General Medical Council

Minutes of the Investigation Committee

Oral hearing on 17 September 2025

This hearing has been conducted in accordance with the General Medical Council (Fitness to Practise) Rules 2004 (*'The Rules'*). The public minutes will be published on the GMC IC Decision webpage.

Name of Doctor	**Dr Alfonso Luis Lastra Canellas**
Doctor's UID	**7048192**

Outcome	Warning given
Hearing location:	Held virtually via MS Teams

Committee Members	Mr Ian Kennedy (Chair – Lay)
	Prof Jennifer Adgey (Medical)
	Dr Richard Khoo (Lay)

Legal Assessor	Mr Richard Barraclough KC
Panel Secretary	Ms Rebecca Jordan

GMC Representative	Ms Louise Cowen, Counsel
Doctor's attendance	Dr Lastra Canellas attended
Doctor's representative	None

Background

1 In June 2024 Dr Lastra Canellas applied to voluntarily remove his name from the medical register, a process known as voluntary erasure. The GMC sought further information from his employer, East Kent Hospitals University NHS Foundation Trust ('the Trust'), and was informed that he had been employed as a Specialty Doctor in Emergency Medicine since 2016 but XXX had not worked since July 2023. Dr Lasta Canellas later withdrew his voluntary erasure application.

2 The Trust also provided two reports relating to an internal investigation carried out under the *Maintaining High Professional Standards in the Modern NHS* framework between February and August 2021 and February 2022. A capability hearing had been scheduled for 12 June 2024; however, Dr Lastra Canellas resigned from his post and the hearing did not go ahead. He moved to Spain and relinquished his GMC Licence to Practise on 9 July 2024.

3 On 23 July 2024, the GMC wrote to him to inform him that it had opened an investigation into the concerns disclosed by the Trust.

4 The GMC commissioned an Expert Report to provide an opinion on the clinical incidents disclosed by the Trust. The expert concluded that his actions in respect of one incident fell seriously below the standard expected of an emergency medicine practitioner.

5 The incident in question occurred on 26 November 2020 when Dr Lastra Canellas attended an elderly patient with suspected dementia and a left fractured neck of femur (hip fracture) in the Emergency Department. He attended to administer a regional nerve block using a procedure called a Fascia Iliaca Block ('the procedure') for pain relief while the patient was awaiting surgery. He carried out this invasive procedure, which involved injecting long-acting local anaesthetic into the groin next to the femoral nerve, on the patient's right side rather than their left side where the fracture was located. He then carried out the procedure on the correct side after the mistake was pointed out by a nurse and a report known as a 'Datix' was raised to record the incident.

6 The GMC expert stated that, as an invasive procedure, an FIB block '*carries clear risks and minimum safety checks should include a chaperone or assistant, identification of allergy, identification of local anaesthetic drug and dose and confirmation of the correct side before starting. There is no indication on record that any of these safety checks were carried out... The injection to the right groin was an avoidable invasive step. An extra dose of anaesthetic had to be used to correct the error, adding to potential risk. Carrying out an invasive procedure on the wrong side of body is a Never Event.'*

7 As part of its investigation, the GMC also obtained a Trust incident investigation report which had established that, at the time, Dr Lastra Canellas was not aware of a recently introduced safety protocol that included checks which would have prevented the mistake. He did not follow the previous departmental guideline that preceded this protocol, which required the identification and marking of the injection site.

8 The report also found that the incident occurred during the Covid pandemic when the usual mechanisms for disseminating new protocols of this type where not in place or had been scaled back. It was also an extremely busy shift. The report opines that this is likely to have contributed to the pre-procedure checks not being done and is also likely to be the reason why there was no one assisting him.

9 On 8 July 2025, once their investigation was complete, the GMC wrote to Dr Lastra Canellas under rule 7 and 11 of The Rules to inform him that the GMC case examiners were minded to conclude his case by issuing a warning. The letter gave him the opportunity to accept the warning proposed by the case examiners.

10 He declined to accept the warning stating that he had '*evidence to demonstrate [his] fresh competence and that a hospital consultant had certified [him] to carry out the procedure following a formal assessment…'.* The GMC were subsequently provided with records completed by his supervising consultant. These show that after the incident he completed practical training focussed on using a checklist to reduce error and then a MiniCEX (a standardised tool used to assess clinical skills) during which he had been observed successfully performing the procedure on a patient.

11 The Case Examiners decided to refer the matter to the Investigation Committee and notice of this hearing was served on 7 August 2025. This notice included the allegation referred to the Committee for consideration, which is that:

1. On 26 November 2020, Dr Lastra Canellas performed a Fascia Iliaca Block ('the Procedure') on Patient DW and he:

a. failed to carry out the minimum safety checks including identification of:

i. any allergy;

ii. local anaesthetic drug and dose;

iii. the correct side and stop point before starting the Procedure;

b. carried out the Procedure, with a large volume of local anaesthetic drug on the wrong side from the fracture subjecting Patient DW to an increased risk of drug toxicity.

