IN THE PROFESSIONAL CONDUCT COMMITTEE OF THE SRI LANKA MEDICAL COUNCIL

In the matter of a disciplinary inquiry conducted pursuant to the provisions of the Medical (Disciplinary Procedure) Regulations, 1990

INQUIRY NO. PPC 366 / PCC 21

BETWEEN

Mr. Masilamani Uthayakumar
[Complainant]

AND

Dr. Selvarajah Suganthan
[Respondent]

Date of Decision: Saturday, 29th August 2026.

Appearance : Ms. Udari Ranathunga, Attorney – at - Law for the Complainant
Mr. Aswida Benedict, Attorney – at – Law for the Respondent

RESERVED FINAL DECISION

A. INTRODUCTION

1. This inquiry arises from a complaint made by Mr. Masilamani Uthayakumar, the father of the late Mr. Uthayakumar Vinson (hereinafter referred to as the "Complainant"), by way of an affidavit dated 15th August 2013 concerning the medical care provided to his son at the District General Hospital, Kilinochchi. At the time of the alleged incident, the Respondent, Dr. Selvarajah Suganthan, was serving as a Medical Officer covering the Hospital's Out-Patient Department and Emergency Treatment Unit.

2. In his affidavit, the Complainant stated that the deceased, who was 23 years of age, had sustained a head injury during the war in 2009 and thereafter occasionally experienced headaches. According to the Complainant, on 20th May 2013, the deceased developed a severe headache accompanied by fever, vomiting and tiredness and was admitted to the Emergency Treatment Unit at approximately 1.44 a.m. The Complainant further alleged that the deceased had a pus-discharging wound on his forehead but was given only two Paracetamol tablets and that no blood test, scan or X-ray was performed.

3. The Complainant further alleged that the deceased was allowed to leave the Emergency Treatment Unit during the same morning without being formally discharged and without either the deceased or any person acting on his behalf signing the Bed Head Ticket. According to the affidavit, the deceased was thereafter found unconscious at the Kilinochchi bus stand and was brought home by his son-in-law. He died at approximately 5.00 a.m. on 21st May 2013. The Complainant stated that the post-mortem examination recorded the cause of death as a brain abscess and alleged that the death resulted from the Respondent's failure properly to examine, diagnose, investigate and treat the deceased.

4. Following the complaint made by way of the aforesaid affidavit and the completion of the prescribed preliminary procedure, a Notice of Inquiry dated 17th July 2020 was issued and served upon the Respondent, setting out six charges. The Respondent appeared before the Professional Conduct Committee (hereinafter referred to as the "PCC") and, upon the charges being read to him, pleaded not guilty to all six charges.

B. THE CHARGES

5. The charges preferred against the Respondent are reproduced below in substance and, where necessary, with only obvious typographical corrections which do not alter their meaning.

Charge 01

During the period from 20th May 2013 to 21st May 2013, while functioning as the Medical Practitioner at the Out-Patient Department (OPD) and/or Emergency Treatment Unit (ETU) of the District General Hospital, Kilinochchi, the Respondent failed to perform his professional duties with due diligence in treating the patient named U. Vincent by failing to record the patient is mentally ill in the Bed Head Ticket and failed to diagnose the patient had an organic illness by examining the external wound in the head amounts to negligence in professional respect.

Charge 02

During the same time period, same tenure during the same course of events in Charge 1 above, by failing to properly report/record the observations/identifications in the Bed Head Ticket of the patient named U. Vincent, thereby acting negligently in a professional respect.

Charge 03

During the same period, tenure and course of events, the Respondent wrongfully recorded in the Bed Head Ticket of U. Vincent that the patient had been discharged when he had not been discharged, thereby acting negligently in a professional respect.

Charge 04

During the same period, tenure and course of events, the Respondent failed to give proper instructions to the nursing staff to keep the patient named U. Vincent under observation, which led the patient to move out of the Hospital without being discharged, which amounts to negligence in a professional respect.

