Strictly Private and Confidential

REPORT OF PROFESSIONAL CONDUCT /HEALTH COMMITTEE FOLLOWING AN INQUIRY HELD PURSUANT TO SECTION 58 OF THE HEALTH AND SOCIAL CARE PROFESSIONALS ACT 2005 ("T HE ACT ").

Name of Registrant:	Ugochukwu Owoh (the "Respondent")
Registrant in Attendance:	Yes
Registration Board:	Radiographers Registration Board
Register:	Radiographers
Registration No:	RA007737
Registered Address:	[redacted]
Case Number:	C210 & C324
Date(s) of Inquiry:	28 and 29 November 2023
Members of Inquiry Committee:	Dr Shane Mc Carthy – Chairperson Daithi Tighe – Radiographer Registrant Member Sarah McNally – Occupational Therapist Registrant Member
Legal Assessor:	Frank Beatty SC
Appearances:	
For the Registrar:	Ms Caoimhe Daly, B.L. Instructed by Fieldfisher Solicitors
For the Registrant:	Donall O'Riordan, BL Instructed by Bowler Geraghty Solicitors
Inquiry held in Public	

The Nature of the Complaint that resulted in the Inquiry:

The Preliminary Proceedings Committee ("the Preliminary Committee") on the 25 November 2020, having considered all information furnished to them in relation to the complaint of [redacted] Radiography Services Manager III, [redacted] (the "Complaint") pursuant to Part 6 of the Act, was of the

opinion that there was sufficient cause to warrant further action being taken in relation to the Complaint against the Respondent on the grounds of professional misconduct within the meaning of Section 52(1)(a) and on the ground of poor professional performance within the meaning of Section 52(1)(b) of the Act respectively and as those terms are defined by Section 50 of the Act.

The Preliminary Committee referred the complaint to the Professional Conduct Committee on the ground(s) of professional misconduct and poor professional performance as set out in section 52(1)(a) and Section 52(1)(b) of the Health and Social Care Professionals Act, 2005

The Committee noted that the following allegations were contained in the Notice of Inquiry:

That the Respondent, being a registered radiographer employed at [redacted] ("the Hospital"):

1. *On or around 24 April 2022, at or around 05.00 when rostered 'on call', failed to complete his shift and/or left the Hospital early in circumstances where he failed to obtain any or any adequate permission to do so; and/or*

2. *On or around 24 July 2022, between at or around 00.12 and at or around 05.57 when rostered 'on call', failed to respond to one or more telephone calls and/or text messages from the Hospital switch board and/or the Respondent's colleagues; and/or*

3. *On or around 24 July 2022, having completed some or all of a 'FAST POSITIVE' brain examination on a stroke patient, ("Patient A"), failed to record the contrast details and/or failed to communicate appropriately with [redacted] the on-duty consultant radiologist, and/or failed to 'close and/or review' the examination in a timely manner and/or at all; and/or*

Evidence presented to the Committee:

The Committee heard evidence from the following witnesses on behalf of the Registrar by way of Witness Statements, which were agreed by the Registrar and the Respondent to be admitted without the necessity for formal proof and as to the truth of their content:

1. Statement of [redacted] dated 16 June 2023.
2. Supplemental Statement of [redacted] dated 15 August 2023.
3. Supplemental Statement of [redacted] dated 1 September 2023.
4. Statement of [redacted] dated 30 June 2023 (redacted).
5. Statement of [redacted] dated 7 September 2023.
6. Statement of [redacted] dated 24 August 2023.
7. Statement of [redacted] dated 12 June 2023.
8. Statement of [redacted] dated 1 September 2023.
9. Statement of [redacted] dated 13 June 2023.
10. Statement of [redacted] dated 30 August 2023.
11. Report of Suzanne Dennan dated 9th of October 2023.

The Committee also heard viva voce sworn evidence from Dr Dennan on 29 November 2023.

The Committee heard evidence from the following persons on behalf of the

Respondent:

None

The Committee considered the following exhibits:

1. Core Book.
2. Booklet of Witness statements.
3. Booklet of Documentation in respect of previous CORU Complaint.
4. Certificate Managing Pressure and Stress to Optomize Your Performance 18 November 2023.

Findings of the Committee:

Allegation 1

That the Respondent, being a registered radiographer employed at the Hospital, on or around 24 April 2022 at or around 05.00 when rostered "on call", failed to complete his shift and/or left the Hospital early in circumstances where he failed to obtain any or any adequate permission to do so.

FINDINGS AS TO FACT
The Committee is satisfied that Allegation 1 was proved as to fact beyond reasonable doubt.

REASONS
Allegation 1 was proved as to fact beyond reasonable doubt by reason of: -

1. The admission of the Respondent.

2. Further the Committee considered and accepted the following evidence: -

   (a) The documentation at Tab 1 of the Core Book including the rota that demonstrates that the Respondent was on 1st Call between 10pm on 23 July 2023 to 9am on 24 July 2023.

   (b) [redacted] uncontroverted evidence as contained in her witness statement. [redacted] stated that she was working as the CT Radiographer on call from 9:00am on 23 April 2022 until 9:00am on 24 April 2022. She stated that, at the time, CT Call was not in-house and so she came in at 9:00am on 23 April 2022 and worked through a list and that she went home when the list was finished so that she could come to the Hospital as required. She confirmed that the Respondent and [redacted] were both working in partnership in-house.

