stated that she had witnessed numerous instrumental and CS births conducted by Dr Thampi and that *"she has always communicated well with the patient and family"*. She stated that Dr Thampi is a skilled practitioner and she had no concerns with any of Dr Thampi's practice. Ms V also stated that Dr Thampi is a highly valued member of the multidisciplinary team and has witnessed Dr Thampi give appropriate feedback to colleagues in a positive and supportive manner as well as teaching and supporting junior colleagues. In her oral evidence, Ms V reiterated the comments in her testimonial. She also stated that she has been on multiple ward rounds with Dr Thampi and that Dr Thampi checks the patient understands. Ms V stated that she had no concerns regarding Dr Thampi's communication skills and that she was a pleasure to work alongside.

- Mr W, General Manager - Gynaecology & Obstetrics Women & Children Division Services at SASH. His testimonial was dated 4 May 2025 and he gave evidence via video link on 6 May 2025;

  Mr W stated that he has come to know Dr Thampi as *"a conscientious, competent, and dedicated clinician with a strong commitment to patient safety and professional integrity"*. He stated that he has always found Dr Thampi to be respective, collaborative, and receptive to feedback. Dr W stated that Dr Thampi's professional demeanour and reliability had earned her the trust and confidence of many colleagues and they had recently offered her further roles of responsibility and extended her contract for a further year. In his oral evidence, Mr W stated that he stood by his comments that he considered Dr Thampi to be *"a conscientious, competent, and dedicated clinician"*. He stated that Dr Thampi has consistently demonstrated a high standard of clinical care in her practice, that he receives lots of compliments about her through the Patient Advice and Liaison

Service (PALS), and that there have been no complaints or issues raised about Dr Thampi since she started working at SASH in 2021.

- Ms X, Clinical Director of the Obstetrics & Gynaecology Department at SASH. She provided two testimonials, the first was dated 6 October 2021 and the second was a more recent document as confirmed by Ms X, although undated. Ms X gave evidence via video link on 6 May 2025.

  Ms X stated that Dr Thampi has been an integral part of the department at SASH and that Dr Thampi has consistently demonstrated *"a high level of expertise and proficiency in her clinical practice"*. Ms X stated that Dr Thampi was not named in any serious incidents in the last three years and has had good surgical outcomes. Ms X stated that Dr Thampi is a team player and a professional leader and is always ready to help colleagues by covering their absences or helping them in emergency situations. Ms X stated that she would like to commend Dr Thampi as an obstetrician. She stated that Dr Thampi *"consistently demonstrates exceptional skill and professionalism on the labour ward"*, and that her decision-making *is "sharp and well considered, particularly in complex situations requiring instrumental deliveries"*. Ms X stated that patients have said that Dr Thampi is an *"amazing and compassionate doctor"* and that she is highly regarded by her peers and the entire multidisciplinary team. Ms X reiterated these comments in her oral evidence. She stated that Dr Thampi has excellent communication skills, that there have been no incidents raised about her, and that she sees the result of what Dr Thampi does at the point of handover after a shift. Ms X stated that Dr Thampi has sound clinical knowledge, an empathetic approach towards patients, and works well under pressure.

Submissions

Submissions on behalf of the GMC

514. Mr Jackson, on behalf of the GMC, submitted that by reason of all the Tribunal's findings of fact in relation to Patient A, Dr Thampi's fitness to practise was and remains currently impaired. He stated that the GMC relies on the Tribunal's determination in respect of Patient A, which sets out clearly Dr Thampi's failure to comply with her duty to have a conversation with Patient A about alternative options for her delivery and to discuss in particular the risks and benefits of procedures in a timely and balanced way in accordance with the GMC's 2008 consent guidance.

515. Mr Jackson submitted that this finding was consistent with Patient A's feeling that she was 'coerced' into agreeing to a forceps delivery. He stated that the GMC submit that no patient should be 'pressured' into agreeing to any procedure that they make clear they do not want. Mr Jackson submitted that the Tribunal's determination represented a very serious finding against Dr Thampi. He stated that it arose from Dr Thampi's overconfidence that her application of the Kiwi delivery would succeed, in circumstances where that belief failed to take account of Patient A's known significant risk factors, which Dr Thampi has now acknowledged may have been factors which led to the failure of the Kiwi.

516. Mr Jackson submitted that, in light of a doctor's overarching duty to comply with all aspects of GMP and the GMC's additional topic specific consent guidance, it was notable that Dr Thampi made no reference to the GMC's 2008 guidance in her extensive first witness statement. Mr Jackson stated that, even in Dr Thampi's oral evidence at this stage, she was still unable to explain why she had not complied with long established GMC guidance in relation to required consenting practice. Mr Jackson submitted that it was troubling that, eight years on, Dr Thampi appears not to have sought advice from senior colleagues in terms of a failure to identify part of the consenting process or undertaken substantive in person training.

517. Mr Jackson stated that the principal bases for the GMC's submission were:

- The seriousness of Dr Thampi's failures in relation to Patient A;
- Dr Thampi's lack of real and early insight into the seriousness of her actions and failures;
- Little evidence of active steps towards substantive remediation;
- The risk of Dr Thampi's attitude being entrenched and therefore the risk of repetition;
- The use of inappropriate language (paragraph 6 of the Allegation) which would attract public opprobrium or otherwise be viewed as disgraceful.

518. Mr Jackson submitted that it was these factors that, in combination, gave rise to the GMC's submission that Dr Thampi's actions amount to misconduct and that her fitness to practise is impaired. He submitted that there was a continuing lack of full insight and an absence of sufficient remediation.

519. Mr Jackson submitted that Dr Thampi's failures amount to serious misconduct as her deliberate course of conduct towards Patient A arose from an entrenched attitude that involved ignoring the positive duty to comply with the GMC's 2008 consent guidance. He stated that, at the heart of this approach, was Dr Thampi's implicit self-belief that she knew

what was 'best for the patient' and her overconfidence that she was going to deliver Patient A's baby by using a Kiwi when there was, and Dr Thampi would have known, an increased risk of failure of an instrumental delivery. Mr Jackson submitted that, in essence, Dr Thampi acknowledged for the first time in her oral evidence at this stage that she believed she could successfully deliver Patient A's baby by Kiwi and so avoid the use of forceps which Patient A had rejected and gave insufficient weight to the known higher risks of failure of any instrumental delivery such that the use of forceps was more likely.

520. Mr Jackson highlighted, in terms of Dr Thampi's continuing serious lack of insight, Dr Thampi's lack of reflection in her witness statement and in her evidence at the Facts stage.

521. Mr Jackson stated that the GMC submit that Dr Thampi's way of treating patients, and her own decision-making processes in relation to the key issues of consenting to an instrumental delivery in the context of Patient A, showed a rigidity of approach, and a lack of willingness to reflect on how things could and should have been done differently. He stated that Dr Thampi had completely failed to regard the relevant provisions of the GMC's 2008 consent guidance and the RCOG's 2015 consent guidance.

522. Mr Jackson submitted that Dr Thampi provided no real explanation for her prior failures in her reflective statement. He stated that she had never addressed these with colleagues and instead had 'attended' online courses. Mr Jackson stated that, in Dr Thampi's evidence, she had spoken of following the approach of her colleagues and yet she never discussed this case with anyone. He stated that, of course, Dr Thampi will have been anxious about her position and being able to continue at SASH.

523. Mr Jackson submitted that, in Dr Thampi's reflective statement, she - perhaps understandably - focuses more on the impact of these proceedings on herself. He stated that it was important to reflect that a Tribunal's principal concern is upon the wider public interest and in the context of the overarching objective, rather than the personal impact on the doctor.

524. Mr Jackson submitted that there was no insightful analysis by Dr Thampi of how she should have acted differently (and when) in the course of her handling of Patient A's labour. He stated that Dr Thampi spoke of what she does now, in terms of being involved in discussing birth preferences, but there was no reflection that she was wrong to treat proof of options [within the birth plan] as consent.

525. In terms of remediation, Mr Jackson submitted that the Tribunal will be focused on how and when Dr Thampi has embarked on her process of remediation and will wish to be

satisfied as to whether it was determination led or derived from her own developing insight as a consequence of her conduct being challenged by Patient A's complaint and the subsequent proceedings and expert evidence adduced.

526. Mr Jackson submitted that there were no admissions or acknowledgement from Dr Thampi that she 'got things wrong' in her evidence at the Facts stage. He also submitted that there was no clear and detailed analysis in Dr Thampi's reflective statement as to how she 'got things wrong', why, and what she would now do differently. Mr Jackson submitted that, crucially, there was no clarity as to whether Dr Thampi had fully reflected as to how she should have communicated with Patient A at each stage of her labour in light of the Tribunal's findings of what she should have done and when.

527. Mr Jackson stated that Dr Thampi has had very difficult issues to address, and the Tribunal now has the difficult task of how to judge how far Dr Thampi has gone down the road to insight and remediation. He stated that the Tribunal may conclude that Dr Thampi is a very self-contained person who has found it difficult to share the issues surrounding the allegations in respect of Patient A for understandable anxiety about her future career, such that none of her colleagues are aware of the detail of the Allegation.

528. Mr Jackson stated that the Tribunal will look at what courses Dr Thampi has undertaken and when, including noting that she undertook an online consent course on 2 May 2025 (the day of the Tribunal's determination on the Facts). Mr Jackson submitted that the Tribunal will also note that there was no reference in Dr Thampi's reflective statement about developing her knowledge and understanding of XXX, although Dr Thampi did speak of reading about it in her oral evidence. Mr Jackson submitted that Dr Thampi gave no examples of how her developing insight and remedial courses had affected the way in which she treats a patient.

529. In terms of impairment, Mr Jackson submitted that the key issue was whether Dr Thampi is currently unfit to practise and in terms of the need for the GMC to set and maintain professional standards and the public's confidence in the medical profession.

530. Mr Jackson submitted that, when the Tribunal is considering impairment, it is required to look forward rather than backwards. He stated that it should note what has happened in the past and Dr Thampi's response to that past misconduct to inform the Tribunal about her insight and remediation and as to current fitness to practise.

531. Mr Jackson submitted that, for all of the reasons set out above, the Tribunal should find that Dr Thampi's fitness to practise is currently impaired by reason of her insufficient

insight and remediation. He submitted that the Tribunal will also need to reflect on public interest considerations in light of the fact that Patient A was 'forced' to agree to the use of forceps which she rejected and the use of inappropriate language during the appraisal of a colleague.

Submissions on behalf of Dr Thampi

532. In response to Mr Jackson's submission, Ms Barnfather, on behalf of Dr Thampi, submitted that Dr Thampi's actions were an isolated error, and the public interest did not require a finding of impairment. In terms of paragraph 6 of the Allegation, Ms Barnfather submitted that the Tribunal's findings did not amount to deliberate misconduct or cause moral outrage. She stated that Mr H put the comment no higher than *"odd"* or *"inappropriate"*.

533. Ms Barnfather submitted that it was factually wrong to say that Dr Thampi's insight was not prompt and active. She stated that the suggestion that insight was only brought about by the Tribunal's findings of Fact was wholly misguided. Ms Barnfather submitted that Dr Thampi's reflective statement was not focused on herself. She submitted that letting a patient down had weighed heavily on Dr Thampi and that this was not self-pity; she is a truly conscientious and caring practitioner. Ms Barnfather also submitted that they did not accept the way in which the GMC has sought to portray the seriousness of the Tribunal's findings. She submitted that Mr Jackson was mistaken that there was little evidence of active steps towards substantive remediation.

534. In response to the suggestion that Dr Thampi has an entrenched attitude, Ms Barnfather reminded the Tribunal that it was dealing with one patient. She stated that there had been a miscalculation of the risk of failure of a Kiwi delivery that had led to communication errors, not least the failure for an earlier and more detailed conversation about CS. Ms Barnfather submitted that it was a very rare miscalculation in very rare circumstances unique to Patient A and therefore no basis for the GMC to suggest that there is a dangerous entrenched attitude such that there was a risk of repetition.

535. Ms Barnfather stated that the GMC has said that Dr Thampi deliberately embarked on a course of conduct and sought to supersede and override the patient. She submitted that this was not compatible with the facts as the Tribunal has found them. Ms Barnfather also submitted that it was also not the Tribunal's finding that Dr Thampi is an arrogant practitioner. She submitted that this was totally incompatible with the person who Dr Thampi is. Ms Barnfather submitted that Dr Thampi's actions were misjudgements or miscalculations and there was nothing deliberate about them.

536. Further, Ms Barnfather stated that Dr Thampi had always set out that she thought that she could deliver Patient A's baby by Kiwi. She stated that the Tribunal has determined the underlying factual matrix in that it decided that Dr Thampi's recollection has been at fault in that she understood there to have been agreement to the use of the forceps. She stated that this had no impact on what Dr Thampi has always said, in that she should have had a more detailed conversation with Patient A at an earlier juncture.

537. In terms of learning, Ms Barnfather submitted that Mr Jackson's comments about Dr Thampi only completing online courses devalued their efficacy and was wrong. She also submitted that the criticism of Dr Thampi for not having undertaken further training regarding XXX was unrealistic. She stated that XXX is a neuromuscular condition outside of Dr Thampi's specialty and that all she can do is read the limited material available as to MC's potential impact on labour, which she has done.

538. Turning to Ms Barnfather's substantive submissions, she submitted that Dr Thampi's fitness to practise is not impaired on the basis of the facts found proved. Ms Barnfather submitted that the Tribunal's findings relate to a single patient and involve, in essence, a miscalculation as to the risk of failure of Kiwi that led on to failures in communication, and in respect of a single *"odd"* and *"inappropriate"* comment to Mr H.

539. Ms Barnfather submitted that Dr Thampi has no previous fitness to practise history and a long and proven track record of dedicated care and service to patients, particularly within the NHS. She stated that there were no longer any clinical care allegations involving negligence in the delivery itself of any mother or baby. Ms Barnfather stated that it was of considerable importance to Dr Thampi that no harm came to either mother or baby as a result of the matters found proved. She submitted that the facts found proved in respect of Patient A were, to a large extent, overlapping and duplicitous as they arise out of the same core failing and could properly be described as isolated.

540. Ms Barnfather stated that, in terms of Dr Thampi's error in the assessment of the risk of the Kiwi failing, Patient A had an extremely rare condition, XXX, and the correspondence from the specialists did not clearly or explicitly identify the risks that did possibly materialise, and which may have led ultimately to the failure of the Kiwi. Ms Barnfather submitted that Dr Thampi's reliance on the input of the neuromuscular specialists and Fetal Medicine Team in the assessment of risk was not wholly unreasonable, which is not to say that Dr Thampi ought not to have done that which the Tribunal has indicated in raising the issue of the XXX as well as the BMI with Patient A to ensure she was aware of the potential complications.

541. Ms Barnfather stated that it was appropriate to recognise that the omissions in communication with Patient A largely flow from this miscalculation as to risk of failure and include the failure to facilitate at 18:26 a discussion regarding those risks, including a discussion of the possibility of forceps in more detail and a discussion in respect of a CS particularly in light of Patient A's concerns and hence a failure ultimately to obtain informed consent to the use of forceps. Ms Barnfather submitted that Dr Thampi's miscalculation was borne of mistaken judgement on behalf of an otherwise highly skilled and highly competent obstetrician. She submitted that this was not borne of arrogance as the GMC has sought to suggest but was a genuine miscalculation by Dr Thampi. Ms Barnfather submitted that Dr Thampi's failings were not in any way the result of a deliberate or reckless disregard for patient safety and fall considerably short of the more serious end of the spectrum of failings.

542. Ms Barnfather invited the Tribunal, when considering the substandard communication with Patient A, to bear in mind Ms L's omission to notify Dr Thampi of Patient A's concerns with regard to instrumental delivery in a timely way. Ms Barnfather stated that this could have led to, in all probability, a more detailed and calmer discussion and the hostile environment that subsequently developed could have been avoided. Ms Barnfather also referred to the Tribunal's comments as to the hostile environment.