Charge 05

By acting in the manner described in Charge 1 and/or Charge 2 and/or Charge 3 and/or Charge 4, the Respondent acted in a manner which brought disrepute to the medical profession.

Charge 06

By doing one or more of the acts set out in Charges 1 to 5, the Respondent acted in an unethical manner, brought the medical profession into disrepute and acted in violation of the "Guidelines on Ethical Conduct for Medical and Dental Practitioners registered with the Sri Lanka Medical Council" and the "Sri Lanka Medical Council Instructions on Serious Professional Misconduct to Medical Practitioners and Dentists" published by the Sri Lanka Medical Counsil in terms of the Medical Ordinance and amendments hereto.

C. PROCEEDINGS AND MATERIAL PLACED BEFORE THE COMMITTEE

6. The disciplinary inquiry commenced before the Committee on 29th October 2022. The Prosecution called the Complainant, Mr. Masilamani Uthayakumar, who testified under oath. The Prosecution relied upon the Bed Head Ticket of the deceased, marked X1, and the post-mortem report, marked X2, including the summary at page 3, marked X2(a), and the diagram of the left side of the head at page 9, marked X2(b).

7. Upon the conclusion of the Prosecution case, the Respondent gave evidence on 28th April 2023. He relied upon his written explanation dated 6th April 2021, marked as R1. Further, the proceeding at which the Complainant had given evidence was marked "R2".

8. The Committee has considered the oral and documentary evidence and the written submissions tendered on behalf of both parties.

D. BURDEN AND STANDARD OF PROOF

9. The legal burden rests upon the Prosecution throughout the inquiry. The applicable standard is the balance of probabilities. The Committee must be satisfied, upon an objective evaluation of the evidence as a whole, that the conduct alleged is more probable than not to have occurred.

10. The seriousness of the allegations does not alter the applicable standard of proof. It does, however, require the Committee to examine the evidence with particular care. The findings of professional misconduct cannot be based upon suspicion, conjecture, hindsight or the unfortunate outcome alone. The evidence supporting an adverse finding must be clear, cogent and convincing, having regard to the gravity of the allegations and the serious professional consequences that may follow.

11. In ***In Re Dematagodage Don Harry Wilbert*** [1989] 2 Sri L.R. 18, the Supreme Court recognised that, although disciplinary proceedings are not criminal proceedings, their consequences may be penal in nature. Accordingly, a finding of professional misconduct must be founded upon clear, cogent and convincing evidence. The Committee has applied that principle in evaluating the evidence placed before it in this inquiry.

E. ELEMENTS OF THE CHARGES TO BE PROVED

12. Charges 1 to 4 allege professional negligence arising from the Respondent's treatment and management of U. Vincent at the Out-Patient Department and/or Emergency Treatment Unit of the District General Hospital, Kilinochchi, during the period from 20th May 2013 to 21st May 2013. The Prosecution must establish that, at the material time and place, the Respondent was functioning as a medical practitioner; that U. Vincent was under his professional care; that he committed the alleged act or omission; and that he thereby failed to exercise the care, skill and diligence reasonably expected of a medical practitioner in the circumstances. An adverse outcome or the patient's subsequent death would not, by itself, prove negligence.

13. To establish **Charge 1**, the Prosecution must prove that, between 20th and 21st May 2013, while functioning as a Medical Practitioner at the OPD and/or ETU of the District General Hospital, Kilinochchi, the Respondent treated U. Vincent; failed to record in the Bed Head Ticket that the patient was mentally ill; and failed to diagnose an organic illness by examining the external wound on the patient's head.

14. To establish **Charge 2**, the Prosecution must prove that, during the same period and course of events, the Respondent failed properly to report or record his observations or findings concerning U. Vincent in the Bed Head Ticket.

15. To establish **Charge 3**, the Prosecution must prove that, during the same period and course of events, the Respondent recorded in the Bed Head Ticket that U. Vincent had been discharged when, in fact, he had not been discharged, and that this incorrect recording amounted to negligence in a professional respect.