   [redacted] states she was called back into the Hospital at around 11:00pm on 23 April 2022 and she scanned 2 or 3 patients. She stated that she was leaving to go back home around 12:30am. She stated that every time a radiographer leaves, they sign out and note the time they are leaving. [redacted] recalled signing the book and asking the Respondent and [redacted] how they were getting on before she left.

   [redacted] stated that she got called back in or around 4.45am on 24 April 2022 and that, as she was driving into the Hospital at around 05:05am–05:10am, she noticed the Respondent driving past her towards where he lived. Further, she noticed that, when she drove into the Hospital car park, the Respondent's car was missing as it had been parked beside [redacted] car. She stated that she went in and scanned the patient and when she was leaving, she met [redacted] in the x-ray room and asked him whether the Respondent had said anything about an issue or if he was not feeling well. She stated that [redacted] stated that nothing was said, and he did not think that the Respondent had left the Hospital, and that he thought that the Respondent was still on site. She stated that [redacted] walked outside with her and realised that the Respondent's car had gone. She stated that she had to leave at this stage as it was 6:00am and she was finishing up her on-call shift. She stated that she walked up to where they got the keys for the apartment and asked whether

the Respondent took the keys but that he had not. [redacted] told [redacted] that the Respondent informed him that he was going to the ultrasound room. [redacted] confirmed that she did not notice anything unusual about the Respondent's demeanour on the night and that he appeared normal enough.

(c) The Committee considered and accepted the uncontroverted evidence contained in the Witness Statement of [redacted] confirmed that he was rostered with the Respondent to work in the Emergency Department on the night of 23-24 April 2022 and that the shift ran from 5:00pm on 23 April 2022 until 9:00am on 24 April 2022. He stated that, at 2:00am, himself and the Respondent split according to the arrangement of the Radiology Department, which is that, at 2:00am one person goes to bed and takes about 3 hours rest. He stated that he was the first to go to bed at 2:00am and that he left the Respondent working and he assumed he would work until 5:00am. He stated that before he left to rest, he talked to the Respondent and was told by the Respondent that he intended to sleep in the ultrasound room. He stated that he did not notice anything unusual about the Respondent on the night.

[redacted] stated that himself and the Respondent parted about 2:00am and then, at around 5:00am, he was bleeped to attend a patient, so he went back and did an x-ray. He stated that he could not find the Respondent but that this was normal as the Respondent would have taken his rest at this time. He stated that he continued to work until after 6:00am and then, [redacted] his colleague, walked in to sign out after doing a CT call. He stated that [redacted] told him that she saw the Respondent driving home and he responded to [redacted] by stating that the Respondent had told him that he was going to sleep in the ultrasound room. He stated that he checked for the Respondent's car, and it was not there.

(d) The Committee considered and accepted the uncontroverted evidence contained in the Statement of [redacted] stated that the radiographers should not go into the Ultrasound Room for their rest, but they may do so at times. She stated that there is an apartment outside the grounds of the Hospital and sometimes the radiographers do not want to walk in the middle of the night across the road for their break. She stated that the Respondent was paid to be on site, and he could have been called at any stage. She stated that this is why the apartment is so close to the Hospital because the radiographers are on call and are required on site, except when they are on their break, and this is when they go to the apartment.

[redacted] stated that [redacted] was on call with the Respondent on the night in question. She stated that, following the report of the Respondent's departure from the Hospital she brought [redacted] into the office and asked him whether the Respondent told him he had to go home early. [redacted] told her that the Respondent did not say anything to him and that he had thought that the Respondent was still on site.

[redacted] stated that the Respondent was off the next day after the incident and that [redacted] did not report the incident to her straight away. [redacted] stated that when the incident was reported to her, she rang the Respondent and asked whether it was true that he had left his shift early and he confirmed that he had. She asked the Respondent whether there was any reason that he left early, and he said that he had no reason. [redacted] confirmed that, if he was to leave early, he needed to inform his colleagues on the night.

(e) The Committee considered and accepted the uncontroverted evidence of [redacted] as contained in her witness statements. [redacted] stated

that she received an e-mail from [redacted] on 3 May 2022 reporting an incident that had occurred during the night of 23-24 April 2022 (contained at Appendix 6 of her Witness Statement). [redacted] stated that [redacted] reported the incident to her because it was a *serious* incident. She stated that the Respondent was paid to be on site until 9:00am. She stated that if a major trauma came in which required two radiographers, the Respondent was not there. She described it as a *major breach* and that this is why it was reported by [redacted] to her.

[redacted] stated that she is not aware of any written local policy or procedure detailing what course a radiographer needs to follow when leaving their shift early but that both the HSE Employee Handbook and the Managing Attendant's Policy and Procedures apply to the Respondent's employment, which provide that employees should not leave before the agreed or rostered finishing time and that they should render efficient and productive service by way of regular and uninterrupted attendances at work.

[redacted] stated that if someone needs to leave their shift, they must let a colleague know and ask them to cover. The Radiographer must then contact a Radiography Services Manager by text or phone call and say that they urgently need to leave and give an update on the Department so that management can see whether it is necessary to call somebody else in. [redacted] stated that a radiographer on call cannot leave the area without notifying somebody and that this is common sense when you are paid to be in work. She stated that, had there been a major trauma, the other radiographer on call with the Respondent would not have been able to find the Respondent.