543. Ms Barnfather stated that Dr Thampi takes full responsibility for the shortcomings in her calculation as to the risk of the Kiwi failing and, in her communication thereafter. She stated that Dr Thampi has always acknowledged her ultimate responsibility and has reflected deeply. Ms Barnfather stated that Dr Thampi has always acknowledged that whatever the Tribunal was to find as being the factual scenario, as the professional, she bore overall responsibility. She stated that Dr Thampi has displayed insight from the outset and that it was wrong to equate a failure to admit parts of the Allegation with lack of insight. Ms Barnfather stated that Dr Thampi was notified of the allegations in 2019 and has genuinely endeavoured to recall events accurately and reflect on the concerns raised. Further, Ms Barnfather stated that Dr Thampi has promptly recognised the issues in regard to her communication and undertaken significant and effective remediation that started in February 2020. Ms Barnfather submitted that the best illustration of the success of this lies in the absence of any repetition in the long years since the index events.

544. In terms of paragraph 6 of the Allegation, Ms Barnfather stated that Dr Thampi had been unable to recall events in sufficient detail due to the passage of time. She stated that, notwithstanding that Dr Thampi contested this allegation, Dr Thampi had again shown insight. Ms Barnfather stated that the finding by the Tribunal, alongside those in connection with Patient A, cause Dr Thampi very genuine distress. Ms Barnfather invited the Tribunal to

remind itself that the comment was not intended to be malevolent or rancorous and that Dr Thampi had endeavoured to help Mr H.

545. Ms Barnfather submitted that, in the Tribunal's assessment at this stage, it should consider the disadvantage to Dr Thampi in her ability to recall matters in the necessary detail due to the delay in Patient A making her complaint. Ms Barnfather also referred to the impact the delay in bringing these proceedings has had on Dr Thampi; the case was originally listed for September 2024 but was unable to proceed due to late and incomplete GMC disclosure. Ms Barnfather stated that Dr Thampi has suffered under the cloud of the GMC's protracted and, in part, flawed investigation. This included the GMC's baffling disregard to Dr Thampi's assertion in respect of her operative note and the GMC's unwillingness to call its own witness (Dr M) who gave important and favourable evidence to Dr Thampi.
Ms Barnfather submitted that Dr Thampi has done well to continue to participate openly and engage whilst labouring under a not unfounded sense that the GMC was not at all times acting as a fair and impartial prosecutor.

546. Ms Barnfather stated that these matters are old, include a number of mitigating factors within their factual matrix, are limited in seriousness, give no rise to concerns about patient safety and were concluded many years ago by the Trust with a first written warning. She submitted that it would be contrary to the public interest to now, coming up to nine and seven years on, in respect of an otherwise skilled and caring doctor whose remediation and insight is complete, to find that her fitness to practise is currently impaired.

547. Ms Barnfather submitted that the failings have been remedied and are not the result of attitudinal or other issues. She referred to the copious CPD and testimonials as well as the oral evidence heard. Ms Barnfather submitted that the Tribunal ought to conclude that remediation has taken place, is clearly embedded and that there is no risk of repetition. She submitted that Dr Thampi ought now to be returned to unrestricted practice and that it would be incompatible with the public interest and all that is known of Dr Thampi to consider any further action against her registration. Ms Barnfather submitted that the public interest includes facilitating an otherwise competent and caring practitioner's return to practise.

The Relevant Legal Principles

548. 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.

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

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

551. The LQC stated that, for the purpose of fitness to practise proceedings and with reference to the case of *Roylance v GMC [No 2]* [2000] 1 AC 311, 'misconduct' is:

> *"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."*

552. The LQC stated that, where the Tribunal finds misconduct, it should say whether it considers this to amount to a serious departure from the relevant guidance documents considered, including GMP. The LQC reminded the Tribunal that it should also consider the expert evidence from Dr S and Dr Q as to whether the actions fell below or seriously below the expected standard.

553. The LQC referred the Tribunal to the comments of Lord Justice Elias in *Remedy UK Ltd v GMC* [2010] EWHC 124, in that:

> *"Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession."*

Further, that the misconduct within the first limb "*must be in the exercise of the doctor's medical calling*". Under the second limb *"if is dishonourable or disgraceful or attracts some kind of opprobrium; that fact may be sufficient to bring the profession of medicine into disrepute. It matters not whether such conduct is directly related to the exercise of professional skills."*

554. The LQC stated that there is no legal definition of the word 'serious' and it should be given its ordinary meaning. She referred to the case of *Nandi v GMC* [2004] EWHC 2317 (Admin), in that it is *"conduct which would be regarded as deplorable by fellow practitioners"*.

555. In terms of impairment, the LQC referred to the approach set out by Dame Janet Smith in the Fifth Shipman Report, as referred to in the case of *CHRE v NMC & Grant* [2011] EWHC 927 (Admin), as follows:

> *"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *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 brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
> *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
> *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future."*

556. The LQC referred to the comments of Mr Justice Silber in *Cohen v GMC* [2008] EWCH 581 (Admin), that:

> *"64. There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practice has not been impaired. Indeed the Rules have been drafted on the basis that the once the Panel has found misconduct, it has to consider as a separate and discreet exercise whether the practitioner's fitness to practice has been impaired. Indeed section 35D (3) of the Act states that where the Panel finds that the practitioner's fitness to practice is not impaired, "they may nevertheless give him a warning regarding his future conduct or performance".*
>
> *65. Indeed I am in respectful disagreement with the decision of the Panel which apparently concluded that it was not relevant at stage 2 to take into account the fact that the errors of the appellant were "easily remediable". I concluded that they did not consider it relevant at stage because they did not mention it in their findings at stage 2 but they did mention it at stage 3. That fact was only considered as significant by the Panel at a later stage when it was dealing with sanctions. It must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and*

third that it is highly unlikely to be repeated. These are matters which the Panel should have considered at stage 2 but it apparently did not do so

66. The Panel must, for example, contrary to Miss Callaghan's submissions be entitled, if not obliged, to consider if the misconduct is easily remediable in the case of the doctor concerned. If this is not so, the Panel would be precluded from considering that it was not because the doctor has psychiatric or psychological problems which mean that he will be unable to remedy the misconduct and is likely to repeat it."

557. The LQC stated that the Tribunal must determine whether Dr Thampi has demonstrated insight. The Tribunal should be concerned with the future risk of repetition as distinguished from remorse for past conduct. She also stated that the relevant case authorities made it clear that, in coming to a conclusion on impairment, the purpose is not to punish practitioners but to protect the public against the acts and omissions of those who are not fit to practise.

558. The LQC also referred to the case of *Sawati v GMC* [2022] EWHC 283 (Admin), that registrants are *"properly and fairly entitled to defend themselves".* She stated that the Tribunal might find it helpful to think about how far lack of insight is evidenced by anything other than their rejected defence.

559. The LQC reminded the Tribunal that it must consider the overall risk to public protection and public interest by considering the impact of its findings on all three elements of the overarching objective. It should therefore ask itself whether a finding that a practitioner's fitness to practise is not impaired would undermine public confidence or undermine the maintenance of proper standards and conduct for members of the profession.

560. The LQC also reminded the Tribunal that it will assign the appropriate weight as it sees fit in respect of the testimonials received on behalf of Dr Thampi.

The Tribunal's Determination on Impairment

Misconduct

561. The Tribunal first considered whether Dr Thampi's actions amount to misconduct.

Paragraph 5(a)(i) of the Allegation

562. The Tribunal had regard to its comments within its Facts determination that, in respect of paragraph 5(a)(i) of the Allegation that no failure was alleged and, in any event, having considered its findings in respect of the entirety of paragraph 5, the Tribunal did not consider that there was any failing attributable to this. As such, Dr Thampi's actions as set out in this sub-paragraph of the Allegation were not something that amounted to misconduct.

Paragraphs of the Allegation regarding Patient A

563. The Tribunal considered the matters in respect of Patient A that were found proved, namely paragraphs 1(a)(i) - (ii), 1(b), 1(c)(i) - (ii), 1(d)(i) to (iii), 1(e)(ii)(1) and (3), 1(h)(i)(1) and (3) of the Allegation.

564. Whilst it had found that Dr Thampi had a confident belief that she could deliver Patient A's baby with a Kiwi vacuum, it also found that at 18:26 / 18:28 Patient A had not provided her consent to any subsequent use of forceps should the need arise and had communicated her opposition to the use of forceps to Dr Thampi, before the application of any instrument, although she had consented to the Kiwi vacuum. Against that backdrop, the Tribunal found that it was incumbent on Dr Thampi to inform Patient A that there was an increased chance of failure of operative vaginal delivery due to her BMI and XXX which she did not do. It has also found that there was a failure to consider and facilitate a discussion with Patient A about the alternative options for her delivery given the increased chance of failure of operative vaginal delivery with a vacuum device. Dr Thampi had not taken into account or acted on Patient A's views in not wanting an instrumental delivery. Further, the Tribunal had found a failure to offer Patient A a transfer to theatre for a CS in light of the Kiwi failing, and Patient A wanting a CS. The sum effect of this was that Patient A was forced down the path and thus pressurised into, having to reluctantly accept, the use of forceps as the only route to deliver her baby. It had regard to Patient A's evidence that she did eventually agree to the forceps as she felt she had no other choice. She stated that she thought her baby was going to die. The Tribunal had found that Dr Thampi had failed to obtain informed consent from Patient A for the forceps delivery. It had also found a failure on Dr Thampi's part to communicate appropriately, within the context of a fraught delivery and a hostile environment developing, which was additional to the failure to obtain informed consent.

565. The Tribunal reminded itself that it had found proved that Dr Thampi had stated to Patient A *"no you can't have a c-section"* or words to that effect, without a discussion about risks and benefits, and *"you need to let me do this as I don't know what is going to happen to your baby"* or words to that effect.

566. Hence, the Tribunal considered that the relevant issues to consider at this stage was a failure to obtain informed consent in addition to the failure to communicate appropriately.

567. The Tribunal also had regard to impact on Patient A from the conduct it had found proved. In her Trust interview of 1 November 2018, Patient A had stated that she could not believe it had been almost two years since the incident and she had stated that she had thought about it every day and that it *"still rules my life"*. Patient A had mentioned attending counselling as result of the delivery and not wanting to get into a relationship due to the fear of delivering another baby. She had also mentioned not pursuing a career as a midwife as she stated she could not face the environment on a labour ward due to the memories that it would trigger. Patient A had referred to her having taken 18 months to write a formal letter of complaint due to the mental trauma revisiting the delivery had caused her.

568. The Tribunal considered that the individual proven paragraphs of the Allegation, as above, were key ingredients to obtaining informed consent. It accepted that there were not any clinical negligence findings in the procedure carried out. The Tribunal also considered that, whilst the findings did relate to a single patient and an isolated incident, both the failure to obtain informed consent and the failure to communicate appropriately were serious matters, both individually and cumulatively.

569. The Tribunal had regard to the relevant guidance and determined that Dr Thampi's actions fell short of what would be proper in all the circumstances and were serious departures from the following:

570. From GMP:

> *"12. You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.*
> *…*
> *31. You must listen to patients, take account of their views, and respond honestly to their questions.*
>
> *32. You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.*
> *…*
> *49. You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:*

a. their condition, its likely progression and the options for treatment, including associated risks and uncertainties..."

571. From 'Consent: patients and doctors making decisions together' (2008):

*"2. Whatever the context in which medical decisions are made, you must work in partnership with your patients to ensure good care. In so doing, **you must** (emphasis added):*

a. listen to patients and respect their views about their health
b. discuss with patients what their diagnosis, prognosis, treatment and care involve
c. share with patients the information they want or need in order to make decisions
d. maximise patients' opportunities, and their ability, to make decisions for themselves
e. respect patients' decisions.

3. For a relationship between doctor and patient to be effective, it should be a partnership based on openness, trust and good communication. Each person has a role to play in making decisions about treatment or care.

5. If patients have capacity to make decisions for themselves, a basic model applies:

a. The doctor and patient make an assessment of the patient's condition, taking into account the patient's medical history, views, experience and knowledge.
b. The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.

.....

28. Clear, accurate information about the risks of any proposed investigation or treatment, presented in a way patients can understand, can help them make informed decisions. The amount of information about risk that you should share with patients

will depend on the individual patient and what they want or need to know. Your discussions with patients should focus on their individual situation and the risk to them.

29. In order to have effective discussions with patients about risk, you must identify the adverse outcomes that may result from the proposed options. This includes the potential outcome of taking no action. Risks can take a number of forms, but will usually be:

a. side effects

b. complications

c. failure of an intervention to achieve the desired aim.

Risks can vary from common but minor side effects, to rare but serious adverse outcomes possibly resulting in permanent disability or death.

30. In assessing the risk to an individual patient, you must consider the nature of the patient's condition, their general health and other circumstances. These are variable factors that may affect the likelihood of adverse outcomes occurring."

572. The Tribunal also considered the evidence from the experts Dr S and Dr Q as the standards expected of a competent consultant obstetrician. The Tribunal referred to its comments at the facts stage, including that:

"During [Dr Q's] *oral evidence to the Tribunal, the Tribunal asked* [Dr Q] *about the next steps in a situation where a natural delivery is no longer considered to be safe.* [Dr Q's] *evidence was that it would be good practice to go for an instrumental delivery and there is then a discussion with the patient. The Tribunal asked whether, at this point, a CS needs to be mentioned as well or whether the discussion of instrumental delivery would be sufficient.* [Dr Q] *stated that, if the CTG is suboptimal or there is the possibility of infection then you would want to expedite delivery of the baby.* [Dr Q] *stated that, in terms of informed consent, mention of all available options should be included but that she would usually refer to CS by saying "I don't think caesarean section is the best or fastest or safest way at the minute". It was put to* [Dr Q] *whether it was incumbent on the obstetrician to mention CS at this point.* [Dr Q] *stated that, in terms of the reasonably competent consultant, it depended. She referred to Patient A, with the* [XXX] *and the high BMI.* [Dr Q] *stated that she thought it was incumbent within that conversation to discuss all options and "the pros and cons". She stated that she thought, within what the RCOG suggests and what informed consent requires, that mentioning a brief discussion of why what may or may not be an option is incumbent."*

573. The Tribunal noted that Dr Q's opinion was that such failures fell seriously below the expected standard. In relation to the communication issues as per paragraphs 1(h)(i)(1) and (3), Dr S had stated that *"that if expressing clinical concern for fetal wellbeing to explain urgency/need for an intervention, then this is not below standard".* The Tribunal did not agree with this and, whilst appreciative of the fraught situation at the point the comments were made, it considered that such failure to communicate appropriately was serious and below the standard expected.

574. In light of its findings, and considerations as above, the departure from GMP and specifically the consent guidance, the Tribunal concluded that Dr Thampi's conduct fell short of the standards of conduct reasonably to be expected of a doctor so as to amount to misconduct which was serious.

Paragraph 6 of the Allegation

575. The Tribunal has found that Dr Thampi inappropriately told Mr H during an appraisal process, that he should not write there had not been anything specific learnt by him because the *"white people won't like it"*, or words to that effect. With reference to its comments at the Facts stage, whilst the Tribunal did think Dr Thampi was trying to help Mr H with his appraisal, it concluded that it was more likely than not that Dr Thampi made the comment alleged. The Tribunal noted that a comment about colleagues' likely response to Mr H's reflective learning, or lack of, being related to their colour, was inappropriate in the Tribunal's view.

576. The Tribunal considered whether this matter is such that Dr Thampi's conduct fell short of what would be proper in all the circumstances, so as to amount to misconduct.

577. The Tribunal had regard to Mr H's view of the comment, that it was *"odd"* and *"not relevant"* and had kind of shocked him at the time. The Tribunal found the comment itself to have been inappropriate in the professional context. The Tribunal did not find there to be any derogatory or hostile attitude attached to the making of this comment and it has found that she was, in essence, trying to assist Mr H. Whilst misguided and inappropriate, the Tribunal noted that this was an isolated comment and concluded that Dr Thampi's conduct in this regard did not fall so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

Impairment by reason of misconduct

578. The Tribunal, having found that the facts found proved in respect of Patient A as detailed above amounted to misconduct, went on to consider whether Dr Thampi's fitness to practise is currently impaired by reason of her misconduct.

579. The Tribunal had acknowledged that this was an isolated incident involving one patient, that there were no clinical negligence findings, and no previous fitness to practise history involving Dr Thampi. It had however considered that the communication failures and the failure to obtain informed consent were serious. Patient A had been in a vulnerable position, was physically in stirrups, with a working epidural and had undergone a procedure that she did not want. It took the view that psychological harm was caused to Patient A. In line with the requirements of GMP, there had been a serious departure on Dr Thampi's part from working in partnership with Patient A. Accordingly, it considered limbs (a), (b) and (c) of the test in the *Grant* case to be engaged.