16. To establish **Charge 4**, the Prosecution must prove that, during the same period and course of events, the Respondent failed to give proper instructions to the nursing staff to

keep U. Vincent under observation; that the patient consequently left the Hospital without being discharged; and that the Respondent's failure amounted to negligence in a professional respect.

17. **Charge 5** is consequential upon Charges 1 to 4. The Prosecution must first establish one or more of the acts or omissions alleged in those charges. It must further prove that the established conduct, having regard to its nature and seriousness and viewed objectively, brought or was reasonably capable of bringing the medical profession into disrepute.

18. To establish **Charge 6**, the Prosecution must prove one or more of the acts or omissions alleged in Charges 1 to 5. It must identify the particular ethical or professional obligation contained in the cited Sri Lanka Medical Council Guidelines or Instructions that applied to the Respondent at the material time and establish how his conduct violated that obligation. It must further demonstrate that the proved conduct was sufficiently serious to constitute unethical conduct or serious professional misconduct and brought, or was reasonably capable of bringing, the medical profession into disrepute.

F. THE EVIDENCE OF THE COMPLAINANT

19. The Complainant in his evidence acknowledged that he had submitted an affidavit to the Sri Lanka Medical Council. He stated that the affidavit had been prepared in English by a lawyer based on the information narrated by him. He also admitted that he did not understand English. The Complainant further stated that the deceased had sustained a head injury during the war. According to his evidence, the injury had not completely healed, and pus had formed at the site of the injury on several occasions.

20. The Complainant stated that, on the occasion relevant to this inquiry, the deceased complained of a headache and had pus at the site of the injury. The deceased was admitted to the Emergency Treatment Unit of the District General Hospital, Kilinochchi, at approximately 1.44 a.m.

21. The Complainant's evidence was that the deceased subsequently left the Hospital after being discharged from the Emergency Treatment Unit. He was brought home by the Complainant's son-in-law. According to the Complainant, the deceased was conscious, was able to walk and complained of a headache when he returned home. The Complainant stated that the deceased died at approximately 6.00 a.m. on the following day.

22. When questioned about the alleged injustice suffered by the deceased, the Complainant stated that the deceased had been given only two Panadol tablets for his complaint of a headache and that there was pus in the wound on his head when he returned home. When

asked how he knew that only two Panadol tablets had been given, the Complainant stated that the deceased himself had told him so:

ප්‍ර: මොකක්ද තමන්ගේ පුතාට වෙච්ච අසාධාරණය කියලා තමුන් නිශ්චිතව කියන්න පුළුවන්ද?

පි: ඔළුව කැක්කුමයි කියලා කියපු එකට පැනඩොල් පෙති 2ක් විතරයි දුන්නේ පුතා ගෙදර එනකොට ඔළුවේ සැරව තිබ්බා.

ප්‍ර: පැනඩොල් විතරයි දුන්නේ කියලා මහත්මයා දැන ගත්තේ කොහොමද?

පි: පුතා තමයි කිව්වේ පැනඩෝල් 2ක් දීලා තමයි එව්වේ කියලා.

(Vide page 03 of the Proceedings dated 22.10.2022)

23. During cross-examination, the Complainant accepted that he had not accompanied the deceased to the Hospital and had not been present when the deceased was examined or treated. His evidence was that his son-in-law had taken the deceased to the Hospital and had subsequently brought him home. The Complainant was questioned specifically about the condition of the deceased when he was brought home. He maintained that the deceased was conscious and spoke with him:

ප්‍ර: තමුන්ගේ පුතා ගෙදර ඇවිල්ලා කතා කළා ද?

පි: ඔව්.

(Vide page 05 of the Proceedings dated 22.10.2022)

24. The Complainant was also questioned about the preparation of his affidavit. He stated that it had been prepared in English by a lawyer based on the correct information given by him.

25. During cross-examination, Learned Counsel for the Respondent drew the Complainant's attention to paragraph 11 of his affidavit. Although that paragraph stated that the deceased had been brought home by the Complainant's son-in-law in an unconscious condition, the Complainant testified that the deceased was conscious when he was brought home.

