PUBLIC RECORD

Dates: 22/03/2021 - 30/03/2021

Medical Practitioner's name:	Dr Anthony OJO
GMC reference number:	6050894
Primary medical qualification:	MD 2000 Katholieke Universiteit te Leuven

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

Summary of outcome

Suspension, 12 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Ms Louise Sweet QC
Lay Tribunal Member:	Mr Colin Sturgeon
Medical Tribunal Member:	Dr Barry Adams-Strump

Tribunal Clerk:	Ms Racheal Gill

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Richard Partridge, Gordons Partnership LLP
GMC Representative:	Ms Carolina Cabral, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 26/03/2021

Background

1. Dr Ojo obtained an academic diploma in General Practice in 2002 at the Catholic University of Leuven, Belgium and later completed various Senior House Officer roles in Belgium and undertook three years of GP training in Europe. Dr Ojo moved to the UK in 2002 working as a locum GP at practices in southern England. Between 2003 – 2006, Dr Ojo worked primarily within the North East Essex Primary Care Trust, providing locum and additional GP assistance. This included working within the 111 Service provided by the Trust. Dr Ojo has remained with the Evergood Locum Agency serving Southern England since 2014. At the time of the events which are the subject of this hearing, Dr Ojo was working as a locum GP at Herts Urgent Care ('HUC') providing an out of hours service.

2. The allegation that has led to Dr Ojo's hearing can be summarised. On 20 May 2017, during an NHS 111 call, Dr Ojo engaged in a telephone consultation with Patient A's mother (Miss B) in relation to Patient A. It is alleged that Dr Ojo failed to obtain an adequate medical history, adequately assess and diagnose Patient A, and take adequate safeguarding action with Patient A. Further, it is alleged that Dr Ojo failed to follow relevant guidance or make an adequate record of the consultation.

3. It is also alleged that Dr Ojo prepared a witness statement, dated 12 June 2017 ('2017 initial statement'), in which he made false statements regarding the content of the telephone consultation with Patient A's mother. It is further alleged that on 19 July 2018, at the coroner's inquest, Dr Ojo maintained that the statements he made in his initial statement

were accurate when he knew them to be untrue. It is alleged that Dr Ojo's actions were dishonest.

4. On 10 August 2018, Dr Ojo self-referred to the GMC following the coroner's inquest regarding the death of Patient A.

The Outcome of Applications Made during the Facts Stage

5. The hearing was held via video link Via Skype for Business. The Tribunal granted the GMC's application, made pursuant to Rule 36(f) of the General Medical Council (Fitness to Practice Rules) 2004 as amended ('the Rules'), to allow Miss B to give evidence as a vulnerable witness. She was granted a special measure to improve the quality of her evidence as she had indicated she felt intimidated by seeing Dr Ojo on the screen. On behalf of Dr Ojo, Mr Partridge did not oppose the application. Dr Ojo's camera was switched off as was his microphone. He was not visible or audible to Miss B throughout her witness evidence. Dr Ojo could still see and hear the witness and the proceedings and participate effectively in the hearing.

The Allegation and the Doctor's Response

6. The Allegation made against Dr Ojo is as follows:

1. On 20 May 2017 at or around 23:35 you engaged in a telephone consultation with Patient A's mother in relation to Patient A and you failed to:

    a. obtain an adequate history from Patient A's mother in that you:

        i. consulted with Patient A's mother for approximately two minutes;
        To be determined

        ii. did not validate the previous history taken by the 111 service with Patient A's mother;
        To be determined

        iii. did not note any differences between the previous history Patient A's mother gave to the 111 service and the history Patient A's mother gave to you;
        To be determined

iv. did not note the specific concerns Patient A's mother had;
Admitted and found proved

v. did not obtain a history of Patient A's;

1. salient positive symptoms;
To be determined
2. salient negative symptoms;
To be determined

vi. did not obtain a history of the duration of Patient A's symptoms;
To be determined

b. adequately assess Patient A in that you:

i. did not advise Patient A's mother to attend an Accident and Emergency department at hospital within two hours of your consultation with Patient A's mother;
Admitted and found proved

ii. did not advise Patient A's mother to attend an Out of Hours Centre within two hours of your consultation with Patient A's mother;
Admitted and found proved

iii. inappropriately organised an appointment for Patient A at 10:00 on 21 May 2017;
Admitted and found proved

c. take adequate safeguarding action in that you did not impress on Patient A's mother the importance of an urgent face to face assessment with Patient A;
Admitted and found proved

d. appropriately diagnose Patient A in that you:

i. recorded your diagnosis in Patient A's medical records as 'IC92 has a sore throat';
Admitted and found proved

ii. did not diagnose Patient A with '?viral/bacterial illness, worsening with worrying features' or words to that effect;
Admitted and found proved

e. adequately follow relevant guidance when assessing whether Patient A was at risk for sepsis/serious illness in that you did not consider Patient A's:
Admitted and found proved

i. age;
Admitted and found proved

ii. history;
Admitted and found proved

iii. symptoms;
Admitted and found proved

f. provide adequate safety-netting advice to Patient A's mother in that you did not advise Patient A's mother to take Patient A to an Accident and Emergency department at a hospital or to call 111 in the event that:

i. Patient A became floppy;
To be determined

ii. Patient A's temperature increased;
To be determined

iii. Patient A developed any new rashes;
To be determined

iv. she was not happy with Patient A's behaviour;
To be determined

g. make an adequate record of your consultation with Patient A's mother in that you did not record:

i. the urgency of the need of Patient A's presenting symptoms;
Admitted and found proved

ii. your validation of the previous history taken in the 111 service;
To be determined

iii. any differences noted between the 111 service and your own assessment of Patient A;
Admitted and found proved

iv. the specific concerns Patient A's mother had;
Admitted and found proved

v. Patient A's history of symptoms;
Admitted and found proved

vi. the duration of Patient A's symptoms;
Admitted and found proved

vii. Patient A's current symptoms;
Admitted and found proved

viii. any parental concern;
Admitted and found proved

ix. any advice given;
Admitted and found proved

x. any safety netting advice;
Admitted and found proved

xi. any provisional diagnosis;
Admitted and found proved

xii. any treatment plan;
Admitted and found proved

xiii. any management plan;
Admitted and found proved

xiv. jointly agreed review/appointments;
Admitted and found proved

h. follow the Out of Hours service procedures in that you contacted Patient A's parents on 22 May 2017 without prior warning to find out the reason for Patient A's death.
To be determined