580. The Tribunal considered whether Dr Thampi's fitness to practise is impaired today.

581. The Tribunal had found that Dr Thampi had a confident belief that she would be able to deliver with the Kiwi only and would be able to avoid the need for use of forceps. The Tribunal had accepted that this was the extent to which Dr Thampi had listened to Patient A's objections in respect of the forceps. Despite Dr Thampi's confidence in her being able to deliver the baby via the Kiwi, this had not been possible. The Tribunal had not found an entrenched attitude as suggested by the GMC, however remained mindful that she ought to have recognised the increased chance of the instrumental delivery with a Kiwi failing and ought to have informed Patient A about that in light of her views on the use of forceps. Dr Thampi ought to have had an earlier discussion with Patient A, before the start of any procedure to consider the alternative option of an elective CS. Further, Dr Thampi ought to have recognised and informed Patient A that any failure to deliver with a Kiwi (where the baby's head had descended low) was likely to lead to the stark choice of a higher-risk CS or a forceps delivery. It considered overall that these consenting and additional communication failures referred to above were remediable.

582. The Tribunal had regard to the Dr Thampi's statement dated 6 May 2025 and her oral evidence.

583. Within her statement, Dr Thampi stated:

"I appreciate the effects that a traumatic birth can have on a mother and baby. I am very sorry that Patient A had the birthing experience that she did. I have reflected on this deeply. It was undoubtedly a tense and difficult delivery and one that I will always remember. I found it truly upsetting to hear Patient A's evidence. I would never wish for any patient to feel the way Patient A feels about her birthing experience. I am very sorry."

584. Dr Thampi accepted that she did not communicate well with Patient A and she told the Tribunal that she has now changed her practice in that she now sits with patients to have an early discussion as to the risks and benefits and the options to ensure there is no repeat of her previous conduct.

585. Dr Thampi stated that she now ensures that she explicitly informs patients with a raised BMI that there is a higher risk of failure with operative vaginal birth. She stated that she clearly explains the rationale for conducting the procedure in theatre and involves the patient fully in deciding whether they are comfortable with attempting delivery in the room or prefer theatre-based care. Dr Thampi further stated that she was now much more conscious of creating space, even in time pressured scenarios, to ensure patients feel informed, respected and central to the decisions being made. Dr Thampi spoke of the changes that she has made- particularly of the importance of shared decision making and consent and ensuring patient autonomy. She stated that she now speaks with more clarity, listens more deeply, and does not compromise on patient care.

586. Additionally, Dr Thampi apologised for her actions to Patient A, to the GMC, and to the Tribunal for the instances where her actions have been found not to have met the expected standards.

587. The Tribunal considered an array of CPD certificates of courses Dr Thampi had completed ranging from 2020 - to date on the topics of communication skills within appraisal scenarios, for handovers, communication skills with patients, colleagues, antenatal counselling. It noted that there was a consent course completed on 2 May 2025 which supported Dr Thampi's acknowledgment and acceptance of the findings made by the Tribunal. The Tribunal also noted Dr Thampi's evidence in having sought out a discussion with Mr Y, Consultant in Gynaecology & Fertility, who stated that she had spoken openly about the circumstances leading to her exclusion from her NHS post and her duty of candour during the appraisal discussion was event. It also noted Dr Thampi discussing the allegations about her clinical practice with Sir Z, Professor Emeritus of Obstetrics & Gynaecology, who advised her on a remediation plan.

588. The Tribunal also noted a vast array of positive testimonials, appraisal documentation including patient feedback which was positive on issues such as 'listening', 'explaining your condition and treatment', 'involving you in decisions about your treatment', 'commitment to care and wellbeing of patients' and 'communication with patients and relatives' and positive patient accolades. It also considered the oral evidence of Dr Thampi's colleagues who had been told of the Allegation/findings in respect of failures to obtain consent and failures in communication. They all consistently considered Dr Thampi to be a safe, compassionate and skilled clinician with excellent communication skills.

589. The Tribunal was of the view that Dr Thampi did have insight into her actions and the failures which led to informed consent not being obtained from Patient A and the failures in appropriate communication. It also considered that Dr Thampi had undertaken sufficient remediation. In light of Dr Thampi's reflections on the findings, it determined that there was a low risk of repetition.

590. The Tribunal considered whether the seriousness of Dr Thampi's actions and failures required a finding of current impairment of her fitness to practise in the wider public interest. It had regard to the overarching objective.

591. The Tribunal had regard to all the circumstances surrounding Patient A, as referred to above, and the impact of the lack of informed consent and inappropriate communication upon Patient A. The Tribunal did appreciate that the misconduct related to one patient and was an isolated incident that Dr Thampi had accepted responsibility for and that it was unlikely to be repeated. However, there had been a serious departure from the relevant sections of GMP and the GMC's 2008 consent guidance as referred to above and it had caused a patient in a vulnerable position to undergo a procedure that she did not want.

592. The Tribunal concluded that a finding of no impairment of Dr Thampi's fitness to practise would undermine the public interest. It was conscious that patients place trust in doctors to give them the information they need and to listen to them. The failure to obtain informed consent was serious and required a finding of impairment to mark the misconduct and necessary to maintain public confidence in the profession, and to promote and maintain proper professional standards and conduct for members of the profession.

593. The Tribunal did not consider that there was a risk to patient safety given its findings as to insight and remediation and that a finding of impairment was not required to protect, promote and maintain the health, safety and wellbeing of the public. Its finding was in respect of limbs (b) and (c) of the overarching objective.

594. The Tribunal has therefore determined that Dr Thampi's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 12/06/2025

595. Having determined that Dr Thampi's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

596. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

597. The Tribunal received further evidence on behalf of Dr Thampi in respect of her current job role and the effect of any suspension of her registration upon it. The Tribunal was provided with a copy of Dr Thampi's employment contract dated 5 December 2022, including the following paragraphs:

> *"12. Registration Requirements - It is a condition of your employment that you are, and remain a fully registered Medical Practitioner and are included on the Specialist Register held by the General Medical Council (GMC)] , and continue to hold a licence to practise.*
> *...*
> *39.6 Employment may be terminated without notice or payment in lieu of notice in cases of gross misconduct, gross negligence, or where your registration as a medical doctor (and/or your registration as a dental doctor) has been removed or has lapsed without good reason."*

598. Dr Thampi gave further oral evidence at the hearing on 9 May 2025. She stated that she had made enquiries with the HR department at East Surrey Hospital and had been provided with the above-mentioned copy of her contract. Dr Thampi stated that she understood that, should a suspension be imposed, her current contract would be terminated immediately. She stated that it would affect or interrupt the continuity of care for her patients and add to the responsibilities of her colleagues. Dr Thampi was asked about her future prospects if she lost her current post due to a suspension. She stated that, given the competitive and cautious nature of the current medical job market, a suspension impairs the likelihood of her securing future roles. Dr Thampi stated that it would probably even

ultimately result in long term or even permanent exclusion from clinical practice in that returning to meaningful clinical practice would be very difficult. She stated that it would also severely restrict her ability to develop professionally and contribute to patient care. Dr Thampi referred to the difficulty she had in finding her current post and that she had been unable to find a permanent post despite sending thousands of applications. She stated that if she was not suspended then her employers were willing to give her a permanent role. Dr Thampi also referred to the personal impact that losing this job would have.

599. Two emails dated 9 May 2025 were provided from Mr W. He stated that, if a suspension was imposed on Dr Thampi's registration, then her employment would be terminated at East Surrey Hospital with immediate effect. Mr W stated that Dr Thampi's locum consultant contract would be terminated with immediate effect as doctors are employed subject to "*fitness to practise issued by the GMC"*. Mr W asked that their concerns be shared with the Tribunal as to the risks that a sudden suspension would cause to their patients *"pertaining to their continuity of care under the care of Miss Thampi let alone the consequences to Miss Thampi personally"*.

Submissions

Submissions on behalf of the GMC

600. Mr Jackson stated that the decision as to the appropriate sanction to impose in this case is a matter solely for the Tribunal exercising its own independent judgement. Mr Jackson took the Tribunal through the various paragraphs of the Sanctions Guidance (5 February 2024) ('the SG'). He also had regard to various case law, including *Bolton v Law Society* [1994] 1 W.L.R. 512, in that sanctions are not intended to be a punishment but they can sometimes have that effect.

601. Mr Jackson stated that the focus of his submissions was with reference to the seriousness of the doctor's failures. Further, that, when the Tribunal is considering the issue of sanction, the key issues to have in mind are:

- The seriousness of Dr Thampi's failures. He stated that no patient should be pressured into undergoing such a procedure without having provided fully informed consent;
- The vulnerability of and the impact on Patient A;
- The seriousness of the departure from GMP;
- The public interest considerations, having regard to the overarching objective. There is a serious issue of public confidence in the context of women coming into hospital

for the delivery of their babies, and to know that they will always be entitled to make a fully informed choice, and not be pressured to undergo any procedure that they do not wish to have, despite the dangers of not doing so.

602. Mr Jackson referred to paragraph 12 of the SG, in that it underlines the importance of GMP to a doctor's professional practice. It states that doctors *"are expected to be familiar with, and follow, the guidance"* and be *"prepared to explain and justify their decisions"*. It also states that *"a serious departure from the professional standards may mean that a doctor poses a current and ongoing risk to public protection and that we need to restrict or remove their registration"*.

603. Mr Jackson stated that the GMC respectfully underlined the Tribunal's primary duty by reference to the overarching objective. He stated that the GMC relies on all of the Tribunal's findings. Mr Jackson submitted that, in all the circumstances, the only appropriate sanction should be one of '*standard*' suspension.

Submissions on behalf of Dr Thampi

604. Ms Barnfather submitted that no further action is required and that the finding of impairment of Dr Thampi's fitness to practise is sufficient to meet the public interest.

605. Ms Barnfather stated that the Tribunal had recognised that Dr Thampi does not have an entrenched attitude, is insightful and has remediated the concerns. It has also noted that Dr Thampi is considered to be a safe, compassionate and skilled clinician with excellent communication skills. Ms Barnfather stated that the Tribunal's finding on impairment was not made on the basis of public protection and was made in order *"to maintain public confidence in the profession and to promote and maintain proper professional standards and conduct for members of the profession".* Ms Barnfather submitted that the finding of impairment had achieved that end and no further action against Dr Thampi's registration was necessary or would be proportionate. She submitted that suspension would be grossly disproportionate, serve only a punitive purpose, and deprive the public and patients from the care of a skilled and compassionate doctor.

606. Ms Barnfather stated that there were a number of factors to be considered including Dr Thampi's long and otherwise unblemished service, and that the facts found proved concern a single patient with no deliberate or reckless disregard for patient safety. She stated that Dr Thampi has shown genuine and sincere regret for the impact on Patient A as well as proactive and insightful remediation. Ms Barnfather also referred to Dr Thampi's exemplary

cooperation with the regulatory process, her good character and positive testimonials, and that she is a hard-working and caring consultant who is a credit to the profession.

607. Ms Barnfather submitted that any broader public interest concerns have been satisfied by what has been the protracted and particularly rigorous regulatory process concluding in the Tribunal's finding of impairment.

608. In addressing the GMC's submissions, Ms Barnfather submitted that Patient A was not a vulnerable *patient* albeit she was in a vulnerable *position* as is inherent with labouring mothers. She submitted that it was wrong to suggest that the Tribunal approach an assessment of the public interest, and the necessity for sanction, by reference to the alleged impact on Patient A. Ms Barnfather submitted that a patient ought only to be described as vulnerable when there are identifiable reasons which in turn raise particular additional obligations upon caregivers. She submitted that the vulnerability of Patient A is not an aggravating feature as set out in the SG.

609. Ms Barnfather referred to the Tribunal's comments as to the impact upon Patient A. She referred to the case of *R (El-Baroudy) v GMC* [2013] EWHC 2894 (Admin) where the court held that, in the absence of causation being expressly particularised, evidence on those issues should not have been led and the Tribunal should not, in any way, have based a judgement as to whether the registrant's fitness to practise was impaired or as to sanction on any question of causation. Ms Barnfather stated that it was not alleged against Dr Thampi that her conduct caused *"psychological harm"* and no evidence was in fact led as to whether there was any such harm or whether any harm had been a direct result of Dr Thampi's failures in consent and communication. Ms Barnfather stated that Dr Thampi has not been permitted to address this accusation. She strongly urged the Tribunal to refrain from placing weight on any consideration of *"psychological harm"* in its assessment as to the public interest and the necessity for any sanction. Mr Jackson confirmed that he agreed with Ms Barnfather's submissions as to *El-Baroudy*.

610. Ms Barnfather submitted that the Tribunal should be extremely hesitant to determine that any of the matters raised on behalf of the GMC amount to aggravating features. She submitted that there was an absence of aggravating features in this case and stated that there were a number of mitigating features including evidence that Dr Thampi understands the problems, she has taken steps to remediate and apologised, is of good character, there has been a lapse of time, and evidence of adherence to important principles of good practice.

611. Ms Barnfather submitted that conditions would be disproportionate and inappropriate. She stated that there were no deficiencies which required remediation and no public safety concerns which needed to be guarded against.

612. Ms Barnfather submitted that suspension would be grossly disproportionate. She referred to paragraph 92 of the SG in that suspension *"will be appropriate for conduct that is serious but falls short of being incompatible with continued registration"*. Ms Barnfather submitted that the conduct in this case falls far short of being incompatible with continued registration.

613. Ms Barnfather stated that suspension carries very significant consequences including financial but more lasting is the professional damage. Ms Barnfather stated that a suspension of any period would likely mean the end of Dr Thampi's career. She submitted that it was a gross overreaction, and an intelligent and well-informed member of the public would be appalled that such a doctor was removed from practice as a result of these matters at all, let alone after nearly nine years of further faultless and dedicated service to patients. Ms Barnfather submitted that the impact of suspension would be to multiply and exacerbate yet further the devastating consequences to Dr Thampi both personally and professionally and amounted to the sacrificing of an otherwise competent and skilled member of the profession on the altar of public confidence.

614. Ms Barnfather submitted that it would be disproportionate, unnecessary and frankly cruel to impose any sanction on Dr Thampi's registration to send a wider signal to the profession and the public about what standards are expected.

615. With reference to Dr Thampi's employment contract, Ms Barnfather stated that it was well recognised that contracts are deemed to have been breached and terminated as a result of any suspension imposed. She submitted that this aspect of the submissions made on Dr Thampi's behalf ought not to be considered determinative of the issue of proportionality. Ms Barnfather stated that it merely underscored yet further why a suspension is disproportionate in relation to the Tribunal's findings. Ms Barnfather submitted that, while the underlying facts are sufficiently serious to merit the opprobrium of the profession and the determination of current impairment, they are not sufficiently egregious to require further action in light of all the other factors referred to. She stated that, in light of the GMC's reference to *Bolton*, the correct interpretation was that the Tribunal weigh the public interest against the interests of Dr Thampi. Ms Barnfather reiterated that those interests align and are in favour of Dr Thampi being able to continue to provide care to her patients unrestricted and uninterrupted.

The Relevant Legal Principles

616. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own judgement.

617. The LQC reminded the Tribunal that it should assess seriousness of the misconduct on a case-by-case basis and appropriately evaluate it against any relevant aggravating and mitigating factors before a sanction is imposed. It must consider the least restrictive sanction first and then, if necessary, consider the other sanctions, taking into account the evidence and submissions that have been heard.

618. In reaching its decision, the Tribunal will take account of the SG and of the overarching objective. The Tribunal was clear that it must apply the principle of proportionality; balancing the doctor's interests with the public interest. Any sanction must be proportionate to the gravity of misconduct and impairment found. The Tribunal has borne in mind that the purpose of the sanctions is not to be punitive, but to protect patients and the wider public interest, although they may have a punitive effect.

619. The LQC referred to the case of *Giele v GMC* (2005) EWHC 2143 (Admin) in that there is a public interest in returning able clinicians to registered practice. The LQC outlined the case of *Bakare v GMC* [2021] EWHC 3278 (Admin), where the principle referred to in *Bolton* was that personal mitigation should be given limited weight as the reputation of the profession is more important than the fortunes of an individual member.

620. Given the reference made to *El-Baroudy*, the LQC stated that Dr Thampi is obliged to meet the allegations levelled against her and no other ones. Further, that Tribunals could only make factual findings against a doctor which are based on an interpretation of events that have previously been disclosed to them and in respect of which they have been provided with adequate opportunity to investigate, call evidence and make submissions.