26. Learned Counsel contrasted that statement with the Complainant's oral testimony that the deceased was conscious when he was brought home, was able to walk and spoke with him. A difference therefore arose between paragraph 11 of the affidavit and the Complainant's oral evidence concerning the condition of the deceased when he was brought home.

(Vide pages 05 of the Proceedings dated 22.10.2022)

G. OBJECTION RAISED ON BEHALF OF THE RESPONDENT

27. The Learned Counsel for the Respondent referred the Committee to Regulation 2(4) of the Medical Disciplinary (Procedure) Regulations 1990, published in Gazette Extraordinary No. 757/7 dated 10th March 1993. Counsel submitted that, where a person makes a complaint based upon facts or matters which are not within his personal knowledge, the complainant is required to disclose how those matters came to his knowledge and to identify the evidence or material upon which they are based.

28. Moreover, the Learned Counsel submitted that the Complainant had not produced evidence or other material establishing the source of information relating to matters which he had not personally observed. It was further submitted that, in giving evidence before the Committee, the Complainant had stated that the affidavit had been prepared for him by a lawyer and that he had signed it.

29. The Learned Counsel therefore contended that the affidavit did not satisfy the requirements of Regulation 2(4) and was contrary to that regulation. He relied upon two matters in support of the objection: first, the alleged failure to disclose and establish the source of matters which were outside the Complainant's personal knowledge; and secondly, the circumstances in which the affidavit had been prepared and signed.

30. On those grounds, Learned Counsel submitted that the complaint should not be permitted to proceed further and respectfully invited the Committee to dismiss the complaint against the Respondent.

H. RESPONSE OF THE PROSECUTION

31. In response, Learned Counsel appearing for the Prosecution submitted that the Preliminary Proceedings Committee had already considered the complaint and the material placed before it and had submitted its report and recommendation to the Professional Conduct Committee that a *prima facie* case existed against the Respondent. He further submitted that the Complainant had now given evidence before the Professional Conduct Committee and had placed his position before the Committee under oath.

32. The Prosecution submitted that any difference between the contents of the affidavit and the oral evidence given by the Complainant was a matter affecting the evidentiary value and weight of his testimony. Such a matter should be evaluated by the Committee when considering the entirety of the evidence and delivering its final determination.

33. The Prosecution therefore requested the Committee not to dismiss the complaint or make a final determination upon the objection at that stage. Counsel submitted that the

Committee should first hear all the evidence and thereafter consider both the objection raised by the Respondent and the evidentiary value to be attached to the Complainant's testimony.

I. DETERMINATION OF THE OBJECTION

34. The Committee has carefully considered the objection raised by Learned Counsel for the Respondent, the response of the Prosecution, the affidavit of the Complainant, his oral testimony and Regulation 2(4) of the Medical Disciplinary (Procedure) Regulations 1990. For the following reasons, the objection is overruled.

(a) Regulation 2(4) provides that, where a fact stated in an affidavit is not within the affirmant's personal knowledge, the affidavit must identify the source of the information and the grounds for believing it to be true. The regulation expressly recognises that a complaint may contain information received from another person. It does not provide that an inconsistency between an affidavit and subsequent oral testimony invalidates the complaint or requires its dismissal.

(b) The objection concerns paragraph 11 of the affidavit, which stated that the deceased had been found unconscious at the Kilinochchi bus stand and brought home by the Complainant's son-in-law in an unconscious condition. In his oral evidence, however, the Complainant stated that the deceased was conscious when brought home, was able to walk and spoke with him.

(c) The Committee accepts that this is a material discrepancy. It affects the credibility and weight of the Complainant's evidence concerning the deceased's condition when brought home. It does not, however, render the affidavit or the entirety of his testimony inadmissible.

(d) Paragraph 11 identifies the Complainant's son-in-law as the person who brought the deceased home. The Complainant's oral testimony likewise identified his son-in-law as the person involved. The source connected with the circumstances in which the deceased was brought home was therefore identifiable. The inconsistency concerns the deceased's state of consciousness, not the absence of any source or factual foundation for the complaint.