2. You prepared a witness statement dated 12 June 2017 ('initial statement') in which you falsely stated:

a. 'I asked if he [Patient A] had been having wet nappies';
To be determined

b. 'I asked her [Patient A's mother] about the rash again';
To be determined

c. that you had told Patient A's mother that 'it would be better to take him [Patient A] to the Accident and Emergency';
To be determined

d. 'mum was not keen to take him [Patient A] to A&E';
To be determined

e. 'I stayed on the phone and asked mother to check on Patient A again and ensure he was responding normally and that no new rash had developed. His mother went away to assess him and then came back to talk to me again on the phone. She reassured me he was ok and was sleeping. I asked if when she went to check, he was breathing and responding normally. His mum said he was responding normally'.
To be determined

3. On 19 July 2018, at the coroner's inquest you maintained that the statements you made in your initial statement as detailed at paragraph 2 were accurate.
Admitted and found proved

4. You knew that the statements contained within your initial statement as detailed at paragraph 2 were untrue.
To be determined

5. Your actions as described in paragraphs 2 and 3 were dishonest by reason of paragraph 4.
To be determined

The Admitted Facts

7. At the outset of these proceedings, through his counsel, Mr Partridge, Dr Ojo made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

8. In light of Dr Ojo's response to the Allegation made against him, the Tribunal is required to determine whether Dr Ojo failed to: obtain an adequate medical history; provide

adequate safety-netting advice to Patient A's mother; and follow the Out of Hours service procedures. The Tribunal is required to determine whether Dr Ojo prepared a witness statement, dated 12 June 2017, in which he made false statements, which Dr Ojo knew to be untrue and was dishonest.

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

- Miss B, mother of Patient A, by video link, together with two witness statements dated 13 November 2019 and 21 January 2020 respectively.

- Dr C, GP and Medical Director for Herts Urgent Care ('HUC'), by video link, together with three witness statements, dated 15 November 2019, 21 January 2020 and 14 October 2020 respectively.

10. Dr Ojo provided his own witness statement, dated 9 March 2020 and also gave oral evidence at the hearing.

Expert Witness Evidence

11. The Tribunal also received evidence from one expert witness, Dr D, instructed by GMC legal. His area of expertise is General Practice. Dr D gave written evidence at this hearing, this consisted of an expert report, dated 17 March 2019. His report was directed at assisting the Tribunal to understand whether, during the telephone call with Patient A's mother, Dr Ojo adequately assessed Patient A and if any of Dr Ojo's care fell below the standard expected of a reasonably competent GP.

12. In addition, Dr D, also gave oral evidence at the hearing to further opine on Dr Ojo's medical assessment of Patient A.

Documentary Evidence

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

- Miss B's statement to the coroner;
- Transcripts of calls with 111, dated 20 May 2017;
- RCA report, dated 2 February 2018;
- Patient A's medical notes, 20 May 2017;

- Transcript of meeting between Dr C and Patient A's parents, dated 30 November 2017;
- Adastra report for cases accessed by Dr Ojo, on 20 May 2017;
- Adastra report showing times of each case, on 20 May 2020;
- Signed form by Dr Ojo confirming he had received induction training, 8 February 2017;
- Appointment report, 16 May 2017, 22 May 2017;
- Various screenshots of computer screen, various dates;
- Transcript of Dr Ojo's evidence at the Coroner's Inquest (the inquest), July 2018;
- Dr Ojo's CV;
- Dr Ojo's statement for the inquest, 12 June 2017;
- Email correspondence between Dr Ojo and Ms E (Head of Integrated Governance at HUC); 22 May 2017;
- Printout of screen shots of Adastra records, 20 May 2017
- Dr C's statements, 15 November 2019, 21 January 2020, 14 October 2020.

The Tribunal's Approach

14. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Ojo does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

15. In relation to the allegation of dishonesty, the Tribunal was reminded that the correct test is as set out in the case of *Ivey v Genting Casinos [2017]*. A two stage test must be applied as follows:

> *1. First ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of their belief is a matter of evidence going to whether they held the belief, but it is not an additional requirement that their belief must be reasonable; the question is whether it is genuinely held.*
>
> *2. When once the doctor's actual state of mind as to knowledge or belief as to facts is established, the question whether their conduct was honest or dishonest is to be determined by [this tribunal] by applying the (objective) standards of ordinary decent people. There is no requirement that the doctor must appreciate that what they have done is, by those standards, dishonest.*

16. The Tribunal were informed that Dr Ojo had a previous finding of misconduct. Parties agreed that because of this, a 'good character' direction could not be given in relation to the Tribunal's consideration of dishonesty. This matter was agreed to be otherwise irrelevant and the Tribunal followed the Legally Qualified Chair's direction to ignore it.

The Tribunal's Analysis of the Evidence and Findings

17. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

Paragraphs 1, (a) (i)

18. The Tribunal noted that it was agreed evidence between Miss B and Dr Ojo that the telephone consultation had started with an open question about Patient A. The Tribunal were of the view that this open question would have provoked a narrative answer from Patient A's mother, which would have included a description of symptoms. Oral evidence from Miss B also confirmed a further discussion had occurred, for example, regarding bringing Patient A to Luton and a discussion of appointment times (changing from 8am to 10am).

19. The Tribunal were of the view that Miss B's memory is likely to have been impacted by her emotional state and her memory adversely impacted by the passage of time. The Tribunal were careful to allow for the fact her perception of time may have been distorted. The Tribunal also accepted evidence from Dr D : *"People do remember consultations shorter than they actually are."*

20. The Tribunal determined that, based on the above facts alone, on the balance of probabilities, it was more likely than not that the consultation between Dr Ojo and Patient A's mother would have taken more than "approximately two minutes". Therefore, the Tribunal found this not proved.

Paragraphs 1 (a)(ii)

21. The Tribunal were satisfied that Dr Ojo opened and looked at both sets of medical notes because the evidence showed that he copied and pasted a section from the Clinical Advisor's notes into his own notes. In addition, he added further information about the updated state of Patient A's symptoms, regarding the presence of a rash namely "no rash". The Tribunal bore the small amount of information in mind and were satisfied that he must have asked further questions about the presence or absence of a rash.