2. In the alternative to paragraph 1a, he failed to record his actions as described in paragraph 1a.

12 The Committee is convened today to determine whether a warning should be issued in respect of this allegation.

Material adduced

13 The Committee has carefully considered the material before it today. The documentary evidence provided by the parties included, but was not limited to:

- Reports arising from the Trust's internal *Maintaining High Professional Standards in the Modern NHS* investigation dated February and March 2022
- 360 patient and colleague feedback
- Datix documentation and an incident investigation report
- A redacted export report by a Lead Consultant in Emergency Medicine, dated 27 January 2025 which was commissioned by the GMC
- Dr Lastra Canellas formal responses to the GMC allegations
- A Professional Support and Remediation (PSR) service Action Plan Progress Review Report dated 17 May 2023
- An email from Dr Lastra Canellas former supervising consultant dated 16 July 2024 with a Directly Observed Procedural Skills (DOPS) form confirming successful completion of Fascia Iliaca Block with safety protocol

14 No witnesses were called and no oral evidence was adduced.

GMC submissions

15 Ms Cowen, on behalf of the GMC, outlined the allegation against Dr Lastra Canellas which is that he performed a Fascia Iliaca Block on a patient without carrying out the minimum safety checks. Failure to do so resulted in him carrying out the procedure on the wrong side.

16 Ms Cowen said that, while working at the Trust, a local investigation was carried out into several incidents, including the one referred for the Committee's consideration. Prior to the local investigation, Dr Lastra Canellas had been subject to a local action plan and so a formal referral to the Practitioner Performance Advice Service took place. Following this, a capability hearing was scheduled because the Trust considered that he was not functioning at the level that he was employed to work at.

17 At today's hearing, Ms Cowen submitted that it was an appropriate and proportionate response to issue Dr Lastra Canellas with a warning. An independent expert has opined that the care provided to the patient was seriously below the expected standard of an emergency medicine practitioner. The incident was a 'never event' and should not have happened; Dr Lastra Canellas should have used 'stop points' to check that he was administering the block to the correct hip.

18 This incident, Ms Cowen submitted, took place in circumstances where there were set protocols and procedures that needed to be followed to ensure patient safety. The steps he has taken since do not fully address the incident and she highlighted the very serious effect his conduct could have had on the patient, particularly in light of their dementia.

19 It was Ms Cowen's submission that a warning would be proportionate and appropriate to protect, promote and maintain the health, safety and the well-being of the public, the need to

promote and maintain public confidence in the medical profession, and the need to promote and maintain proper professional standards of conduct for members of the profession. She said that his admitted conduct is a significant departure from the requirements of *Good medical practice*.

20 Ms Cowen submitted that a warning is both necessary and proportionate to send a clear message to the doctor, and the profession as a whole, that these actions were inappropriate and should not have occurred or be repeated. Dr Lastra Canellas conduct did not meet with the standards required of a doctor at the time, nor would it meet the current standards in force. It risks bringing the profession into disrepute and must not be repeated. In these circumstances, a warning is necessary and proportionate to maintain public confidence in the medical profession and to ensure that proper professional standards are upheld and patients are protected.

Dr Lastra Canellas's submissions

21 In his written responses to the GMC, Dr Lastra Canellas described a difficult working environment. He said the additional supervision and constant scrutiny affected his confidence, put him under a lot of stress and had affected his health and led to him leaving the UK. His 'short' remediation plan ended up extending to three and a half years. He said that his working relationship with his educational supervisor had deteriorated to the point that they had been disrespectful and physically attacked him. He had raised concerns about bullying and feeling unsupported with the Trust but no action was taken.

22 In comments to the GMC, dated 4 May 2025, regarding the incident he said:

> '*after reviewing the X-ray and patient case, I went to the patient's cubicle to do the block. However, the patient with severe dementia was soiled and decided to help the nurse change the clothes and sheets. After that, I ended up on the wrong pelvis side. When I pressed on the patient's pelvis, she screamed, and I thought I was on the right side. I gave half the dose of the anaesthetic drug as it is the right dose due to the elderly patient. Later, the nurse told me I had put the block on the wrong side. I informed the Consultant immediately, and he advised me to repeat it on the right side. I decided to write a [Datix report] myself on this case. Thanks to this mistake, the hospital created a new protocol on the application of FIB (fascia iliac block) to avoid this in the future. I was retrained on this and was certified on the application of this type of block by [a] consultant.*'

23 Dr Lastra Canellas ended these comments by explaining that, as a result of everything that had happened, he had, '*ended up losing my job, my house, and most importantly, my medical confidence. I'm 60 years old, and I don't have any plans to work in the UK anymore. Until the last 13 years, I was very happy working as an AE doctor in the UK and appreciated the opportunity*.'