(e) The Complainant further identified the deceased as the source of his information that two Panadol tablets had been administered:

පු: පැනඩොල් විතරයි දුන්නේ කියලා මහත්මයා දැන ගත්තේ කොහොමද?

පි: පුතා තමයි කිව්වේ පැනඩෝල් 2ක් දීලා තමයි එව්වේ කියලා.

(Vide page 03 of the Proceedings dated 22.10.2022)

(f) The Committee has also considered the fact that the affidavit was prepared in English, a language which the Complainant admitted he did not understand. Nevertheless, he acknowledged that he had narrated the relevant information to a lawyer and signed the affidavit prepared on that basis. The attestation expressly records that its contents were read over and explained to him, that he understood them and that he thereafter affirmed and signed the affidavit before a Justice of Peace. No evidence was placed before the Committee to displace that attestation.

(g) During cross-examination, Learned Counsel for the Respondent drew attention to the discrepancy. After the conclusion of the Complainant's evidence on the same day, Counsel formally raised the objection and sought the dismissal of the complaint. The inconsistency and the circumstances in which the affidavit was prepared were therefore fully placed before the Committee.

(h) The affidavit initiated the disciplinary process; it is not conclusive proof of every allegation contained in it. The charges must be determined upon the entirety of the evidence adduced at the inquiry. A discrepancy affecting one factual issue must be addressed when assessing credibility and evidentiary weight, not by rejecting the entire complaint.

(i) The Respondent has not established that the complaint was made without an identifiable source, that the affidavit was unauthorized or that the discrepancy caused procedural prejudice. Regulation 2(4) does not prescribe dismissal of the complaint as the consequence of such an inconsistency.

(j) Accordingly, the objection is overruled. The discrepancy between paragraph 11 of the affidavit and the Complainant's oral evidence will be taken into account when determining the weight to be attached to his evidence concerning the deceased's condition when brought home. Therefore, we are of the view that it provides no sufficient basis for dismissing the complaint or terminating the inquiry.

J. EVIDENCE OF THE RESPONDENT

35. The Respondent gave evidence and relied upon his written explanation dated 6th April 2021, which was marked and produced as "R1". He identified that explanation, adopted its contents and reiterated the positions taken therein.

36. The Respondent also identified the record of the earlier proceedings at which the Complainant had given evidence. That record was marked "R2". He adopted the legal objections previously raised on his behalf, and the relevant portion of the proceedings containing those objections was marked "R2A". The Respondent maintained that the

complaint should be dismissed upon those objections before his evidence was considered.

(Vide pages 02–03 of the Proceedings dated 28.04.2023)

37. The Respondent stated that he had been attached to the District General Hospital, Kilinochchi, since 11th January 2011. In May 2013, he was covering both the Out-Patient Department and the Emergency Treatment Unit. He further accepted that, on the night the deceased was admitted, he was the on-call Medical Officer from 8.00 p.m. until 8.00 a.m. on the following day:

Question: In May 2013, May you were you attached to the OPD or not?

Answer : OPD + ETU = Common ward, that Night.

Question: Doctor, on that day when the admission was made at the hospital, were you the medical officer on duty at the OPD on that day?

Answer : Yes. OPD + ETU from 8.00 p.m. to the next day 8.00 a.m. I was the on-call doctor.

(Vide page 04 of the Proceedings dated 28.04.2023)

38. The Respondent accepted that the deceased patient was brought to the OPD at approximately 1.44 a.m. He stated that he attended to the patient, obtained a short history, performed an examination and thereafter sent him to the ETU. According to the Respondent, the patient had arrived alone and was not accompanied by a relative or other bystander. He stated that the patient's principal complaint was a headache and that the patient informed him that there were foreign bodies in his head:

Question: Now doctor, you said, you were the medical officer who examined him at the OPD.

Answer : As OPD MO I have to first handle that patient. I have examined and a short history taken Examination I have done.

