MPTS Medical Practitioners Tribunal Service

Record of Determinations – Medical Practitioners Tribunal

PUBLIC RECORD

Date: 27/05/2026

Doctor:	Dr Charles ANIGALA
GMC reference number:	6039186
Primary medical qualification:	MB BS 1998 University of Lagos

Type of case	**Outcome on impairment**
Review - Misconduct	Not Impaired

Summary of outcome

Suspension to expire

Tribunal:

Legally Qualified Chair:	Ms Jayne Wheat
Lay Tribunal Member:	Mr Darren Shenton
Registrant Tribunal Member:	Dr Juliet Bennett

Tribunal Clerk:	Miss Emma Saunders

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Ms Penny Maudsley, Doctors Defence Service, instructed directly
GMC Representative:	Ms Lucy Chapman, 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.

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection 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 Impairment - 27/05/2026

1. At this review hearing the Tribunal has to decide in accordance with Rule 22(1)(f) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules') whether Dr Anigala's fitness to practise is impaired by reason of misconduct.

Background

2. Dr Anigala qualified in 1998 from the University of Lagos, Nigeria. He initially practised medicine in Nigeria before moving to Dublin in the Republic of Ireland, where he completed further examinations. Immediately prior to the events which led to Dr Anigala's substantive hearing, he had been working as a long-term locum at Altnagelvin Hospital in Northern Ireland ('the Hospital') for over eight years.

2025 Tribunal

3. A Medical Practitioners Tribunal (MPT) convened to consider Dr Anigala's case on 6 to 9 October 2025 ('the 2025 Tribunal').

4. Dr Anigala made admissions to the entirety of the Allegation. On 16 October 2023 Patient B attended the Emergency Department of the Royal Victoria Hospital in Belfast ('RVH'). A CT scan was ordered and Dr Anigala subsequently reviewed the results. The radiologist report included that neurosurgical input and referral was advised. However, Dr Anigala determined that Patient B was suitable for discharge home and this took place later that day. Patient B died two days later on 18 October 2023. On 2 November 2023 Dr C, the clinical lead of the Emergency Department at RVH, was advised of the death of Patient B

and of a request for statements for the Coroner from all the relevant medical personnel who had treated Patient B. Dr C met with Dr Anigala on 7 November 2023.

5. The Allegation set out that, on 7 November 2023, Dr Anigala had a discussion with Dr C regarding Patient B in which he was asked if he had *"any contact with the neurosurgery team at RVH"*, or words to that effect, to which Dr Anigala replied that he had *"made contact with the neurosurgery team at the RVH and that they had advised that Patient B did not need to be transferred to the RVH"* or words to that effect. Dr Anigala made admissions to the fact that he knew his response to Dr C was false as he did not contact a Neurosurgical Registrar to discuss Patient B's care.

6. The patient records did not reflect the contact and discussion so Dr C asked Dr Anigala to prepare a retrospective note recording it so that it could be added to Patient B's medical records. Dr Anigala made the retrospective entry in the notes later that day. Dr C made enquires and learned there was no evidence that Dr Anigala had spoken to the Neurosurgical Registrar and no record of any call or discussion relating to Patient B on or around the relevant date. Dr C spoke to Dr Anigala again on 16 November 2023, who volunteered that he had reflected, that the call was not made, and that he was regretful that he had not been truthful before.

7. The Allegation also set out that Dr Anigala made a false retrospective note for the purpose of being added to Patient B's medical records that stated that he had contacted a Neurosurgical Registrar to discuss Patient B's care and that the Registrar had confirmed that Patient B did not need to be transferred to the RVH. Dr Anigala made admissions that his actions were dishonest.

8. The 2025 Tribunal found that Dr Anigala's conduct was deliberate. The 2025 Tribunal did not accept Dr Anigala's evidence that he was in no way consciously or knowingly trying to hide his errors. It also found that, by implicating the Neurosurgical Registrar at RVH in the decision not to transfer Patient B, Dr Anigala was attempting to deflect any error away from himself. The 2025 Tribunal concluded that, at the time, Dr Anigala had not considered the ripple effect of his actions such as the cost in time, the reputational harm, and the stress caused to others, as he had acted solely with his own interests in mind. The 2025 Tribunal concluded that Dr Anigala's behaviour represented a serious departure from the standards of conduct expected of doctors. The 2025 Tribunal found that Dr Anigala's actions amounted to serious misconduct.

9. The 2025 Tribunal found that Dr Anigala had made tangible progress towards remediation but had not yet fully remediated his dishonesty. It determined that Dr Anigala's insight remained partial, and his tendency to conflate the seriousness of his dishonesty with issues of clinical judgment, albeit perhaps subconsciously, remained an area of concern. The 2025 Tribunal concluded that Dr Anigala's understanding of the wider impact of his dishonesty had not yet fully developed. The 2025 Tribunal accepted that there remained a risk of repetition but that it had been reduced due to insight developed by Dr Anigala. The 2025 Tribunal determined that Dr Anigala's fitness to practise was impaired by reason of his misconduct.

10. The 2025 Tribunal determined to suspend Dr Anigala's registration for a period of four months and directed that a review hearing should take place. This period would allow Dr Anigala sufficient time to reflect and to prepare further evidence of meaningful insight and remediation.