621. The LQC stated that, whilst the Tribunal has had regard to the impact of the events it has found proved in terms of Patient A and taken a view that there was psychological harm, it should remain mindful that there had not been any allegations particularised or found in respect of psychological harm being caused as a result of the failings found. The Tribunal should be cautious and not place weight on this view when considering the issue of any sanction as that would lead the tribunal into procedural irregularity and be unjust to the overall fairness of the case. This issue was clarified in the case of *Chauhan v GMC* [2010] EWHC 2093 (Admin) and also confirmed in the case of *El-Baroudy* - i.e. that pursuing allegations of any causation based on misconduct should have that clearly stated in the

charges and, in the absence of that, evidence directed to those issues should not be led and the Tribunal should not base its judgment on it.

The Tribunal's Determination on Sanction

Aggravating and mitigating factors

622. The Tribunal was unable to identify any aggravating factors in this case.

623. In respect of the point raised by Mr Jackson and Ms Barnfather as to vulnerability, the Tribunal appreciated that there is an aggravating factor listed within the SG at paragraph 55(d)(i) (and with further guidance at paragraphs 142-150) in respect of abuse of professional position particularly where this involves vulnerable patients. The Tribunal referred to its determination on Impairment that Patient A was in a vulnerable *position*. It was clear that this was in relation to Patient A being in stirrups and having had an epidural; it was not stating that she was a vulnerable patient. The Tribunal did not consider that vulnerability was a relevant aggravating feature in this case in the terms that are set out within the SG.

624. The Tribunal also understood Mr Jackson's submission that an aggravating factor would be Dr Thampi not offering a CS to Patient A after the Kiwi had failed. The Tribunal determined that this point was not an aggravating factor and considered that this would have effectively been 'double counting' of this aspect of the Allegation that was found proved.

625. The Tribunal identified the following mitigating factors in this case:

- Expressions of regret and apology: The Tribunal was of the view that Dr Thampi has taken steps to improve *"by learning from mistakes and preventing similar events recurring"* as well as being open and honest and apologising;
- Insight and remediation: The Tribunal has found Dr Thampi to have insight into the concerns. She has taken timely steps to remediate, has completed learning and courses, sought advice from two Professors since the concerns arose, and has given the Tribunal clear evidence about how she has changed her practice;
- Lapse of time: It has been nearly nine years since the index events, which relate to a single patient, and there has been no repetition or further concerns raised about Dr Thampi's practice. She has continued to work since the concerns arose and received positive feedback and testimonials.

No action

626. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Thampi's case, the Tribunal first considered whether to conclude the case by taking no action.

627. The Tribunal reminded itself of the duties owed and failures that it had found on part of Dr Thampi and why it had considered these failures to be serious requiring impairment on the grounds of maintaining public confidence and promoting proper professional standards for the medical profession. It had found that Dr Thampi had a confident belief that she could deliver Patient A's baby with a Kiwi vacuum. It also found that, at 18:26 / 18:28, Patient A had not provided her consent to any subsequent use of forceps should the need arise and had communicated her opposition to the use of forceps to Dr Thampi, before the application of any instrument, although she had consented to the Kiwi. Against that backdrop, the Tribunal found that it was incumbent on Dr Thampi to inform Patient A that there was an increased chance of failure of operative vaginal delivery due to her BMI and XXX which she did not do. It also found that there was a failure to consider and facilitate a discussion with Patient A about the alternative options for her delivery given the increased chance of failure of operative vaginal delivery with a vacuum device. Dr Thampi had not taken into account or acted on Patient A's views in not wanting an instrumental delivery. Further, the Tribunal had found a failure to offer Patient A, a transfer to theatre for a CS in light of the Kiwi failing, and Patient A wanting a CS. The sum effect of this was that Patient A was forced down the path and thus pressurised into, and having to reluctantly accept, the use of forceps as the only route to deliver her baby. Overall, the Tribunal had found that Dr Thampi had failed to obtain informed consent from Patient A for the forceps delivery.

628. The Tribunal reminded itself that it had found proved that Dr Thampi had stated to Patient A *"no you can't have a c-section"* or words to that effect, without a discussion about risks and benefits, and *"you need to let me do this as I don't know what is going to happen to your baby"* or words to that effect. It had found a failure on Dr Thampi's part to communicate appropriately, within the context of a fraught delivery and a hostile environment developing, which was additional to the failure to obtain informed consent.

629. The Tribunal had found these failures as serious departures from GMP and the consent guidance. In respect of the standards doctors are expected to meet, the Tribunal appreciated paragraph 11 of the SG. This paragraph referred to other professional guidance that is provided on ethical principles such as consent. The Tribunal had particular regard to paragraphs 12, 31, 32 and 49 of GMP and paragraphs 2 -5, 28-30 of the Consent guidance 2008, as quoted in its determination on Impairment. The Tribunal had taken the view that, in

light of the seriousness of these departures, Dr Thampi was impaired in respect of the wider public interest.

630. Further, the Tribunal referred to its comments in its determination on Impairment including that Dr Thampi's actions had caused a patient in a vulnerable position to undergo a procedure that she did not want. The Tribunal reiterated its comments above that it did not categorise Patient A as a vulnerable *patient*, the issue was that she was in a vulnerable *position* in so far as she was physically in stirrups and subject to an epidural. This was when the Kiwi had failed and when, in accordance with its earlier finding, Dr Thampi had failed to offer Patient A, a transfer to theatre and the option of a CS, which was part and parcel of the failure to obtain informed consent.

631. The Tribunal bore in mind the reference in SG that a departure from GMP did not automatically mean that action would be taken. It considered that GMP set out the principles, values and standards of care and professional behaviour of all doctors registered with the GMC, including working in partnership with patients.

632. The Tribunal had keen regard to the principle of proportionality; balancing Dr Thampi's interests with the public interest. The Tribunal appreciated that Dr Thampi is otherwise a good and competent clinician and various testimonials have been provided to demonstrate this. The Tribunal referred to the mitigating factors it has identified above, and the lack of any aggravating ones. It has evaluated the seriousness of the misconduct found in respect of its findings.

633. For the avoidance of doubt, in considering its decision on sanction, the Tribunal clarified that it did not place weight on the view as to psychological harm in respect of Patient A, as referred to above in terms of *El-Baroudy.*

634. In light of the duties and failures established, and the departures from GMP and the Consent guidance 2008, the Tribunal did not consider there to be exceptional circumstances in this case that justified it taking no action to protect the public interest. The Tribunal determined that, in view of its findings on impairment, it would be neither sufficient, proportionate nor in the public interest to conclude this case by taking no action. The Tribunal considered that sufficient action was required in light of the seriousness of its findings. The Tribunal was of the view that there are no exceptional circumstances in this case to justify the Tribunal taking no action and did not consider that this would send a sufficient signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor.

Conditions

635. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Thampi's registration. It has borne in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

636. The Tribunal noted that, with reference to paragraph 81 of the SG, conditions might be most appropriate in cases involving a doctor's health, where there is a lack of necessary knowledge of English or involving issues around the doctor's performance. The Tribunal was of the view that these factors were not relevant in this case.

637. With reference to paragraph 82 of the SG, the Tribunal has found that Dr Thampi has insight into her actions and would be satisfied that she would comply with any conditions imposed. However, it appreciated that Dr Thampi has changed her practice and has continued to work without any further concern.

638. In all the circumstances, the Tribunal determined that, in view of the seriousness of its findings on impairment on public interest grounds, it would not be sufficient or appropriate to direct the imposition of conditions on Dr Thampi's registration.

639. In balancing Dr Thampi's interests with the public interest, it took into account that she has worked under interim conditions for a period of time. The Tribunal also appreciated the impact that anything above the imposition of conditions on Dr Thampi's GMC registration was likely to have on her personally and professionally in terms of the termination of her current employment contract. It did not wish this to be the case but understood the contract terms were such that this may happen if a period of suspension was imposed. The Tribunal has also heard of the likely longer-term implications on Dr Thampi's career prospects. It noted that Dr Thampi is caring for patients at present and it considered there was a public interest in retaining and returning able clinicians to registered practice. Whilst these were matters of significant consideration for the Tribunal, it considered that the countervailing factor (which was maintaining public confidence and upholding proper professional standards and conduct for members of the medical profession) was significant and action was needed to mark the serious failings in respect of informed consent and appropriate communication.

Suspension

640. The Tribunal then went on to consider whether suspending Dr Thampi's registration would be appropriate and proportionate.

641. The Tribunal considered the paragraphs of the SG in relation to suspension, including paragraph 91:

> *"Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention."*

642. The Tribunal determined that the following sections of paragraph 97 of the SG applied in this case:

> *"97. Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate:*
>
> > *a. A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*
> > *...*
> > *f. No evidence of repetition of similar behaviour since incident.*
> >
> > *g. The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour."*

643. The Tribunal had regard to the duties owed and failures found. It noted that suspension can be used to send out a signal to the doctor, the profession and the public about what is regarded as behaviour unbefitting a registered doctor. While considering this, the Tribunal recognised that there had been no repetition of similar behaviour since the incident in 2016, which was nearly nine years ago. It was also satisfied that Dr Thampi had insight and did not pose a significant risk of repeating behaviour. In taking this view, the Tribunal also considered that the failings were such that, whilst serious, the conduct fell short of being fundamentally incompatible with continued registration.

644. Furthermore, the Tribunal had regard to paragraphs of the SG 129 to 132 of the SG, under the heading of "*Failing to provide an acceptable level of treatment or care*", which had

been asserted by the GMC as applicable. The Tribunal considered that it had not found a deliberate or reckless disregard for patient safety on Dr Thampi's behalf. It was of the view that Dr Thampi has shown insight and remediated and did not consider these paragraphs to be applicable.

645. The Tribunal considered the relevant paragraphs of the SG in respect of erasure but did not consider any of those to be appliable to this case. It had not found an entrenched attitude or that the conduct was difficult to remediate. The Tribunal had found in fact that sufficient remediation had taken place. It continued to bear in mind that, whilst the conduct involved one patient a significant number of years ago, the failure to obtain informed consent, Patient A being pressurised into agreeing to a forceps delivery, and inappropriate communication were serious and action was needed to mark the seriousness to uphold the wider public interest.

646. In all the circumstances, and having balanced Dr Thampi's interests with the public interest, the Tribunal determined that suspension of Dr Thampi's registration would be appropriate and proportionate in this case. It considered that suspension would properly mark the seriousness of her misconduct and send a necessary signal to Dr Thampi, the medical profession, and the public, that such behaviour is unacceptable. The Tribunal also determined that suspension would be sufficient to uphold limbs *b* and *c* of the overarching objective, namely, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of the profession.

Length of suspension

647. The Tribunal had regard to paragraphs 99 to 102 of the SG, including paragraph 100 which sets out the factors which are relevant when determining the length of suspension. They are:

> *"a. the risk to patient safety/public protection*
> *b. the seriousness of the findings and any mitigating or aggravating factors...*
> *c. ensuring the doctor has adequate time to remediate."*

648. The Tribunal was also mindful that, as at paragraph 101 of the SG, its *"primary consideration should be public protection and the seriousness of the findings"*.

649. In light of its decision that suspension was necessary in this case, the Tribunal considered the length of suspension needed given the seriousness it had found. It bore in

mind its earlier conclusions having balanced the mitigating and (lack of) aggravating factors. The Tribunal was also mindful that Dr Thampi had remediated, had shown insight including apologising to Patient A, and the risk of repetition was low. It has also not found impairment on the ground of public/patient safety and wellbeing and has borne in mind its earlier consideration of balancing Dr Thampi's interests against the public interest.

650. In light of all of these factors, the Tribunal considered that a short period of suspension was sufficient, albeit necessary to mark the seriousness of the departures from GMP and the Consent guidance that it had found. The Tribunal considered that this adequately reflected the balancing exercise that it has undertaken.

651. The Tribunal determined that a period of three weeks of suspension of Dr Thampi's registration was appropriate and proportionate in light of all of the circumstances of this case.

Whether to direct a review hearing

652. The Tribunal considered whether to direct a review hearing in Dr Thampi's case. It had regard to the relevant paragraphs of the SG, including the following:

> *"163. It is important that no doctor is allowed to resume unrestricted practice following a period of conditional registration or suspension unless the tribunal considers that they are safe to do so.*
>
> *164. In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. However, in most cases where a period of suspension is imposed, and in all cases where conditions have been imposed, the tribunal will need to be reassured that the doctor is fit to resume practice – either unrestricted or with conditions or further conditions. A review hearing is therefore likely to be necessary, so that the tribunal can consider whether the doctor has shown all of the following (by producing objective evidence):*
>
> *a. they fully appreciate the gravity of the offence*
> *b. they have not reoffended*
> *c. they have maintained their skills and knowledge*
> *d. patients will not be placed at risk by resumption of practice or by the imposition of conditional registration."*

653. The Tribunal reminded itself that it had not found limb (a) of the overarching objective to be engaged in respect of patient safety. It has found that Dr Thampi has insight, has demonstrated sufficient remediation, and the risk of repetition is low.

654. The Tribunal, with reference to paragraph 164 of the SG, determined that Dr Thampi appreciated the gravity of her misconduct and there have been no further concerns raised since the index incident. There was clear evidence before the Tribunal that Dr Thampi has maintained her skills and knowledge and she has continued to practise effectively (albeit under interim conditions). It considered that patients would not be placed at risk by Dr Thampi's resumption of practice following a short period of suspension of her registration.

655. In all the circumstances, the Tribunal determined not to direct a review in Dr Thampi's case. The Tribunal determined that the public interest is served by the period of suspension and, given the comprehensive evidence of insight and remediation shown, it was not necessary to direct a review hearing in this case.

Determination on Immediate Order - 12/06/2025

656. Having determined to suspend Dr Thampi's registration for 3 weeks, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Thampi's registration should be subject to an immediate order.

Submissions

On behalf of the GMC

657. Mr Jackson submitted that the GMC had no submissions in terms of an immediate order. He confirmed that the immediate order of conditions would need to be revoked.

On behalf of Dr Thampi

658. Ms Barnfarther submitted that no immediate order is necessary. She reminded the Tribunal that it had found there was no issue of public protection and submitted that there was no risk either to the public interest. She added that the reputational aspects of this case fall far short of rendering an immediate order necessary.

659. Ms Barnfather submitted that Dr Thampi was considered by those in a position of knowledge to be a safe and compassionate and skilled doctor and she has continued to treat

patients without incident since these events that occurred many years ago. Ms Barnfather submitted that it would not only be grossly disproportionate to impose an immediate order now, it would furthermore be '*perverse*' as it runs contrary to the SG, and contrary to the principles of proportionality. She referred the Tribunal to paragraphs 172 and 172 of the SG.

660. Ms Barnfather highlighted that Dr Thampi has had less than a week's notification of this hearing's resume date and has not been able to make arrangements on the various appointments and professional obligations she has upcoming. Ms Barnfather set out that imposing an immediate order would mean that patient care would be significantly compromised, but more primarily submitted that, in any event, such an order was not necessary and is disproportionate.

The Tribunal's Determination

661. The Tribunal had careful regard to the submissions made by the parties and to the guidance in the SG including paragraphs 172, 173 and 178:

> '*172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'*

662. The Tribunal bore in mind that there are no patient safety concerns in this case and that the risk of repetition was low. The Tribunal noted that there have been no issues relating to Dr Thampi's conduct in her practise since the events set out in the Allegation.

663. The Tribunal was also mindful of the public interest but was of the view that as there were no patient safety issues, the public interest could be met by the imposition of the substantive suspension.

664. Therefore, acknowledging the seriousness of the case, but noting the low risk of repetition, the Tribunal determined that an immediate order was not necessary in this case.

665. This means that Dr Thampi's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless she lodges an appeal. If Dr Thampi does lodge an appeal, she will remain free to practise unrestricted until the outcome of any appeal is known.