Question: According to the short history can you recollect what was his cause of injury or cause of admission to the hospital.

Answer : There were no any other by stander with him and the patient himself mentioned that his complaint was the headache. It was his main complaint and also, the patient said that he has some foreign bodies in his head.

(Vide page 04 of the Proceedings dated 28.04.2023)

39. The Respondent further stated that the patient informed him that he had sustained injuries in a blast during the war. He stated that the patient did not have his previous medical records and that he asked him to bring the relevant records. When specifically questioned whether he had physically examined the patient's head for an injury, the

Respondent maintained that he had examined the area but had not found any injury or other abnormal finding:

Question: So, when he said that specifically, when he informed you that there were foreign bodies in the head, and complained of headache, did you physically observe or physically checked his head area, to see whether there are any injuries.

Answer: He was injured in 2009, and on and off headache he felt, and after five years he came to me. As OPD MO I generally examined him. At that time period, I couldn't find any injuries or any other findings. I have asked for the clinic book and also the relevant documents. That I mentioned before.

Question: No Doctor, my question is doctor whether you observed or whether you examined his head area to see whether there are any physical injuries present.

Answer: Head area, as I remember, I couldn't find any injuries at that time.

(Vide page 05 of the Proceedings dated 28.04.2023)

40. The Respondent identified Bed Head Ticket as the form used at the relevant time and stated that it had been completed by him. He further identified the entries appearing on the admission form as being in his handwriting. The document was thereafter marked and produced as "X1". The Respondent confirmed that he had recorded "severe headache" and "FB in scalp" in X1. He explained that "FB" meant foreign bodies. He also confirmed that the patient's blood pressure and pulse rate had been checked and recorded.

(Vide page 05 of the Proceedings dated 28.04.2023)

41. The Respondent stated that he recommended Paracetamol and sent the patient to the ETU as the ETU was the place in which the patient could receive emergency treatment and remain under observation. The Respondent admitted that the patient remained under his supervision during the period between approximately 2.00 a.m. and 3.00 a.m. The Respondent stated that, at approximately 3.00 a.m., he called for the observation chart and inquired about the patient's condition. He was then informed that the patient was missing. He accepted that the patient had gone missing from the ETU.

(Vide page 06 of the Proceedings dated 28.04.2023)

42. The Respondent accepted that, as the doctor in charge or on-call Medical Officer covering the ETU, he was responsible for the patient. The Respondent stated that, where a patient went missing, the normal procedure was to search for the patient for up

to two hours and thereafter inform the medical supervisors and the Director. He admitted that he had not followed that procedure:

Question : Now doctor, after the patient was missing what was the next step that you took?

Answer : Normally up to two hours we will search for the patient. After two hours we have to inform our medical supervisors and the Director.

Question : Have you done that?

Answer : I didn't do it.

Question : You didn't?

Answer : Yes. After two hours around 3.00 am, I as the on-call doctor up to 8.00 a.m. that day I was available. But I forgot to do so as the ticket was not given to me to inform the medical supervisors / Director.

(Vide page 07 of the Proceedings dated 28.04.2023)

43. The Respondent stated that an ETU nursing officer had informed him that the patient was missing. He nevertheless accepted that he did not record the patient as missing. He also admitted that the doctor responsible for the unit was required to report a missing patient to the Director or the Medical Superintendent, following which the police would be informed. The Respondent admitted that this procedure had not been followed. He stated that he had not recorded the patient as missing and did not possess any document recording that the patient had gone missing or left the Hospital.

(Vide pages 07 & 08 of Proceedings dated 28.04.2023)

44. In response to Charge 3 in the Respondent's written explanation dated 6th April 2021, which was marked as R1, the Respondent stated that he had recorded in the Bed Head Ticket that the patient wanted to go home and had written "like Discharge". He further stated that the patient had not signed the Bed Head Ticket and referred to his responsibility to determine that the patient was missing after two hours. The Respondent also stated in R1 that he later learned that the diagnosis had been written by another person and that the Bed Head Ticket had been placed in the discharge file without being returned to him to record that the patient was missing. In his oral evidence, however, the Respondent admitted that the patient had not been formally discharged, that the patient had not signed the Bed Head Ticket and that he had not recorded the patient as missing.