22. Furthermore, the initial statement from Dr Ojo, dated 13 June 2017, he stated clearly that he *"reviewed the recorded outcomes of both the health advisor and the clinical advisor".* In this 2017 witness statement, Dr Ojo sets out the results of the conversation he had with Miss B regarding Patient A's symptoms. The Tribunal noted that the statement recalls that he has asked about wet nappies, sore throat and whether the "rash" had improved. The Tribunal noted in particular that Miss B had told Dr Ojo she had *"given him sips of dioralyte".* Miss B had accepted in her evidence to the coroner at the inquest that she had been giving Patient A sips of dioralyte, therefore the Tribunal were satisfied that this information derived from the consultation with Miss B as it was not contained in either sets of 111 notes. Thus, the Tribunal was satisfied that Dr Ojo had validated the previous history taken by the 111 service and found this not proved.

Paragraphs 1 (a)(iii)

23. Having reviewed the 111 notes and the fact there were not many differences; the Tribunal applied the same rationale to the consideration of paragraphs 1 (a)(iii) as the above, paragraph 1 (a)(ii). Accordingly, the Tribunal found this not proved.

Paragraphs 1 (a)(v 1 and 2)

24. The Tribunal reviewed Dr Ojo's medical notes which listed Patient A's salient positive symptoms as vomiting, diarrhoea, conscious, cold and clammy, fever in the past 12 hours and responding normally. Furthermore, it listed Patient A's salient negative symptoms as no rash, no cough, no allergies, no medications and no past medical history. As such, the Tribunal were not satisfied on the evidence before it that Dr Ojo had failed to obtain a history of Patient A's salient positive and negative symptoms. It therefore determined this paragraph as not proved.

Paragraphs (a)(vi)

25. The Tribunal had sight of Dr Ojo's medical notes and witness statements and found that there was nothing in his medical notes of the consultation regarding the duration of the symptoms. While the Tribunal were aware that there was a note of seeing the GP in the last 24 hours and some discussion of symptoms no longer being present with Patient A, such as the rash ("no rash"), there were no indication of how long Patient A had suffered from these symptoms. There was no evidence of this in the initial June 2017 statement of Dr Ojo, nor was there any evidence given by Miss B or Dr Ojo at this hearing to suggest that this had happened. Based on the totality of the evidence on the balance of probabilities, the Tribunal were satisfied this had not happened and found this paragraph be found proved.

Paragraphs 1, (f)(i, ii, iii, iv)

26. The Tribunal bore in mind that Dr Ojo gave evidence that it was his usual routine to give safety netting advice but it was not satisfied that he did so in this case. The Tribunal accepted Miss B's oral evidence that she was adamant no such advice was given to her to take Patient A to Accident and Emergency at all. There was nothing in Dr Ojo's consultation notes which indicated safety setting advice, which the Tribunal found particularly surprising if he had thought Patient A should have been seen within 2 hours. Furthermore, there was no evidence in Dr Ojo's June 2017 witness statement that he gave adequate safety netting advice. It was clear that from Dr Ojo's oral evidence that if he did give any advice, he was not able to articulate that he had advised what to do: if Patient A became floppy; if temperature increased; if Patient A had developed any new rashes; or if Miss B was unhappy with Patient A's behaviour. The Tribunal determined that safety netting advice was not given and found this paragraph proved.

Paragraphs 1 (g)(ii)

27. The Tribunal examined the medical notes, dated 20 May 2017, time 23:35, and were satisfied that it did not adequately record the fact Dr Ojo had validated the previous history taken by the 111 service. It bore in mind Dr D's evidence that although there was no difficulty in cutting and pasting the 111 notes into your own consultation notes he was not able to tell which of those notes had been validated by Dr Ojo from the notes. There was nothing in the consultation notes to demonstrate validation had taken place. Dr Ojo had to give evidence to explain which note was his and which note was from the 111 and had to explain his process of validation. It was accepted by him that his consultation notes overall were not up to standard. The Tribunal determined this included his record of validation of symptoms recorded by others. Accordingly, the Tribunal found this paragraph as proved.

Paragraphs 1 (h)

28. It is admitted by Dr Ojo that he did not follow the Out of Hours procedures, specifically he accepted that he contacted Patient A's parents and he did so without prior warning. The Tribunal were of the view that Dr Ojo was obviously upset upon hearing of Patient A's death. The Tribunal are satisfied that Dr Ojo made contact and he did so for two reasons; to find out the reason for Patient A's death and the other was to offer his condolences. The Tribunal accepted the evidence of Miss B, who presented a vivid picture of her 3 year old son in the back of the car, and the call being received on speaker phone, and as such her son would have heard the content of the call. Miss B recalled that she was

alarmed by Dr Ojo asking what the "cause of death" was because she had yet to break news of Patient A's death to his brother.

29. Furthermore, the questions submitted by Miss B and her husband to the Herts Urgent Care (HUC) investigation, in particular question number 26, posed the question *"Is it standard procedure for Herts Urgent Care GP to call a family the day after a child's death and asking for a cause of death?".* This demonstrated to the Tribunal that this was a concern raised in 2017 by the family, when events were fresher in their minds. The Tribunal found this matter proved.

Paragraphs 2 (a, b)

30. For the reasons already set out in Paragraph 1 (a)(i), the Tribunal were satisfied that the telephone consultation was longer than "approximately 2 minutes" and the conversation had included questions regarding wet nappies and Patient A's rash. The Tribunal were not satisfied that Dr Ojo had made false statements relating to those matters. It bore in mind Miss B had not provided a statement until 12 months after the events. She was now giving evidence four years after the events and she fairly accepted during her evidence that he may have asked these questions. She accepted that dehydration had been a concern and so, the Tribunal determined that this was likely to have provoked a conversation about wet nappies. The Tribunal notes that she had attended Accident and Emergency the next day and told Dr Small (on duty doctor in Accident and Emergency), amongst other things, that Patient A had "2 wet nappies". Dr Ojo gave evidence that he asked about those matters and pointed to the fact that "No rash" was reflected in this consultation notes. Having accepted that Dr Ojo asked about a rash, the Tribunal also accepted it was probable that he has also asked about wet nappies. Therefore, the Tribunal found (a and b) of Paragraph 2 not proved.

Paragraphs 2 (c, d, e)

31. The Tribunal found that c, d and e were false statements because having considered the evidence as a whole there was no evidence of any degree of urgency displayed at the time of this consultation at all. There was no evidence in Dr Ojo's consultation notes that he made this suggestion to Miss B at all. As the Tribunal have previous stated, this is surprising if he had thought the baby had to be seen within 2 hours and Miss B was going against his medical advice with such a vulnerable patient. The Tribunal accepted the evidence of Miss B that had she had been told it "would have been better to take Patient A to Accident and Emergency" she would have acted upon that advice. It was evident that Miss B was a worried mother who was calling very late at night, concerned about the health of her child and she

told the Tribunal that she had already gone upstairs to pack a bag, anticipating that she and Patient A may have to go to Accident and Emergency.