3. Based on the uncontroverted evidence of Messrs. [redacted] and [redacted] the Committee is satisfied beyond reasonable doubt that on or around 24 April 2022, at around 5.00am, when rostered "on-call", the Respondent failed to complete his shift and left the Hospital early in circumstances where he failed to obtain any or any adequate permission to do so.

4. The Committee has considered the letter from Bowler Geraghty & Company dated 25 November 2022 wherein it is stated that the Respondent left because he was not feeling well and asserts that there was at all material times cover when the Respondent was absent. The Committee notes that this excuse is contrary to what the Respondent stated to [redacted] namely that he had no reason for leaving early. In any event, the Committee note that, even if he was feeling ill, there is no evidence that he communicated this to management and/or that fact that he was leaving. The Committee does not accept that there was sufficient cover or that this affords the Respondent an excuse for leaving, or that it explains his departure. The Committee accept Dr Drennan's evidence that the Respondent is expected to be on site and that on-call periods can be unpredictable and emergencies can happen so that even if it were quiet at a specific time, it could get busy later. Also, insofar as the Respondent tested Dr Drennan by asserting that the Respondent did not want to disturb [redacted] when leaving and this is why he did not inform him. The Committee accept Dr Drennan's opinion that, when on call, the Respondent is on call, he is rostered to work and is being paid so that he should remain unless he notifies colleagues that he is unable to stay.

PROFESSIONAL MISCONDUCT

The Committee is satisfied that Allegation 1, as proved, individually, amounts to Professional Misconduct beyond reasonable doubt.

REASONS

1. The Committee accepts the uncontroverted evidence of Dr Suzanne Dennan as contained in her Report that Allegation 1, if proved, individually, constitutes professional misconduct as being a breach of paragraphs 1(e), (f), 3.1(c), 13(f), 22(1)(a) and 22(1)(b) of the Radiographers Registration Board Code of Professional Conduct and Ethics adopted by the Radiographers Registration Board (contained in the Schedule to the Radiographers Registration Board Code of Professional Conduct and Ethics Bye-Law 2019 (S.I. 44/2019) (the "Code of Conduct") was breached. The Committee note also the uncontroverted evidence of Dr Drennan that Allegation 1, if found, was serious.

2. Further, the Committee note Dr Dennan's evidence that if a number of emergencies or a major trauma case had arisen, requiring both radiographers (first on-call and house-on call), then the required level of on-call radiographers was not in place once the Respondent left his shift. The Committee accept that this posed a serious risk to patient safety and that it would not have been possible for the Respondent to return to the Hospital within a safe timeframe to handle any emergencies without compromising patient care.

3. The Committee note also the evidence of Dr Dennan that the Respondent did not inform the other on-site house on-call radiographer [redacted] that he was leaving the Hospital so that the House and ED On-Call Service was covered during this time. [redacted] was unaware that the Respondent had left the Hospital. This could have resulted in him spending valuable time attempting to contact the Respondent for support if needed for emergency cases.

4. Dr Dennan noted in her report that the Respondent's on-call radiographer colleagues only became aware that he had left the Hospital because the off-site CT on-call radiographer [redacted] saw him leave in his car as she was driving to the Hospital at around 05:05 – 05:10. Dr Dennan notes that the Respondent stated that he had left his shift early because he was unwell but comments that the appropriate course of action, would have been for the Respondent to contact the House On-Call Radiographer [redacted] and inform him that he was unwell and needed to leave early urgently. She states that the Respondent should then have contacted his line manager, the Radiographic Services Manager (RSM) and explained that he needed to leave his shift early. She notes that the RSM could then have made the necessary arrangements to put alternative emergency on-call radiographer cover in place. Dr Dennan notes that Respondent did not inform the in-house on-call radiographer or the RSM that he was leaving. On-call radiographer resources needed to ensure that emergencies could be covered, and this was not in place by reason of the Respondent leaving his shift and not informing his colleagues.

5. Finally, Dr Dennan notes, and the Committee accepts, that the Respondent did not act in the best interest of patients as his actions put patient safety at risk because the required level of on-site radiographer on-call cover was not in place to manage unexpected and unpredictable emergencies. The Committee accepts Dr Drennan's opinion that, the Respondent did not act in the best interests of his on-call radiography team or work in partnership with them because they were unaware that he was not available to provide emergency support if needed and they would have been unable to manage emergencies requiring more than one radiographer or a major trauma case. The Committee accept that the Respondent failed to communicate with other members of the team to ensure safety continuation of patient care. The Committee accepts that, by leaving the Hospital

without informing the House On-Call Radiographer [redacted] and seeking permission to leave from the RSM, the Respondent did not carry out his duties in a professional way to protect the public or with honesty. The Committee accept also that, by not declaring to the RSM on his return to work the following week that he did not complete a shift he was paid to cover until 09:00am, the Respondent did not behave with integrity and honesty.

POOR PROFESSIONAL PERFORMANCE
The Committee is satisfied that Allegation 1, as proved, individually, amounts to Poor Professional Performance beyond reasonable doubt.