K. FINDINGS AND ANALYSIS OF THE COMMITTEE

45. Charge 1 –

(a) X1 is the contemporaneous admission record relating to the deceased's treatment at the District General Hospital, Kilinochchi. The Respondent identified X1 and admitted that its material entries were in his handwriting. It records the deceased's complaint of a "severe headache", "FB in scalp", blood pressure and pulse. The Respondent explained that "FB" meant foreign bodies and admitted that the deceased had informed him of a previous blast injury to the head. The Committee is therefore satisfied that the Respondent was aware of symptoms and a history directly concerning the deceased's head.

(b) Despite those matters, X1 contains no adequate history of the previous blast injury, description or assessment of the reported foreign bodies, neurological or mental-state assessment, or working diagnosis, etc. It also contains no record of the Respondent's stated intention to obtain a mental-health opinion.

(c) The Respondent's statement in R1 that he had considered obtaining a mental-health opinion demonstrates that the deceased's presentation caused him to consider a possible mental-health condition. Nevertheless, he failed to record that clinical impression, conduct or record a mental-state assessment, or set out a plan for obtaining such an opinion. Those matters were material to the deceased's assessment, observation and continuing care.

(d) As to the organic illness, the deceased presented with a severe headache, referred to foreign bodies in his scalp and disclosed a previous blast injury to the head. The Complainant stated that pus was present at the site of the previous injury when the deceased returned home. X2 establishes that the deceased subsequently died from a brain abscess and therefore confirms that he had an organic illness affecting the brain.

(e) The Committee has not inferred negligence merely from the deceased's subsequent death or the post-mortem diagnosis. It has considered X2 together with the severe headache, previous blast injury, reported foreign bodies and evidence of pus at the wound. Those matters required a careful examination of the head and consideration of an organic cause.

(f) The Respondent maintained that he generally examined the deceased and observed no external injury. That assertion is not supported by any adequate contemporaneous record. X1 contains no description of the scalp or wound, neurological findings, clinical reasoning excluding an organic cause, or plan for further investigation. Had an adequate examination and assessment been undertaken, the material findings, whether positive or negative, ought to have been recorded.

(g) Upon considering X1, X2, the oral evidence and the Respondent's admissions, the Committee finds that the Respondent failed to record the mental-health concern

which he had himself considered and failed adequately to examine and assess the deceased's head for an organic illness.

46. Charge 2

(a) It is observed that X1 records only the deceased's severe headache, "FB in scalp", blood pressure, pulse and the medication prescribed. It does not adequately record the previous blast injury, the condition of the scalp, any neurological or mental-state assessment, the Respondent's consideration of a mental-health opinion, etc.

(b) The Respondent stated that the deceased had informed him of the previous injury and his wish to return home. He also relied in R1 upon matters said to have formed part of his assessment and intended management. Those matters do not appear in X1. The Respondent thereby admitted that clinically material information known to him was not recorded.

(c) The Committee is of the view that these omissions were not minor or merely clerical. The deceased had been sent to the ETU for emergency treatment and observation. An adequate record was necessary to inform the nursing staff and other practitioners of his clinical presentation, the matters requiring further assessment and the risks requiring observation. Thus, we opined that the omissions materially affected continuity of care and patient safety and amounted to negligence in a professional respect.

47. Charge 3 – Wrongful discharge entry

(a) It is evident that X1 contains an entry indicating that the deceased had been discharged; however, the deceased had not been formally discharged, had not signed the Bed Head Ticket and had instead gone missing from the ETU. The Respondent also admitted that he failed to record the deceased as missing.

(b) In R1, the Respondent admitted that he had written "like Discharge". His further explanation that another person had written the diagnosis and placed the Bed Head Ticket in the discharge file does not alter his admission concerning the discharge entry or explain why discharge was recorded when the deceased was, in fact, missing.