32. The Tribunal accepted that had she been given this advice, she would have followed it. The Tribunal rejected any suggestion that Miss B was reluctant in any way to take her child to any face to face appointment. The assertion that Dr Ojo told Miss B that it would be better to go to Accident and Emergency is contradicted by Dr Ojo own actions, as he did not attempt to pass on the need for Patient A to be seen by the other on call doctor who was nearer to the home address. He did not pursue an appointment overnight at all. In fact he allowed the booking of the appointment in the morning at 8am and further allowed this to be changed to the later time of 10am to suit Miss B's other child care needs. The Tribunal determined that all the evidence demonstrated Dr Ojo did not state "it was better to take Patient A to Accident and Emergency" and rejected the suggestion that "mum was not keen".

33. The Tribunal determined that Dr Ojo had falsely stated to Patient A's mother that "it would be better to take Patient A to Accident and Emergency" and consequently found (c and) of Paragraphs 2 proved.

34. The Tribunal was satisfied by the evidence of Miss B that she had Patient A beside her for the evening, and the only time that she left him was to pack a bag for the hospital, in case they needed to go. Therefore, the Tribunal had accepted, there was no need for her to go anywhere else while Dr Ojo waited on the phone for her to check on Patient A.

35. The Tribunal noted that there was an inconsistency within the body of Dr Ojo's June 2017 witness statement, specifically he stated that Patient A *"was conscious and holding her hand"* as compared to the assertion he makes that Miss B had to go somewhere else to check again on Patient A.

36. The Tribunal accepted the evidence of Miss B that she was reassured and was told to leave her baby sleeping. The tribunal were of the view that Dr Ojo had been satisfied of the health of Patient A and had not asked for any second checks of Patient A at all. Therefore, the Tribunal found paragraph 2 (e) proved.

Paragraphs 4

37. Having found the Allegation at Paragraphs 2 (a and b) not proved and Paragraph 2 (c, d, and e) proved, the Tribunal went on to consider whether statements made at (c, d and e) were untrue. As per its previous rationale and findings, the Tribunal found these statements

to be false and therefore it was satisfied Dr Ojo had made untrue statements and found paragraph 4 proved.

Paragraphs 5

38. Taking all the relevant factors into account, the Tribunal considered whether Dr Ojo had realised that something had gone horribly wrong when he learned of Patient A's death. He must have considered that he may have made mistakes in his clinical management. He was asked to write a statement whilst events were fresh. He gave evidence that he did this over the course of about three weeks. He realised his note taking was deficient. There was nothing in his notes to explain his consultation and how he had reached the decisions he made. The Tribunal determined that he then sought to minimise his potential mistakes, namely his failure to diagnose and treat Patient A appropriately.

39. The Tribunal were of the view that he filled in the gaps to minimise his potential mistakes, he filled in gaps dishonestly and he was aware what he was doing. This is particularly clear with his attempt to blame Miss B for Patient A not attending A and E when he knew he had not given that advice at all.

40. The Tribunal found Dr Ojo's actions to be both subjectively and objectively dishonest. It found that Dr Ojo had made false statements which he knew to be untrue. As soon as he realised that Patient A had died, he was undoubtedly very upset and very concerned about his own potential failings, in particular that he had not urged Miss B to seek out a face to face appointment for Patient A, given the symptoms that the baby had presented and he had not advised or urged for Patient A to go to Accident and Emergency. There was no support from the documentation for Dr Ojo's contention he tried to get Patient A an appointment before the morning. The Tribunal accepted the submissions of the GMC, that Dr Ojo realised what he could and, as he now accepts, should have done, and sought to fill in the gaps in his consultation notes by suggesting that he was more proactive than he really was and by suggesting it was Miss B who was not keen to bring Patient A to be seen. The Tribunal found paragraph 5 of the allegation was proved.

The Tribunal's Overall Determination on the Facts

41. The Tribunal has determined the facts as follows:

1. On 20 May 2017 at or around 23:35 you engaged in a telephone consultation with Patient A's mother in relation to Patient A and you failed to:

    a. obtain an adequate history from Patient A's mother in that you:

i. consulted with Patient A's mother for approximately two minutes;
Determined and found not proved

ii. did not validate the previous history taken by the 111 service with Patient A's mother;
Determined and found not proved

iii. did not note any differences between the previous history Patient A's mother gave to the 111 service and the history Patient A's mother gave to you;
Determined and found not proved

iv. did not note the specific concerns Patient A's mother had;
Admitted and found proved

v. did not obtain a history of Patient A's;

1. salient positive symptoms;
Determined and found not proved
2. salient negative symptoms;
Determined and found not proved

vi. did not obtain a history of the duration of Patient A's symptoms;
Determined and found proved

b. adequately assess Patient A in that you:

i. did not advise Patient A's mother to attend an Accident and Emergency department at hospital within two hours of your consultation with Patient A's mother;
Admitted and found proved

ii. did not advise Patient A's mother to attend an Out of Hours Centre within two hours of your consultation with Patient A's mother;
Admitted and found proved

iii. inappropriately organised an appointment for Patient A at 10:00 on 21 May 2017;
Admitted and found proved

c. take adequate safeguarding action in that you did not impress on Patient A's mother the importance of an urgent face to face assessment with Patient A;
Admitted and found proved

d. appropriately diagnose Patient A in that you:

i. recorded your diagnosis in Patient A's medical records as 'IC92 has a sore throat';
Admitted and found proved

ii. did not diagnose Patient A with '?viral/bacterial illness, worsening with worrying features' or words to that effect;
Admitted and found proved

e. adequately follow relevant guidance when assessing whether Patient A was at risk for sepsis/serious illness in that you did not consider Patient A's:
Admitted and found proved

i. age;
Admitted and found proved

ii. history;
Admitted and found proved

iii. symptoms;
Admitted and found proved

f. provide adequate safety-netting advice to Patient A's mother in that you did not advise Patient A's mother to take Patient A to an Accident and Emergency department at a hospital or to call 111 in the event that:

