Guidance on Sanctions Imposed by the Medical Council pursuant to the Medical Practitioners Act 2007

2013 - 2018
INTRODUCTION

Pursuant to the Medical Practitioners Act 2007 ("the Act") the object of the Medical Council is to protect the public by promoting and better ensuring high standards of professional conduct and professional education, training and competence among registered medical practitioners. One of the statutory means of discharging this object is the fitness to practise procedure set out in Part 8 of the Act whereby complaints regarding registered medical practitioners are considered.

At the conclusion of an Inquiry into a registered medical practitioner before the Fitness to Practise Committee ("the Committee") of the Medical Council, the Committee may, if it has found an allegation proven, make a recommendation to the Medical Council as to appropriate sanction(s). If the Committee has found any allegation proven against the registered medical practitioner, the Medical Council shall decide to impose one or more than one sanction on the registered medical practitioner pursuant to Part 9 of the Act.

Pursuant to section 74 of the Act, a decision by the Medical Council to impose certain sanctions must be confirmed by the High Court.

This document is divided into two parts, Section A and Section B.

Section A contains guidance on the principles used by the Fitness to Practise Committee/Medical Council when recommending/determining appropriate sanction(s).

Section B contains a summary of the sanctions imposed by the Medical Council arising from allegations found proven by the Fitness to Practise Committee.

Section B will be updated on a biannual basis.

Section A of this document will be amended, updated and revised when required.

The Medical Council has prepared this document for the assistance of:

a) the Committee in recommending sanction(s) to the Medical Council;
b) registered medical practitioners who may wish to make submissions in relation to the appropriate sanction(s) to be imposed; and
c) the Medical Council in imposing sanction(s).

It is hoped that this document will promote transparency in the interests of both the public and medical practitioners.
This document is not binding on the Committee in recommending sanction(s). It is also not binding on the Medical Council in determining sanction(s) to be imposed. Both the Committee and the Medical Council retain the discretion to impose sanction(s) they deem appropriate to the particular circumstances of a case.

Registered medical practitioners are advised to take independent legal advice if they are the subject of a complaint to the Medical Council.

SECTION A
The Purpose of Sanctions

The primary aim of a sanction is the protection of the public and not the punishment of the practitioner.

Other factors which may be taken into account when recommending or determining sanction(s) to be imposed include:

- deterring the practitioner from carrying out a similar act or omission again;
- demonstrating the gravity of the offence to other practitioners; and
- upholding the reputation of the profession and maintaining public confidence in the profession.

Factors that may be considered

The following factors may be considered by the Committee and the Council prior to recommending or imposing sanction(s):

a) Proportionality

In determining what sanction(s) to recommend, the Committee will have regard to the principle of proportionality, measuring the nature of the proven allegations against the range of available sanctions. The Committee will consider the sanctions available under the Act, commencing with the least restrictive. The same principles apply to the Medical Council when determining which sanction(s) to impose.

b) Outcome
Outcome is not necessarily relevant when considering sanction. For example, the fact that a patient ultimately came to no harm may be less relevant than the risk posed by the behaviour of the practitioner.

c) Insight

Evidence of the practitioner’s understanding of any underlying deficit in his approach to the issue which led to the complaint and his attempts to address it may be considered. This may include an admission of the facts of the case, an admission of professional misconduct and/or poor professional performance and/or relevant medical disability, an apology by the practitioner to the complainant or injured party, efforts made by a practitioner to prevent recurrence and improve deficiencies.

d) Ethical Guide

Evidence of the practitioner’s adherence to important principles of good practice may be taken into account. These general principles appear at paragraph 1 of the Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 7th edition, 2009, as follows:

Medical Professionalism is a core element of being a good doctor. Good medical practice is based on a relationship of trust between the profession and society, in which doctors are expected to meet the highest standards of professional practice and behaviour. It involves a partnership between patient and doctor that is based on mutual respect, confidentiality, honesty, responsibility and accountability.

In addition to maintaining your clinical competence as a doctor you should also:

- Show integrity compassion and concern for others in your day to day practice,
- Develop and maintain a sensitive and understanding attitude with patients,
- Exercise good judgment and communicate sound clinical advice to patients,
- Search for the best evidence to guide your professional practice, and
- Be committed to continuous improvement and excellence in the provision of health care, whether you work alone or as part of a team.

Furthermore, the Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 7th edition, 2009, includes at paragraph 18.2 – 18.3, the following guidance to a medical practitioner when an adverse event occurs:

If an adverse event occurs you must ensure that the effects of the event on the patient are minimised as far as possible. If the patient needs further care because of the adverse event, you must make sure that they are helped and supported throughout this process.
Patients and their families are entitled to honest, open and prompt communication with them about adverse events that may have caused them harm. Therefore you should:

- Acknowledge that the event happened,
- Explain how it happened,
- Apologise, if appropriate, and
- Give an assurance as to how lessons have been learned to minimise the chance of this event happening again in the future.

e) Testimonials/references

A practitioner may present references and/or testimonials to demonstrate his/her good standing. The Committee and Council may consider whether the authors are aware of the events leading to the Inquiry and what weight, if any, to give to these documents.

f) Previous findings/sanctions

If it is the case that a practitioner has been subject to a previous sanction by the Medical Council arising from an allegation similar or the same than that being considered by the Medical Council the Council may have regard to that sanction.

**Undertakings and Consents**

Section 67(1) of the Act states as follows:

1) The Fitness to Practise Committee may, at any time after a complaint is referred to it, request the registered medical practitioner the subject of the complaint to do one or more than one of the following:

a) If appropriate, undertake not to repeat the conduct the subject of the complaint;
b) Undertake to be referred to a professional competence scheme and to undertake any requirements relating to the improvement of the practitioner’s competence and performance which may be imposed;
c) Consent to undergo medical treatment;
d) Consent to being censured by the Council.
2) Where a registered medical practitioner refuses to give an undertaking or consent the subject of a request under subsection (1) by the Fitness to Practise Committee, the Committee may proceed as if the request had not been made.

In requesting a practitioner to provide one or more undertakings pursuant to section 67, the Committee may consider the following:

a) Do the undertakings cover any conditions that the Committee would otherwise recommend to Council or sanction(s) that the Council would be likely to impose?

b) Are the undertakings sufficient to protect patients and the public interest?

Sanctions under the Act

The sanctions provided for in section 71 of the Act are as follows:

a) An advice, or admonishment or censure in writing;
b) A censure in writing and a fine not exceeding €5,000.00;
c) The attachment of conditions to the practitioner’s registration, including restrictions on the practice of medicine that may be engaged in by the practitioner;
d) The transfer of the practitioner’s registration to another division of the register;
e) The suspension of the practitioner’s registration for a specified period;
f) The cancellation of the practitioner’s registration; and
g) The prohibition from applying for a specified period for the restoration of the practitioner’s registration.

Each sanction is set out below, together with the factors that may be considered prior to recommending or imposing one or more sanction.

a) An advice or admonishment or censure in writing.

The Medical Council may decide to impose one or more of the sliding scale of the sanctions of advice, admonishment or censure in writing in circumstances where the findings against a practitioner are less serious. These sanctions convey the disapproval of the Medical Council regarding the allegations which have been proven against the medical practitioner. The Medical Council may decide to advise a practitioner in a particular respect ie that he shall in future ensure that appropriate patient records are maintained.
b) A censure in writing and a fine not exceeding €5,000.

The factors that maybe considered by the Medical Council in deciding what fine to impose on a practitioner may include the nature of the allegations found proven and the means of the practitioner. For the avoidance of doubt, fines against a registered practitioner are not imposed for the purpose of compensating a complainant/injured party.

c) The attachment of conditions to the practitioner’s registration, including restrictions on the practice of medicine that may be engaged in by the practitioner.

In such circumstances the medical practitioner is entitled to continue to work but must comply with the conditions imposed.

The nature of the conditions imposed will vary from case to case.

The Medical Council has prepared a conditions bank from which templates can be used or adapted as appropriate. This conditions bank appears at Appendix 1 to this guidance document.

d) The transfer of the practitioner’s registration to another division of the register.

The Medical Council may impose this sanction where it is of the opinion that it is incompatible with the practice of medicine for the medical practitioner to engage in a specialized form of medicine and that medical practitioner should instead be restricted to a more general area of medicine. A medical practitioner is entitled in the future to make an application for restoration to the previous division of the register.

e) The suspension of the practitioner’s registration for a specified period.

Suspension is likely to be imposed for events that that are serious but are not serious enough to merit cancellation of the practitioner’s registration.

Suspension may be appropriate in cases where the Medical Council is of the view that a period of rehabilitation/retraining on the part of the practitioner would be appropriate before he engages in the practice of medicine.

Where the Medical Council imposes suspension on a medical practitioner, the Medical Council will impose a period of suspension rather than a start/end date to the period of suspension.

f) The cancellation of the practitioner’s registration.
Cancellation of a practitioner’s registration is obviously the most serious sanction that can be recommended or imposed on a medical practitioner. The sanction of cancellation may be imposed where the Medical Council is of the opinion that the allegations proven are incompatible with being a registered medical practitioner.

Professional misconduct arising from findings of disgraceful or dishonorable behaviour may result in cancellation of registration in the following circumstances:

a) Dishonest/fraudulent behaviour regarding professional practice i.e. falsifying records
b) Abuse of patients
c) Inappropriate sexual relations
d) Certain criminal behaviour

Professional misconduct arising from a breach of the “expected conduct” standard may result in cancellation of registration in the following circumstances:

a) Reckless and willfully unskilled practice
b) Breach of confidentiality
c) Inappropriate prescribing
d) Breach of conditions or undertaking to the Medical Council

The Medical Council may determine that a medical practitioner should not apply for restoration for a specified period. That period will be determined based on the nature of the allegations proven against the medical practitioner and the circumstances surrounding the event.

**Reasons**

The report of the Committee recommending sanction(s) and the Council’s determination on sanction(s) will give reasons for recommending or imposing a particular sanction(s).
SECTION B

Sanction Decisions

The Medical Council has prepared a summary of cases found proven by the Fitness to Practise Committee in respect of complaints made pursuant to the Act since the commencement of Parts 7, 8 and 9 of the Act. The complaints have been categorised according to the nature of the allegation(s) against the registered medical practitioner.

Although some of the Inquiries referred to below were held in public, others were held in private. The identities of all parties have been anonymised.

The only allegations contained below are the allegations found proven at the Fitness to Practise Inquiry. All allegations against the practitioner which were considered at the Inquiry are not set out below.
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# Professional Misconduct

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<tr>
<td>C9</td>
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<td>C10</td>
<td>Failure to meet the standards of competence and clinical judgement and/or performance expected of an Obstetrics/Gynaecology Registrar in history taking, examination and treatment of patients. A failure to comply with conditions and a failure to notify employer of conditions.</td>
<td>Cancellation</td>
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## Relevant Medical Disability

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<td>D4</td>
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A contravention of a provision of the Act (including a provision of any regulations or rules made under the Act)

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Professional misconduct and a failure by you to comply with a relevant condition and a contravention of the Medical Practitioners Act 2007

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<td>Allegations arising from a failure to comply with conditions and CPD and a failure to respond to correspondence from the Medical Council.</td>
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<td>L1</td>
<td>Concealed a camera phone in the toilet to record patients and staff of the Clinic undressing. Additional allegations of relevant medical disability.</td>
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<td>M1</td>
<td>Allegations arising from carrying out an intimate examination without the option of a chaperone, without gloves and without adequate consent. Additionally the practitioner failed to respond to correspondence from the Medical Council.</td>
<td>Censure and conditions</td>
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<td>Allegations arising from a breach of a Section 67 undertaking and failure to provide a medical report in a timely manner.</td>
<td>Advise</td>
<td>[Appendix 15 (i)] Page 124</td>
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Professional Misconduct

Appendix 1 (i)

That the registered medical practitioner,

1. Failed to carry out all appropriate examinations of Ms. A and or failed to carry out one or more examinations in a competent manner and/or
2. Failed to give adequate consideration to the symptoms Ms. A was suffering from as reported by her and the members of Ms. A’s family on or around the 29 June 2007 and on or around the 30 June 2007.
Appendix 1 (ii)

That the registered medical practitioner,

1. In respect of the examination conducted by him of the patient, failed:
   a) to explain adequately or at all to the patient what the examination, to include the examination of her pubic area, would entail and/or
   b) to seek any or any adequate permission from the patient Ms A for the examination, to include the examination of her pubic area, and/or

2. Failed to keep any or any adequate records in respect of the consultation with the patient and/or
Appendix 1 (iii)

That the registered medical practitioner,

A. Being on the Supervised Division of the Register of Medical Practitioners, while employed as a Senior House Officer at the Hospital, in or around December 2011:

1. Left his post as a Senior House Officer, on or around the 22 December 2011, without providing any or adequate notice to the hospital; and/or