666. The interim order is hereby revoked.

667. That concludes this case.

ANNEX A - 26/09/2024

Application to amend the Allegation

668. On 13 September 2024 Mr Jackson, KC on behalf of the GMC, made an application for amendment of the Allegation under Rules 17(2)(c) and 17(6) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), which read as follows:

> *"17(2)(c) the Chair of the Medical Practitioners Tribunal shall enquire whether the representative for the GMC wishes to amend the particulars of the allegation, and if that representative so wishes, the Medical Practitioners Tribunal shall consider whether to amend the particulars under paragraph (6).*
> *…*
> *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."*

Submissions

Submissions on behalf of the GMC

669. Mr Jackson stated that the GMC was withdrawing paragraphs 1(f) and 1(g) of the Allegation. Further, following a query from the Tribunal in respect of paragraph 4 of the Allegation and what was the alleged 'mischief', Mr Jackson submitted that it was inappropriate behaviour which had been implied but, nevertheless, he sought the insertion of the word *"inappropriately"*. The proposed amendment would read as follows:

> *"You inappropriately introduced Midwife G on the labour ward a few weeks after Patient B had delivered her baby as "the midwife who had Datix me by saying the baby was battered, bruised and injured after my delivery", or words to that effect."*

Submissions on behalf of Dr Thampi

670. Ms Barnfather, Counsel, stated that there was no objection on behalf of Dr Thampi to the withdrawal of paragraphs 1(f) and 1(g) of the Allegation. She submitted that Dr Thampi's case had always been that the answers to these paragraphs of the Allegation were within the

medical records and so it was right that these paragraphs were deleted. Ms Barnfather stated that the withdrawal created no prejudice to Dr Thampi.

671. In terms of the amendment to paragraph 4 of the Allegation, Ms Barnfather stated that this did not cause prejudice to Dr Thampi as they had always taken the meaning of this paragraph to be that the GMC was saying it was inappropriate. Ms Barnfather stated that they were not sure why, specifically, it was said to be inappropriate but that the insertion of the word *"inappropriately"* was not objected to.

Relevant Legal Principles

672. In terms of legal advice, the Legally Qualified Chair (LQC) referred to Rule 17(2)(c) and 17(6) of the Rules and stated that this would encompass both amendment and withdrawal. The LQC stated that application could be allowed if it could be done without injustice to either party. She also referred to the considerations set out in the case of *Ahmedsowida v GMC* [2021] EWHC 3466 (Admin), to consider whether the amendments can be made without injustice and without being procedurally unfair. The LQC stated that the Tribunal should also consider how far any amendments would be compatible with a proper consideration of the issues and that the registrant would be capable of fully understanding the case that is being put and be able to respond accordingly, or how far the proposed amendments would create a new case requiring investigation. The LQC stated that there was a high public interest in the proper administration of professional disciplinary hearings.

Tribunal's Decision

673. The Tribunal had regard to the submissions from Mr Jackson and Ms Barnfather, Rule 17(6) of the Rules, and the documentation before it.

674. In terms of paragraphs 1(f) and 1(g), the Tribunal noted that the two expert witnesses did not agree with these parts of the Allegation in the light of Patient A having declined to see Dr Thampi, which was evidenced within the medical records.

675. In terms of paragraph 4, the Tribunal had raised this issue with the GMC to enquire as what the alleged 'mischief' was. The Tribunal noted that Mr Jackson clarified that it was alleged that the behaviour at paragraph 4 was inappropriate and so the application to amend was made. The Tribunal determined that the insertion of the additional word to paragraph 4 to clarify the 'mischief' alleged was needed for its proper consideration of the matter.

676. In all the circumstances, the Tribunal determined to grant the GMC's application for amendment of the Allegation as set out above. It concluded that the amendments could be made without injustice.

ANNEX B - 26/09/2024

Second application to amend the Allegation

677. On 17 September 2024 Mr Jackson, KC on behalf of the GMC, made a further application for amendment of the Allegation under Rule 17(6) of the Rules. This Rule is set out in full in Annex A.

678. The proposed amendments to the Allegation were for withdrawal of paragraphs 3(a)(i)(1) to (3), 3(iv), and 3(e)(ii) to (iv). Mr Jackson also asked for the removal of the words *"receive and"* from paragraph 5(a)(i) as follows:

> *5. Between 11 and 12 August 2018 you were the on-call consultant and you were telephoned for advice and assistance by Dr D, during the labour and/or delivery of Patient C's baby, and you:*
>
> *a. declined to:*
>
> *i. ~~receive and~~ review the cardiotocography ('CTG') that Dr D had expressed concerns about during a call she made to you at around 2:05am ('Call 1'), by text message when Dr D offered to send an anonymised picture of it to you.*

679. The Tribunal also proposed that the word *"you"* should be inserted at paragraph 3(d) of the Allegation so that it would read:

> *3. On or around* [XXX] *June 2018, you were involved in delivering Patient B of her baby and:*
>
> *d. <u>you</u> inappropriately disregarded Midwife G's repeated reminders about the number of pulls you had carried out, and her request for you to cease the instrumental delivery.*

Submissions

Submissions on behalf of the GMC

680. Mr Jackson stated that the GMC had an ongoing duty to continue to review its allegations and to look at what disclosure was made available to the GMC, often by looking at guidance and protocols and seeking expert opinion. Mr Jackson stated that it was against this background that the GMC had taken the view that it was appropriate for paragraphs 3(a)(i)(1) to (3), 3(iv), and 3(e)(ii) to (iv) of the Allegation to be withdrawn. He stated that the GMC would be analysing what the reasonable prospects were and whether or note the failure crossed the required threshold in terms of seriousness.

681. In terms of paragraph 3(a)(iv), Mr Jackson referred to the matter of the operative summary and stated that it had become apparent more recently that the GMC had been provided with additional information from Dr N about a hitherto unavailable drop-down menu on the Trust system, which confirmed that the operative note was made by Dr Thampi. Mr Jackson stated that this confirmation was the difference that caused the GMC to revisit this paragraph of the Allegation.

682. With regard to paragraphs 3(e)(ii) to (iv), Mr Jackson stated that recent further disclosure, in terms of a policy document (Obstetric Haemorrhage Guideline) from the Trust, had led the GMC to review these sub-paragraphs of the Allegation such that this sub-paragraph should be withdrawn.

683. In terms of paragraph 5(a)(i), Mr Jackson stated that Dr Thampi admits declining to receive the CTG by email, WhatsApp or other means. He stated that the issue had been reviewed in the light of policies and the GMC took the view that it would not be appropriate to argue that Dr Thampi was under a duty to have received the images of the CTG from Dr D electronically.

Submissions on behalf of Dr Thampi

684. Ms Barnfather stated that it was accepted that these amendments could be made without causing injustice.

Tribunal's Decision

685. The Tribunal had regard to the submissions from Mr Jackson and Ms Barnfather, Rule 17(6) of the Rules, the documentation before it, and the relevant legal principles as set out in

Annex A. The Tribunal also requested to see the Obstetric Haemorrhage Guideline that Mr Jackson had referred to and a copy was provided to the Tribunal.

686. In respect of all of the amendments, the Tribunal determined to grant the GMC's application as set out above. It concluded that the amendments could be made without injustice and were in keeping with the evidence as it had been presented and the agreements within the joint expert report.

ANNEX C - 26/09/2024

Further amendment to the Allegation

687. The Tribunal had asked the GMC for clarification about paragraphs 5(a) and 5(c) of the Allegation. After discussion, Mr Jackson indicated that the GMC would not be making an application to amend these parts of the Allegation.

688. On 20 September 2024 the Tribunal raised the possibility that it would seek to amend the Allegation of its own volition to ensure it was clear as to what wrongdoing the GMC was alleging. The Tribunal invited submissions from the parties on this point.

689. The Tribunal proposed to add the word *"inappropriate"* to paragraphs 5(a) and 5(c) of the Allegation (or *"failed"* to paragraph 5(a)) to provide the clarification.

Submissions

<u>Submissions on behalf of the GMC</u>

690. The GMC proposed the following amendments to the Allegation as follows:

> *5. Between 11 and 12 August 2018 you were the on-call consultant and you were telephoned for advice and assistance by Dr D, during the labour and/or delivery of Patient C's baby, and you:*
>
> > *a. declined to~~: i. receive and~~ review the cardiotocography ('CTG') that Dr D had expressed concerns about during a call she made to you at around 2:05am ('Call 1'), by text message when Dr D offered to send an anonymised picture of it to you;*

~~*ii. attend in person when specifically requested to do so, by Dr D, when she rang you on a second occasion at or around 02:30am ('Call 2');*~~

b. failed to:

i. attend in person to review Patient C's CTG in person following Call 1;

ii. attend in person when specifically requested to do so, by Dr D, when she rang you on a second occasion at or around 02:30am ('Call 2');

~~*ii.*~~ *iii. attend in person prior to delivery to review Patient C and agree a treatment plan;*

~~*iii.*~~ *iv. explain your rationale for recommending treatment of Patient C with antibiotics to Dr D in Call 2;*

c. told Dr D not to deliver Patient C's baby by caesarean section in spite of the fact that you had ~~*not*~~ *failed to personally review*~~*ed*~~*:*

i. Patient C;

ii. the CTG(s).

691. Mr Jackson stated that the GMC took the view that the failures to attend, at paragraphs 5(a) and 5(b), should be listed chronologically.

692. In terms of paragraph 5(c) of the Allegation, Mr Jackson noted that the Tribunal had suggested the wording *"inappropriate"* rather than a failure. He stated that the GMC took the view, in its pleading directions or code, that there was a duty and so it should be characterised as a failure to not personally review Patient C in the CTG.

693. Mr Jackson submitted that, in reality, there was nothing new in this proposed amendment. He submitted that the GMC had always characterised these paragraphs of the Allegation in this way, and it could only have been understood, to be a failure. Mr Jackson stated that the GMC saying that it was a failure was clarified earlier in the hearing when the Tribunal raised it. He stated that the issue was the question of fairness and reiterated that the amendments were not creating a new allegation going beyond the current position. Mr Jackson stated that the Tribunal must always have regard to the overarching objective in terms of ensuring the case is properly presented based on the evidence. He stated that the Allegation was based on evidence that had been served a long time ago from Dr Q.

Submissions on behalf of Dr Thampi

694. Ms Barnfather took the Tribunal through the history of the Allegation, with service of the Rule 15 finalised allegations on 24 March 2024, and the various applications and time taken by the GMC during this hearing.

695. Ms Barnfather referred to Rule 17(6) of the Rules and stated that the Tribunal's powers were confined to circumstances where it appeared that there should be an amendment, which indicated a degree of necessity. Ms Barnfather further submitted that there is a requirement that the Tribunal consider whether any amendment could be made without injustice. She submitted that the least amendments necessary should be made and it was not an opportunity to 'tidy up' the Allegation or arrange the paragraphs into chronological order.

696. Ms Barnfather stated that it was not absolutely right to say that there was no injustice or disadvantage. She stated that Dr Thampi had made factual admissions to that which she had been accused of and that it was right and proper that these are acknowledged and recognised. Ms Barnfather stated that the purpose behind the Tribunal's suggestion was to ensure clarification and no misunderstanding as to the interpretation of the paragraph of the Allegation, but what it was actually thinking to do was allege the mischief at each part because the GMC's drafting omitted to do so.

697. In terms of paragraph 5(a)(i) of the Allegation, Ms Barnfather stated that the GMC had already removed the words *"receive and"* and it had now come back and said that this was a paragraph where no gravamen was intended to be alleged and it was purely a factual pleading. As such, this paragraph could be left as it was.

698. With regard to paragraph 5(a)(ii), Ms Barnfather submitted that the GMC was effectively saying that it had made an omission and that it should have put that there was a failure to attend in person. Ms Barnfather stated that no prejudice had in fact been caused to Dr Thampi because it had been understood that what the GMC was alleging against her was a failure to attend when requested to do so. Ms Barnfather stated that, if the Tribunal wished add *"failed"*, there would be no particular additional prejudice caused to Dr Thampi.

699. Ms Barnfather stated that the GMC's application, to rearrange paragraph 5(b) and change the numbering, was strongly objected to. She stated that the numbering in the expert reports would no longer correspond with the numbering in the Allegation. Ms Barnfather

submitted that a 'tidying up' was not a compelling reason to make an amendment and discouraged the Tribunal from this course.

700. In terms of paragraph 5(c)(i) and (ii), Ms Barnfather stated that factual admissions had been made in respect of the first call. She stated that the drafting, as a factual drafting, had always struck them as odd. Ms Barnfather referred to Dr Q's expert reports. She stated that the overall thrust of Dr Q's criticism had always been that Dr Thampi failed to come in. As such, Ms Barnfather stated that the amendments did not cause any particular prejudice, beyond the fact that factual admissions had been made to the paragraph as drafted and that Dr Thampi has answered the case on that basis. She asked that the Tribunal remain cognisant of the original factual admissions to what was originally alleged.

Tribunal's Decision

701. The Tribunal had regard to the submissions from Mr Jackson and Ms Barnfather, Rule 17(6) of the Rules, the documentation before it, and the relevant legal principles as set out in Annex A.

702. In terms of paragraph 5(a)(ii) of the Allegation, the Tribunal was of the view that the addition of the words *"and failed to"* properly addressed what was being alleged by the GMC, and in terms of how this paragraph had been understood by Dr Thampi. As such, paragraph 5(a)(i) would remain as originally drafted and paragraph 5(a)(ii) would now read:

> *5. Between 11 and 12 August 2018 you were the on-call consultant and you were telephoned for advice and assistance by Dr D, during the labour and/or delivery of Patient C's baby, and you:*
>
> *a. declined to:*
> *…*
> *ii. and failed to attend in person when specifically requested to do so, by Dr D, when she rang you on a second occasion at or around 02:30am ('Call 2')*

703. The Tribunal determined not to change the order and numbering within paragraphs 5(a) and 5(b) of the Allegation as suggested by the GMC. The Tribunal appreciated that the proceedings had now reached the point where all the experts and factual witnesses had referred to these paragraph numbers as originally set out and that changing the numbering and/or order would cause unnecessary confusion.

704. In terms of paragraph 5(c)(i) and (ii) of the Allegation, the Tribunal was of the view that changing the words to *"failed to personally review"* was in keeping with, and would ensure consistency with, the way in which the earlier paragraphs of paragraph 5 of the Allegation had been pleaded. This also fit with how this paragraph had been understood by Dr Thampi. As such, paragraph 5(c)(i) and (ii) would now read:

> *5. Between 11 and 12 August 2018 you were the on-call consultant and you were telephoned for advice and assistance by Dr D, during the labour and/or delivery of Patient C's baby, and you:*
>
> *…*
>
> *c. told Dr D not to deliver Patient C's baby by caesarean section in spite of the fact that you had ~~not~~ failed to personally review~~ed~~:*
>
> *i. Patient C;*
>
> *ii. the CTG(s).*

705. The Tribunal had raised these amendments of its own volition and determined that it was necessary to make them, to ensure that there was clarity for the parties and the Tribunal as to the wrongdoing alleged by the GMC. It concluded that the amendments could be made without injustice to either party.

ANNEX D - 09/10/2024

Issue arising during witness evidence

706. On 1 October 2024 the Tribunal was hearing evidence from a witness, Midwife G. An issue arose as to whether Mr Jackson, in re-examination of this witness, should be permitted to continue asking questions of Midwife G regarding Syntocinon. As there was disagreement between the parties, the Tribunal made a decision on this issue.

Submissions

707. Mr Jackson stated that the plan for Patient B was going to be a vaginal birth and that Dr Thampi had overruled the decision made by the registrar. He referred to the chronology within the medical notes of the administration and dosage of Syntocinon. Mr Jackson stated that this was part of the background to Dr Thampi continuing to pursue a vaginal delivery and altering the course from Dr J's suggestion/plan of a caesarean section. Mr Jackson submitted that his line of questioning of Midwife G was relevant background to Dr Thampi's approach.

He stated that it was not a new allegation but was relevant background to the development of events.

708. Ms Barnfather asked what paragraph of the Allegation that Mr Jackson's questions related to and on what basis the evidence was being adduced at this point. She submitted that the witness was really being asked for her opinion as to Dr Thampi's conduct in respect of the Syntocinon and its use. Ms Barnfather stated that there was no criticism in respect of such conduct on the part of Dr Thampi. She submitted that the witness was effectively being asked to comment on the appropriateness of the Syntocinon. Ms Barnfather submitted that the questioning did not relate to any paragraph of the Allegation and amounted to an entirely fresh and mistaken point that Dr Thampi would then have to respond to. She submitted that it was a completely inappropriate line of questioning. Ms Barnfather also stated that there was a suggestion that this issue arose out of cross-examination but that the question had been whether Midwife G had questioned Dr Thampi's management plan. She submitted that this did not open up this line of questioning by Mr Jackson in re-examination.