i. Patient A became floppy;
Determined and found proved

ii. Patient A's temperature increased;
Determined and found proved

iii. Patient A developed any new rashes;
Determined and found proved

iv. she was not happy with Patient A's behaviour;
Determined and found proved

g. make an adequate record of your consultation with Patient A's mother in that you did not record:

i. the urgency of the need of Patient A's presenting symptoms;
Admitted and found proved

ii. your validation of the previous history taken in the 111 service;
Determined and found proved

iii. any differences noted between the 111 service and your own assessment of Patient A;
Admitted and found proved

iv. the specific concerns Patient A's mother had;
Admitted and found proved

v. Patient A's history of symptoms;
Admitted and found proved

vi. the duration of Patient A's symptoms;
Admitted and found proved

vii. Patient A's current symptoms;
Admitted and found proved

viii. any parental concern;
Admitted and found proved

ix. any advice given;
Admitted and found proved

x. any safety netting advice;
Admitted and found proved

xi. any provisional diagnosis;
Admitted and found proved

xii. any treatment plan;
Admitted and found proved

xiii. any management plan;
Admitted and found proved

xiv. jointly agreed review/appointments;
Admitted and found proved

h. follow the Out of Hours service procedures in that you contacted Patient A's parents on 22 May 2017 without prior warning to find out the reason for Patient A's death.
Determined and found proved

2. You prepared a witness statement dated 12 June 2017 ('initial statement') in which you falsely stated:

a. 'I asked if he [Patient A] had been having wet nappies';
Determined and found not proved

b. 'I asked her [Patient A's mother] about the rash again';
Determined and found not proved

c. that you had told Patient A's mother that 'it would be better to take him [Patient A] to the Accident and Emergency';
Determined and found proved

d. 'mum was not keen to take him [Patient A] to A&E';
Determined and found proved

e. 'I stayed on the phone and asked mother to check on Patient A again and ensure he was responding normally and that no new rash had developed. His mother went away to assess him and then came back to talk to me again on the phone. She reassured me he was ok and was sleeping. I asked if when she went to check, he was breathing and responding normally. His mum said he was responding normally'.
Determined and found proved

3. On 19 July 2018, at the coroner's inquest you maintained that the statements you made in your initial statement as detailed at paragraph 2 were accurate.
Admitted and found proved

4. You knew that the statements contained within your initial statement as detailed at paragraph 2 were untrue.
Determined and found proved

5. Your actions as described in paragraphs 2 and 3 were dishonest by reason of paragraph 4.
Determined and found proved

Determination on Impairment - 29/03/2021

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Ojo's fitness to practise is impaired by reason of misconduct.

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence from the GMC in the form of a determination from a previous hearing which concluded on 2 October 2015, where Dr Ojo was found not impaired by reason of misconduct. They were also informed that Dr Ojo had received a warning in 2005.

3. On behalf of Dr Ojo, Mr Partridge submitted a bundle of documents which included Dr Ojo's CV, a reflective piece, appraisals and audits of Dr Ojo's work, letters of feedback, evidence of Dr Ojo's continuous professional development and testimonials.

Submissions

On behalf of the GMC

4. Ms Cabral submitted that the facts found proved established that Dr Ojo's fitness to practice is currently impaired by reason of his misconduct. Ms Cabral drew the attention of the Tribunal to various paragraphs of Good Medical Practice (2013) ('GMP') 15, 21, 27 and 72, which she submitted had been breached by Dr Ojo.

5. Ms Cabral submitted that there had been *'a string of failings',* namely Dr Ojo's failures to diagnose and assess Patient A, including history taking; assessments; diagnosis; late scheduling of the appointment, lack of safeguarding; safety netting; and record keeping. She submitted that all of this conduct was inextricably linked to Dr Ojo's practice and undoubtedly amounts to serious misconduct. She further submitted that given the nature of Dr Ojo's contact with Patient A's parents, which was without prior arrangement and the distress it occasioned, also constituted serious misconduct. Ms Cabral submitted that the Allegations surrounding dishonesty had brought the medical profession into disrepute.

6. Ms Cabral submitted that Dr Ojo has continued to minimise his own errors and has sought to lay blame with Patient A's mother. Additionally, with the Tribunal's previous facts

findings in mind, Ms Cabral submitted that Dr Ojo has lied to the Herts Urgent Care (HUC) investigation, and perhaps more seriously, on oath to the coroner. Ms Cabral submitted that Dr Ojo's insight into his actions is *"close to 0".*

7. In summary, Ms Cabral submitted that, given the significant departures from GMP and the lack of insight and remediation, Dr Ojo presents a risk to members of the public. She submitted that the need to uphold professional standards and public confidence in the profession would be undermined if a finding of impairment was not made.

On behalf of Dr Ojo

8. Mr Partridge accepted that Dr Ojo's fitness to practice was currently impaired and did not seek to make further submissions. However, he drew the Tribunal's attention to the considerable professional development work undertaken and testimonials presented on behalf of Dr Ojo.

The Relevant Legal Principles

9. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

10. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts found proved amounted to misconduct and whether any misconduct found was serious and then, whether the finding of that misconduct which was serious could lead to a finding of impairment.

11. The Tribunal must determine whether Dr Ojo's fitness to practise is impaired today, taking into account Dr Ojo's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

12. As outlined in Ms Cabral's submissions, the Tribunal also had regard to the case of Roylance v General Medical Council (No.2) [2000]1 AC 311 (UKPC). It states:

> *'Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [medical] practitioner in the particular circumstances. The misconduct is*

qualified in two respects. First, it is qualified by the word professional which links the misconduct to the profession [of medicine]. Secondly, the misconduct is qualified by the word serious. It is not any professional misconduct which would qualify. The professional misconduct must be serious.'

13. In reaching its determination, the Tribunal had regard to the case of Meadow v GMC [2006] EWCA Civ 1390 which outlined that the purpose of fitness to practise proceedings is not to punish the practitioner for past misdoings but to protect the public against acts and omissions of those who are not fit to practise. Tribunals therefore should look forward and not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past.

14. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report,* as adopted by the High Court in the case of *Council for Healthcare Regulatory Excellence v NMC and Grant* [2011] EWHC 927. In particular the Tribunal considered whether its findings of fact show that Dr Ojo's fitness to practise is impaired in the sense that he:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d. has in the past acted dishonestly and/or liable to act dishonestly in the future.

The Tribunal's Determination on Impairment

Misconduct

15. In determining whether Dr Ojo's fitness to practise is currently impaired by reason of misconduct, the Tribunal first considered whether the facts proved amount to misconduct.