2. By absenting himself without any or adequate notice to the hospital, he abdicated his responsibilities as a doctor and/or he breached his duty to ensure that patient care would not be compromised; and/or

3. Told Ms A, Medical Manpower Manager, Mayo General Hospital, on or around 23 December 2011, that he would be attending the hospital to work the shifts from 6pm to 2am for the week commencing 26 December 2011 when he knew or ought to have known that was not the case

B. Being on the Supervised Division of the Register of Medical Practitioners while employed as a Senior House Officer at Letterkenny General Hospital, in or around March 2013:

1. Left his post as a Senior House Officer, after working only three days in the Emergency Department, without providing any reason and/or adequate notice to the hospital; and/or

2. By absenting himself without any or adequate notice, caused the Non-Consultant Hospital Doctor numbers in the hospital to fall below the minimum on one or more days; and/or

3. By absenting himself without any or adequate notice to the hospital, he abdicated his responsibilities as a doctor and/or breached his duty to ensure that patient care would not be compromised; and/or
C. On or around 19 July 2013:

1. During an interview for a post as a Senior House Officer in Cork University Hospital, with Dr A, concealed the fact and/or failed to disclose that he absented himself from his post as a Senior House Officer in both Mayo General Hospital and Letterkenny General Hospital, without providing any or adequate notice and/or working out his notice period, when he knew or ought to have known it was material to the job application.
Appendix 1 (iv)

That the registered medical practitioner,

1. despite being diagnosed with the Hepatitis C Virus on or around 25 October 2012, failed to disclose his said condition to “the Hospital.”
2. Put the health of patient(s) of “the Hospital” potentially at risk by being available to carry out Exposure Prone Procedures.
Appendix 1 (v)

That the registered medical practitioner,

1. During the period between in or around 02 February 2011 and in or around 22 May 2011 and/or the period between in or around 25 May 2011 and in or around 09 June 2011 engaged in the practise of medicine at the Hospital, during which time he knew or ought to have known that he was not registered as a medical practitioner with the Medical Council, and/or;

2. On or around 23 May 2011 or 24 May 2011, carried out a medical procedure on the Patient at the Hospital, in circumstances where he knew or ought to have known that he was not registered as a medical practitioner with the Medical Council, and/or;
Appendix 1 (vi)

That the registered medical practitioner,

1. Following the birth of Patient A’s daughter, carried out an excessive and/or unreasonable number of repeated attempts of the manual removal of the placenta; and/or

2. Failed to recognise after a number of attempts of the manual removal of the placenta that Patient A’s placenta was abnormally adherent and/or that this was likely to represent a morbidly adherent placenta; and/or

3. Failed to consider adequately or at all, alternative management of the retained placenta, to include, but not limited to, the conservative management of the retained placenta by leaving the placenta in situ.

4. Caused and/or permitted one or more further attempt(s) of the manual removal of the placenta by his junior colleague a, Obstetric Registrar, which he knew or ought to have known was inappropriate in the circumstances; and/or

5. Failed to record any or all of the following in the operation note and/or in the medical records:
   a. The use of the surgical curette referred to at allegation no.6 above; and/or
   b. the number of attempts made at the manual removal of the placenta; and/or
   c. the point in the procedure when Patient A began to haemorrhage; and/or

6. Put the health and safety of Patient A at risk through the repeated attempts to remove the placenta manually to include, but not limited to causing a massive obstetric haemorrhage; and/or

7. Caused Patient A unnecessary distress and/or suffering to include but not limited to causing Patient A to suffer extensive damage and trauma to her vagina from the repeated attempts to remove the placenta and/or the subsequent suturing, laparotomy and/or hysterectomy procedures.
Appendix 1 (vii)

That the registered medical practitioner,

1. Failed to make any or adequate arrangements so that the patient or her representatives would have access to the records of the treatment afforded by him to her; and or
Appendix 1 (viii)

That the registered medical practitioner,

1. Attended for duty in circumstances where he knew or ought to have known;
   a) that he was not fit to do so; and/or
   b) it was not safe to do so; and/or

2. Provided care to Ms A (a minor) in circumstances where he knew or ought to have known;
   a) that he was not fit to do so; and/or
   b) it was not safe to do so; and/or
Appendix 1 (ix)

That the registered medical practitioner,

1. On or around 28 October 2011, prescribed Cyclimorph, a controlled drug, and/or Cialis (Tadalafil) for himself in circumstances where he knew or ought to have known that this was inappropriate and/or was contrary to the guidance issued by the Medical Council at paragraph 51.2 of the Guide to Professional Conduct and Ethics for Registered Medical Practitioners; and/or
Appendix 1(x)

That the registered medical practitioner

1. In respect of the note which was made by the RMP, retrospectively amended the note by changing the description of the CTG from “satisfactory” to “unsatisfactory” and/or by adding the word “non-reassuring”, in circumstances where the RMP knew or ought to have known this was inappropriate; and / or

2. Failed to record the date and/or time of the amendment referred to above in circumstances where the RMP knew or ought to have known it was appropriate to do so; and / or
Appendix 1 (xi)

That the registered medical practitioner,

1. In circumstances where the Interim Orders Panel of the General Medical Council had imposed conditions on her registration, submitted an application online to the Hospital, on 9 November 2008 for a post as a part time Locum Consultant Paediatrician with a special interest in Community Child Health, and, in so doing;

   a. She failed to inform the Hospital that her General Medical Council Registration was subject to conditions, in breach of condition 7(c) imposed on her registration by the Interim Orders Panel; and/or,
Appendix 1 (xii)

That the registered medical practitioner,

1. In or around October 2014, in the context of supporting an application to defer an examination, submitted a handwritten certificate dated 07 October 2014 on the Hospital’s headed paper to the Royal College of Ophthalmologists, London when he knew or ought to have known that the handwritten certificate was fabricated; and/or,

2. In or around October 2014 presented a handwritten certificate dated 04 October 2014 on “Doctor on Duty” headed paper to Dr M, ENT Registrar and/or other members of the ENT clinical team at the Hospital when he knew or ought to have known that the handwritten certificate was fabricated;
Appendix 1 (xiii)

That the registered medical practitioner,

1. Engaged inappropriately with Ms C, a patient in his care, when he told her that she was “very pretty” or words to that effect in circumstances where he knew or ought to have known that this was inappropriate; and/or

2. Engaged inappropriately with Ms C when he made the following statement or used words to similar effect to Ms C in respect of an unnamed person: “she was at me all night” in circumstances where he knew or ought to have known that this was inappropriate; and/or

3. Engaged inappropriately with Ms C when he asked her the meaning of the phrase “hung like a stallion” or words to that effect in circumstances where he knew or ought to have known that this was inappropriate;
Appendix 1 (xiv)

That the Registered medical practitioner

1. Failed, either adequately or at all, to clean the wound(s) on the Patient’s hand and/or forehead; and/or,
2. Failed to ensure that the wound on the Patient’s forehead was dressed using a sterile dressing; and/or,
3. Failed to suture and/or arrange for the suturing of the wound(s) on the Patient’s hand and/or forehead; and/or,
4. Failed to prescribe and/or arrange for the prescribing of an antibiotic to the Patient; and/or,
Appendix 1 (xv)

That the registered medical practitioner,

1. Failed to provide adequate and/or appropriate treatment to his patient Patient A; and/or

2. On one or more occasions prescribed Stilnoct to Patient A in an inappropriate and/or irresponsible manner; and/or

3. Continued to prescribe Stilnoct to Patient A in circumstances where the registered medical practitioner knew or ought to have known that Patient A was suffering from an addiction to Stilnoct; and/or

4. Provided Patient A with a prescription for Stilnoct in a different person’s name, namely Ms. Y; and/or

5. Failed to keep accurate and/or adequate medical records in respect of Patient A; and/or

6. Falsely stated to the Medical Council by letter dated 10 December 2012 that Patient A was not a patient of his and/or his practice when he knew or ought to have known that she was and had been since in or about 2007; and/or

7. Tampering with and/or amending the medical records of Patient A such that the said medical records failed to constitute a proper and/or accurate record of her treatment; and/or

8. Purporting to produce contemporaneous and/or accurate medical records relating to Patient A on foot of a direction made by the Preliminary Proceedings Committee dated 30th November, 2012 when such records were neither contemporaneous and/or accurate by reason of the fact that he had tampered and/or amended the said records following their creation; and/or

9. Purporting to produce contemporaneous and/or accurate medical records relating to Patient A on foot of the said direction made by the Preliminary Proceedings Committee when such medical records were not contemporaneous and/or accurate; and/or

10. Falsely and/or dishonestly represented, in or around May 2013, that he produced and/or provided a copy of all medical records relating to his treatment of Patient A and/or

11. Falsely and/or dishonestly represented to the Fitness to Practise Committee on one or more occasions that the said records were the complete and/or accurate set of medical records held by the registered medical practitioner.
Appendix 1 (xvi)

That the registered medical practitioner;

1. On or around 19 April 2014, exposed his erect penis to Nurse A and/or

2. On or around 25 June 2014, exposed his penis and/or testicles to a patient Miss B, being a minor
Appendix 1 (xvii)

That the registered medical practitioner,

1. On or around 28 January 2011, made one or more inappropriate comment(s) to patient A.

2. On or around 02 February 2011, refused and/or failed to attend on a patient, either at all or within an adequate time frame, which patient he knew to be suffering from chest pains, notwithstanding that he was requested on one or more occasions to do so.
Appendix 1 (xviii)

1. That Dr X failed to treat Patient A with any or adequate dignity or respect.
Appendix 1 (xix)

That the registered medical practitioner,

1. Used his professional position to pursue and/or form a relationship of an emotional and/or sexual and/or exploitative nature with Patient A; and/or

2. Engaged in an emotional and/or sexual and/or exploitative relationship with Patient A, during some or all of which time Patient S was his patient, which he knew or ought to have known was inappropriate; and/or

3. Engaged in the relationship(s) listed at allegations (1) and/or (2) above in circumstances where Patient A was suffering from generalised anxiety and/or queried alcohol dependence syndrome of which he knew or ought to have known; and/or

4. Sent one or more intimate and/or explicit photograph(s) of himself to Patient A’s mobile phone; and/or

5. Engaged in the relationship(s) listed at one or more of allegations (1) and/or (2) above and/or the behaviour(s) listed at one or more of allegations (3) – (5) above in the Surgery during opening hours; and/or

6. Failed to treat Patient A with due dignity and respect; and/or
Appendix 1 (xx)

That the registered medical practitioner:

1. During patient A's admission period from 07/10/2010 to 12/10/2010 sexually assaulted patient A on one or more occasions
2. During a further hospital admission period for patient A from 25/02/2011 to 03/03/2011 sexually assaulted patient A on one or more occasions
3. On or around 28/02/2011, in relation to patient A, who was then 16 years old sexually assaulted patient A
Appendix 1 (xxi)

That the registered medical practitioner

1. Carried out a digital examination of the Patient’s vagina in a manner which, by reason of its nature, was not in keeping with normal clinical practice in circumstances where during the course of the said examination, on one or more occasions you:

   a. Touched the Patient’s clitoris; and/or,
   b. Touched and/or massaged the Patient’s labia; and/or,
   c. Moved your hand back and forward penetrating the Patient’s vagina deeply with your fingers; and/or,
   d. Made circular movements with your fingers inside the Patient’s vagina; and/or,
   e. Touched the Patient’s left breast and/or nipple with your left hand while carrying out a digital examination of the Patient’s vagina with your right hand; and/or,
   f. Attempted to hold the Patient’s right hand with your left hand while carrying out a digital examination of the Patient’s vagina with your right hand; and/or,

2. Carried out a digital examination of the Patient’s vagina in a manner which was inappropriate by reason of the fact that it was sexually motivated and in circumstances where, during the course of the examination, on one or more occasions, you:

   a. Touched the Patient’s clitoris; and/or,
   b. Touched and/or massaged the Patient’s labia; and/or,
   c. Moved your hand back and forward penetrating the Patient’s vagina deeply; and/or,
   d. Made circular movements with your fingers inside the Patient’s vagina; and/or,
   e. Touched the Patient’s left breast and/or nipple with your left hand while carrying out a digital examination of the Patient’s vagina with your right hand; and/or,
f. Attempted to hold the Patient’s right hand with your left hand while carrying out a digital examination of the Patient’s vagina with your right hand; and/or,

3. Failed to respond adequately when the Patient queried the nature of the internal vaginal examination referred to at allegations 2 and/or 3 and/or 4 above and asked “What are you doing?”; and/or,

4. Failed to respond appropriately when the Patient asked you to stop the internal vaginal examination referred to at allegations 2 and/or 3 and/or 4 above by asking if she was sure; and/or,