709. Mr Jackson stated that he was questioning the recommended dose of Syntocinon. He referred to paragraph 3(d) of the Allegation and stated that the continuation of pulls and ignoring what was being said by a midwife was part of the GMC's case. Mr Jackson submitted that his line of questioning was looking at the issue of whether or not Dr Thampi determined that this should be a vaginal delivery and that the Syntocinon at the levels it was being prescribed was part of seeking to achieve that. He stated that Midwife G had dealt with the fact that there was an instruction to 'stop' and that she had raised her anxiety with Dr Thampi. Mr Jackson stated that he sought to clarify, within the chronology, what the position was and to track her involvement. He submitted that his questioning was admissible in the context of what he had outlined.

710. Ms Barnfather stated that she disagreed that the questioning went in some way to paragraph 3(d) of the Allegation. She submitted that Mr Jackson was seeking to adduce the midwife's opinion as expert opinion evidence as to Dr Thampi's management plan with regard to the Syntocinon. Ms Barnfather also submitted that that it was not an allegation that was foreshadowed in the expert report of Dr Q and she had not been critical in this respect. Ms Barnfather stated that she did not accept that the questioning arose out of cross-examination, nor that it was appropriate. She stated that Mr Jackson was effectively seeking to lay a completely separate allegation through the mouth of this midwife and, if it was permitted to continue, there would have to be expert evidence in respect of it.

Tribunal's Decision

711. The Tribunal's ruling is that it does not consider the line of questioning being advanced on behalf of GMC as relevant or fair. The line of questioning, namely Midwife G being taken through a step-by-step chronology and tracking of the administration and dosage of Syntocinon and in obtaining the midwife Midwife G's opinion evidence on its continuation or otherwise.

712. The Tribunal reviewed the notes it had taken of the evidence given by Midwife G in cross-examination. This issue was raised by Ms Barnfather in the context of whether any critical view of the stop/start of Syntocinon was communicated to Patient B's partner, Mr I. The answer was that Midwife G would not have shared any critical views with him. Ms Barnfather had pointed out to Midwife G that there was no criticism to the use of hormones (i.e. Syntocinon) and that two experts had looked at this. That line of questioning had then stopped.

713. The Tribunal took the view that such questions in cross-examination did not 'open up' the line of enquiry being advanced by the GMC in re-examination. Further, the Tribunal did not think that those enquires were relevant in respect of supporting paragraph 3(d) of the Allegation (*[Dr Thampi] inappropriately disregarded Midwife G's repeated reminders about the number of pulls [she] had carried out, and her request for [Dr Thampi] to cease the instrumental delivery*) or as background to establishing whether or not there is propensity for Dr Thampi altering a course and continuing to a vaginal delivery or overruling a plan or reminders from a colleague. The specific questions in respect of the appropriateness and use of Syntocinon had also not been put to Dr J nor addressed by Dr Q or Dr S specifically within their expert reports as to the administration/dosage of Syntocinon or put to Dr Q in her oral evidence. As such, the Tribunal did not permit Mr Jackson to continue with this line of questioning.

ANNEX E - 03/10/2024

Application under Rule 17(2)(g)

714. The GMC closed its case on 2 October 2024, and it was therefore open to Dr Thampi, under Rule 17(2)(g) of the Rules, to make submissions as to whether sufficient evidence, taken at its highest, had been provided for a Tribunal, properly directed, to find some or all of the facts proved. Rule 17(2)(g) of the Rules states:

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

715. Ms Barnfather confirmed that the application related to the following paragraphs of the Allegation: 3(a)(i)(4), 3(e)(i), and 5(a)(ii).

716. As part of his submissions in response, Mr Jackson made an application for amendment of the Allegation, in respect of paragraph 5(a)(ii), under Rule 17(6) of the Rules. This Rule is set out in full in Annex A.

717. The proposed amendment was:

5. Between 11 and 12 August 2018 you were the on-call consultant and you were telephoned for advice and assistance by Dr D, during the labour and/or delivery of Patient C's baby, and you:

a. declined to:

…

ii. and failed to attend in person when specifically requested to do so, by Dr D, when ~~she rang you~~ she spoke to you on a second occasion ~~at or around~~ between 02:30am and 04:00am ('Call 2')

Submissions on behalf of Dr Thampi

718. Ms Barnfather referred to the case of *R v Galbraith* [1981] 1 WLR 1039 and stated that her submissions were made under the first limb of this case, namely that there was no evidence in respect of these three paragraphs of the Allegation.

Paragraph 3(a)(i)(4)

719. Ms Barnfather stated that this paragraph had caused some confusion as to what it purported to capture in terms of either the evidence or the gravamen behind it. She stated that they had looked at the GMC's opening note but that this did not reference the factual matrix said to lie behind this paragraph of the Allegation. Ms Barnfather stated that they had endeavoured to see where the allegation comes from within Dr Q's reports and has found a suggestion within her fifth report. The section was redacted in the copy before the Tribunal and so she set out that it said:

"It is not clear what information Dr Thampi explained or confirmed with Patient B during the process of verbal consent for operative delivery."

720. Ms Barnfather stated that questions had been asked of Patient B, on behalf of Dr Thampi, about whether the plan for instrumental delivery and/or caesarean section was confirmed with Patient B in theatre and, indeed, it was confirmed with her before the instrumental delivery commenced. She referred to Patient B's evidence on Day 5 of the hearing, as follows:

"Q Yes. So at the time you were in theatre before anything happened, you understood and knew the position and it was confirmed with you, wasn't it, that you were there for an instrumental delivery plus or minus a C-section?
A Yes.

Q And that that is what you had consented to?
A Yes."

721. Ms Barnfather stated that Mr I, Patient B's partner, had been asked the same question and he said he could not remember. Ms Barnfather submitted that this was not positive evidence and did not provide a prima facie case in any way.

722. Ms Barnfather stated that the question was then put to Dr M who agreed that there would have been a further vaginal examination in theatre and confirmation in theatre before the instrumental delivery commenced. Ms Barnfather stated that this matter was also put to the midwife who confirmed this would be the ordinary scenario, although she was not suggesting she had a particular distinct recollection.

723. Ms Barnfather submitted that there was not a prima facie case in respect of paragraph 3(a)(i)(4) of the Allegation.

<u>Paragraph 3(e)(i)</u>

724. Ms Barnfather stated that the origin of this paragraph of the Allegation was Dr Q's criticisms as set out in her seventh report. She stated that Dr Q made a number of criticisms and there was cross-examination about this, as to why she had not raised the issue of the absence of the maternal observation records, which have now recently been provided by the Trust.

725. Ms Barnfather stated that there was discussion between Dr Q and Dr S in the joint expert meeting and it was agreed that these matters had been recorded elsewhere. She stated that this was why the GMC withdrew paragraphs 3(e)(ii) to (iv) of the Allegation and it was somewhat of a puzzle as to why paragraph 3(e)(i) was not similarly deleted. Ms Barnfather stated that it had been accepted and agreed that, although not in the operative note of Dr Thampi, there clearly was a management plan that was adequate and appropriate because blood loss, as with the urine output, haemoglobin count and observations, are recorded elsewhere. Ms Barnfather stated Dr Q accepted this in her evidence on 1 October 2024 and indicated that it was not mandatory for the consultant to personally record blood loss if it was recorded elsewhere. Ms Barnfather stated that it was recorded in a number of places, including a page within Patient B's medical records entitled *'Blood Loss Chart'*.

726. Ms Barnfather submitted that there was not a prima facie case in respect of paragraph 3(e)(i) of the Allegation and not a criticism that Dr Q stands by.

Paragraph 5(a)(ii)

727. Ms Barnfather stated that, within the drafting of this paragraph of the Allegation, there was reference to a specific request. She submitted that there was no evidence at all to suggest that there was a specific request or, indeed, any call at 02:30am. Ms Barnfather submitted that, ultimately, this paragraph of the Allegation specifying that call, and at that time, was not borne out by the evidence. Ms Barnfather stated that Dr D was asked about this call at 02:30am a number of times and ultimately confirmed that she did not make such a call or such a request, certainly at this stage, which was quite apart from being able to specifically recall the words of any such request.

728. Ms Barnfather referred the Tribunal to the following sections of Dr D's oral evidence on Day 7 of the hearing:

> *"Q No dispute you wanted to do a C-section. What I'm suggesting to you, Dr D, is that at that first call you were not asking her to come in and she had explained to you to leave it for 30 minutes.*
> *A I do remember the plan to leave for 30 minutes. I remember accepting that. I'm junior, she's got a lot of experience and I would accept her decision. I did say that I wanted to do a caesarean section.*
> *…*
> *Q… Can I just ask you about that? Looking at your own note, does that jog your memory? What she was saying at 2.05 was actually wait, see if this recovers further, and not for C-section now.*

A Yes, I agree that was the plan that was discussed, yes.

Q When you say she was adamant the baby would deliver vaginally, she in fact was seeking to be reassuring saying, really, with the benefit of her experience, she thinks this is going to recover and this is going to be a vaginal delivery.
A Yes.

Q "Fresh eyes completed …
CTG observing on centrale …"
and so forth. There was no request then, was there, at 2.05 for her to come in? The plan was to see if the recovery continued and fresh eyes in 30 minutes.
A From what I recall and what I've written in my notes, yes, that's what we discussed.
…
Q Okay. I think we can agree that you hadn't asked her to come in, had you?
A I don't remember."
…
Q Yes, okay. I'll come back to the 'you wouldn't overtly question the plan'. What happened thereafter is that she called back to be told that the CTG had continued to recover and that was at about 2.30.
A Again, I don't remember this anymore but what I've written in my statement is that I was called away at that point to deliver another woman's baby. So she called and spoke to the co-ordinator I think.
…
Q I suggest that there's no record anywhere in the records of you asking her to come in and not coming in. I'm not suggesting that you didn't want her to come in, I'm sure we all understand why you would have wanted her to, but there's no record of you specifically asking and her refusing, and at 2.30 the patient's CTG was recovering, the acute concerns of what was seen to be a pathological trace between I think about 1.30 and 1.50. I'm not saying it was in any way perfect but you were no longer in that acute phase of concern.
A I think it was better than it was but it wasn't normal.

729. Ms Barnfather referred to the 02:05am call and stated that this might have been thought to have been the most urgent of the calls. She stated that the significance of the timing of the calls was that the clinical presentation was different at those various times. Ms Barnfather stated that this paragraph of the Allegation and the suggestion of the 02:30am call arose from a reading of Dr D's written statement that she produced for the Trust on 20 October 2018. Ms Barnfather submitted that Dr D had agreed that there was no request, and

she had not phoned Dr Thampi at this time. The likelihood was that Dr Thampi phoned in herself at 02:30am.

730. Ms Barnfather referred to another section of Dr D's oral evidence:

> *"Q Okay. As I say, there's no dispute you might throughout the whole evening have wanted her there, frankly, to assist but what I suggest to you is at no stage at this time at 2.30 did you ask her to come in.*
> *A It's happened six years ago and it was 2.00 in the morning and there were other things going on. At 2.30 I wouldn't have been able to ask her to come in because I was doing something else."*

731. Ms Barnfather stated that Dr D's account became increasingly consistent in her oral evidence that there was no call at 02:30am. The calls were at 02:05am and, potentially, about 03:28am or so.

732. Ms Barnfather submitted that there was no evidence before the Tribunal in support of paragraph 5(a)(ii) of the Allegation.

733. Ms Barnfather submitted that the GMC had deliberately particularised the time of the call and added the words *"specifically requested"* to this paragraph of the Allegation. She submitted that the inclusion of the time of the call was significant; it was not an incidental or irrelevant feature due to the clinical position being different at each of the points of communication. Ms Barnfather submitted that her application in respect of paragraph 5(a)(ii) of the Allegation should be successful.

734. In response to a question from the Tribunal about paragraph 5(b)(iii) that also references 'Call 2', Ms Barnfather stated that if her submission about paragraph 5(a)(ii) was successful then it followed that paragraph 5(b)(iii) would fall as a matter of consequence as currently drafted. She stated that there were other implications too.

Submissions on behalf of the GMC

Paragraph 3(a)(i)(4)

735. Mr Jackson invited the Tribunal to look at Dr Q's report dated 6 March 2024:

> *"I have not found evidence of Dr Thampi having addressed these risks with Patient B. Assessment of Dr Thampi's practice at this point will link to Patient B's comments.*

If it is accepted that Patient B articulated her preferences about her delivery with Dr Thampi and Dr Thampi did not work through discussion of options, risks and benefits and confirm Patient B's final choices as informed and up-to-date, her practice at that point fell seriously below the expected standard."

736. Mr Jackson stated that the Tribunal will have to bear in mind the processes that were gone through in terms of the admission to theatre and what was signed. He submitted that it was a question of whether or not, within all of that, this represented Patient B's final choice in the real sense or was it that she considered she had no option.

Paragraph 3(e)(i)

737. Mr Jackson referred to Dr Q's report dated 6 March 2024, including reference that Dr Q would expect a reasonably competent Consultant in Obstetrics and Gynaecology to have included comment about the blood loss at delivery. She agreed that this blood loss was recorded on the Perioperative Care Plan within Patient B's medical records.

738. Mr Jackson stated that he had heard Ms Barnfather's submissions about the note that she had taken from the evidence given by Dr Q during cross-examination. He stated that he had been unable to find his note of this evidence but submitted that if the Tribunal was satisfied, by reference to its own notes, that Dr Q did make the concession then it would be an appropriate conclusion to come to.

Paragraph 5(a)(ii)

739. Mr Jackson stated that the first issue at paragraph 5(a) was declining to review the CTG and paragraph 5(a)(ii) of the Allegation related to failing to attend as the result of a request. Mr Jackson stated that the GMC says there was a duty to review the CTG in person.

740. Mr Jackson referred to Dr D's written statement that she produced for the Trust on 20 October 2018. This included:

"At the 30 minute review at 02:30, I was delivering another pathological trace by Neville Barnes forceps. The review was conducted by [Ms O] *who called Miss Thampi at home as the CTG remained abnormal. I was called away from my delivery once completed to speak to Miss Thampi on the phone… I asked her to attend, and she refused, telling me that she was 30 minutes away."*

741. Mr Jackson submitted that the issue in relation to the first call was the declining of the receipt of the CTG and that the next sub-paragraph was the failure to attend following that. He stated it was not due to the request but it was a duty. Mr Jackson submitted that it was the GMC's case that the focus in respect of this paragraph (5(a)(ii)) of the Allegation was not in relation to the circumstances, i.e. the clinical changes over the period of time. He submitted that, when looking at whether or not it was fair to make his proposed amendment, the Tribunal has to look at whether or not there was any injustice to Dr Thampi. Mr Jackson submitted that it was relevant to consider that Dr Thampi's position was that she had no record and no recollection of any such call having been made at that time in terms of a request being made to her. Indeed, Dr Thampi has said that she would have attended if a request had been made. Mr Jackson submitted that this was important in the context of submitting that there was no injustice.

742. Mr Jackson submitted that illumination was brought to this by Ms Barnfather's questioning and referred the Tribunal to Dr D's oral evidence on Day 7 of the hearing. Mr Jackson submitted that, in this context, the timing had some relevance but that it was not determinative of this in terms of the issue of fairness. He referred to the following parts of Dr D's evidence:

> *"Q When you spoke to Dr Thampi the first time on the telephone – and I'm going to fix that in time by a reference to you offering to send the CTG by message to her. Do you recall?*
> *A Yes. The first time we spoke at 2.05.*
> *…*
> *Q… Just so that we're clear, or the Tribunal are clear, is it your recollection that there were two calls or more than two calls, because of the sequence?*
> *A My recollection is that we had a conversation initially at 2.05 and then we had a second conversation. It would be difficult for me to remember at what point of the night shift that happened. It looks like, from the records that I've seen today for the first time recently, that that would be 3.30, because that's when I've written the second note. But there was another consultation that I wasn't a part of, because I was delivering another – so there've (sic) been three discussions, but I've been part of the first and the third. This is what it looks like from the contemporaneous documentation. When I've written at the 30-minute review at 2.30, I obviously wasn't part of that. But then this conversation here, that's the conversation that is documented at 3.30.*
>
> *Q "I asked her to attend and she refused, telling me that she was 30 minutes away."*

Is that your recollection then? Is that your recollection now?

A I don't remember this conversation now. It was six years ago. But this would be how I remembered it at the time. So this was whenever I wrote the statement, which was within a couple of months of the events.