REASON

1. The Committee accept the uncontroverted evidence of Dr Dennan that Allegation 1, if proved, individually, amounts to Poor Professional Performance. The Committee note also the uncontroverted evidence of Dr Drennan that Allegation 1, if found, was serious.

2. The Committee note and accept the evidence of Dr Dennan that the Respondent did not exercise a professional duty of care to patients because his actions put patient safety at risk, as a required level of on-site radiographer on-call cover was not in place to manage unexpected and unpredictable emergencies. The Committee accepts Dr Dennan's evidence that the Respondent failed to act responsibly with his on-call radiographer team to ensure the best patient centered service delivery. Further, the Committee note and accept that the House on Call Radiographer [redacted] was unaware that the Respondent was not available to provide emergency support and would have been unable to manage emergencies that required more than one radiographer or a major trauma case. The Committee notes and accepts also that the Respondent did not communicate with other members of the team or the RSM to ensure safety and continuity of patient care. The Committee notes and accepts that the Respondent did not practice within the ethical boundaries of the profession by not declaring to the RSM on his return to work the following week that he did not complete a shift he was been paid to cover until 09:00am.

Allegation 2

That the Respondent, being a registered radiographer employed at the Hospital, on or around 24 July 2022, between at or around 00.12 and at or around 05.57 when rostered 'on call', failed to respond to one or more telephone calls and/or text messages from the Hospital switch board and/or the Respondent's colleagues.

FINDINGS AS TO FACT
The Committee is satisfied that Allegation 2 was proved as to fact beyond reasonable doubt.

REASONS
Allegation 2 was proved as to fact beyond reasonable doubt by reason of: -

1. The admission of the Respondent.

2. Further the Committee considered and accepted the following evidence: -

   (a) The documentation at Tab 2 of the Core Book including (i) the rota that demonstrates that the Respondent was on CT Call on 23 July 2023 into 24 July 2023, (ii) Patient

details relating to patient [redacted] being a 7 month old patient admitted after a fall with a head injury, multiple episodes of vomiting, drowsiness with "r/o intracranial bleed", (iii) calls that were made to the Respondent between 00.12am and 00:50am on 24 July 2023 and (iv) text messages between the Respondent and [redacted] wherein the Respondent states at 05.57 on 24 July 2023 that he did not hear his phone ring (and the Committee notes that the previous text from [redacted] was not read until 05.56am on 24 July 2023, i.e., immediately prior to him responding to [redacted]

(b) [redacted] uncontroverted evidence as contained in her witness statement. [redacted] stated that she found the Respondent to be hard-working and willing to help when asked.

She stated and the Committee accepts that, on 23-24 July 2022 [redacted] was rostered as first call/ ED (emergency department) in the Radiology Department of the Hospital, which meant that she started working at 5pm on the Saturday night (23 July 2022) and was on shift until 9am the following morning (24 July 2022).

[redacted] stated that another radiographer, [redacted] was rostered as House call. First call and House call work together and cover the same department, namely x-rays and in-house which is inpatients and ED. The only difference is that House call gets their rest period 2am until 5am whereas first call/ED gets their rest period from 5am until 9am. However, both remain on-site and available if they are needed until 9am.

[redacted] stated that she only got trained in CT towards the end of November 2022. CT has been in-house since then, so radiographers are now on call 24 hours a day. However, in July 2022, CT was on an 'on call' basis. This meant, as far as she understands the process, that the radiologist would contact the radiographer when a consultant contacted them. The radiologist would inform the radiographer of patients to be seen, and the radiographer would then have around an hour to get onsite. Therefore, at the time, the CT radiographer on call could be at home and just come in when they received a call.

(c) [redacted] uncontroverted evidence as contained in her witness statement. [redacted] stated that she was rostered to work on-call in the emergency department on the night of 23-24 July 2022. She remembers that her on-call shift started at 10pm on 23 July 2022. She stated that the Respondent was working as the CT radiographer on call on that night. She stated that, at around 11pm (and certainly before midnight), the Respondent was called in to scan a patient. [redacted] stated that it was a child who had a head injury. She stated that the Respondent did not respond or answer his phone. [redacted] stated that the switchboard tried to call the Respondent but could not get through to him. She stated that the switchboard then called ED and asked if they could get in touch with the Respondent. [redacted] stated that she tried to call the Respondent two or three times and each time it went to voicemail. She stated that she also tried to call another colleague to see if they knew whether the Respondent had another number that she could try him on. She stated that the colleague in question was not working and, therefore, she did not get through to him. When this colleague saw [redacted] missed call, he called her back to ask what happened and she explained.

[redacted] stated that she was working with a senior colleague, [redacted] and that she told her what was happening. [redacted] then reported it to the manager, [redacted] She stated that [redacted] requested her to go and scan the

child because no one could get through to the Respondent [redacted] was trained in CT and it was a trauma with a child. [redacted] stated that she went down and carried out the scan. She stated that, at around 5am, the Respondent called her back and she asked him where he was. The Respondent stated that he did not hear his phone. [redacted] told the Respondent that the department had been looking for him and that he would need to speak to the manager about it.