24 The retraining he referred to is detailed in a Professional Action Plan Progress Report, dated 17 May 2023 and completed by his supervising consultant. Under an objective headed: *Ability to safely perform a Fascial Illiaca compartment block in the emergency department using a LocSIPP* it says that he has formally reflected on the previous incident and the factors which led to this. Dr Lastra Canellas has discussed the event in some detail, reviewed the local protocol and talked

through how it would be used in clinical practice. The progress report confirms that he demonstrated his competence in undertaking the procedure and applying the safety protocol in a clinical skills laboratory and under observation on a patient.

25 In his oral submissions today, he told the Committee that he was very experienced in the procedure, carrying it out about 40 times a month before the incident. He said that the Trust has not reported how many times he had done it successfully. He explained that he has been trained to carry out the block using a manual location technique and also with the assistance of ultrasound. Part of his training was to check the X-ray to ensure that a block is appropriate and that medication was checked for contraindications.

26 Dr Lastra Canellas has no specific memory of checking the x-ray in this particular case but he explained that a task, such as this, would normally have been delegated to him by the consultant while they were at their computer; x-rays were often viewed then.

27 The incident had to be viewed in the context of what was a busy department and a patient with severe dementia who was unable to communicate where her injury was. Dr Lastra Canellas had moved around to the right hand side of the bed in the process of helping the nurse change the patient, and the patient had then appeared to indicate pain on their right side. Dr Lastra Canellas had had a momentary loss of concentration. On this single occasion he made a mistake; it was human error. He said that he had learnt from the incident and that in the past he, at times, worked 'too fast'.

28 Dr Lastra Canellas said there was no protocol or checklist to complete in place at the time, these were introduced after the incident, and as a result of it. He did not have an educational supervisor and was only told later, during his remedial training, about the protocol. He said this was not used by his colleagues – they were not aware of it.

29 The moment he found out there was a problem he informed the supervising consultant, who then instructed him to administer the block on the correct side. Dr Lastra Canellas completed the Datix report himself to log the incident.

30 He submitted that a warning for a single mistake would be unfair and disproportionate. He has no plans to return to the UK but he is contesting the proposed warning for the sake of his own dignity.

Legal advice

31 The Legal assessor reminded the Committee of its powers under rule 11(6), its task today and the purpose of issuing a warning. He advised that a warning is a serious response to concerns which fall just below the threshold for a finding of impairment. For a warning to issue there must be a significant departure from standards which is not to be repeated. The committee should take account of whether there has been a clear and specific breach of *Good medical practice*.

32 The Committee should consider whether the concerns are sufficiently serious that if there were a repetition they would likely result in a finding of impairment and the degree to which conduct could affect patient care, public confidence in the profession or the reputation of the profession.

33 It should also consider any level of insight; expressions of regret and apology; any previous good history; whether the incident was isolated; whether it is likely to be repeated; any rehabilitative or corrective steps taken; references and testimonials.

34 The committee should apply the principle of proportionality weighing the interests of the public with those of the practitioner. It should ask itself, in the context of the case, what is required and do no more than necessary to achieve public protection.

Committee Determination

12 The Committee accepts the independent advice provided by the Legal Assessor on the process to be adopted and the guidance that applies.

The Committee's approach to considering a warning

13 The Committee is aware that the GMC has a legal duty to protect the public. The Medical Act 1983 splits this duty into three distinct parts and requires the GMC to act in a way that:

- protects, promotes and maintains the health, safety and wellbeing of the public ('patient safety')
- promotes and maintains public confidence in the profession
- promotes and maintains proper professional standards and conduct for members of the profession.

14 In addition to the part warnings play in maintaining public confidence and upholding standards for the profession, they also serve to formally indicate to a doctor the behaviour or performance that has significantly departed from the professional standards expected and which should not be repeated. The GMC *Guidance on warnings* states that they should be viewed as a deterrent. They are intended to remind the doctor that repetition of the given conduct is likely to result in a finding of impaired fitness to practise, which may lead to restrictions being placed on their registration.

15 The Committee considered whether Dr Lastra Canellas' admitted error constituted a significant departure from expected standards and, if so, whether this departure was sufficiently serious to warrant a formal response in the form of a warning. In determining this, and in line with the GMC *Guidance on warnings*, the Committee considered whether:

a) there has been a clear and specific breach of the professional standards

b) the conduct, behaviour or performance approached, but just fell short of, that which would pose a risk to public protection

c) a repetition of the given conduct is likely to elevate the seriousness to a degree where would be a risk to public protection and restrictive action by the GMC would be necessary.