…

Q In the note that you did in October 2018, the Tribunal will see, from memory, you refer to another delivery which was a forceps delivery. If we stay with this page, we can see:

"[Dr AA] *now able to speak to Miss Thampi as intended forceps delivery in room 5 resulted in a SVS.* [Dr AA] *spoke to Miss Thampi at 03.27 hrs."*

Is the position that you accept in terms of the timing that your second call was at 3.27 or thereabouts?

A Yes. It looks like that's the second time that we spoke at that time. It's about an hour and 20 minutes after the first time that we spoke.

Q In terms of the content of that call, is the content that which you ascribe to it in your statement to the Trust which you described as being "a 2.30 call" that we looked at a moment ago?

A I don't think the statement says that it's a 2.30 call. It says there's a 30 minutes review at 2.30 and at that point I was doing another delivery. Then I talk about a discussion. But that was after the delivery had taken place.

Q Is it during this call that Dr Thampi refuses to come in and she uses the words, "Because it's more than 30 minutes away", or words to that effect?

A I'm assuming so, yes."

743. Mr Jackson stated that Dr D has said that she does not remember the events now and was reliant on her recollection as set out in her statement.

744. Mr Jackson also referred to the following parts of Dr D's evidence:

"Q… From looking at this, can you assist the Tribunal as to when this call takes place?

A The notes shows that the midwife has documented that myself and Miss Thampi had a conversation at 3.27 and this note is started at 3.28. It looks like it's been initially finished at 3.38. So it looks like that is the same conversation from this record. My recollection is that we had the initial conversation and then a follow-up conversation. So that would go with my current recollection as well.

Q Can you assist the Tribunal, in the context of this call that you recorded at 3.38, whether or not Dr Thampi was asked to attend or not?

A This is what I've written at the time. I haven't documented that I've asked her to attend or that she's refused to attend. In all honesty, on my first shift on-call, I probably would find that difficult to do and it may be that I recorded a separate statement and then that's the statement that's gone through. I haven't written that in the medical records, but my recollection would be that it would be at this time that we had that discussion. But as you say, it's not in the medical records that have been documented at the time.

…

Q Are you able to assist the Tribunal as to whether or not during this conversation you asked Dr Thampi to come in or not?

A My statement says that I have asked her to come in on the night shift. It looks like it would be at this point, yes. But if you're asking me if I currently remember the details of this conversation, I don't remember the details at this point. My statement is that I asked her to attend and she refused."

745. Mr Jackson submitted that, this being the evidence, the GMC sought to apply under Rule 17(6) of the Rules for amendment of the Allegation. He submitted that that it was right and proper and, whilst it might be said that he should have applied more promptly after Dr D gave her evidence, it was only with the benefit of receiving the transcripts on 27 September 2024 that he had the opportunity to review. Mr Jackson submitted that there was no additional disadvantage by reason of that 24- or 48-hour delay. He submitted that the Tribunal should have regard to the overarching objective and that this amendment should be allowed and that the application under Rule 17(2)(g) to strike this paragraph at this stage should be resisted. Mr Jackson stated that the gravamen was the fact of a conversation, with a request, and with the refusal.

Ms Barnfather's response to the application for amendment

746. Ms Barnfather submitted that, in respect of paragraph 5 of the Allegation, there had been various amendments raised during the first few days of this hearing and, upon being told there were no more amendment, the Tribunal raised the possibility of an amendment of its own volition. Ms Barnfather stated that the hearing had now reached the conclusion of the GMC's case and it had called all of the evidence it intended to call and the opportunity of Dr Thampi to test the evidence had come to an end. Ms Barnfather stated that the submission under Rule 17(2)(g) was in respect of the paragraph of the Allegation as currently drafted. She submitted that this was an allegation that Dr Thampi came prepared to defend and had sought to defend through the questioning of the relevant witnesses.

747. Ms Barnfather commented that it was unusual that the response to a submission under Rule 17(2)(g) was a GMC application for amendment, including amendment to the time. She submitted that this amendment was to match evidence that, incidentally, emerged in re-examination and Tribunal questions which was when Dr D said the request would have been made in the 03:27am call. Ms Barnfather referred to the second limb of *Galbraith* about the tenuous nature of the evidence as to the request. She submitted that Dr D had been unable to recall the specific words used, either in her oral evidence or in her original statement or Trust interview. Ms Barnfather clarified that this was not the submission being made at this stage.

748. Ms Barnfather stated that Mr Jackson was seeking to say that the amendment did not cause any prejudice as the time of the call was immaterial. However, Ms Barnfather submitted that the way this paragraph of the Allegation was drafted included the time at which it was alleged the request was made and that Dr Thampi declined to attend in person when *"specifically requested"* to do so. Ms Barnfather submitted that, when drafted, these words were used to avoid any miscommunication and the time was specifically stated to be Dr D calling Dr Thampi on a second occasion around 02:30am. She submitted that the reason the time was specifically stated was because the time was significant to the clinical picture. Ms Barnfather referred to the questions she had asked Dr D in cross-examination in that the first 02:05am call was the acute call due to what she had seen on the CTG trace with regards to the bradycardia. She submitted that the 02:05am call and 02:30am request as originally alleged were very closely connected. Ms Barnfather stated that the nature of the cross-examination of Dr D was predicated on the wording as presently drafted and she would have conducted the questioning differently if the call was at a later time. She stated that it came as a considerable surprise when Dr D appeared, at the end of her evidence, to pinpoint that request at 03:27am when the clinical picture was different and there was *"a window of relative stability"* compared to an earlier point and then, after that, the CTG trace deteriorated again. Ms Barnfather identified a number of points in the evidence and stated that she would have addressed the questioning differently.

749. Ms Barnfather also stated that the amendment had consequences for the other linked paragraphs of the Allegation and that the GMC's expert had been addressing her mind to the clinical scenario as at 02:30am. Ms Barnfather referred to Dr Q's oral evidence when she was asked whether her opinion had changed having read the transcript of Dr D's oral evidence. She submitted that Dr Q said that it appeared there was no specific request at the time and, seemed unclear, as to whether there was any specific request to attend. Ms Barnfather submitted that the opportunity to cross-examine Dr Q on the proposed new position had now also been lost. She also submitted that there was further prejudice to Dr

Thampi in that her statement was predicated and focused on the allegation as drafted, and that it would call for an addendum report from Dr S as to the clinical picture at the time of 03:27am.

750. Ms Barnfather submitted that the delay in the GMC's application to amend had led to a cumulative prejudice such that it was not remediable at this stage. She submitted that it would be wrong and inappropriate, at the close of the GMC case, to effectively be asked to meet a different allegation.

Relevant Legal Principles

751. The Tribunal had regard to Rule 17(2)(g) of the Rules. It reminded itself that, at this stage, its purpose was not to make findings of fact but to determine whether sufficient evidence, taken at its highest, had been presented by the GMC such that a Tribunal, correctly directed as to the law, could properly find the relevant paragraphs proved to the civil standard.

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

753. The Tribunal had particular regard to the case of *Galbraith*, which sets out that:

> *"(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.*
> *(2) The difficulty arises where there is some evidence but it is of a tenuous character; for example, because of inherent weakness or vagueness, or because it is inconsistent with other evidence.*
> *(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.*
> *(b) Where, however, the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury…"*

754. The Tribunal also noted that this authority had been applied by the courts to disciplinary proceedings in the case of *Solicitors Regulation Authority v Sheikh* [2020] EWHC

3062 (Admin). In that case Lord Justice Davis held that the key question at the half-time stage was whether, on one possible view of the evidence, there was evidence upon which a reasonable Tribunal (not all reasonable Tribunals) could find the matter proved when making the final adjudication. If the answer was 'yes', then there was a case to answer.

755. The Tribunal also had regard to the relevant legal principles as set out in Annex A in terms of the application for amendment of the Allegation under Rule 17(6) of the Rules.

Tribunal's Decision

Paragraph 3(a)(i)(4)

756. The Tribunal initially sought to consider what was being alleged by this paragraph of the Allegation. It bore in mind that the remainder of the sub-paragraph of the Allegation had been withdrawn. The Tribunal noted that, within the evidence, there was a written consent form signed by Patient B, consenting to the trial of instrumental delivery + or - a caesarean section, which had been undertaken by Dr M. The Tribunal had regard to Dr Q's fifth report where it stated:

> *"It is not clear what information Dr Thampi explained or confirmed with Patient B during the process of verbal consent for operative delivery."*

757. It also had regard to the passage Mr Jackson directed the Tribunal's attention to within Dr Q's seventh report, which he submitted was supportive of this allegation:

> *"Did Dr Thampi adequately address with Patient B all the relevant and important risks associated with her planned delivery?*
>
> *I have not found evidence of Dr Thampi having addressed these risks with Patient B. Assessment of Dr Thampi's practice at this point will link to Patient B's comments. If it is accepted that Patient B articulated her preferences about her delivery with Dr Thampi and Dr Thampi did not work through discussion of options, risks and benefits and confirm Patient B's final choices as informed and up-to-date, her practice at that point fell seriously below the expected standard."*

758. The Tribunal also considered paragraphs 56 to 59 of Mr Jackson's opening submission, which referred to the consenting process and the alleged failure to discuss the risks and benefits of all options [Head of Charge 3a.i.3] which had now been withdrawn. It considered paragraph 59 which framed the allegation that Dr Thampi was under a duty to

confirm Patient B's *"final choice"*, in terms of preferred method of delivery [Head of Charge 3a.i.4]. The Tribunal noted references from the transcript of Patient B's evidence, where she had confirmed that she understood the plan for a trial of instrumental delivery + or - caesarean section and had consented to it. Her evidence had been that, whilst she preferred a vaginal delivery, she had been agreeable to any method that was considered best for the safe delivery of her baby.

759. The Tribunal further referred to the passage from Dr Q's seventh report where she had referred to Patient B's *"final choices"*, which the Tribunal considered would encompass the agreement to a trial of instrumental delivery and, if needed, a caesarean section. It also considered Dr M's evidence that there would have been a further vaginal examination in theatre and confirmation of the plan.

760. Whilst the Tribunal acknowledged Dr Q's evidence taken in-chief on the issue of informed consent at developing stages of the delivery process, the Tribunal did not consider that to be within the gravamen of this part of the Allegation within the context of paragraph 3(a)(i) of the Allegation in respect of Patient B.

761. In the light of its interpretation of this paragraph of the Allegation as it stood, within the context of the remainder of the sub-paragraphs of the Allegation having been withdrawn, and in light of the factors listed above, the Tribunal determined that there was no evidence to support paragraph 3(a)(i)(4) of the Allegation in respect of a failure to confirm Patient B's final choice. As such, the Tribunal granted the application under Rule 17(2)(g) made on behalf of Dr Thampi.

Paragraph 3(e)(i)

762. The Tribunal had regard to Dr Q's expert report dated 6 March 2024, which included:

> *"Please comment upon whether Dr Thampi's management plan for Patient B's delivery was adequate and appropriate with regards to any risk of post-partum haemorrhage.*
>
> *I would expect a reasonably competent Consultant in Obstetrics and Gynaecology to have included comment about the blood loss at delivery [noted as 1500 mls in the care plan at page 578 of the bundle of medical records].*
> *This would usually include use of an hourly urometer, when to check the patient's haemoglobin count by blood test and the duration and frequency of postnatal observations such as pulse and blood pressure."*

763. The Tribunal took account of the joint expert report from Dr Q and Dr S dated 11 September 2024, which included:

> *"There is documentation that* [Dr Q] *and* [Dr S] *both agree is a record of blood loss after the delivery as evidenced on page 535 of the Records Bundle Part 4, albeit not by Dr Thampi."*

764. There was an issue of the absence of the maternal observation records from Patient B's medical records, which the Tribunal was told had been raised by Dr Thampi, and which had recently been provided by the Trust.

765. As referred to by Ms Barnfather and Mr Jackson, the Tribunal had regard to its notes of Dr Q's evidence in respect of this point. Ms Barnfather had asked Dr Q what she relied upon to state that it was mandated for an obstetrician to record the blood loss at delivery. Dr Q said that if it was recorded then that would be sufficient. Ms Barnfather had further asked, that if it had been recorded (and in more than one place) why did it follow that the management plan was not adequate? Dr Q said that, in that case, it was appropriate, i.e. if it had been recorded by another, and not Dr Thampi.

766. The Tribunal concluded that this point was therefore conceded by Dr Q.

767. As such, in the light of this concession and noting the recordings of the blood loss, the Tribunal determined that the evidence before it was such, that taken at its highest, a Tribunal properly directed could not find this paragraph of the Allegation proved. The allegation being that Dr Thampi's management plan for Patient B was not adequate or appropriate with regards to the risk of post-partum haemorrhage, in that she did not record blood loss at delivery.

768. The Tribunal granted the application under Rule 17(2)(g) made on behalf of Dr Thampi.

<u>Paragraph 5(a)(ii)</u>

769. The Tribunal noted that Ms Barnfather has made an application under Rule 17(2)(g) in respect of this paragraph and that Mr Jackson made an application or amendment under Rule 17(6) in response.

770. The Tribunal had regard to Dr D's written statement that she produced for the Trust on 20 October 2018.

"I called the consultant on call, Miss Thampi at 02:05… I was told not to do a CS by the consultant as the baby 'would deliver vaginally'. I expressed my concerns to the consultant that the issue was really in what condition and that I considered this an unacceptably risky decision in view of the high head and her not being in established labour. I offered to send an anonymised picture of the CTG trace but she declined. I told her I would observe the CTG and call back in 30 minutes.

…

At the 30 minute review at 02:30, I was delivering another pathological trace by Neville Barnes forceps. The review was conducted by [Ms O] *who called Miss Thampi at home as the CTG remained abnormal. I was called away from my delivery once completed to speak to Miss Thampi on the phone. I told her that the reactive tachycardia was improved but baseline was still 160 with reduced variability and no accelerations… I re-expressed my concerns that this trace was abnormal, that she was not in established labour… asked her to attend, and she refused, telling me that she was 30 minutes away."*

771. The Tribunal took account of Dr D's GMC witness statement dated 25 February 2021, which included:

"I felt that Dr Thampi would agree that I should perform a Caesarean. However, she declined to allow this and also to come in to support me in managing the subsequent labour when asked. I offered to send an anonymised photograph of the CTG for her to view, and she declined this also."

772. The Tribunal referred to Dr D's oral evidence in respect of this point, and the various quotations from the transcript as set out above.

773. The Tribunal was careful not to make any finding of fact at this point.
The Tribunal determined that, the way in which matters were borne out during the evidence, there was insufficient evidence to support this paragraph of the Allegation as it currently stood.

774. The Tribunal, as part and parcel of its considerations, also considered the proposed GMC amendment to this paragraph of the Allegation.

775. The Tribunal noted Mr Jackson's submissions, including in respect of the *timing* having some relevance but it not being determinative in terms of the issue of fairness. It had regard to Mr Jackson's questions put in-chief to Dr Q. The Tribunal was of the view that

Dr Q's evidence in this regard, relating to Dr D's evidence, focused on the telephone call and linked that to the clinical position at the time. The Tribunal acknowledged Mr Jackson's submission that the gravamen of the said allegation, was the fact of a conversation, with a request, and with the refusal. However, the Tribunal concluded that the specific timing alleged within this paragraph of the Allegation was reflective of the clinical picture at the time.

776. The Tribunal further considered that the cross-examination and defence on behalf of Dr Thampi in respect of this paragraph of the Allegation had been framed based on its current wording. It further accepted with Ms Barnfather's submission that her questions in cross-examination to Dr D would have been different if it had been asserted that the request to come in had taken place at a later point, i.e. 03:27am, as the clinical picture was evolving throughout. The Tribunal also noted that, at this stage of the proceedings, both Dr D and Dr Q's evidence had been heard and completed.

777. Given these factors, the Tribunal determined that amendments in the terms proposed by the GMC would cause injustice and procedural unfairness to Dr Thampi.

778. As such, the Tribunal determined to refuse the GMC's application for amendment of this paragraph of the Allegation under Rule 17(6) of the Rules.

779. The Tribunal was mindful of its duty to protect the public interest and the ventilation of the issue of whether there was a failure to attend in person on Dr Thampi's part could still take place through the remainder of the allegations pertaining to Patient C.

780. In the light of refusing Mr Jackson's application for amendment, the Tribunal considered its conclusions above as to the application under Rule 17(2)(g) of the Rules.