[redacted] stated that it is not normal practice for an ED radiographer to fill in for a CT radiographer if they cannot tend to a scan, nor the other way around. Each and everyone had their own role. There are two radiographers in ED and one radiographer in CT. ED is always busy and everyone is paid for their own work. She stated that she cannot go and do someone else's work unless it is agreed beforehand that cover was needed and then that would not be a problem once ED is not busy.

(d) [redacted] uncontroverted evidence as contained in his witness statement. [redacted] is employed as an operator at the Hospital, and has been for 12 years. [redacted] referred to Appendix 1 of his witness statement being the on-call sheet on 23-24 July 2022. He stated that he was rostered to work as the switch operator on 23-24 July and that he tried contacting the Respondent on a number of occasions but that the Respondent did not answer any of his calls.

(e) The Committee considered and accepted the uncontroverted evidence of [redacted] as contained in her witness statements. [redacted] stated that she received an email from [redacted] on 26 July 2022 reporting an incident that had occurred on the night of 23-24 July 2022 when the Respondent was not contactable whilst rostered as the CT radiographer on-call.

[redacted] stated and the Committee accepts that where ED requires a CT radiographer, the CT radiographer can make the difference in terms of getting the diagnosis and treatment for the patient. If a radiographer on call cannot be contacted, then time is lost and there will be delay in the patient's diagnosis and treatment and so it is significant. [redacted] stated that, in this instance, an infant required an urgent CT brain scan and only urgent exams are approved for an on-call service. The radiographer should be at the end of the phone as they get paid a stand-by rate and so the onus is on them to check their phone.

3. Based on the uncontroverted evidence of [redacted] and [redacted] the Committee is satisfied beyond reasonable doubt that on or around 24 April 2022, between at around 00.12am and at or around 05.57, when rostered "on-call", the Respondent failed to respond to one or more telephone calls and/or text messages from the Hospital switch board and/or the Respondent's colleagues.

4. The Committee has considered and taken into account the letter from Bowler Geraghty & Company dated 12 August 2022 wherein it is stated that the Respondent's mobile had its volume turned down inadvertently and that he was arranging for a land-line to be installed in his home to prevent this occurring again.

PROFESSIONAL MISCONDUCT

The Committee is satisfied that Allegation 2, as proved, individually, amounts to Professional Misconduct beyond reasonable doubt.

REASONS

1. The Committee accepts the uncontroverted evidence of Dr Suzanne Dennan as contained in her Report that Allegation 2, if proved, individually, constitutes professional misconduct as being a breach of paragraph 1(e) of the Code of Conduct. The Committee note also the uncontroverted evidence of Dr Drennan that Allegation 2, if found, was serious.

2. Further, the Committee notes and accept Dr Dennan's evidence that, as the radiographer on CT on-call, it was the Respondent's responsibility to ensure that he was always contactable. Whilst she stated that it is positive that the Respondent planned to install a landline to prevent a reoccurrence of this issue, the Committee accepts her opinion that the Respondent should have prevented this issue occurring by checking that his phone was not on silent and was working correctly before sleeping.

   The Committee notes Dr Drennan's opinion that, as a result of this error, an urgent CT scan was delayed unnecessarily with potentially serious patient care consequences for the young child. Also, the Committee notes and accepts Dr Drennan's opinion that the 1st on-call radiographer [redacted] covering the House/ED service, was required to leave his area of responsibility to perform this urgent CT scan. The Committee also notes and accepts that, during this time, service cover for ED and inpatients could have been compromised if there had been multiple emergencies or a major trauma case requiring two radiographers. Furthermore, the Respondent was not available to cover other CT on-call emergencies until he woke up at 05.56 and the Committee accepts Dr Dennan's evidence that the Respondent did not act in the best interests of patients because he did not do everything within his control to ensure the health, safety or welfare of this patient or other potential patients requiring emergency CT. He was covering CT on-call, and it was his responsibility to take all reasonable steps to ensure that he was always contactable for CT emergencies by checking that his phone was not on silent and was working correctly before sleeping. This omission on the Respondent's part resulted in an unnecessary delay for an urgent CT scan with potentially serious patient care consequences for this young child.

POOR PROFESSIONAL PERFORMANCE

The Committee is satisfied that Allegation 2, as proved, individually, amounts to Poor Professional Performance beyond reasonable doubt.

REASON

1. The Committee accept the uncontroverted evidence of Dr Dennan that Allegation 2, if proved, individually, amounts to Poor Professional Performance. The Committee note also the uncontroverted evidence of Dr Drennan that Allegation 2, if found, was serious.

2. Further, the Committee notes and accept Dr Dennan's evidence that, as the radiographer on CT on-call, it was the Respondent's responsibility to ensure that he was always contactable for CT emergencies and that, by not doing so, he did not exercise a professional duty of care to patients requiring emergency CT. The Committee notes and accepts Dr Drennan's evidence that the Respondent did not demonstrate the knowledge or understanding of the necessary steps required to maintain patient safety and that he Respondent could have prevented this issue and ensured that he was always contactable by checking that his phone was not on silent and was working correctly

before sleeping. The Committee accepts that this omission on the Respondent's part resulted in an unnecessary delay for an urgent CT scan with potentially serious patient care consequences for this young child. Also, the Respondent would not have been available to cover other potential CT emergencies until 05.56 and this also went to public safety and posed a serious risk to patient safety.