5. Made one or more remarks of an inappropriate and/or sexual nature after you had carried out the examination on the Patient to include but not limited to:
   a. Responded to the Patient’s question “...what was the purpose of that?” by stating “well, I just kind of started liking it and got carried away”, or words to that effect; and/or,
   b. Following the response at allegation 9(b) above, responded to the Patient’s question “what?” by stating “well you know I am just a man, not only a doctor”, or words to that effect; and/or,
Poor Professional Performance

Appendix 2 (i)

That the registered medical practitioner

1. Carried out a left trigeminal radiofrequency lesioning procedure (the “procedure”) in circumstances where indicated in a letter to Patient A general practitioner on or around 24 August 2011 that the procedure was not suitable for Patient A’s condition of trigeminal neuralgia; and/or,

2. Failed to inform Patient A that he could not administer a Glycerol injection as planned because there was no Glycerol available in the Hospital; and/or,

3. Failed to take any or adequate consent from Patient A for the procedure carried out by on 11 November 2011; and/or,

4. Failed to explain the procedure and/or the risk(s) of the procedure to Patient A; and/or,

5. Failed to ensure that 2, 3 and/or 4 were carried out; and/or,

6. Failed to follow the Consent Policy for the Hospital Group issued on 08 September 2009 and reviewed on 01 October 2010 and/or Section D of the Medical Council’s Guide to Professional Conduct and Ethics (7th Edition 2009); and/or,

7. Told Patient A that the reason the RMP had decided to carry out the procedure was because had spoken to a Professor in Bristol who confirmed that Patient A had a diagnosis of trigeminal neuralgia and in the circumstances this was the best procedure for Patient A when the RMP knew or ought to have known this was not the reason why the Glycerol injection would not be administered; and/or,

8. Failed to ensure that Patient A was kept in the Hospital overnight for observation in circumstances where this was clinically indicated; and/or,

9. Prior to Patient A’s discharge from the hospital:

   a) Failed to assess Patient A adequately or at all in circumstances where the registered medical practitioner knew or ought to have known his Registrar did not have the requisite experience or expertise to discharge the patient; and/or,
b) Failed to carry out and/or ensure all necessary assessment(s) and/or test(s) were carried out to include, but not limited to, assessing Patient A’s corneal sensation; and/or,

c) Failed to provide or arrange to provide Patient A with advice in relation to the post-operative care of her eye, to include but not limited to failing to warn Patient A of the necessary precautions following the administration of corneal anesthesia; and/or,

10. Failed to prepare a Medical Discharge Summary or arrange a Medical Discharge Summary to be prepared in relation to the procedure carried out on Patient A; and/or,

11. Failed to provide or arrange to provide Patient A’s general practitioner with a Medical Discharge Summary; and/or,

12. Failed to put in place and/or document any or any adequate follow up plan for Patient A; and/or,

13. Carried out the procedure in such a manner as to cause to Patient A injury to include an anesthetic cornea, neuropathic keratitis, and persistent pain;
Appendix 2 (ii)

1. That the registered medical practitioner respect of Patient A:
   
a. Failed to request the following basic tests to include, but not limited to:
   
i. Blood test(s); and/or
   ii. Urine test(s); and/or
   iii. Kidney function test(s); and/or
Appendix 2 (iii)

That the registered medical practitioner,

6. On or around 8 February 2012, failed to develop an appropriate management plan for Mrs A, to include what further investigations were to be considered and/or carried out and/or what follow up was to be undertaken and/or

7. On or around 8 February 2012, failed to document in Mrs A’s medical records, either adequately or at all;
   a) a comprehensive management plan for Mrs A, to include what further investigations were to be considered and/or carried out and/or
   b) a differential diagnosis in relation to the possible cause and/or causes of Mrs A’s pain and/or

8. On or around 11 April 2012, failed to document in Mrs A’s medical records, either adequately or at all:
   a) The nature of any discussion(s) with Mrs A, to include any update provided by Mrs A in relation to the complaint with which she presented on 8 February 2012 and/or
   b) The nature of any review undertaken in relation to Mrs A’s symptoms and/or
   c) The management plan for Mrs A, to include what further investigations were to be considered and/or carried out and/or
Appendix 2 (iv)

1. That the registered medical practitioner failed to pursue one or more of the investigations notwithstanding:
   a. a telephone call and/or message from Patient A on or around 10th September 2009 and/or;
   b. receipt of a letter dated 17th September 2009 from Patient A & Ms A and/or;
   c. letter(s) to Patient A and/or Patient A’s GP dated 23rd November 2009 and/or;

2. That the registered medical practitioner at or after the consultation on or around 13th December 2010:
   a. failed to recognise that one or more of the investigations that he had planned in 2009 had not been carried out and/or;
   b. failed to arrange for one or more of the investigations that he had planned in 2009 to be carried out and/or;
   c. failed to re-explore the issue of hyponatraemia identified by him in August 2009 and/or;
   d. failed to take and/or any adequate steps consequent on his consultation with Patient X and/or;
   e. failed to respond in a timely manner to the referral letter from Patient X’s General Practitioner and/or;
   f. prescribed “Nifedipine” for Patient X when he knew or ought to have known that this was the generic name for “Adalat” which had already been prescribed for Patient X and/or,

3. That the registered medical practitioner failed to ensure that he had any or any adequate system in place for tracking and/or monitoring investigations and/or tests.

4. That the registered medical practitioner failed to respond adequately or at all to one or more of the letters sent by Mrs A dated 15th May 2011 and/or 25th May 2011 and/or 13th June 2011.
Appendix 2 (v)

The registered medical practitioner,

1. In respect of a consultation with the patient in or around 16th September 2011:
   (a) Failed to conduct an adequate examination of the patient and/or

2. In respect of a consultation with the patient on or around 4th October, 2011:
   (a) Failed to give adequate consideration to any other diagnosis apart from sciatica in circumstances where that diagnosis was not entirely consistent with the patient’s symptoms and/or
   (b) Failed to carry out and/or arrange appropriate investigations to establish the correct diagnosis and/or
Appendix 2 (vi)

That the the registered medical practitioner

1. On or around 09 March 2010, following the Patient’s attendance at the Hospital Out-patient Clinic, failed to undertake and/or arrange to undertake further examination and/or investigation of the lesion identified by ultrasound in the Patient’s cervix, via hysteroscopy and biopsy and curettage in a timely manner and/or,

2. On or around 14 May 2010, during the performance of a hysteroscopy on the Patient, failed to pay sufficient attention when visualising the endocervical canal; and/or;
Appendix 2 (vii)

That the registered medical practitioner

1. On one or more occasions between on or around 3 July 2008 and on or around 7 January 2013: prescribed to Ms A one or more of the drugs in the approximate quantities and/or strengths listed in the Schedule set out in the letter from McDowell Purcell to Tughans dated 10 November 2016, when knew or ought to have known this was inappropriate.

2. On one or more occasions between on or around 3 July 2008 and on or around 7 January 2013 failed to implement appropriate governance and/or monitoring practices and/or procedures at Naas General Practice to ensure appropriate prescribing to Ms W and/or the review of the prescribing for Ms A.

3. On one or more occasions between on or around 3 July 2008 and on or around 7 January 2013 failed to maintain adequate medical records in relation to Ms A, to include but not limited to documenting one or more prescriptions written by for Ms A.
Appendix 2 (viii)
That the registered medical practitioner,

1. While engaged as a Locum Senior House Officer left his/ her post prior to his/her designated finishing time, without informing any member of staff adequately or at all that he/ she was leaving the Hospital; and
2. That prior to leaving the Hospital, failed to provide a clinical handover in respect of one or more patient(s) he/she was treating.
Appendix 2 (ix)

That the registered medical practitioner

1. Failed to correctly interpret the cardiotocograph (CTG) as being abnormal/non-reassuring and/or failed to recognise and/or respond appropriately to one or more significant findings on the CTG; and/or

2. Failed to recommend a period of further CTG monitoring in the Maternity Assessment Unit and/or hospital admission for continuing monitoring and/or hospital admission for consideration of delivery by caesarean section and failed to consult with the on-call consultant in respect of the management plan for A; and/or
Appendix 2 (x)

That the registered medical practitioner:

1. Prescribed the drugs in the quantities and/or strengths recited in the attached spreadsheet which was inappropriate; and/or

2. Failed to refer one or more of the patients to a specialist substance misuse practitioner or drug treatment centre; and/or

3. Failed to take any or adequate history prior to or during the treatment of one or more patients; and/or

4. Failed to maintain any or adequate medical records in relation to one or more of the patients; and/or
Appendix 2 (xi)

That the registered medical practitioner,

1. Failed to take any or adequate action, having been made aware that one or more of the following patients were experiencing post-operative haemorrhage:

   i. Patient A;
   ii. Patient B;
   iii. Patient C;

2. Failed, during the period referred to in allegation 1, to make any or adequate arrangements for the provision of out of hours post-operative care for patients undergoing circumcision procedures.
Appendix 2 (xii)

The registered medical practitioner:

1. On or around 28 October 2014, failed to:
   a) take an adequate history from Mrs A in relation to her presenting complaint; and/or
   b) carry out any or any appropriate examination of Mrs A to include but not limited to:
      I. ascertaining Mrs A’s temperature; and/or
      II. ascertaining Mrs A’s blood pressure; and/or
      III. monitoring Mrs A’s heart rate; and/or
      IV. carrying out a breast examination; and/or
      V. carrying out an abdominal examination; and/or
      VI. carrying out a chest examination; and/or
   c) arrange for initial relevant investigations to be undertaken to include:
      I. urine tests; and/or
      II. high vaginal swab and/or
   d) include one or more of the following in the differential diagnosis:
      I. a possible uterine infection; and/or
      II. a possible upper UTI/pyelonephritis; and/or
      III. a possible wound infection; and/or
      IV. a possible viral illness; and/or
   e) develop an appropriate management plan for Mrs A, to include but not limited to:
I. what further investigations were to be considered and/or carried out; and/or
II. arranging a follow up appointment for Mrs A; and/or
III. arranging a referral to hospital for further management; and/or
IV. obtaining advice from the consultant involved in Mrs A’s obstetric care; and/or
Appendix 2 (xiii)

1. That, on or around 26 April 2014, while affording obstetric care to Patient C (Mrs C):
   a. Following your arrival to the hospital in or around 16.45, failed to decide that immediate delivery of Baby C by emergency caesarean section was required; and/or
Appendix 2 (xiv)

That the registered medical practitioner on or around 15 to 17 June 2012

a. following the birth of Patient A, failed to put in place an adequate plan for the treatment of Patient BT’s diagnosis of Hypoxic ischaemic encephalopathy (Hypoxia); and/or

b. failed to consider and/or follow adequately or at all the National Neo-Natal Transport Programme’s Guidelines dated September, 2011 in respect of the transfer of infants for hypothermic treatment; and/or,

c. following the birth of Patient A failed to arrange for the transfer of Patient A to a neo-natal intensive care unit for specialist treatment to include hypothermic treatment (cooling of the baby’s head and/or body); and/or,

d. failed to obtain a second opinion from a paediatrician, either in the Hospital or another hospital, in relation to the management and/or treatment of Patient A’s condition; and/or

e. on or about 16 June 2012 failed to arrange for the transfer to the Patient A in circumstances where he had been categorised as a high dependency care neonate; and/or

f. on one or more occasion(s), on or around 16 to on or around 17 June 2012, in circumstances where Patient A was displaying seizure like/type activity, told Patient A’s parent(s) that Patient A was “fine” in circumstances where he knew or ought to have known that was not the case;
Appendix 2 (xv)

The registered medical practitioner

1. Failed to demonstrate the levels of competence and/or skill and/or knowledge in one or more of the following areas which could reasonably be expected of a Senior House Officer providing safe medical care:
   a. the formation of adequate clinical impressions and/or making diagnoses; and/or
   b. effective communication with colleagues; and/or
   c. taking feedback and/or advice from senior colleagues; and/or

2. On or around 15 April 2015, in the case of Patient A, failed to respond appropriately to the patient’s condition, and/or;
Appendix 2 (xvi)

That Dr the registered medical practitioner in relation to Patient A, a patient under her care:

1. Diagnosed Patient A with the Herpes Virus and/or treated accordingly in circumstances where there was no clinical evidence of this diagnosis; and/or
2. On one or more occasion(s) informed Patient A that she was suffering from the Herpes Virus when she knew or ought to have known that was not the case; and/or
3. Failed to take into account Patient A’s medical history, to include but not limited to Patient A informing her that she was in a monogamous relationship; and/or
4. Failed to consider adequately or at all Patient A’s presenting symptom(s); and/or
5. Prescribed Patient A, the medication Daktacort, which is contra-indicated for patients who have the Herpes Virus; and/or
6. Failed to maintain adequate and/or accurate medical records in respect of Patient A; and/or
7. Caused Patient A and/or her husband, undue distress as a result of her informing Patient A that she had the Herpes Virus; and/or
Appendix 2 (xvii)