781. Having regard to all of the circumstances, the Tribunal was thus of the view that the evidence was such that, taken at its highest, a properly directed Tribunal could not find this paragraph of the Allegation (the 02:30am call) proved. As such, the Tribunal, applying the legal test, determined that there was no case to answer in respect of paragraph 5(a)(ii) of the Allegation and granted the application under Rule 17(2)(g) made on behalf of Dr Thampi.

ANNEX F - 09/10/2024

Issue arising during Dr Thampi's oral evidence

782. On 7 October 2024 the Tribunal was hearing oral evidence from Dr Thampi. An issue arose during Mr Jackson's cross-examination as to whether he should be permitted to continue asking questions of Dr Thampi about consent in respect of Patient A with reference to two guidance documents, namely:

- GMC: *'Consent: patients and doctors making decisions together'* (2008);
- Royal College of Obstetricians & Gynaecologists (RCOG): *'Obtaining Valid Consent - Clinical Governance Advice No. 6'* (January 2015).

783. Mr Jackson indicated that he also wanted to put two articles to Dr Thampi. Ms Barnfather objected to the admission of these documents. The Tribunal took this whole issue in a step-by-step approach and the first matter was to consider the two above documents and the line of questioning in this respect. It would return to the question of the articles and seek further submissions before reaching any decision on that application (see Annex G).

Submissions

784. Mr Jackson submitted that he could put the two guidance documents to Dr Thampi, given the answers she had given in her oral evidence about XXX and the issue of consent regarding Patient A.

785. Ms Barnfather stated that all the relevant guidance should have been set out. She stated that Dr Q had identified the RCOG guidance on *'Operative Vaginal Delivery'* from 2010 and parts from the GMC's *Good Medical Practice* ('GMP'). Ms Barnfather submitted that the guidance now referred to was outwith what the expert had identified and outwith what Dr Thampi and her legal team had been put on notice of. She stated that the only way it would be even vaguely fair was if Dr Thampi was given advance notice at this point of all the relevant paragraphs and allowed to go away and look at the two documents.

786. Mr Jackson stated that this arose as Dr Thampi has indicated that she follows the Royal College's guidance. He stated that he did not want Dr Thampi to be disadvantaged and that he was happy for Dr Thampi to be provided with a copy of the two guidance documents.

787. Following further discussion, Mr Jackson provided a list of the relevant paragraphs within the two guidance documents that he would be referring to. Dr Thampi would be allowed time to read the two documents and have access to the list of relevant paragraphs.

788. Ms Barnfather stated that, if the documents were of such significance that there were all these paragraph references and were instrumental to the allegations, it would have been expected that these would have been referenced in Dr Q's reports. Mr Jackson stated that it was the GMC's position that all doctors need to be familiar with the contents of GMP. Ms Barnfather stated that the issue was with Mr Jackson saying that these paragraphs were particularly relevant to the duty that he said was incumbent upon Dr Thampi in terms of Patient A's BMI and XXX.

789. Mr Jackson stated that the issue was whether the GMC was entitled to ask Dr Thampi about her familiarity with the guidance with which she is expected to comply. He stated that it did not become evidence but was a touchstone about which Dr Thampi can be asked because it is her duty to comply with it and, in terms of the RCOG document, it is something Dr Thampi has referenced herself.

Relevant Legal Principles

790. The LQC referred the Tribunal to Rule 34(1) of the Rules:

> *"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."*

She stated that the above principles applied to any line of questioning not agreed between the parties. The LQC reminded the Tribunal that it should also consider the interests of justice and the overarching objective in making its decision.

Tribunal's Decision

791. The Tribunal had regard to the GMC's *'Consent: patients and doctors making decisions together'* (2008) document first. It noted that this guidance document was referred to in Dr Q's report dated 6 July 2020 and was repeated in her report dated 6 March 2024. The first reference included quotation of paragraphs 28 to 30 of the consent document.

792. The Tribunal also considered the position in respect of the RCOG 2015 guidance. It identified that there was mention to the earlier 2008 iteration of the guidance within Dr Q's

reports, including with another RCOG document, the Consent Advice guideline No. 11, entitled *'Operative Vaginal Delivery'* (2010).

793. The Tribunal noted that 2015 was the year before the allegations in respect of Patient A, which took place in 2016. It also was mindful that Dr Thampi had referenced the Royal College guidance in her oral evidence and said that it *"changes now and again"*.

794. The Tribunal noted that the questions being put to Dr Thampi were in relation to the issue of informed consent for Patient A, against the background of Patient A's specific clinical circumstances. The Tribunal determined that the questions were relevant.

795. The Tribunal considered the potential unfairness to Dr Thampi in that there had not been a previous reference to the 2015 guidance within Dr Q's report. However, Dr Thampi had now been given time to read and consider the documents in full before the resumption of the questions being put to her.

796. The Tribunal noted that the document was guidance as opposed to new evidence and the basis of the cross-examination on this issue was predicated on Dr Q's views outlined in her report and in her oral evidence. The Tribunal therefore determined the questions to be relevant and, in the light of the time afforded to Dr Thampi to read the documents in full, it considered that allowing the questions on the additional documents to be fair. As such, the Tribunal permitted Mr Jackson to continue with this line of questioning.

ANNEX G - 09/10/2024

Application for the admission of further evidence during Dr Thampi's oral evidence

797. On 7 October 2024, and following the decision at Annex G, the Tribunal was invited to consider the question of the two research articles that Mr Jackson was seeking to put to Dr Thampi in oral evidence. The Tribunal invited further submissions from the parties before making its decision. It had not seen the two articles and considered, as part of its deliberations, whether it should see them or not.

Initial submissions

798. Mr Jackson invited the Tribunal to admit two articles that he stated had arisen out of Dr Thampi indicating that she was not familiar with XXX and its implications for labour.

799. Ms Barnfather stated that, quite apart from the late disclosure of the articles, there had been prior disclosure of expert reports and a joint expert meeting to discuss all relevant matters. She submitted that the hearing was now at the stage where the expert evidence on behalf of the GMC had been completed and that proposing to ask Dr Thampi about the articles was an 'ambush' as they were a matter for expert evidence. Ms Barnfather stated that it was quite possible that Dr Thampi was more than able to deal with the articles but that the principles of fairness required that the appropriate course of procedures are followed. She also stated that the articles were something that Dr S could consider and address in due course.

800. Ms Barnfather stated that the approach from Mr Jackson was unfair and completely inappropriate to seek to ambush a registrant with research articles that they have not had notice of and without the benefit of the input of both experts.

801. Mr Jackson stated that, against the background of Dr Thampi saying she had never come across a patient with XXX and that she had relied on the assessment by UCLH, he did more research to see what could be found and looked on the internet. He stated that the issue of a XXX had been put to Dr Thampi and that she had indicated that it was a matter for the anaesthetist. Mr Jackson submitted that, it was against that background, he was entitled to ask Dr Thampi about the two articles. He stated that the first article was from 2014 and that the second wider and more recent paper dealt with possible complications in relation to XXX in labour and how that might be managed. Mr Jackson submitted that this was all relevant to, what the GMC say, is Dr Thampi's rather narrow and closed approach to what she discusses, and when, with Patient A, in respect of her condition and what needs to be addressed. He submitted that the articles did not arise by way of ambush but due to what Dr Thampi had said in her oral evidence that she did not think that she needed to do anything more as it had been covered by either Ms BB (consultant) or the Neuromuscular Unit at UCLH. Mr Jackson submitted that it would be fair and reasonable that he should be allowed to ask Dr Thampi about the articles. He stated that the GMC say that there was a positive duty for her to act and have a discussion and take account of what may happen.

802. Mr Jackson stated that the GMC was entitled to put matters, without notice, to a witness. He stated that the issue of admissibility was not contingent upon the need to recall Dr Q. He stated that it was fair and reasonable for Dr S to deal with it. Mr Jackson further submitted that he was entitled to ask questions which go to Dr Thampi's state of knowledge, awareness and attitude to inquiry and relating to facts which were available.

803. Ms Barnfather responded to Mr Jackson on this point. She submitted that, bizarrely, Mr Jackson had done his own web search for articles to which he has addressed his own lay

interpretation that he perceives to signify something that in some way Dr Thampi should have been aware of. Ms Barnfather submitted that this was a wholly misguided approach and that the introduction of the two articles did not go to any of the issues in the case.

804. Ms Barnfather submitted that there was grotesque injustice to Dr Thampi. She stated that Dr Thampi was not in a position where she could discuss this matter with her legal team or hear the expert's interpretation of them. Ms Barnfather stated that Dr Thampi would effectively be answering to a lay interpretation of the research articles. Ms Barnfather submitted that this would put Dr Thampi at a considerable disadvantage and was not the appropriate way that these proceedings should take place. Ms Barnfather strongly urged the Tribunal to robustly decline this application.

Additional submissions

805. Mr Jackson stated that these issues should have been the subject of discussion in terms of how the labour was to be managed in the light of the patient's difficulties and those have already been canvassed during cross-examination. He stated part of it was how Dr Thampi addressed the issues which she has given evidence about earlier (on 7 October 2024) that she relied on the UCLH letter. Mr Jackson stated that Dr Thampi indicated that she had never come across a patient with XXX before and that she did not feel that she needed to do anything more to look it up as UCLH had said there was no contraindication for a vaginal delivery. Mr Jackson stated that this was set against Dr Thampi's note within Patient A's medical records that she wrote the day after the delivery. He stated that the outcome of the birth plan and the correspondence about the XXX was such that it was not easy to carry out an instrumental assisted delivery as Dr Thampi had not thought about what was going to happen and meant that the consent was concertinaed to a very short period. Mr Jackson submitted that the literature raised an issue about whether or not this was something that ought to be considered and discussed in terms of awareness and so the GMC would seek to be able to ask Dr Thampi and/or Dr S about it in the light of what Dr Thampi has said.

806. In terms of the question of any potential unfairness, Mr Jackson stated that Dr Thampi could have a look at the articles and, as Dr S was yet to give evidence, he could deal with it. Mr Jackson also submitted that the articles were not to raise any new argument and were just a question of seeking to test what Dr Thampi's understanding was and whether or not, in the light of what she had said, to simply rely on what she had read in the documentation.

807. Ms Barnfather stood by her objections and the reasoning already given in respect of prejudice. She took the Tribunal to the various medical records. Ms Barnfather stated that

she thought that it was being suggested, despite Dr Thampi not being a specialist in neuromuscular disorders and not party to the maternal medicine specialist interventions, she ought to have known better than them in respect of the XXX and effectively have overruled the birth planning advice they gave. Ms Barnfather stated that she thought this was predicated on the basis that Dr Thampi should have overruled them because she should have been aware of the two articles, or the information contained with them.

808. Ms Barnfather referred to the content of the two articles. She stated that one was published online in 2019, which was after the events in question, and the second was May 2014. Ms Barnfather stated, upon their reading (and it would be a matter of expert evidence), that there was no consensus on the ideal mode of delivery and no contraindication to vaginal or assisted vaginal delivery, or that the condition leads to issues in respect of the pelvic floor muscles. Ms Barnfather submitted that the articles, if they were to be adduced, required expert evidence and that Dr Q should have produced them. She submitted that it was not right for a registrant to be asked about this matter while she was under cross-examination and having to address these in isolation from her expert and legal team. Ms Barnfather stated that Dr Q had not sought to produce the articles to support her opinion as to what the duty incumbent on Dr Thampi was and that, in terms of the dangers of lay people googling clinical websites, it was to be dealt with by the expert rather than the registrant on oath.

809. Mr Jackson stated that it was not a question of Dr Thampi overruling advice that had been given by the Neuromuscular Unit at UCLH. He stated that the GMC's case was that Dr Thampi was responsible for making judgements about how Patient A's baby was to be delivered. Mr Jackson stated that the GMC was not seeking to rely on the articles to suggest that vaginal births were not possible but simply to show that it was an issue that, although not within Dr Thampi's experience, was within the knowledge of obstetricians and gynaecologists and relevant to Dr Thampi's steadfast refusal to consider having a dialogue with the patient at an early stage. Mr Jackson stated that the guidance required that there was material that needed to be discussed and this was something to be flagged in reference to the articles.

810. Ms Barnfather submitted that the articles did not assert that XXX was a condition within the experience and knowledge of reasonable competent obstetric gynaecologist. Mr Jackson stated that he did not say that. Ms Barnfather encouraged the Tribunal to see the articles.

Relevant Legal Principles

811. The LQC referred the Tribunal to Rule 34(1) of the Rules:

> *"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."*

She further advised that the Tribunal should consider the interests of justice and the overarching objective in making its decision.

Tribunal's Decision

812. The Tribunal had regard to whether it could make the decision without seeing the two articles. After consideration, it determined to look at them on the invitation of both parties and was of the view that it could not undertake a proper consideration of this application without doing so.

813. The Tribunal considered the two articles proposed to be admitted in evidence, on behalf of the GMC. It had regard to the extensive submissions made by both parties. It noted that the GMC expert, Dr Q had not presented these articles as part of the GMC's case and, as far as the Tribunal were aware, nor had Dr Q seen or commented upon them and they had been presented to the Tribunal part-way through Dr Thampi's evidence, and after the close of the GMC case.

814. Within the GMC's submissions, reference was made to Dr Thampi's *"closed, narrow approach"* as to what she discusses and, specifically, with Patient A in respect of her condition and what needed to be addressed. The Tribunal noted that Dr Thampi's evidence on this relevant issue was also within her witness statement dated August 2024. The Tribunal considered that any relevant articles could have been advanced earlier in the proceedings which would have afforded the opportunity to Dr Q to give evidence upon their relevance and reliability. Further, adducing any relevant articles earlier, would have enabled Dr Thampi to discuss them with Dr S and her legal representatives. This was not an option now open to her.

815. The Tribunal considered the relevance of the articles. In respect of the article entitled *'*[XXX]*'* dated May 2014, the Tribunal was of the view that, whilst the article described the condition, the case report within the article considered a patient for whom the elective caesarean section decision was after two previous pregnancies and births also by caesarean

section and, as such on a lay reading, did not appear to be directly comparable to the case of Patient A.

816. The Tribunal considered the article in Obstetric Medicine - the Royal Society of Medicine Journals - entitled '[XXX]', which was published online in March 2019. This article provided a summary of the different types of XXX and included information on the clinical features of XXX. The Tribunal noted a diagram showing the clinical features and triggers of XXX. The Tribunal considered that such information highlighted the importance of comments/evidence needed as to its interpretation, relevance and reliability - by both independent experts. The Tribunal was concerned about the way in which this article was sourced and did not have any information from the GMC itself as to its reliability against the potential of numerous other articles supporting it or countering its contents. The Tribunal could also not see the link or relevance of the information within this article to the basis upon which the GMC had sought to adduce this late evidence. The basis being its relevance to the tenability of Dr Thampi's evidence thus far about her reliance on the expertise of the Neuromuscular Unit at UCLH, the birth plan and the input of maternal medicine department/clinicians and Dr Thampi's noted description of, and reasons relating to, the delivery of Patient A's baby. Additionally, the Tribunal was concerned about the date of this article [2019] post-dating the date of the allegations [2016] by several years.

817. Overall, in the light of its considerations, the Tribunal determined that the admission of the two articles at this stage would not be fair and it also did not consider them to be relevant due to the factors listed above. For the avoidance of doubt, the Tribunal did consider the questions on the issues relating to informed consent and actions on Dr Thampi's part to be relevant, just not by reference to these two articles which the Tribunal has determined not to admit.

818. As such, the Tribunal will put the contents of the articles out of its mind in the continuation of the case, and in its consideration of all the evidence when making its decision on the facts.

ANNEX H - 09/10/2024

Adjournment

819. Dr Thampi concluded her oral evidence to the Tribunal at the end of the day on 8 October 2024. The Tribunal was next due to hear evidence from Dr S, the expert on behalf of Dr Thampi. His evidence had originally been listed for 3 and 4 October 2024, but the

updated witness timetabling had been such that this was pushed back during the course of the hearing. Despite making himself available at various other dates to try to assist, it had not been possible to interpose Dr S's evidence at any earlier point and he was unavailable on 9 to 11 October 2024 due to clinical commitments.

820. There were two remaining sitting days in this current listing but there were no further matters that could be dealt with prior to Dr S's evidence. As such, the Tribunal determined that it was appropriate to adjourn this hearing part heard at this point. The hearing will reconvene at a date to be confirmed in due course.