Allegation 3

That the Respondent, being a registered radiographer employed at the Hospital, on or around 24 July 2022, having completed some or all of a 'FAST POSITIVE' brain examination on a stroke patient, ("Patient A"), failed to record the contrast details and/or failed to communicate appropriately with [redacted] the on-duty consultant radiologist, and/or failed to 'close and/or review' the examination in a timely manner and/or at all.

FINDINGS AS TO FACT

The Committee is satisfied that Allegation 3 was proved as to fact beyond reasonable doubt.

REASONS

Allegation 3 was proved as to fact beyond reasonable doubt by reason of: -

1. The admission of the Respondent.

2. Further the Committee considered and accepted the following evidence: -

   (a) The documentation at Tab 3 of the Core Book including (i) the rota that demonstrates that the Respondent was on CT Call on 23 July 2023 into 24 July 2023, (ii) Patient details relating to patient being an 80 year old the subject of a request for a FAST POSITIVE CT Scan with a status of "2 Very Urgent", and (iii) text messages between the Respondent and [redacted] dated 24 July 2023.

   (b) [redacted] uncontroverted evidence as contained in her witness statement. [redacted] stated that an "angio study" is when dye is injected into a patient's vessel so that the dye is live in the vessels. The procedure is carried out when there is a stroke patient to check where the blocked vessel is located. There are two parts to the procedure involving the carrying out of a FAST + examination, the CT scan and then the angio study. This request is called a thrombolysis call and is where the patient is presenting with stroke-like symptoms. The sooner the scan takes place, the sooner that medication can be given to unblock the clot.

   A process is followed in the Hospital when a FAST + request is received. Firstly, the patient is brought in and assessed by the medical team. A thrombolysis alert then goes off which alerts doctors and porters that there is a FAST + patient in resuscitation. A doctor rushes to the resuscitation patient and the radiographer warms up a scanner and rings resus to tell them to come down with the patient when they are ready. The quicker this is done, the better chance the patient has of recovery.

   All radiographers in the Hospital can scan a brain but not all are trained in CT. Therefore, a radiographer in-house, while warming up the scanner, rings the CT radiographer on call at home and asks them to come in.

(c) The uncontroverted evidence of [redacted] stated that, when he is on-call, he gets a call from the team with a referral and he accepts the referral. He then calls the radiographer to inform them about the patients scan because they will need to perform the scan. After the radiographer performs the scan, it is closed in the PACS system (by the radiographer), and after the reviewing process (by the radiographer), he can then report the scan.

[redacted] stated that, in the case of a FAST+ scan, the radiographer has to inform the radiologist that the scan has been closed and reviewed so that he can report it. This is because it is a time sensitive situation for FAST+ scans. All teams are involved in the care of these patients, and there is a timeframe in which we have to respond for these types of scans. Therefore, the radiographer needs to inform him (the radiologist) when they have closed and reviewed a FAST+ scan (for any other scan, they do not need to inform the radiologist, as it will appear on their reporting list that they check regularly).

[redacted] exhibits a copy of the document that sets out the procedure to be followed when a FAST+ referral is received in the radiology department of the Hospital at Appendix 1 of his witness statement. [redacted] stated that it is the radiologist who accepts the scan and refers it to the radiographer. The radiographer then performs the scan and then calls the radiologist to say that the scan is done and closed and reviewed and the radiologist then reports it. The only difference between acute CVA scans (i.e. FAST+ scans) and other scans is that the radiographer needs to inform the radiologist that the scan is completed and reviewed when it is an acute CVA scan.

[redacted] stated that, on 26 July 2022, he sent an email to [redacted] Radiography Services Manager to inform her of an incident that had occurred on the morning of 24 July 2022 and a copy of the email was appended to his witness statement (for completeness, the Committee notes that [redacted] clarified an error in the body of his email where it should confirm that he was *not* informed by radiographer regarding the fast +scan). Otherwise, [redacted] is satisfied that the email accurately reflects his recollection of events on 24 July 2022 (subject to the clarifications contained in his witness statement).

[redacted] stated that [redacted] was the radiographer on call on 24 July 2022 and he contacted her asking whether she knew about the scan, but she did not. The scans were done but not reported and [redacted] asked that she close them. [redacted] also contacted the Respondent and asked that he review the scans. Whilst [redacted] knew that the Respondent's shift had ended, he wanted to be in contact with the person who scanned the patient and he refers to the text communication between himself and the Respondent.

[redacted] stated that acute CVA protocol necessitate certain scans to be reported within a certain timeframe and that the scans in question were very time sensitive as it determines when treatment can start to allow the patient improve.

3. Based on the uncontroverted evidence of [redacted] and [redacted] the Committee is satisfied beyond reasonable doubt that on or around 24 April 2022, having completed some or all of a FAST POSTIVE brain examination on a stroke patient, the Respondent failed to record the contrast details and/or failed to communicate appropriately with [redacted] and/or failed to close and review the examination in a timely manner or at all.

4. The Committee has considered and taken into account the letter from Bowler Geraghty & Company dated 14 September 2022 wherein it is stated that the Respondent was suffering from extreme anxiety and nervousness knowing the potential repercussions of his inadvertent error and that this state of distress caused him to fail to close the patient file properly notwithstanding that the work was complete.