1. That the registered medical practitioner

   a. On one or more occasions prescribed psychotropic, hypnotic and/or psychoactive medications, to Ms A in an inappropriate and/or irresponsible manner; and/or

   b. Failed to observe the Department of Health’s and Children’s guidelines on Benzodiazepine prescribing when prescribing to Ms Sheppard; and/or

   c. Failed to keep proper and/or adequate medical records in respect of the treatment provided by him to Ms A and/or in respect of medication prescribed by him; and/or
Appendix 2 (xviii)

That the registered medical practitioner, in respect of the care afforded to patient Ms A:

1. In relation to the hysterectomy and/or cystocele repair procedures (the “procedures”) carried out by the registered medical practitioner on 23 August 2011, the registered medical practitioner failed to arrange for the procuring of informed consent from Ms. A in that he:

   a) Failed to review Ms. A pre-operatively and/or prior to the anesthetic review; and/or
   b) Failed to explain adequately or at all the following to Ms. A:
      i. The procedures to be carried out; and/or
      ii. The risk(s) of the procedures; and/or
      iii. Any adverse consequences of the procedures; and/or

2. Communicated with Ms A and/ or her family on one or more occasion in an incorrect and/ or inappropriate manner
Appendix 2 (xix)

1. That the registered medical practitioner made serious errors in one or more of the 22 cases identified by the expert witness in his report dated 1st July 2015.
Appendix 2 (xx)

That the registered medical practitioner

1. In respect of Patient A, failed in radiological report dated on or around 11 September 2014 to record and/or identify the following finding(s) in respect of an MRI examination of the left knee performed on or around 11 September 2014:
   a) A vertical tear of the posterior horn of the medial meniscus; and/or
   b) An osteochondral injury in the medial femoral condyle; and/or
   c) Bone contusion in the medial tibial condyle; and/or

2. In respect of Patient B, failed in radiological report dated on or around 17 July 2014 to record and/or identify the following finding(s) in respect of an MRI examination of the spine lumbar and sacral performed on or around 16 July 2014:
   a) A disc bulge and/or foraminal stenosis to the right side at L4/5; and/or
   b) Probable compression of the right L4 nerve root; and/or

3. In respect of Patient C, failed in radiological report dated on or around 5 August 2014 to record and/or identify the following finding(s) in respect of an x-ray examination of the chest performed on or around 5 August 2014:
   a) An area of consolidation adjacent to the right hilum; and/or

4. In respect of Patient D, failed in radiological report dated on or around 4 June 2014 to record and/or identify the following finding(s) in respect of an x-ray examination of the right hand performed on or around 29 May 2014:
   a) A fracture at the base of the distal phalanx of the third finger; and/or

5. In respect of Patient E, failed in radiological report dated on or around 4 August 2014 to record and/or identify the following finding(s) in respect of an x-ray examination of the chest performed on or around 4 August 2014:
   a) A pneumo-mediastinum; and/or
6. In respect of Patient F, failed in radiological report dated 4 June 2014 to record and/or identify the following finding(s) arising from an x-ray examination of the right elbow performed on or around 27 May 2014:
   a) An elbow joint effusion and/or
   b) That Patient F required a referral to the fracture clinic; and/or

7. In respect of Patient G, failed in radiological report dated on or around 30 July 2014 to record and/or identify the following finding(s) in respect of a Doppler ultrasound examination of both carotid arteries performed on or around 30 July 2014:
   a) A right internal carotid artery stenosis of in or around 70% or greater; and/or
   b) A stenosis on the left side; and/or

8. In respect of Patient H, failed in radiological report dated on or around 2 July 2014 to record and/or identify the following finding(s) in respect of a Doppler ultrasound examination of both carotid arteries performed on or around 2 July 2014:
   a) A stenosis of in or around 70% or greater; and/or

9. In respect of Patient I, failed in radiological report dated on or around 6 August 2014 to record and/or identify the following finding(s) in respect of an ultrasound examination of the pelvis performed on or around 6 August 2014:
   a) A cyst measuring in or around 3cm, which described as being 6mm; and/or
   b) An accurate measurement of the endometrial layer, which recorded as 9mm; and/or

10. In respect of Patient J, failed in radiological report dated on or around 1 August 2014 to record and/or identify the following finding(s) in respect of an ultrasound of the pelvis performed on or around 31 July 2014:
    a) An endometrial layer measuring in or around 12mm; and/or

11. In respect of Patient K, failed in radiological report dated on or around 12 August 2014 to record and/or identify the following finding(s) in respect of an ultrasound examination of the pelvis performed on or around 12 August 2014:
    a) That the 24 mm thickness of endometrial material identified was possibly retained products of conception; and/or
b) That a Doppler ultrasound was required in order to distinguish between retained products of conception and haemorrhage; and/or

12. In respect of Patient L, failed in radiological report dated on or around 21 July 2014 to record and/or identify the following finding(s) in respect of an ultrasound examination of the testes performed on or around 21 July 2014:
   a) A hypoechoic right testicle suggesting evidence of orchitis; and/or

13. In respect of Patient M, failed in radiological report dated on or around 22 July 2014 to record and/or identify the following finding(s) in respect of an ultrasound examination of the testes performed on or around 22 July 2014:
   a) A heterogeneous and/or hypervascular right testicle with a relatively clear epididymorchitis; and/or

14. In respect of Patient N, failed in radiological report dated on or around 12 July 2014 to record and/or identify the following finding(s) in respect of a CT examination of the brain performed on or around 12 July 2014:
   a) A dense right middle cerebral artery in keeping with acute infarction; and/or
   b) A right frontal hypodensity in keeping with acute infarction; and/or
   c) Hypodensity in the internal capsule in keeping with acute infarction; and/or

15. In respect of Patient O, failed in radiological report dated on or around 2 September 2014 to record and/or identify the following finding(s) in respect of a CT examination of the thorax, abdomen and pelvis performed on or around 2 September 2014:
   a) A peri-nephric haematoma; and/or
   b) Mesenteric stranding; and/or
   c) Free fluid in the pelvis; and/or

16. In respect of Patient P, failed in radiological report dated on or around 10 August 2014 to record and/or identify the following finding(s) in respect of a CT examination of the abdomen and pelvis performed on or around 10 August 2014:
   a) an intra-peritoneal haemorrhage; and/or
b) Active arterial bleeding within the pelvis; and/or

c) A cystic structure within the pelvis suggesting a possible rupture; and/or

d) That this was a potential surgical emergency; and/or

17. In respect of Patient Q, failed in radiological report dated on or around 8 September 2014 to record and/or identify the following finding(s) in respect of a CT examination of the pelvis performed on or around 8 September 2014:

a) A fractured sacrum; and/or

b) A calcified mass in the right iliac fossa; and/or

c) Extensive ascites; and/or

d) One or more calcified deposits; and/or

e) That the finding(s) identified at 17(c) and/or (d) above was/were in keeping with pseudomyxoma peritonei suggesting a possible rupture of a mucinous tumour of the appendix; and/or

18. In respect of Patient R, failed in radiological report dated on or around 24 July 2014 to record and/or identify the following finding(s) in respect of a CT urogram performed on or around 24 July 2014:

a) A calculus in the bladder; and/or

b) Left sided peri-nephric stranding; and/or

19. In respect of Patient S, a patient, failed in radiological report dated on or around 5 July 2014 to record and/or identify the following finding(s) in respect of a CT examination of the abdomen performed on or around 5 July 2014:

a) A collection in the gallbladder fossa measuring in or around 7 x 4.5 cm; and/or

b) One or more para-aortic nodes; and/or

20. In respect of Patient T, failed in radiological report dated on or around 5 September 2014 to record and/or identify the following finding(s) in respect of a CT examination of the brain performed on or around 5 September 2014:
a) A large pituitary adenoma; and/or

21. In respect of Patient U, failed in radiological report dated on or around 15 July 2014 to record and/or identify the following finding(s) in respect of a CT examination of the abdomen and pelvis performed on or around 15 July 2014:
   a) A liver abscess adjacent to the gallbladder identified; and/or

22. In respect of Patient V, failed in radiological report dated on or around 31 July 2014 to record and/or identify the following finding(s) in respect of a CT examination of the pelvis performed on or around 31 July 2014:
   a) That the fracture of the iliac bone extended into the anterior column; and/or
   b) A vertical fracture of the sacrum involving the foramina; and/or

23. In respect of Patient W, failed in radiological report dated on or around 31 July 2014 to record and/or identify the following finding(s) in respect of a CT pulmonary angiogram performed on or around 31 July 2014:
   a) An embolus in the right upper lobe pulmonary artery; and/or

24. In respect of Patient X, failed in radiological report dated on or around 26 June 2014 to record and/or identify the following finding(s) in respect of a CT pulmonary angiogram performed on or around 26 June 2014:
   a) One or more small pulmonary emboli in both lower lobes; and/or

25. In respect of Patient Y, failed in radiological report dated on or around 10 August 2014 to record and/or identify the following finding(s) arising from a CT examination of the brain performed on or around 10 August 2014:
   a) An incidental right orbital mass measuring in or around 12mm; and/or

26. In respect of Patient Z, failed in radiological report dated on or around 6 June 2014 to record and/or identify the following finding(s) in respect of a CT examination of the neck performed on or around 30 May 2014:
   a) A necrotic mass in the left tonsillar region; and/or
27. In respect of Patient AA, failed in radiological report dated on or around 24 July 2014 to record and/or identify the following finding(s) in respect of a CT examination of the thorax, abdomen and pelvis performed on or around 24 July 2014:
   a) A splenic artery aneurysm measuring in or around 13mm; and/or
   b) Possible cholecystitis; and/or
   c) A pelvic fluid collection; and/or

28. In respect of Patient BB, failed in radiological report dated on or around 22 July 2014 to record and/or identify the following finding(s) in respect of a CT examination of the thorax performed on or around 1 July 2014:
   a) A nodule in the apical segment of the left lower lobe measuring in or around 11mm; and/or

29. In respect of Patient CC, failed in radiological reports dated on or around 3 September 2014 and/or on or around 8 September 2014 to record and/or identify the following finding(s) in respect of CT examinations of the brain performed on or around 2 September 2014 and/or 8 September 2014:
   a) A right frontal subarachnoid haemorrhage; and/or
   b) A subarachnoid haemorrhage over the left temporal lobe; and/or
   c) A contusion in the right temporal lobe; and/or
   d) A newly appearing right sided parietal haemorrhage visible in the second CT scan (6 days post trauma). and/or

30. In respect of Patient DD, failed in radiological report dated on or around 10 August 2014 to record and/or identify the following finding(s) in respect of a CT examination of the abdomen and pelvis performed on or around 10 August 2014:
   a) A marked thickening of the sigmoid colon at the anastomosis; and/or

31. In respect of Patient EE, failed in radiological report dated on or around 4 June 2014 to record and/or identify the following finding(s) in respect of a CT examination of the thorax, abdomen and pelvis performed on or around 30 May 2014:
a) In or around 3 supra-clavicular nodes, 2 on the left hand side and/or one on the right hand side which would demonstrate cancer spread; and/or

32. In respect of Patient FF, failed in radiological report dated on or around 7 July 2014 to record and/or identify the following finding(s) in respect of a CT angiogram of the aortic arch and/or carotid performed on or around 7 July 2014:
   a) Occlusion of the left vertebral artery in the neck; and or
   b) Congenital abnormalities of the Circle of Willis; and/or

33. In respect of Patient GG, failed in radiological report dated on or around 24 July 2014 to record and/or identify the following finding(s) in respect of a CT examination of the thorax, abdomen and pelvis performed on or around 24 July 2014:
   a) Spread of a tumour into the spinal canal at T10 with possible compression of the spinal chord; and/or
   b) That the finding identified at 33(a) above was potentially an emergency; and/or
   c) That an MRI would be required to exclude cord compression; and/or

34. In respect of Patient HH, failed in radiological report dated on or around 5 July 2014 to record and/or identify the following finding(s) in respect of a CT examination of the abdomen and pelvis performed on or around 5 July 2014:
   a) Colitis within the descending colon; and/or

35. In respect of Patient II, failed in radiological report dated on or around 11 September 2014 to record and/or identify the following finding(s) in respect of a CT examination of the thorax, abdomen and pelvis performed on or around 11 September 2014:
   a) One or more mediastinal nodes; and/or
   b) A node at the gastro-oesophageal junction measuring in or around 2cm; and/or
   c) Gastro hepatic ligament; and/or
   d) Left para-aortic notes; and/or
   e) A likely pre-sacral recurrence at the rectal stump; and/or
36. In respect of Patient JJ, failed in radiological report dated on or around 3 September 2014 to record and/or identify the following finding(s) in respect of a CT examination of the thorax performed on or around 3 September 2014:
   a) A pleural based mass in the right lower lobe measuring in or around 3x5 cm; and/or
   b) A mass in the left renal bed measuring in or around 8cm; and/or
   c) A mass in the spleen measuring in or around 4 x 2cm; and/or
   d) A right adrenal lesion measuring in or around 3 cm; and/or