16. When considering Dr Ojo's failures in clinical management, the Tribunal had its previous findings in mind and the following paragraphs of the Allegation:

- Paragraph 1 (b) failure to adequately assess Patient A, who was an 11-month-old vulnerable patient,
- Paragraph 1 (c) failure to give appropriate advice regarding a face to face consultation to Patient A's mother and attendance of Accident and Emergency;
- Paragraph 1 (d) inappropriate diagnosis,
- Paragraph 1 (e) failure to follow sepsis/ serious illness guidance
- Paragraphs 1 (f) failure to give adequate safety netting advice to Patient A's mother.

17. The Tribunal determined that failings, taken both individually and together, amounted to serious misconduct. It noted that these clinical management failures led Dr Ojo to fail to consider sepsis as a diagnosis. It is not known if the subsequent tragic death of Patient A could have been prevented by better clinical management on his part.

18. The Tribunal were also of the view that a higher standard of note taking was to be expected when dealing with patients in an Out of Hours service, where patients were not well known to the clinician and where there may be more potential for clinical emergencies.

19. When the Tribunal considered Dr Ojo's failures in note taking solely alone, the Tribunal were of the view that it would not have amounted to serious misconduct but the Tribunal were concerned that this was the third time Dr Ojo had been investigated by his regulatory body for his inadequate note taking. The Tribunal were of the view that this made the current case more serious, and when taken together with Dr Ojo's other clinical management failings amounted to serious misconduct.

20. The Tribunal considered paragraphs 1 and 15 of GMP were engaged in respect to Dr Ojo's failings in clinical management:

> ***1*** *Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are* ***honest and trustworthy, and act with integrity*** *and within the law.*
>
> ***15*** *You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> > ***a*** *adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*

b promptly provide or arrange suitable advice, investigations or treatment where necessary
c refer a patient to another practitioner when this serves the patient's needs.

21. The Tribunal found that, in the course of the proceedings, Dr Ojo made false representations in his 2017 witness statement, which he knew to be untrue and dishonest. The Tribunal were of the view that by making false representations in his witness statement, to cover up his clinical failings, Dr Ojo was intentionally dishonest. Furthermore, Dr Ojo had maintained the falsehoods on oath at the Coroner's Inquest. The Tribunal determined Dr Ojo's actions amounted to serious misconduct.

22. The Tribunal found that Dr Ojo's dishonest actions were responsible for significant breaches of GMP. It considered the following paragraphs to be engaged for the reasons that follow.

1 Patients need good doctors. Good doctors……are honest and trustworthy and act with integrity and within the law.

55 You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should: a put matters right (if that is possible) b offer an apology c explain fully and promptly what has happened and the likely short-term and long-term effects.

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

72 *You must be honest and trustworthy when giving evidence to courts or tribunals. You must make sure that any evidence you give or documents you write or sign are not false or misleading.*

a You must take reasonable steps to check the information is correct.
b You must not deliberately leave out relevant information.

Impairment

23. The Tribunal having found that the facts found proved amount to misconduct, which was serious, went on to consider whether, as a result of that misconduct, Dr Ojo's fitness to practise is currently impaired.

24. The Tribunal considered evidence of insight or remediation on the part of Dr Ojo and whether there was a likelihood of him repeating his misconduct in the future. The Tribunal firstly looked at the clinical management failings.

25. Having considered the passage of time and Dr Ojo's extensive efforts in his appraisal and CPD work in the areas of effective consultations, sepsis and note keeping, the Tribunal were of the view that Dr Ojo had sufficiently remediated his clinical failings.

26. Therefore, the Tribunal determined that in respect of his clinical management, Dr Ojo was not impaired.

27. Secondly, the Tribunal considered the dishonest false representations. The Tribunal found the dishonesty in this case to be serious, in particular, Dr Ojo's attempted deflection of some blame to Miss B who was a mother grieving the loss of her child. She deserved his candour from the outset. It was wholly inappropriate for him to ring the family and ask for the cause of death. Although the Tribunal accepted he also offered his condolences.

28. The Tribunal noted the four year passage of time and found that this was of less relevance as Dr Ojo has continued to maintain his 2017 witness statement beyond the HUC investigation, into the Inquest and up to and including the current proceedings. The Tribunal determined that this was persistent and compounded the damage it caused to his reputation and the medical profession as a whole as well as distress to Miss B.

29. However, the Tribunal also took into account the number of testimonials submitted in support of Dr Ojo's behalf. He is well regarded otherwise. Those who knew him and worked with him were "shocked" by allegations of dishonesty. The Tribunal determined that his dishonesty was not a deep-seated character trait but his actions were born out of a grave error of judgment on his part not to be candid about his clinical failings at the outset. The Tribunal could find no insight into his dishonesty as it had not been admitted or remediated. It accepted dishonesty was difficult to remediate. It was therefore unable to reach any conclusions about the risk of repetition and could not completely rule it out.

30. In the circumstances of the case as a whole, and notwithstanding its conclusions in respect of the likelihood of repetition, insight or remediation, the Tribunal concluded that a finding of impairment was necessary in Dr Ojo's case in order to satisfy the overarching objective to promote and maintain public confidence in the medical profession and to promote and maintain proper professional standards and conduct for the members of that profession.

31. The Tribunal considered that public confidence in the profession would be undermined if a finding of impairment were not made in this case.

32. Accordingly, the Tribunal determined that Dr Ojo's conduct fell far short of the standards of conduct reasonably to be expected of a doctor, such that it was necessary to make a finding of impairment.

Determination on Sanction - 30/03/2021

74. Having determined that Dr Ojo's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

75. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

76. In addition, the Tribunal received a letter of apology from Dr Ojo, dated 29 March 2021.

Submissions

On behalf of the GMC

77. Ms Cabral submitted that the appropriate and proportionate sanction in this case was one of erasure. She acknowledged that the Tribunal had only found impairment on the basis of Dr Ojo's dishonesty. Ms Cabral reminded the Tribunal of the importance of honesty and integrity in upholding public confidence in the medical profession. Ms Cabral referred the Tribunal to case law and the relevant paragraphs of the Sanctions Guidance (November 2020) ('the SG') on erasure and dishonesty.