(c) It is apparent that a patient who leaves or goes missing from the Hospital without authorization cannot be considered to have been formally discharged. The hospital record was required to accurately describe what had occurred and to facilitate the applicable missing-patient procedure. By recording discharge instead of recording that the deceased was missing, the Respondent rendered the official hospital record inaccurate and failed to ensure that the necessary administrative and protective measures were taken.

(d) Having considered the Respondent's admission, the contents of X1 and the undisputed fact that the deceased had not been formally discharged, the Committee is satisfied that the discharge entry was wrongful and therefore amounted to negligence in a professional respect.

48. Charge 4

(a) It is observed that the Respondent admitted that he sent the deceased to the ETU because it was the place in which the deceased could receive emergency treatment and remain under observation. He further admitted that the deceased remained under his supervision and that, as the on-call Medical Officer covering the ETU, he was responsible for the patient.

(b) The need for observation was therefore admitted. Nevertheless, X1 contains no specific instruction directing the nursing staff to keep the deceased under observation, identifying the matters to be monitored or warning them that he wished to leave. The Respondent did not identify any specific oral instruction given by him. His general assertion that the deceased had been sent to the ETU for observation does not establish that proper instructions concerning the nature and degree of observation were communicated to the nursing staff.

(c) The deceased thereafter left the ETU without being formally discharged. The Respondent became aware that he was missing but failed to record his disappearance, report it to the Director or Medical Superintendent, or initiate the missing-patient procedure which he admitted was applicable. His explanation that he forgot to do so confirms the absence of professional supervision and follow-up required in the circumstances.

(d) The Committee has considered the absence of instructions in X1 together with the Respondent's admissions and the undisputed sequence of events. That evidence establishes that no adequate observation instruction was recorded or shown to have been communicated and that, in the absence of effective observation, the deceased left the ETU unnoticed and without being discharged.

(e) The Committee is therefore satisfied that the Respondent failed to give proper instructions to the nursing staff to keep the deceased under observation and that this failure materially contributed to his leaving the Hospital without being discharged.

49. Having found Charges 1 to 4 proved, the Committee is satisfied that the Respondent's failure adequately to assess and record the deceased's condition, give proper observation instructions, accurately record his departure and initiate the applicable missing-patient procedure constituted serious professional deficiencies rather than isolated or merely technical omissions. Viewed cumulatively and objectively, such conduct was capable of undermining public confidence in hospital care, the accuracy

of medical records and the accountability of medical practitioners. The Committee therefore finds that the Respondent brought the medical profession into disrepute and that Charge 5 has been proved.

50. Having considered cumulatively the conduct established under Charges 1 to 5, the Committee is satisfied that the Respondent's failures in clinical assessment, documentation, patient observation, accurate reporting and professional accountability constituted serious departures from the obligations concerning competent patient care, proper clinical records and patient safety contained in the applicable Sri Lanka Medical Council Guidelines and Instructions. The Committee accordingly finds that the Respondent's conduct was unethical, brought the medical profession into disrepute and contravened the professional standards applicable to registered medical practitioners. The Committee is therefore of the view that Charge 6 has been proved.

L. CONCLUSION

51. For the reasons set out above, the Committee unanimously determines that Charges 1, 2, 3, 4, 5 and 6 have been proved and, accordingly, finds the Respondent guilty of all six charges.

52. Pursuant to Regulation 18(4) of the Medical (Disciplinary Procedure) Regulations, 1990, the Respondent is now invited to address the Committee in mitigation and to show cause why action should not be taken against him under section 25(1)(a) of the Medical Ordinance (Cap. 105).

.....
Prof. Jayantha Jayawardena
Chairman of the PCC

.....
Prof. Manori Gamage
Member of PCC

.....
Dr. Chandana Dharmarathne
Member of PCC

.....
Dr. D.S. Samaraweera
Member of PCC

.....
Dr. Haritha Aluthge
Member of PCC