37. In respect of Patient KK, failed in radiological report dated on or around 13 August 2014 to record and/or identify the following finding(s) in respect of a CT examination of the abdomen and liver performed on or around 13 August 2014:
   a) One or more liver metastases; and/or
   b) A possible posterior rectal mass with one or more nodes; and/or
   c) A pulmonary nodule; and/or

38. In respect of Patient LL, failed in radiological report dated on or around 13 June 2014 to record and/or identify the following finding(s) in respect of a CT examination of the thorax, abdomen and pelvis performed on or around 10 June 2014:
   a) A nodule in the right middle lobe measuring in or around 9 mm; and/or

39. In respect of Patient MM, failed in radiological report dated on or around 3 September 2014 to record and/or identify the following finding(s) in respect of a CT examination of the thorax, abdomen and pelvis performed on or around 8 August 2014:
   a) A large pre-sacral mass; and/or

40. In respect of Patient NN, failed in radiological report dated on or around 19 August 2014 to record and/or identify the following finding(s) in respect of a CT examination of the chest, abdomen and pelvis performed on or around 5 August 2014:
   a) One or more pelvic nodes, including but not limited to peri-rectal and/or iliac; and/or
   b) A node anterior to the left pulmonary artery measuring in or around 14mm; and/or
c) One or more nodules in the right middle lobe and/or left upper lobe and/or left lower lobe; and/or

41. In respect of Patient OO, failed in radiological report dated on or around 13 August 2014 to record and/or identify the following finding(s) in respect of a CT examination of the chest abdomen and pelvis performed on or around 13 August 2014:
   a) An abdominal wall mass demonstrating spread or the lung tumour; and/or
   b) A mass adjacent to the left adrenal gland measuring in or around 6cm; and/or

42. In respect of Patient PP, failed in radiological report dated on or around 1 September 2014 to record and/or identify the following finding(s) in respect of a CT examination of the chest, abdomen and pelvis performed on or around 21 August 2014:
   a) A breast mass measuring in or around 6cm; and/or
   b) One or more sclerotic metastases in the thoracic spine; and/or
   c) A coeliac node measuring in or around 2 cm; and/or

43. In respect of Patient QQ, failed in radiological report dated on or around 26 August 2014 to record and/or identify the following finding(s) in respect of a CT examination of the thorax performed on or around 19 August 2014:
   a) A mass in the left lower lobe measuring in or around 6 cm; and/or
   b) Adjacent pleural thickening possibly representing a mesothelioma; and/or
Professional Misconduct and Poor Professional Performance

Appendix 3 (i)

That the registered medical practitioner,

1. Following Patient A’s labiaplasty surgery on or around 28 October 2011, failed to arrange any or adequate follow up care for Patient A; and/or

2. Following contact from Nurse A on or around 8 November 2011 in relation to complication(s) being suffered by Patient A:
   a. Failed to liaise with Patient A’s general practitioner in relation to the treatment for such complication(s); and/or
   b. Failed to refer Patient A to another appropriate specialist for treatment for such complication(s); and/or

3. In or around November 2011, having performed a surgery on Patient A on or around 28 October 2011, failed to arrange any or adequate cover for his period of absence from the Hospital; and/or

4. Following the procedure carried out on or around 17 November 2011, failed to arrange any or adequate follow up care for Patient A and/or abdicated responsibility for Patient A’s care to Nurse A and Dr A, Anesthetist and/or
Appendix 3 (ii)

That, the registered medical practitioner, over the period from September 2008 to 2011:

1. (a) Failed to follow the correct practice for the administration of primary childhood vaccines in that he failed to administer vaccines due on the same day as separate injections and/or in the correct site(s) in respect of one or more of the patients the subject matter of the Report of the HSE DML Incident Management Team dated March 2012.

   (b) Made inaccurate returns to the HSE in relation to the administration of primary childhood vaccines in that vaccines were incorrectly recorded as having been given in different limbs to the limbs in which there were actually administered.

2. From December 2010, the RMP administered the Pneumococcal Conjugate vaccine (PCV 7) for babies born after October 2010 instead of PCV 13 when he knew or ought to have known that this was inappropriate.

3. Failed to maintain any patient records and/or or accurate patient records for children vaccinated during the period from September 2008 to 2011.
Appendix 3 (iii)

The registered medical practitioner,

1. In circumstances where:
   a. the blood pressure monitor indicated that the Patient’s blood pressure was low; and/or
   b. the blood pressure monitor did not display a blood pressure reading; and/or
   c. the blood pressure monitor issued warning messages such as “long inflation time” and/or “weak pulsation”; and/or
   d. the blood pressure monitor alarm sounded,

   Failed, on one or more occasions, to take any or any adequate steps, during the course of the surgery, to include, but not limited to, one or more of the following:

   i. requesting the operating surgeon, Mr A, to step back from the operating table and then rechecking the blood pressure; and/or
   ii. changing, within an adequate time frame or at all,
      a. the position of the cuff connected to the Monitor; and/or
      b. the cuff itself or the monitor itself; and/or
   iii. taking the Patient’s pulse manually; and/or
   iv. ensuring that you had a continuous and reliable source of measurement of the Patient’s blood pressure; and/or
   v. informing the operating surgeon, Mr A, within an adequate time frame that you were experiencing difficulties in measuring the Patient’s blood pressure;

2. Absented yourself, on one or more occasions, from the theatre during the said surgical procedure, at all but especially in the circumstances set out at Allegations 1 a and/or 1 b and/or 1 c and/or 1 d; and/or

3. Failed to record in the anaesthetic chart:
a. the lower blood pressure readings that appeared on the blood pressure monitor; and/or

b. the blood pressure monitor having failed to display blood pressure readings; and/or

4. Made entries in the Patient's anaesthetic chart of one or more blood pressure readings in respect of which;

   a. you had no accurate measurement; and/or

   b. were inconsistent with the readings that had been displayed on the blood pressure monitor; and/or

5. Failed to record on one or more occasions the administration of ephedrine and its effects, if any; and/or

6. In the RMP's actions during the surgical procedure, fell seriously short of the standards of clinical judgment and/or performance that might reasonably be expected from a Consultant Anaesthetist to include on the one hand conducting your anaesthetic care in a manner that would suggest the RMP was comfortable that the Patient's blood pressure was within normal parameters, despite the readings appearing on the monitor, and yet on the other hand, administering ephedrine to raise the Patient's blood pressure and/or

7. Arising from one or more of the above, failed to have adequate regard for the Patient's safety; and/or
Appendix 3 (iv)

The registered medical practitioner,

1. Made one or more remarks of an inappropriate and/or a sexual nature to the Patient to include but not limited to:
   a. Stated that if women he were sexually involved with wanted rough sex with him that he was afraid that hr might get carried away and hurt them because he was so strong, or words to that effect; and/or,
   b. Responded to the Patient pulling her arm away from him by stating that he was demonstrating the move he uses on women who want rough sex because it diffuses the situation, or words to that effect; and/or

2. Squeezed and/or rubbed and/or touched the Patient’s shoulder(s) and/or back in an inappropriate manner; and/or,

3. Failed to treat the Patient with due dignity and respect; and/or,
Appendix 3 (v)

That the registered medical practitioner,

1. In his annual retention application form for registered medical practitioners in 2013, submitted on or around 21 June 2013, answered “No” to the following question:

   “Have you ever been convicted of a criminal offence in or outside this State?”

In circumstance where you knew or ought to have known that the response was not true, and/or;

2. In his annual retention application form for registered medical practitioners in 2013, submitted on or around 23 June 2013, answered “No” to the following question:

   “Have you ever been convicted of a criminal offence in or outside this State, or are you aware of any criminal investigations against you?

In circumstance where you knew or ought to have known that the response was not true, and/or;

3. That during the period from in or around 20 July 2011 to in or around January 2014, failed to notify the Medical Council that he had been convicted of one or more criminal offences in circumstances where he knew or ought to have known that you were obliged to notify the Medical Council of such material matters pursuant to section 55(6) of the Medical Practitioner’s Act, 2007, and/or;

4. That during the period from in or around January 2012 to in or around May 2012:
   a. treated his son for a depressive episode and/or anxiety, and/or
   b. Prescribed one or more medications to his son to include but not limited to, Lustral and/or Olanzapine.
5. That during the period from in or around January 2012 to in or around September 2013, failed to take any or adequate steps to ensure his son received appropriate and/or independent medical care in circumstances where he knew or ought to have known that such independent medical care was required, and/or
Appendix 3 (vi)

That the registered medical practitioner,

1. While practising as a surgical SHO failed to provide timely medical care to patients on the following occasions:
   
i. On or about 1 October 2012, while working in the day ward:
       (a) failed to respond to a number of bleeps/pages from nursing staff; and/or,
       (b) failed to admit patients and/or obtain patient consent to procedures on the day ward in a timely manner or at all; and/or,
   
ii. On or about the 5 October 2012, failed to respond to one or more bleeps/pages when his attendance was required in the day ward; and/or,

2. While practising as a Surgical SHO displayed poor and/or inappropriate and/or aggressive behaviour when interacting with colleagues/patients on the following occasions:
   
i. On or about 5 October 2012, attended the day ward, and spoke to members of staff, and in particular Ms A, student nurse and Ms B, staff nurse, in an aggressive manner; and/or,
   
ii. On or about 24 September 2012, spoke to the patient in an inappropriate manner, while trying to obtain her consent to continue his attempts at cannulation; and/or,

3. On or about 12 and/or 13 December 2013, while practising as a surgical SHO, in circumstances where Dr A, intern, required assistance in managing the care of a patient who was experiencing an upper gastrointestinal haemorrhage:
   
   (a) failed to respond clinically in a manner that contributed to the assessment, resuscitation and/or welfare of the patient; and/or,
   (b) left the ward without providing any support to the surgical intern and/or,
   (c) failed to implement a plan with regard to the immediate management and/or welfare of the patient; and/or,
   (d) failed to provide appropriate support to a junior member of the clinical team in circumstances where he was his more senior colleague; and/or,
4. While practising as an Orthopaedic SHO failed to provide timely medical care to patients on the following occasions:

   i. On or about the 28 January 2014, when asked to review a patient, who had experienced an episode of weakness, by Ms C:

      (a) were slow to react to assess the patient; and/or,
      (b) failed to appreciate the seriousness of the patient’s condition; and/or,
      (c) failed to make a timely referral to the relevant medical specialist; and/or,

   ii. On or about the 3 February 2014, in the context of being requested by Ms D, staff nurse, to attend to a patient who had presented with a bi-lateral calcaneum, and was experiencing significant pain, failed to attend to review the patient in a timely manner or at all; and/or,

   iii. On or about 30 January 2013, when working with Mr A, Orthopaedic Registrar challenged and/or refused to follow Mr A’s instruction to him to contact the on-call medical team to review a patient who had presented with a patellar fracture, in a timely manner or at all; and/or,

   iv. Between on or about 2 February 2014 to on or about 3 February 2014, failed to prioritise a 3 year old child’s admission in circumstances where he had presented with a fractured humerus and was awaiting orthopaedic review, in a timely manner or at all; and/or,

   v. On or about the 2 February 2014 to on or about 3 February 2014, in the context of attending to a patient who had been diagnosed with acute pancreatitis with elevated Amylase levels (700), failed to order a CT scan for the patient in the manner requested by Mr B, Senior Orthopaedic Registrar and Spine Fellow, in a timely manner or at all; and/or,
vi. On or about the 2 February 2014 to on or about 4 February 2014, in the context of attending to a patient who had undergone a hip-hemiarthroplasty, failed to document a telephone interaction with the consultant microbiologist, during which it was recommended that there should be a change to the patient’s antibiotic regimen, in timely manner or at all; and/or,

5. i. On or about the 13 January 2014 to on or about the 3 February 2014, in the context of affording care to an elderly patient who had presented with a neck of femur fracture, failed to demonstrate an adequate or any knowledge of proper prescribing practices in that he:

   a) prescribed a two week dose of OxyContin and Oxynorm to the patient in circumstances where this medication was not clinically warranted; and/or,
   b) Failed to review the patient’s drug chart in order to consider the patient’s medications while she was a patient in UHG; and/or,
   c) Failed to demonstrate an understanding of the level of pain that the patient was experiencing; and/or,
   d) failed to demonstrate a level of clinical knowledge expected of an SHO in that he was unable to explain the difference between OxyContin and Oxynorm when asked by a colleague; and/or,

ii. On or about the 13 January 2014 to on or about the 3 February 2014, in the context of attending to a patient, who was diagnosed with pulmonary oedema, failed to provide adequate care in that he:

   a) failed to intervene when the patient’s condition deteriorated; and/or,
   b) failed to take charge of the patient’s care; and/or,
   c) allowed an intern and nursing staff to take charge of the treatment of the patient; and/or,