78. Ms Cabral made submissions on the nature, extent and seriousness of Dr Ojo's dishonesty. She submitted that Dr Ojo had chosen to try and cover up his clinical failings and in so doing had compounded Ms B's trauma by putting the blame on her for Patient A's

death. Ms Cabral submitted that, while the Tribunal had found Dr Ojo's dishonesty not to be a deep-seated character trait, his dishonesty had been sustained over four years. Ms Cabral submitted that Dr Ojo had lied on oath to both the coroner and to this Tribunal. She submitted that Dr Ojo's dishonesty represented a particularly serious departure from standards expected of a registered medical professional.

79. Ms Cabral reminded the Tribunal to consider the aggravating and mitigating features of the case. She submitted that Dr Ojo's lack of insight was a substantial aggravating factor in this case. Ms Cabral acknowledged that Dr Ojo had no previous regulatory findings of impairment against him, that he had made admissions to his clinical failings and that four years had lapsed without further incident. However, she submitted that Dr Ojo's dishonesty was persistent and covered up. Ms Cabral submitted that notwithstanding his apology to Patient A's parents, his clinical admissions and the favourable testimonials that speak to him as a doctor and a man, Dr Ojo's actions were not compatible with future registration.

On behalf of Dr Ojo

80. On behalf of Dr Ojo, Mr Partridge submitted that while Dr Ojo's dishonesty had been persistent; he did not have a fundamental attitudinal problem. Mr Partridge submitted that while Dr Ojo had failed to take complete ownership of his actions, those actions were in response to shocking events that had led to a serious error of judgement. He submitted that this error did not define him as a person nor as a doctor. Mr Partridge reminded the Tribunal of the testimonials before it and submitted that in all other respects Dr Ojo has been a good doctor and is ordinarily a man of honesty and good character.

81. Mr Partridge accepted that there was no direct evidence of Dr Ojo's insight into his dishonesty. However, he submitted that the Tribunal could infer from the testimonials presented on behalf of Dr Ojo, that he has *"nascent"* insight. He further submitted that Dr Ojo has apologised for his actions and taken ownership of his clinical failings. Mr Partridge submitted that these factors were important indicators of both the insight Dr Ojo has already achieved and the insight he is capable of achieving in the future, given further opportunity to reflect. Mr Partridge reminded the Tribunal of Dr Ojo's background and submitted that he had been working in a difficult area of primary care for many years and that he had continued to work and modified his practice since these events in 2017 to ensure that there would be no repeat of his misconduct.

82. Mr Partridge stated that this Tribunal has a balancing exercise to undertake. He accepted that a serious sanction was required in this case and that the Tribunal's balancing exercise was between suspension and erasure. In its balancing exercise, Mr Partridge

submitted that the Tribunal should consider the public interest as a whole. Dr Ojo is an otherwise clinically competent doctor who had served the public and he should be given the opportunity to remediate. He submitted that there are significant mitigating features in this case and given the passage of time and in the absence of a pervasive attitudinal problem, that a substantial period of suspension followed by a review hearing would be appropriate. Mr Partridge submitted that at a review hearing, Dr Ojo would be required to provide evidence of sufficient insight to demonstrate that he was fit to return to the medical register.

The Tribunal's approach

83. The decision as to the appropriate sanction to impose, if any, is a matter for the Tribunal exercising its own judgement. No party bares any burden.

84. In reaching its decision, the Tribunal has taken account of the SG and of the overarching objective. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Ojo's interests with the public interest. The Tribunal also bore in mind that the purpose of sanctions is not to punish a doctor but to protect patients and the wider public interest, although sanction may have a punitive effect. The Legally Qualified Chair ('LQC') stated that the Tribunal should consider the available sanctions in order of seriousness, starting with the least restrictive.

85. The Tribunal has already given detailed determinations on facts and impairment and has taken those matters into account during its deliberations on sanction.

86. The Tribunal followed the guidance to assess the seriousness of the dishonesty on the facts of the case. As per the following relevant authorities, amongst others, which were referred to by the LQC in the presence of the parties:

- *GMC v Nwachuku [2017] EWHC 2085 (Admin);*

  Para 37. "…this court has stated often enough that any finding of dishonesty in a professional person is extremely serious and will often lead to the sanction of erasure."

  Para 57 "… dishonesty is not necessarily a monolithic concept. That has two consequences. First of all, questions of degree obviously arise, that much must be self evident but secondly, that dishonesty in an individual does not have to be an all pervading or immutable trait".

- *Lusinga v GMC [2017] EWHC 1458 (Admin)*

  Para 103 "dishonest conduct can take various forms; some criminal, some not; some destroying trust instantly, others merely undermining it to a greater or lesser extent."

The Tribunal's Determination on Sanction

Aggravating and mitigating factors

87. Before considering what action, if any, to take in respect of Dr Ojo's registration, the Tribunal first considered the aggravating and mitigating factors present.

88. The Tribunal considered the following to be aggravating factors in this case:

- Dr Ojo maintained the false statements in his 2017 witness statement at the Inquest and this hearing.
- By his false representations Dr Ojo had sought to deflect blame for his clinical failings towards Patient A's mother.
- There was no insight into his dishonesty.

89. It considered the following to be mitigating factors to be of relevance:

- Dr Ojo self-referred to the GMC.
- Dr Ojo has fully engaged with the GMC investigation and the hearing.
- Dr Ojo made certain admissions at the outset of the hearing, (although those admissions did not concern dishonesty matters)
- Dr Ojo has sufficiently remediated the clinical management problems including consultation skills, notetaking, sepsis knowledge, safeguarding, safety netting, through evidence of CPD.
- A significant time has lapsed since the incidents giving rise to the Allegation and he has continued to work unrestricted for the past 4 years. There is no evidence of repetition of misconduct or dishonesty in the intervening period.
- Dr Ojo's fitness to practise has never previously been found to be impaired.
- Dr Ojo has shown genuine remorse for his failings, the Tribunal were of the view these proceedings would have a salutary learning experience for him and therefore was of the view that he is less likely to repeat his misconduct.

- The Tribunal had received testimonial evidence regarding his honesty, good character and clinical competence, which also indicated that there was no significant risk of repetition.

No action

90. In coming to its decision as to the appropriate sanction, the Tribunal first considered whether to conclude the case by taking no action. The Tribunal reminded itself that there should be exceptional circumstances to justify taking no action where a finding of impairment has been made.

91. The Tribunal considered that there were no exceptional circumstances to justify taking no action in this case. It determined that given the serious nature of the Tribunal's findings on impairment, it would be neither sufficient, proportionate nor in the public interest, to conclude this case by taking no action.