16 The Committee's role is not to review the case examiners' decision on whether a warning is appropriate, but to consider the matter afresh.

Committee's decision on a warning

17 Dr Lastra Canellas does not contest the allegations; he has admitted that he made a mistake. The Committee finds that this mistake amounts to a significant departure from expected standards.

18 There is a degree of contradiction in the evidence regarding whether a clear and well-communicated guideline on the necessary pre-procedure checks was in place at the time of the incident. The evidence from the Trust states that there had been a long-standing local guideline, which had been recently replaced by a more specific protocol. However, there is also an acknowledgement from the Trust that during the Covid pandemic the usual mechanisms for disseminating such information were not fully effective.

19 In his submissions today Dr Lastra Canellas said that there was not a guideline in use and that the protocol was introduced after the incident, potentially as a result of it. However, the Committee finds that, regardless of whether or not there was a formal guideline or protocol available, and regardless of whether or not he had been made aware of such a document, there would have been a normal procedure to follow. With or without a formal checklist, a senior middle grade doctor with extensive experience of this particular procedure would have been expected to carry out basic checks to ensure they were working on the correct side before undertaking an invasive procedure.

20 The Committee accepts the expert's opinion that his mistake would have been prevented had basic pre-intervention checks been done. His failure to carry out checks put a frail patient through an unnecessary additional invasive procedure and increased their risk of experiencing drug toxicity. His chosen course of conduct constitutes a significant departure from the standards expected of a doctor.

21 The Committee then considered whether this departure was sufficiently serious to warrant a formal response in the form of a warning. This was a single incident which occurred on a busy shift and which Dr Lastra Canellas promptly reported himself after it was identified. He has provided evidence of the training he has undertaken since on pre-procedure safety checks and has demonstrated his competence through an assessment. He has told the Committee that he has reflected that he may have worked 'too fast' in the past.

22 However, there are inconsistencies in the account of the incident between the documentary evidence in the hearing bundle and the doctor's submissions today. For example, the Datix form records that the patient was apologised to, but Dr Lastra Canellas told the Committee that the patient did not have sufficient mental capacity for this to be appropriate. It is also recorded that the nurse identified the mistake which conflicts with what the Committee heard today. These

inconsistencies make it difficult for the Committee to rely fully on the account given by Dr Lastra Canellas.

23 Although these inconsistencies make it hard to establish some of the specific details around the incident, the Committee finds that Dr Lastra Canellas took insufficient care in his assessment of this patient immediately prior to starting the invasive procedure. It considers this failure to be serious, especially in light of his experience, the fact that the patient had an injury that should have been visible with a cursory inspection and the fact that extra care should have been taken with a patient who could not indicate her pain site due to dementia. Should a similar incident reoccur the threshold for restrictive action by the GMC is likely to be met.

24 The Committee concludes that the seriousness of the incident warrants marking with a warning in the interests of maintaining proper professional standards and conduct for doctors and to uphold the public confidence in the medical profession. The Committee therefore issues you with the following warning:

> On 26 November 2020, Dr Lastra Canellas performed an invasive procedure (a Fascia Iliaca Block) on a patient with an identified fractured left hip without carrying out the minimum safety checks. Failure to do so resulted in him administering the Fascia Iliaca Block to the right groin instead of the left groin.
>
> This conduct does not meet the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in *Good medical practice* (2024). In this case paragraphs 4, 6 and 7(a and e) are relevant, these state:
>
> > 4 You must follow the law, our guidance on professional standards, and other regulations relevant to your work.
> >
> > 6 You must provide a good standard of practice and care. If you assess, diagnose, or treat patients, you must work in partnership with them to assess their needs and priorities. The investigation or treatment you propose, provide or arrange must be based on this assessment, and on your clinical judgement about the likely effectiveness of the treatment options.
> >
> > 7 In providing clinical care you must:
> >
> > (a) adequately assess a patient's condition(s), taking account of their history, including
> >
> > i. symptoms
> >
> > ii. relevant psychological, spiritual, social, economic, and cultural factors
> >
> > iii. the patient's views, needs, and values
> >
> > (e) propose, provide or prescribe effective treatment based on the best available evidence.

Whilst this failing in itself is not so serious as to require any restriction on Dr Lastra Canellas' registration, it is necessary in response to issue this formal warning. This warning will be published on the medical register in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy .

That concludes the determination of the Investigation Committee in this case.

Ian Kennedy
Investigation Committee Chair