6. While practising as an orthopaedic SHO demonstrated a lack of clinical knowledge and/or poor insight on the following occasions:

   i. On or about 1 February 2014, in the context of treating a patient who presented for a semi-elective tumour biopsy and had a low grade temperature on admission, failed to demonstrate the level of knowledge expected of an orthopaedic SHO, in that the RMP was not familiar with the appropriate blood tests to be carried out on the patient when asked by Dr B consultant orthopaedic surgeon; and/or,
   
   ii. Failed to demonstrate basic knowledge of protocols in relation to *inter alia*: antibiotic thromboprophylaxis and treatment, deep venous thrombosis prophylaxis and analgesia; and/or,
iii. On or about the 2 February 2014 to on or about 3 February 2014, failed to demonstrate an acceptable level of knowledge of infection control and/or appropriate aseptic practices for theatre in that he:
   a. after scrubbing his hands in preparation for theatre, proceeded to re-contaminate them by touching a non-sterile area; and/or,
   b. failed to wear theatre shoes or overshoe covers when entering an aseptic area; and/or,

iv. On or about the 2 February 2014 to on or about 3 February 2014, in the context of affording care to a 3 year old child who had presented with a fractured humerus, failed to display an adequate and/or any knowledge regarding the significance of non-accidental injury in children; and/or,

v. On or around 3 February 2014, while attending a trauma conference, failed to demonstrate an acceptable level of clinical knowledge in that he:
   a. failed to demonstrate an understanding of the implications for treatment for an intracapsular versus extracapsular fracture of the femur; and/or,
   b. failed to understand the implications of possible renal failure on the elderly when prescribing analgesia; and/or,

vi. On or about the 17 February 2014, during a trauma meeting/teaching session, misidentified an x-ray image of an ankle as being one of an elbow; and/or,
Appendix 3 (vii)

That the registered medical practitioner,

1. On or before 06 July 2013 failed to recite in his Curriculum Vitae furnished to the Hospital that he had worked in the another regional Mental Health Service, which failure was significant in circumstances where he knew or ought to have known that this Mental Health Service had concerns about his practice and/or had not provided/ would not provide him with a satisfactory reference; and/or

2. While practising as a locum Senior House Officer SHO at the Hospital between on or about 6 July 2013 and on or about 8 July 2013, failed to display the requisite level(s) of competence in one or more of the following areas which competence could reasonably be expected of a Senior House Officer providing safe medical care:

   a) Prescribing, to include appropriate dosage(s) and/or administration method(s) and/or frequency; and/or
   b) Knowledge of medication(s) and/or their appropriate application(s) and/or use(s); and/or
   c) Accurate and/or appropriate record keeping; and/or
   d) Ability to appropriately and/or adequately examine one or more patient(s); and/or
   e) Ability to respond appropriately to patient(s’) symptom(s); and/or
   f) Ability to identify and/or respond appropriately to a medical emergency; and/or

3. While practising as a locum SHO at the Hospital on or about 8 July 2013, in the context of affording care to Patient D:

   i) Did not have the ability and/or competence to manage a paracetamol overdose; and/or
   ii) Failed to take appropriate instruction and/or advice from a senior nurse in relation to the paracetamol overdose protocol; and/or
   iii) Failed to demonstrate an ability to communicate adequately or at all with the National Poison Information Service (“the NPIS”); and/or
Appendix 3 (viii)

That the registered medical practitioner:

1. On or around 10\textsuperscript{th} March, 2009 in relation to Patient A:
   
   a) Failed to adequately react and/or respond in relation to a course of treatment suggested by Nurse X upon Patient A’s admission to the hospital and/or
   
   b) Attempted to cannulate Patient A or were about to attempt to cannulate Patient A with the use of scalpel to cut Patient A’s hand and/or

2. On or around 10\textsuperscript{th} March 2009, attempted to read and/or examine a c spine x-ray while holding it upside down and/or

3. In or around the period 09 March 2009 to 12 March 2009:
   
   a) Asked a member of the hospital nursing staff whether a patient’s pulse rate reading of 165 beats per minute was high and/or
   
   b) Failed to cannulate a patient due antibiotics intravenously and/or

4. On or around 09 April 2009, made an excessive number of attempts to take a blood sample from patient B’s arm(s) and/or

5. During the period of in or around 30 March 2009 to in or around 12 April 2009, when he had been removed of all clinical responsibility and was being monitored Mr A, Consultant Surgeon and/or members of his team:
   
   a) Informed Mr A and/or members of his team that a patient was “fine” in circumstances where the patient had an abnormally low oxygen saturation value and was receiving oxygen in the intensive care unit and/or
   
   b) Informed Mr A and/or a member of his team that a patient had a benign prostate condition when that was not the case and/or
   
   c) Were unable to inform Mr A and/or a member of his team of the name of an artery on the foot called the dorsalis pedis artery and/or
   
   d) Were unable to identify the nasal bone in an x-ray when asked to do so by Mr A and/or a member of his team and/or
e) Were unable to inform Mr A and/or a member of his team of the medical term used to describe the symptom of difficulty in swallowing i.e. dysphagia and/or
f) Were unable to diagnose a fungal infection of a nail and/or
Appendix 3 (ix)

That the registered medical practitioner,

1. In relation to treatment provided him to the patient, Patient B during the period on or around 10 January 2008 -25 September 2008, on one or more occasions:
   A. Failed to take a skin biopsy and/or to arrange for a skin biopsy to be taken for review and/or
   B. Failed to inform Patient B’s general practitioner adequately or at all of the diagnosis, treatment and/or plan for management in respect of Patient B

2. In relation to treatment provided by you to your patient, Patient C during the period on or around 26 October 2007 - 21 May 2008, on one or more occasions:
   A. Failed to take a skin biopsy and/or to arrange for a skin biopsy to be taken for review and/or
   B. Failed to diagnose Patient C with crusted scabies and/or
   C. Failed to provide any or adequate treatment for Patient C’s condition and/or
   D. On or around 29 February 2008, upon examining Patient C and discontinuing his treatment with Methotrexate on or about 29 February 2008, failed to consider other differential diagnosis and/or take or arrange for a skin biopsy to be taken for review and/or
   E. On or around 7 March 2008, failed to provide appropriate treatment to Patient C in circumstances where you diagnosed Patient C with psoriasis and/or
   F. On or around 7 March 2008, prescribed Prednisolone to Patient C, which you ought to have known was not an appropriate treatment for psoriasis and/or
   G. On one or more occasions, abruptly discontinued the systemic steroids prescribed to Patient C, which you ought to have known was inappropriate in the circumstances and/or
   H. On or around the 18 April 2008, failed to inform Patient C’s sister adequately or at all in relation to the seriousness of Patient C’s condition and/or
   I. On or around 18 April 2008, failed to contact Patient C’s general practitioner to advise him of Patient C’s condition and/or the need for Patient C to be admitted to hospital and/or
   J. Failed to refer Patient C in a timely manner or at all to hospital and/or
   K. Failed to recognise the seriousness of Patient C’s condition and/or
   L. Failed to advise Patient C’s sister adequately, or at all, that Patient C should be admitted to hospital and/or
   M. Failed to apply appropriate standards of clinical judgment in the care afforded by you to Patient C and/or
N. Placed the health and safety of Patient C at risk and/or

3. In relation to treatment provided by you to your patient, Patient D during the period on or around 5 May 2008 – 2 October 2008:
   A. On or around 2 October 2008, increased Patient D’s dose of Neotigason to 25mg/BD, which you knew or ought to have known was inappropriate in the circumstances and/or
   B. On or around 2 October 2008, failed to take a blood test prior to prescribing the increased dose of Neotigason 25mg BD to Patient D and/or
   C. Failed to inform Patient D’s general practitioner adequately or at all of the diagnosis, treatment and/or plan for management in respect of Patient D and/or
   D. Failed to provide any or appropriate adequate treatment for Patient D’s condition and/or
   E. Failed to apply appropriate standards of clinical judgment in the care afforded by you to Patient D and/or
   F. Placed the health and safety of Patient D at risk and/or

4. In relation to treatment provided by you to your patient, Patient E, on or around 8 August 2008:
   A. Failed to take any pre-treatment blood tests for a baseline check for blood count and/or liver and/or renal function prior to prescribing methotrexate to Patient E and/or
   B. Failed to take blood tests or arrange for weekly blood tests to be carried out on Patient E to monitor Patient E during the course of his treatment with methotrexate and/or
   C. Failed to provide any or adequate treatment for Patient E’s condition and/or
   D. Failed to arrange any or adequate follow up for Patient E and/or
   E. Placed the health and safety of Patient E at risk and/or

5. In relation to treatment provided by you to your patient, Patient F on or around 13 March 2009:
   A. Failed to take a skin biopsy and/or to arrange for a skin biopsy to be taken for review and/or
   B. Failed to take any or adequate history from Patient F and/or
   C. Failed to take and/or arrange for any pre-treatment blood tests to be carried out for a baseline check for blood count and/or liver and/or renal function prior to prescribing Dapsone to Patient F and/or
   D. Failed to take blood tests or arrange for blood tests to be carried out on Patient F to monitor Patient F during the course of her treatment with Dapsone and/or
E. Failed to provide any or adequate treatment for Patient F’s condition and/or
F. Failed to arrange any or adequate follow up for Patient F and/or
G. Failed to apply appropriate standards of clinical judgment in the care afforded by you to Patient F and/or
H. Placed the health and safety of Patient F at risk and/or

6. In relation to treatment provided by you to your patient, Patient G, during the period on or around 12 November 2007 – 16 May 2008:
   A. On or around 30 January 2008, following a phone call from Patient G’s general practitioner indicating that Patient G had a non-healing ulcer at the side of the excised lesion, failed to review Patient G in a timely manner and/or
   B. Failed to provide adequate treatment for Patient G’s condition and/or
   C. Failed to arrange adequate follow up for Patient G and/or
   D. Failed to apply appropriate standards of clinical judgment in the care afforded by you to Patient G and/or

7. In relation to treatment provided by you to your patient, Patient H during the period on or around 31 July 2006 - 28 February 2008:
   A. On one or more occasions failed to take a skin biopsy and/or to arrange for a skin biopsy to be taken and/or
   B. Failed to provide any or adequate treatment for Patient H’s condition and/or
   C. Failed to arrange any or adequate follow up for Patient H and/or
   D. Failed to establish an adequate system of review to monitor Patient H’s condition and/or
   E. Failed, having diagnosed Patient H with eczema, to initially treat Patient H with topical treatments as opposed to systemic steroids and/or
   F. Failed to take a skin biopsy and/or to have a skin biopsy taken prior to prescribing Pimozide to Patient H on or around 28 February 2008 and/or
   G. Failed to inform Patient H’s general practitioner adequately or at all of the diagnosis, treatment and/or plan for management in respect of Patient H and/or
   H. Failed to apply appropriate standards of clinical judgment in the care afforded by you to Patient H and/or
   I. Placed the health and safety of Patient H at risk and/or

8. In relation to treatment provided by you to your patient, Patient J during the period in or around 21 May 2009:
   A. Failed to consider adequately or at all one or more differential diagnoses for Patient J’s condition and/or
   B. Prescribed Dapsone to Patient J without confirming Patient J’s diagnosis and/or
C. Failed to take and/or arrange for any pre-treatment blood tests to be carried out, for a baseline check for blood count and/or liver and/or renal function, prior to prescribing Dapsone to Patient J and/or
D. Prescribed a starting dose of Dapsone 200mg daily to Patient J which you knew or ought to have known that such dose was inappropriate and/or
E. Prescribed oral and topical steroids in addition to Dapsone to Patient J which you knew or ought to have known was inappropriate and/or
F. Failed to take blood tests or arrange for blood tests to be carried out on Patient J to monitor Patient J during the course of her treatment with Dapsone and/or
G. Failed to take any or adequate history from Patient J and/or
H. Failed to provide any or adequate treatment for Patient J’s condition and/or
I. Failed to arrange any or adequate follow up for Patient J and/or
J. Failed to apply appropriate standards of clinical judgment in the care afforded by you to Patient J and/or
K. Placed the health and safety of Patient J at risk and/or

9. In relation to treatment provided by you to your patient, Patient K on or around 30 March 2006:
   A. Failed to examine Patient K adequately or at all and/or