Conditions

92. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Ojo's registration. The Tribunal bore in mind that any order of conditions would need to be appropriate, proportionate, workable and measurable.

93. The Tribunal bore in mind that neither party made submissions to impose conditions. The Tribunal had regard to the various paragraphs of the SG which indicate the cases in which an order of conditions might be appropriate. Given the serious nature of the Tribunal's findings, specifically Dr Ojo's limited insight in his dishonest actions, the Tribunal considered that an order of conditions would not be appropriate or proportionate, nor would it be in the public interest. The Tribunal determined that it could not formulate appropriate conditions to address the issues of dishonesty raised by Dr Ojo's misconduct.

Suspension

94. The Tribunal then went on to consider whether imposing a period of suspension on Dr Ojo's registration would be appropriate and proportionate. It has borne in mind the SG in relation to suspension, including paragraphs 91 and 92, which state:

> ***91.*** *Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a*

punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

92. *Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e. for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession)*

95. The Tribunal also considered the following factors as set out in paragraph 97 of the SG to be relevant in Dr Ojo's case, which indicate that suspension may be appropriate where there is:

97 *Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*

a *A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*
b *…*
c *…*
d *…*
e *… No evidence that demonstrates remediation is unlikely to be successful, e.g. because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
f *No evidence of repetition of similar behaviour since incident.*

96. The Tribunal considered that Dr Ojo's misconduct was unacceptable for a medical practitioner.

97. His dishonest representations were serious, which he persisted with at two formal hearings. Dr Ojo made a grave error of judgment in not acknowledging his clinical failings

arising out of the 20 May 2017 telephone consultation and not being candid with the family regarding poor care.

98. The most serious aspect of the misrepresentation was that Dr Ojo sought to deflect blame to Miss B, Patient A's mother at an emotionally difficult time for her and her family. The impact on her and public confidence as a whole cannot be quantified but is wholly unacceptable conduct.

99. However, the Tribunal also took into account that these were not persistent acts of repeated dishonesty. They were the same false representations persisted with at the Inquest and at this hearing. The Tribunal took into account the significant testimonials provided on behalf of Dr Ojo which demonstrate that he is a man who is ordinarily honest and straight forward. The Tribunal have already come to the view that his dishonest actions of 2017 are outside his normal character. None of the evidence presented revealed an irremediable attitudinal problem.

100. The Tribunal have also determined upon all of the material before it that, although it cannot determine there is no risk, there is no significant risk of repetition.

101. The Tribunal noted that there was good evidence that Dr Ojo was capable in engaging in a learning process and it was clear that he had done so extensively with regard to his clinical failings. The Tribunal had already noted that it had already been presented with considerable evidence of reflection and professional development. The Tribunal were of the view that Dr Ojo was capable of reflecting on his dishonesty and the impact that it had had on Patient A's family and the damage it had caused to the medical profession as a whole.

102. The Tribunal accepted that in all other respects that he was a good doctor. The Tribunal accepted that from 2002 he had served the public, in a difficult area of primary care, namely the out of hours service, where patients are not known to a doctor and the stresses are greater. Testimonials and appraisals showed he was well regarded, has had no other complaints about his probity, had generally good patient feedback and has been a valuable doctor serving the public.

103. In conducting its balancing exercise, the Tribunal concluded that its decision was very finely balanced. The Tribunal were of the view that a serious sanction was required to have a deterrent effect and to remediate the adverse impact on public confidence. The Tribunal bore in mind paragraphs 124, 125 and 128 of the SG which related to dishonesty. The Tribunal accepted that Dr Ojo's dishonesty was serious (and persisted with) but was not so

engrained or so incapable of remediation that it is fundamentally incompatible with his continued registration.

104. The Tribunal determined that the elements of upholding proper standards within the profession, and of maintaining public confidence in the profession would be maintained by a maximum period of suspension. Accordingly, it concluded that the maximum period of suspension of 12 months was the appropriate and proportionate sanction in this case.

Review Hearing Directed

105. The Tribunal determined to direct a review of Dr Ojo's case. A review hearing will convene before the end of the period of suspension. The Tribunal reminds Dr Ojo that at the review hearing, the onus will be on him to demonstrate the extent to which he has remediated, addressed his insight and is safe to return to unrestricted practice. The Tribunal considered that it may assist the reviewing Tribunal if Dr Ojo provided:

I. Written evidence of further reflection and remediation: Dr Ojo may wish to reflect on his past actions, his dishonesty, and the impact upon public confidence in the medical profession as well as upon his colleagues.
II. Reflection on the importance of honesty and candour with patients.
III. Targeted courses in professional probity and ethics. Preferably including face-to-face courses, rather than just conducted online (can be via video link).
IV. Reflection piece written post his professional courses. He may wish to give the reviewing Tribunal each course aims and objectives, show examples of what he has learnt and demonstrate how he will apply that learning if allowed to resume practicing.
V. Evidence that he has kept up to date clinically during his period of suspension.

This is not intended to be an exhaustive list and Dr Ojo may provide any other information he considers will assist him and another Tribunal at a review hearing.

Determination on Immediate Order - 30/03/2021

106. Having determined that Dr Ojo's registration is to be suspended for a period of 12 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Ojo's registration should be subject to an immediate order.

Submissions

On behalf of the GMC

107. Ms Cabral submitted that an immediate order of suspension is required. She drew the Tribunal's attention to paragraphs 172 and 173 of the Sanctions Guidance (November 2020) ('the SG'). She submitted that it would be in the public interest for such an order to be imposed.

On behalf of Dr Ojo

108. Mr Partridge submitted that a decision on immediate order was one for the Tribunal and wished to make no further submissions.

The Tribunal's Determination

109. The Tribunal was mindful that an immediate order is not an automatic decision, and if one were to be made it needed to be proportionate and meet the overarching objective.

110. In deliberating on the matter, the Tribunal took into account the paragraphs of the SG which deal with the matter of immediate orders, in particular paragraph 172 which states:

> *172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*

111. The Tribunal had regard to the principle of proportionality and balanced Dr Ojo's interests with the public interest. It has already noted the seriousness with which it regards his dishonesty. The Tribunal were of the view that it is necessary to maintain public confidence for the order to start immediately.

112. This means that Dr Ojo's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from when written notice of this

determination has been served upon Dr Ojo, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

113. There is no interim order to revoke.

114. This concludes this case.

Confirmed

Date 30 March 2021 Ms Louise Sweet QC Chair