PROFESSIONAL MISCONDUCT

The Committee is satisfied that Allegation 3, as proved, individually, amounts to Professional Misconduct beyond reasonable doubt.

REASONS

1. The Committee accepts the uncontroverted evidence of Dr Suzanne Dennan as contained in her Report that Allegation 3, if proved, individually, constitutes professional misconduct as being a breach of paragraphs 1(e), 1(f), 9 13 and 18 of the Code of Conduct. The Committee note also the uncontroverted evidence of Dr Dennan that Allegation 3, if found, was serious.

3. Further, the Committee notes and accepts Dr Dennan's evidence that the Respondent did not do everything within his control to enhance the health, safety and welfare of the patient concerned. The Committee notes that the Hospital has a thrombolysis protocol which the Respondent should have followed in order to ensure that the patient received treatment as soon as possible. The Committee is similarly satisfied that the Respondent did not follow the thrombolysis protocol because he did not complete the study correctly on RIS and he did not inform [redacted] that the study was ready for reporting and so he did not meet professional standards of practice and work in a safe and effective manner.

   The Committee accepts Dr Dennan's opinion that, by not informing [redacted] that the study was completed, the Respondent did not communicate clearly and effectively with other members of the team involved in the care of his patient to ensure the safety and continuity of care for his patient. The Committee accepts also that, had the Respondent contacted [redacted] upon exam completion, [redacted] would have been able to advise the Respondent earlier that the study could not be reported because the contrast details had not been added and the Respondent could have rectified this and closed the study on RIS before he left the hospital. In the circumstances, the Respondent did not ensure that all the records were completed as soon as practicable following the CT study.

   As regards the explanation that the Respondent stated through his solicitor that he was suffering from extreme anxiety and nervousness knowing the potential repercussions of the previous incident (the subject of Allegation 2) resulting in him failing to complete the study correctly on RIS during his on-call shift, Dr Dennan states that as a member of his team, the Respondent had professional responsibility for the service he provided to his patient regardless of any upset he was feeling about the previous incident during his on-call shift. The Respondent could have contacted the RSM for advice and sought immediate assistance from his on-call radiographer colleagues if he judged that his performance might be adversely affected by emotional distress and the Committee accept this opinion.

   The Committee accept the evidence of Dr Dennan that the FAST + CT brain examination is a time sensitive scan because the sooner treatment can be commenced, the better the outcome for the patient and the Respondent's failure to correctly close this patient's study on RIS and inform the consultant radiologist that the examination was ready for reporting,

resulted in a delay in the reporting of the CT study and an unnecessary delay in patient care.

POOR PROFESSIONAL PERFORMANCE

The Committee is satisfied that Allegation 3, as proved, individually, amounts to Poor Professional Performance beyond reasonable doubt.

REASON

1. The Committee accept the uncontroverted evidence of Dr Dennan that Allegation 3, if proved, individually, amounts to Poor Professional Performance. The Committee note also the uncontroverted evidence of Dr Drennan that Allegation 3, if found, was serious.

2. The Committee accepts Dr Drennan's evidence that the Respondent had a duty of care to his patient but that he did not operate in accordance with national and international guidelines for the optimal care of patients presenting with stroke-like symptoms. The Committee accept also that, by not informing the radiologist that the study was ready for reporting and not doing a handover with the day on-call CT radiographer, the Respondent did not contribute to effective team working to ensure the best patient-centred service delivery and he did not demonstrate appropriate communication skills and that the Respondent, as a diagnostic radiographer, must accept responsibility for his own work, operate within professional guidelines and ensure patient safety.

3. The Committee accept that insofar as the Respondent relies on his distress as explaining his failure to complete the study correctly, he should have contacted the RSM or his radiographer colleagues if he believed that his performance was affected by emotional distress. In this respect, also, the Committee accept that, by failing to close the patient's study on the RIS, the Respondent delayed the reporting of the CT study in question and this caused delay in patient treatment.

Other matters relating to the Respondent as the Committee considers is appropriate to specify:

The Committee recommends that the Council impose the Sanction of suspension of the Respondent's registration for a period of six months (from the date that such sanction becomes effective) pursuant to s.66(1)(c) of the Health and Social Care Professionals Act 2005 as amended (the "Act").

Rationale for Sanction:

1. The Committee has made findings in relation to Allegations 1, 2 and 3. These include findings that, on one occasion, on 24 April 2023, the Respondent, while on-call duty, failed to complete his duty and, on a further occasion on 24 July 2023 failed to answer calls when on on-call duty and failed to complete some or all of a FAST + brain examination on a stroke patient in a timely manner or at all. The Committee has found that each of Allegations 1, 2 and 3. Individually, constitute professional misconduct and poor professional performance.

2. The Committee considers that, except for the mitigating factors identified below, the appropriate sanction is cancellation of the Respondent's registration pursuant to s.66(1)(c) of the Act for the following reasons:-

(a) Allegations 1, 2 and 3, as found, are each serious incidences that go to public safety. The Committee note the evidence of [redacted] and Dr Drennan, as set out above, that the misconduct raised issues of significant patient risk and Dr Drennan's evidence that it included failures of follow-through, communication, continuity with patient care and inadequacies in team work.