10. In relation to treatment provided by you to your patient, Patient L, on or around 25 January 2011 to on or around 14 March 2011:
    A. Failed to consider Patient L’s medical condition adequately or at all when making your differential diagnosis of psoriasis and/or
    B. Failed to examine Patient L adequately or at all when she attended your clinic in and around 25 January 2011 and/or
    C. Failed to take any or adequate history from Patient L and/or her sister when she attended your clinic in and around 25 January 2011 and/or
    D. Failed to examine Patient L adequately or at all when she attended your clinic in and around 8 March 2011 and/or
    E. Failed to review your initial diagnosis and/or prescribe appropriate treatment for Patient L when she attended your clinic in or around 8 March 2011 and/or
    F. Failed to consider immediate referral of Patient L to hospital when she attended your clinic in or around 8 March 2011 and/or
    G. Failed to provide any or adequate treatment for Patient L’s condition and/or
    H. Failed to arrange any or adequate follow up for Patient L and/or
    I. Failed to inform Patient L’s general practitioner adequately or at all of the diagnosis, treatment and/or management plan in respect of Patient L and/or
    J. Failed to apply appropriate standards of clinical judgment in the care afforded by you to Patient L and/or
    K. Placed the health and safety of Patient L at risk and/or
Appendix 3 (x)

That the registered medical practitioner,

1. In relation to patient, Ms “A”:
   a. Failed to perform an elective caesarean section with due skill, care and attention in that that he made a significantly asymmetrical and/or abnormal wound incision during the operation on or around 4 December 2013 and/or
   b. Failed to document the asymmetrical and/or abnormal wound incision made and/or

2. In relation to patient, “Ms B”:
   a. Failed to procure appropriate and/or informed consent prior to carrying out a membrane sweep on the occasion of the ante natal visit on 15 August 2013 and/or

3. In relation to patient, “Ms C”:
   a. Failed to ensure that you were familiar with all of Ms C’s relevant medical history on the occasion of her out-patient appointment on 19 August 2013 and/or
   b. Failed to perform any or any adequate speculum examination on or around the occasion of the said out-patient appointment referred to at 3(a) above and/or
   c. Failed to establish on or around the occasion of the said out-patient appointment referred to at 3(a) above whether Ms C was relying on the Mirena IUS for the purposes of contraception and/or management of her heavy menstrual bleeding and/or
   d. Failed to establish the presence or absence of Mirena coil threads on or around the occasion of the said out-patient appointment referred to at 3(a) above and/or

4. In relation to patient, “Ms D”:
   a. Failed to adequately assess Ms D and/or
   b. Failed to arrange, on or around 12 August 2013, for diagnostic testing for deep venous thrombosis by way of a lower limb Doppler ultrasound and/or
c. Prescribed Tinzaparin at a time when it was not appropriate for Ms D and/or

d. Failed to document the basis upon which you prescribed a dose of 3,500 units of Tinzaparin and/or

e. Failed to engage adequately with the Consultant on-call, Dr S, in relation to Ms D and/or

5. In relation to patient, “Ms E”

a. Undertook a speculum examination on or around 19 February 2014 in circumstances where you had not established the absence of placenta praevia and/or

b. Failed to make adequate enquiries as to whether Ms E had previously undergone an ultrasound and/or

6. In relation to patient, “Ms F”:

a. Failed to display any or any adequate surgical skill in respect the closure of the uterotomy on or around 22 January 2014 and/or

b. Failed, on or around 22 January 2014, to adopt a systematic approach to identifying angles and upper and lower borders of the uterotomy and/or

c. Failed to recognise that the said closure of the uterotomy on or around 22 January 2014 had been erroneous and/or substandard and/or

7. On or after commencing a post as an Obstetrics/Gynaecology Registrar at “the Hospital” on or around 24 July 2013, failed to comply, either adequately or at all, with one or more of the conditions attaching to the retention of the doctors name on the Specialist Division of the Register of Medical Practitioners and/or

8. Misrepresented to one or more of the appropriate representatives of the Hospital at an interview of the 28 June, 2013, that on restoration to the register, there would be no conditions attached to the retention of the RMP’s name on the Specialist Division of the Specialist Register of Medical Practitioners and/or
9. Failed to disclose to one or more of the appropriate representatives of the Hospital, around the time that he had commenced the post referred to at 8 above, the fact that there were conditions attaching to the retention of his name on the Specialist Division of the Specialist Register of Medical Practitioners and/or
**Appendix to Relevant medical disability**

Appendix 4 (i)
That Dr X suffers from a mental disability, to include but not limited to bipolar delusional disorder, which may impair his ability to practise medicine or a particular aspect thereof.

Appendix 4(ii)
That Dr X, being a Registered Medical Practitioner;

1. Suffers from one or more mental disabilities, to include persistent delusional disorder, which may impair his ability to practise medicine or a particular aspect thereof;

Appendix 4 (iii)
That Dr X suffers from a mental illness which may impair his ability to practise medicine or a particular aspect thereof.

Appendix 4 (iv)
That Dr X being a registered medical practitioner; suffers from a mental illness which may impair her ability to practise medicine or a particular aspect thereof.

Appendix (v)
That Dr X being a registered medical practitioner; suffers from a mental illness which may impair her ability to practise medicine or a particular aspect thereof.
Appendix to A contravention of a provision of the Act (including a provision of any regulations or rules made under the Act)

Appendix 5 (i)

That following the registered medical practitioner’s selection for participation in an audit by the Professional Competence Committee of the Medical Council at its meeting on or around 28 November 2012, the registered medical practitioner:

1. Failed to submit, pursuant to a request by the Professional Competence Section, the supporting documentation required by the Medical Council for the purpose of monitoring and assessing declared compliance with the Medical Council’s requirements in respect of professional competence schemes and as such breached the following:
   
   (a) Regulation 5 of the Medical Council Rules for the Maintenance of Professional Competence (S.I 171/2011) made pursuant to Section 11 of the Medical Practitioners Act, 2007 and/or Section 94(2) of the Act; and/or

2. Failed to comply with the Medical Council’s requirements when he became the subject of an audit and as such breached:

   a) Regulation 6 of the Medical Council Rules for the Maintenance of Professional Competence (S.I 171/2011) made pursuant to Section 11 of the Medical Practitioners Act, 2007; and/or

   b) And/or Section 94(2) of the Act; and/or

3. Failed to respond adequately or at all to correspondence sent to him by the Professional Competence Section of the Medical Council
Appendix 5 (ii)

That the registered medical practitioner;

1. Failed to comply with the Medical Council’s professional competence requirements in respect of one or more of the following professional competence periods and in so doing contravened Section 94 of the Medical Practitioners Act, 2007 and/or Rule 5 and/or Rule 6 of the Rules of the Maintenance of Professional Competence (No. 1) (S.I. 171 of 2011)
   i. 01 May 2014 to 30 April 2015; and/or,
   ii. 01 May 2015 to 30 April 2016; and/or,
Appendix 5 (iii)

1. That the registered medical practitioner following selection for participation in an audit by the Medical Council on or around 24 October 2013, failed to comply with Section 94(1) and/or 94(2) of the Act and/or one or more of the rules set out in the Rules for the Maintenance of Professional Competence (No. 1) (SI No. 171/2011); and/or
Appendix 5 (iv)

The registered medical practitioner,

1. Failed to comply with the Medical Council’s professional competence requirements, in respect of the professional competence period 01 May 2013 to 30 April 2014 and, in so doing, contravened Section 94 of the Medical Practitioners Act 2007 and/or the Rules for the Maintenance of Professional Competence (No. 1) (S.I. 171 of 2011); and/or,

   i. 01 May 2011 to 30 April 2012; and/or,

   ii. 01 May 2012 to 30 April 2013; and/or,

   iii. 01 May 2013 to 30 April 2014; and/or,
Appendix 5 (v)

That following the registered medical practitioner’s selection for participation in an audit by the Professional Competence Committee of the Medical Council at its meeting on or around 28 November 2012, the registered medical practitioner:

a) Failed to submit, pursuant to a request set out in a letter sent on or around 7 December 2012 by the Professional Competence Section of the Medical Council, the supporting documentation required by the Medical Council for the purpose of monitoring and assessing declared compliance with the Medical Council’s requirements in respect of professional competence schemes and as such breached the following:

   i. Regulation 5 of the Medical Council Rules for the Maintenance of Professional Competence (S.I 171/2011) made pursuant to Section 11 of the Medical Practitioners Act, 2007 and/or Section 94(2) of the Act; and/or

b) Failed to comply with the Medical Council’s requirements when he became the subject of an audit and as such breached:

   ii. Regulation 6 of the Medical Council Rules for the Maintenance of Professional Competence (S.I 171/2011) made pursuant to Section 11 of the Medical Practitioners Act, 2007; and/or Section 94(2) of the Act; and/or
Appendix 5 (vi)

That the registered medical practitioner;

1. Failed to comply with the Medical Council’s professional competence requirements in respect of one or more of the following professional competence periods and in so doing contravened Section 94 of the Medical Practitioners Act, 2007 and/or Rule 5 and/or Rule 6 of the Rules of the Maintenance of Professional Competence (No. 1) (S.I. 171 of 2011)
   
   i. 01 May 2014 to 30 April 2015; and/or,
   
   ii. 01 May 2015 to 30 April 2016; and/or,
Appendix 5 (vii)

That the registered medical practitioner;

1. Failed to comply with the Medical Council’s professional competence requirements in respect of one or more of the following professional competence periods and in so doing contravened Section 94 of the Medical Practitioners Act, 2007 and/or Rule 5 and/or Rule 6 of the Rules of the Maintenance of Professional Competence (No. 1) (S.I. 171 of 2011)
   i. 01 May 2014 to 30 April 2015; and/or,
   ii. 01 May 2015 to 30 April 2016; and/or,
Appendix to Failure to comply with a relevant condition and Relevant Medical Disability

Appendix 6 (i)

That the registered medical practitioner:

1. Failed to comply either adequately or at all with Condition (1) which was attached to his registration on the Register of Medical Practitioners on or around 11 March 2013, as follows:

   “You must place yourself and remain under the supervision of a GP and/or Psychiatrist and/or other Healthcare Professional nominated by you and acceptable to the Medical Council, and attend upon them as required and follow their advice and recommendations including particular reference to alcohol; and/or”

2. Failed to comply either adequately or at all with Condition (3) which was attached to his registration on the Register of Medical Practitioners on or around 11 March 2013, as follows:

   “You must make contact with the Health Sub Committee of the Medical Council and co-operate with all recommendations of the Sub Committee; and/or”

3. Suffers from a physical and/or mental disability, which may impair his ability to practice medicine or a particular aspect thereof.
Appendix to Professional Misconduct and a contravention of the Act

Appendix 7 (i)

That the registered medical practitioner,

1. On or around June 2013, answered “No” to one or more of the following questions in his Application Form for Registration in the Register of Medical Practitioners in circumstances where he knew or ought to have known that one or more of the said responses were not true;
   i. Have you given any undertaking regarding your entitlement to practice to any licencing or registration authority?; and/or

2. On or around June 2014, answered “No” to one or more of the following questions in his Application Form for Registration in the Register of Medical Practitioners in circumstances where he knew or ought to have known that one or more of the said responses were not true;
   i. Has any disciplinary process been commenced against you and/or have any findings been made against you by any other licensing or registration authority, in any jurisdiction?; and/or,
   ii. Have you given any undertaking regarding your entitlement to practice to any licencing or registration authority?

3. That the registered medical practitioner,
   i. Failed to give notice in writing to the Medical Council of one or more of the following material matters which were likely to affect the continuation of his registration, within 30 days of having knowledge thereof:
   ii. That on or around 19 November 2012 the registered medical practitioner provided an undertaking to the College of Physicians and Surgeons of Ontario, Canada to complete an educational program in communications; and/or,
   iii. That on or around 19 November 2014 his Certificate of Registration with the College of Physicians and Surgeons of Ontario, Canada was suspended by the Discipline Committee, effective from 19 November 2014 at 11:59pm;
Appendix 7 (ii)

That the registered medical practitioner,

1. On or around 20 June 2014, answered “No” to the following question in his Application Form for Registration in the Register of Medical Practitioners in circumstances where he knew or ought to have known that the said response was not true;

   “Has any Registration Authority ever Refused to Grant you Registration to Engage in the Practice of Medicine as a Registered Medical Practitioner?”

2. On or around 18 June 2015, answered “No” to the following question in his Annual Retention Application Form in circumstances where he knew or ought to have known that the said response was not true;

   “Has any licencing or registration authority refused to grant you registration or a practice licence or only granted conditional registration or a conditional licence?; and/or,”

3. Failed to give notice in writing to the Medical Council of the following material matter which was likely to affect the continuation of his registration, within 30 days of having knowledge thereof, namely that in or around 15 April 2015 his application for registration with the General Medical Council was refused; and/or,
Appendix 7 (iii)

That the registered medical practitioner:

1. Failed to comply with the Medical Council’s professional competence requirements in respect of one or more of the following Professional Competence periods and in so doing contravened Section 94 of the Medical Practitioners Act 2007 and/or Rule 5 and/or Rule 6 of the Rules for the Maintenance of Professional Competence (No. 1) (S.I. 171 of 2011):
   
   i. 01 May 2011 to 30 April 2012; and/or,
   
   ii. 01 May 2012 to 30 April 2013; and/or,
   
   iii. 01 May 2013 to 30 April 2014; and/or,

2. During the period in or around 18 November 2015 to in or around 28 June 2016 failed to respond adequately or at all to correspondence from the Medical Council and thereby his conduct amounted to conduct which doctors of experience, competence and good repute consider disgraceful or dishonourable; and/or,
Appendix 7 (iv)

That the registered medical practitioner,

1. Provided one or more false responses within sections 5 and/or 6(8) and/or 7 and/or 8(a) and/or 8(i) and/or 8(j) and/or 9(c) of his application for registration dated 15 April 2012 and that same amounts to professional misconduct

2. Failed to disclose to the Medical Council that his licence to practice in Nova Scotia, Canada had been revoked in or around October 2012 and that same amounts to a breach of section 55 (6) of the Act.

3 Failed to disclose the fact of disciplinary proceedings against him in Nova Scotia, Canada to one or more of the following:
   (a) North Lee Mental Health Services and/or
   (b) Cavan Monaghan Area Mental Health Service and/or
   (c) Locumotion, locum agency and/or
Appendix to Professional Misconduct and a conviction in the State of an offence triable on indictment or a conviction outside the State for an offence consisting of acts or omissions, that if one or made in the State, would constitute an offence triable on indictment

8 (i) That the registered medical practitioner,

1. On or around 26 May 2009, answered “No” to the following question in his Application Form for Registration in the Register of Medical Practitioners under the Provisions of the Medical Practitioners Act 2007 and Registration Rules 2009:

   i. Have you ever been convicted in a Court of law (including a drunken driving charge)? and/or
   
   In circumstances where he knew or ought to have known that the response was not true

2. On or around 26 May 2009, made a declaration in his Application Form for Registration in the Register of Medical Practitioners under the Provisions of the Medical Practitioners Act 2007 and Registration Rules 2009 that he knew: “…of no reason why the Medical Council should not grant [you] registration in the Register of Medical Practitioners in accordance with the provisions of the Medical Practitioners Act 2007, as amended by the Health (Miscellaneous Provisions) Act 2007”
   
   in circumstances where he knew or ought to have known that the declaration was not true and/or

3. On or around 05 June, 2014 at the Crown Court at Newry in the jurisdiction of Northern Ireland was convicted upon indictment of the following offences, which if committed in this State would be triable on indictment:

   i. On a date unknown between the 1st day of December 2004 and the 1st day of April 2007, in the County Court Division of Armagh and South Down, or elsewhere within the Crown Court jurisdiction of Northern Ireland, the registered medical practitioner conspired together and with other persons to use an instrument, namely, a document bearing the date the 6th December 2004 and purporting to be the signed will of Catherine Haughey deceased, which was false and which they knew or believed to be false with the intention of inducing another to accept it as genuine and by reason of so accepting did some act to his own or some other person’s prejudice contrary to Article 9(1) of the of the Criminal Attempts and Conspiracy (Northern Ireland) Order 1983 and Section 3 of the Forgery and Counterfeiting Act 1981;

   ii. On a date unknown between the 1st day of December 2004 and the 1st day of April 2007, in the County Court Division of Armagh and South Down, or elsewhere within the Crown Court jurisdiction of Northern Ireland, conspired together with other persons to use an instrument, namely, a purported agreement for the sale of property dated the 6th December 2004 between Catherine Haughey and Francis Tiernan, which was false and which they knew or believed to be false with the intention of inducing another to accept it as genuine and by reason
of so accepting it did some act to his own or some other person’s prejudice contrary to Article 9(1) of the Criminal Attempts and Conspiracy (Northern Ireland) Order 1983 and Section 3 of the Forgery and Counterfeiting Act 1981;
Appendix to Professional Misconduct, Poor Professional Performance and Relevant Medical Disability

Appendix 9(i)

That the registered medical practitioner,

1. On or about 11 July 2013, while under the supervision of Dr A, was unable to carry out any or adequate neurological examination on Patient A and/or admitted that he did not know how to carry out a neurological examination; and/or

2. On or about 28 July 2013, prescribed diazepam for Patient B without first making contact with Dr A notwithstanding that he had previously agreed to contact Dr A if there were to be any proposed clinical interventions; and/or

3. On or about 19 August 2013, failed to complete “referral to psychologist” forms accurately or at all in relation to Patient C, and, as a result, these referrals were declined; and/or

4. On or about 20 August 2013, failed to record within Patient D’s chart any adequate treatment plan; and/or

5. On or about 23 August 2013, prescribed an intramuscular anticholinergic to Patient E notwithstanding that he had previously agreed that he would contact Dr A if there were to be any proposed clinical interventions and/or when subsequently questioned by Dr A as to why he had prescribed it, he stated that the nurses had told him to so prescribe and that he did not know what it was; and/or

6. While under the supervision of Dr A, failed to demonstrate any or adequate understanding of one or more of the following:
   a. The function of the liver in the context of prescribing; and/or
   b. The difference between proprietary and generic medication; and/or
   c. Pharmacotherapy generally; and/or
   d. Malignant melanoma; and/or
   e. The management of a basic medical emergency; and/or
   f. CPR and the “ABC” of cardiac life support; and/or
   g. How to carry out a fundoscopy; and/or
   h. How to interpret simple tests such as a full blood count; and/or

7. On or about 24 September 2013, in a letter to Patient F’s GP, wrote “clozapine 70mg bd” which was the incorrect dosage and which required correction from Dr A; and/or
8. On or about 24 September 2013, in a letter to Patient G’s GP wrote “lamictal 30mg mane” which was the incorrect dose and which required correction from Dr A; and/or

9. On or about the 4 October 2013, in a letter to Patient H’s GP, wrote “flurazepam 0.5 mg tds” which was the incorrect dosage and which required correction from Dr A; and/or

10. On or about 7 October 2013, in relation to Patient I’s GP Prescribed an incorrect dosage of sertraline; and/or

11. On or about 15 November 2013, in a letter to Patient J’s GP, wrote “effexor 20mg” which is the incorrect dosage and required correction from Dr A; and/or

12. On or about 19 November 2013, in a letter to Patient K’s GP, wrote “lyrica 135 mg tds” and “lexotan 20mg” both of which were incorrect dosages and required correction from Dr A; and/or

13. On or about 19 November 2013, in a letter to Patient L’s GP wrote “quetiapine XR 15mg” which is the incorrect dosage and which required correction from Dr A; and/or

14. While under the supervision of Dr A, failed on one or more occasions to respond adequately or at all to one or more of the following requests/instructions:

   a. Upskill on basic physical examination skills; and/or

   b. Prepare for his supervision session(s); and/or

   c. Improve his understanding of basic medicine generally; and/or

   d. Improve his knowledge as to pharmacotherapy; and/or
Appendix to Poor Professional Performance and A contravention of a provision of the Act (including a provision of any regulations or rules made under the Act)

Appendix 10(i)

That the registered medical practitioner,

1) On or around 16 January 2013, while accompanying Dr M on a ward round;
   a) was unable to write an accurate record of Dr M’s examination(s) in one or more of the patients’ medical notes without being provided with assistance from Dr M; and or
   b) when Dr M asked him to order a kidney function(s), urea and electrolytes test did not appear to understand the nature of the test(s) and/or what it was Dr M was asking him to do; and or
   c) was unable to order a kidney function, urea and electrolytes test(s) for a patient despite Dr M explaining the process to him on more than one occasion.

2) In relation to the theatre list on or around 18 January 2013; during the theatre list contaminated the sterile field in that he touched Mr B, Consultant Paediatric Surgeon and/or Dr E; and/ or

3) On or around 21 January 2013; in relation to a patient undergoing a herniotomy procedure;
   a) despite being instructed not to consent any patient by Dr S and/or Mr B obtained consent from the patient’s parents; and/or
   b) obtained parental consent for an herniorrhaphy procedure in circumstances where he ought to have known the patient was scheduled for a herniotomy procedure; and/or
   c) indicated to Mr B on or around the 21 January 2013 that he believed that a herniorrhaphy procedure and a herniotomy procedure were the same procedure when he ought to have known that was not the case; and or

4) On or around 23 January 2013, brought a patient and family into a room on the day ward that may have posed an infection risk and/or remained in the room with the patient in circumstances where signage had been placed on the door that read “This Room needs to be cleaned-Please do not use” and/or there was a plastic yellow hazard sign in the room beside an area of water.
5) On one or more occasion(s) the RMP failed to attend in a timely manner and/or make himself available to the surgical team, including but not limited to any or all of the following:

   a. On or around 18 January 2013, despite being told by Mr B to take a 30 minute break between theatre cases at approximately 1.00pm, did not return to theatre until approximately 3.00pm; and/or
   b. On or around 21 January 2013, attended the Paediatric Surgery office at approximately 8.15 am in circumstances where Dr S told him to attend the day ward at 7.30 am on 18 January 2013 to admit patients; and/or

6) Failed to respond to a notice seeking information in relation to the events which form the basis of the allegations and/or sub allegations listed at 1-13 above, which issued to him pursuant to section 59(7) of the Medical Practitioner’s Act, 2007 by the Chairperson of the Medical Council’s Preliminary Proceedings Committee in or around the 2 October 2013.
Appendix to Professional misconduct and a failure by you to comply with a relevant condition and a contravention of the Medical Practitioners Act 2007

Appendix 11 (i)

That the registered medical practitioner:

1. Failed to comply with Condition (F) which was attached to his registration on the Register of Medical Practitioners by way of High Court Order dated 27 July 2015 and perfected on 30 July 2015 (“the Order”), as follows:

   “Within a period of 1 month following confirmation from the High Court, sign a declaration that you will comply with these conditions;”

2. On or after 30 July 2015, failed to engage with and/or respond either adequately or at all to one or more of the letters sent to him by the Medical Council in relation to:

   a) compliance with one or more of the conditions attaching to the registration of his name on the Register of Medical Practitioners pursuant to the Order, and/or;

   b) registration in a Professional Competence Scheme and/or participation in Continuing Professional Development (CPD), and/or;

3. On or after 6 October 2015, failed to comply with sections 94 (1) and/or 94 (2) of the Medical Practitioners Act 2007 and/or rules 5 and/or 6 of the Rules for the Maintenance of Professional Competence (No.1) (SI No. 171/2011), and/or
Appendix to Professional misconduct and relevant medical disability

Appendix 12 (i)

That the registered medical practitioner,

1. Concealed a camera phone in the toilet to record patients and staff of the Clinic undressing and/or using the toilet; and/or
2. Suffers from a relevant medical disability.
Appendix to Professional Misconduct, Poor Professional Performance and a contravention of the Act

Appendix 13 (i)

That the registered medical practitioner,

1. Carried out an examination of Ms A in circumstances where:
   a. A chaperone was not present and/or he did not provide Ms A with the option of having a chaperone present; and/or
   b. Some or all of the examination was intimate and he did not use gloves and/or
   c. Failed to procure any or any adequate consent in respect of some or all of the examinations referred to above.

2. Failed to respond to a notice seeking information in relation to the complaint, which issued to him pursuant to section 59(7) of the Medical Practitioners Act, 2007 by the Chairperson of the Medical Council’s Preliminary Proceedings Committee in or around the 2 October 2013.
Appendix to Professional Misconduct and failure to comply with a condition

Appendix 14(i)

That the registered medical practitioner:

1. In respect of the ground that he failed to comply with a relevant condition, that he failed to comply after 3 January 2012, either adequately or at all, with one or more of the conditions attaching to the retention of his name on the Register of Medical Practitioners within an adequate timeframe

2. Failed to respond either adequately or at all to one or more of the letters sent to him by the Medical Council in relation to his compliance with the conditions referred to in 1 above
Appendix to Professional Misconduct and breaching an undertaking

Appendix 15(i)

That the registered medical practitioner,

1. Failed to provide a medical report in a timely manner to Ms Ruth Lynch, Solicitor, of Mr Richard Grogan & Associates, being a firm of Solicitors practising at 16 &17 College Green, Dublin 2 (“the Complainant”).

2. Failed to reply, adequately or at all, to one or more letters and/or emails sent to him by the Complainant.

3. Failed to comply with an undertaking, in relation to the provision of medical reports, given by him in response to a request from the Fitness to Practise Committee pursuant to section 67(1) (a) of the Medical Practitioners Act, 2007 on 1 October 2012