(b) In relation to Allegation 1, the Respondent asserted that he failed to complete his shift because (i) he felt unwell, and (ii) there was cover in the Radiography Department. In relation to his claim that he felt unwell, this was unsubstantiated and is contrary to the uncontroverted evidence of [redacted] who stated that the Respondent informed her that he had no reason to leave his shift. Moreover, the Respondent leaving his shift for reasons of illness seems at odds with the fact that the Hospital approached him regarding his absence rather than him approaching them (at the time or after he left). As regards the Respondent stating that there was cover in the Department when he left, which is an assertion that he pursued during the hearing of the inquiry, this demonstrates a lack of insight and understanding, i.e., that his assessment of the demands on the Department could ever be justification for leaving the Radiology Department unannounced, and fails to address the risk of a subsequent emergency necessitating his presence consistent with the rota and his shift for which he was paid.

(c) Allegation 1 and Allegation 2 (with Allegation 3) consist of separate incidences where on different dates, the Respondent did not provide cover to Department of Radiology consistent with his rostered hours.

(d) Allegation 1 and Allegation 2 (with Allegation 3) occurred within 12 months of the Respondent giving an undertaking regarding his alleged conduct, that on-call on 28 June 2020, he was drinking beer when on a break at 9:15pm.

(e) Whilst the Respondent has undergone a course entitled "*Managing Pressure and Stress to Optimize Your Performance*" (November 2023), and has installed a landline and given the number to the Hospital, he has otherwise taken minimal steps by way of training or otherwise since 2022 to ensure that conduct such as that the subject of the findings relating to Allegations 1, 2 and 3 is not repeated.

3. In light of the mitigating circumstances identified below, the Committee recommends a sanction of suspension for a period of six months. The Committee makes the recommendation for the following reasons: -

(a) The Sanction highlights to the Respondent the serious view taken of the extent and nature of the misconduct to deter him from being likely to be guilty of similar or like conduct when he resumes practice.

(b) The Sanction of suspension points to the gravity of Professional Misconduct to other members of the profession thereby upholding the reputation of the profession and maintaining public confidence in the profession and the regulatory process and for the purpose of declaring and upholding professional standards.

(c) The sanction is necessary to protect the public. The misconduct raises issues of public safety and, as stated, the sanction highlights to the Respondent and other members of the profession the seriousness of the misconduct.

(d) The Committee consider the sanction of suspension to be the most lenient appropriate. Whilst the Respondent demonstrated insight by not concealing his misconduct at the time and by making admissions as to fact, professional misconduct and poor professional performance at the inquiry, and whilst this goes to his credit, the insight shown was limited and issues of insight remain..

(e) The Sanction of suspension is proportionate and affords the Registrant as much leniency as is appropriate. In this respect, the Sanction of suspension relates to the findings made and is aimed at correcting and deterring breaches of the Code that serve the public. It weighs up the interests of the public and the interests of the Respondent. The Committee considered each of the lesser sanctions (individually and in combination) provided for at s.66 of the Act but did not consider that such sanctions were appropriate or sufficient. The Committee consider that the period of six months regarding the suspension is proportionate as it balances the seriousness of the misconduct, the mitigating circumstances identified below and allows the Respondent to continue working in his chosen profession (following the period of suspension), which time period also give him the opportunity to reflect and acquire further insight. The Committee did not consider admonishment, censure or the imposition of conditions as appropriate or proportionate, individually or together, in circumstances where the conduct the subject of the findings was serious and went to public safety and in circumstances where they did not relate to clinical competency but were behavioural in nature.

4. The Committee has considered the CORU *Sanction Guidance Notes* including the factors to be considered when imposing (and in the case of the Committee, recommending) sanction including the sanction of suspension.

5. In recommending suspension, the Committee has considered the mitigating circumstances, including the following: -

(a) In relation to Allegation 2, the Respondent submitted that it was due to inadvertence as opposed to it being intentional. Also, in relation to Allegation 3, the Respondent submitted that it was due to stress caused by him realising that he had failed to respond to calls to his mobile when on-call (Allegation 2). The Committee has given the Respondent credit for these explanations when recommending sanction. Also, there was an overlap in relation to Allegation 2 and Allegation 3 insofar as the incidences related to the same shift.

(b) The Respondent admitted the Allegations and the fact that each individually constituted professional misconduct and poor professional performance and co-operated with the inquiry.

(c) The Respondent has taken undergone a course entitled "*Managing Pressure and Stress to Optimize Your Performance*" (November 2023) and has installed a landline and given the number to the Hospital.

(d) The Respondent was subject to an Investigative and/or Disciplinary process at the workplace and received a written warning and that this has resulted in him not being on-call since the investigation up to the time of this Inquiry with consequential financial loss.

(e) The witness statements include reference to the Respondent being a technically good radiographer and a willing and supporting staff member.

Despite these mitigating circumstances, the Committee consider a six-month suspension necessary due to nature and seriousness of the misconduct and the fact that the Respondent showed limited insight. The recommended Sanction is necessary in light of the risk to the public caused by the misconduct and as it points to the gravity of the professional misconduct and poor professional performance to the Respondent and other members of the profession thereby upholding the reputation of the profession and maintaining public confidence in the profession and the regulatory process and declaring and/or upholding professional standards.

Chairperson

Date 30th November 2023