<u>March 2026 Tribunal</u>

11. A reviewing MPT convened on 6 and 20 March 2026 ('the March 2026 Tribunal'). The March 2026 Tribunal noted that Dr Anigala provided reflective written material and supporting documentation, including detailed reflections addressing his misconduct, a reflective journal evidencing ongoing insight, and documentation of Continuing Professional Development (CPD) and training undertaken during his suspension. The March 2026 Tribunal also had regard to testimonials and correspondence from colleagues and prospective employers indicating support for Dr Anigala's remediation and potential return to practice.

12. In relation to insight, the March 2026 Tribunal was satisfied that Dr Anigala accepted that his actions were dishonest and that he should have acted differently. It determined that Dr Anigala had demonstrated an understanding that his conduct undermined trust and accepted that he had let himself, his colleagues and the profession down. The March 2026 Tribunal also noted that Dr Anigala had not attempted to apologise directly to those affected and that his understanding of the impact on colleagues, including those potentially affected by his actions, appeared limited. The March 2026 Tribunal considered that Dr Anigala's insight remained 'developing'. It found that Dr Anigala's reflections and oral evidence were, at times, focused on the impact of the misconduct on himself, rather than demonstrating a full appreciation of the wider impact.

13. In relation to remediation, the March 2026 Tribunal acknowledged that Dr Anigala had undertaken reflective work, attended courses, and delivered presentations on topics such as honesty and professionalism. However, the March 2026 Tribunal found that this work was largely general in nature and not sufficiently tailored to address the specific concerns arising from his dishonesty.

14. The March 2026 Tribunal further noted that there was limited independent or third-party evidence before it to support the extent of Dr Anigala's remediation. The March 2026 Tribunal stated that there was no detailed evidence of the nature, frequency or content of mentoring undertaken nor any independent evaluation of his progress. The March 2026 Tribunal therefore determined that, whilst there had been some remediation, it was not yet complete.

15. In relation to record keeping, the March 2026 Tribunal was concerned by the evidence relating to a presentation Dr Anigala gave in February 2026. Dr Anigala had listed a presentation he gave as having taken place on 6 February, then the 8 February, when he corrected that it was actually on 9 February 2026. Further, a colleague had expressed concerns about the accuracy of the attendance record for the presentation that Dr Anigala had kept, which Dr Anigala later corrected. The March 2026 Tribunal noted inconsistencies in the documentation and accepted Dr Anigala's evidence that certain individuals signed attendance records despite not attending the presentation in full. Whilst the March 2026 Tribunal was encouraged by the steps Dr Anigala had taken to develop his insight and to remediate the misconduct, it was concerned about his lack of appreciation as to his understanding of the importance of accurate and honest record keeping.

16. The March 2026 Tribunal reached the view that Dr Anigala had addressed the concerns about his dishonest actions sufficiently, and that there was a low risk of him repeating his misconduct. The March 2026 Tribunal determined that the level of risk was therefore reduced from medium to low, although this was at the higher end of the lower spectrum of risk to public protection. The March 2026 Tribunal concluded that it did not eliminate the risk and that Dr Anigala had not fully addressed the concerns relating to his actions. The March 2026 Tribunal determined that Dr Anigala's fitness to practise remained impaired by reason of his misconduct.

17. The March 2026 Tribunal determined to suspend Dr Anigala's registration for two months and directed this review hearing. The March 2026 Tribunal stated that a reviewing Tribunal may be assisted by Dr Anigala providing:

- Evidence of his insight into the Tribunal's findings in relation to his misconduct, particularly record keeping. This could include a personal reflections document; and
- Any other evidence he considers may assist his case.

The Evidence

18. The Tribunal has taken into account all the evidence received, both oral and documentary.

Documentary Evidence

19. Dr Anigala provided a document dated 20 March 2026 setting out his reflections on the decision of the March 2026 Tribunal. Dr Anigala stated that he understood the issue raised prior to the arrival of the March decision. He stated that he had worked very hard through his remediation journey and was looking forward to challenging himself if and when he goes back to clinical practice should his sanction be lifted. Dr Anigala stated that he was disappointed with the decision of the March 2026 Tribunal but that he had reflected on the concerns raised and the decision as a whole. He stated that he was in no way challenging the decision or outcome of the hearing, that he always looks forward to improving himself and, with hard work, will address the concerns raise about his insight into his dishonesty and poor record keeping.

20. Dr Anigala stated that the issue about the error on the attendance sheet for one of his presentations had taken central focus on 6 March 2026. He stated that he did explain to the March 2026 Tribunal that the matter had been looked into at the time by his Trust and they had found no evidence of dishonesty or misrepresentation. Dr Anigala stated that he took full responsibility for the confusion and should have made a clearer distinction or two separate attendance sheets for the two different attendees; his central focus was on the presentation. A letter dated 18 March 2026 from Dr D, DMD Unscheduled Care at the Emergency Department of Craigavon Area Hospital, was provided to the Tribunal. Dr D stated that he had reviewed an incident that took place on 9 March 2026 with the Medical Director and Director of HR at the Southern Trust Medical and Dental Oversight committee on 19 March. He stated that *"We did not feel that there had been any dishonesty. The doctors who signed the attendance sheet had received the teaching".*

21. Dr Anigala stated that the March 2026 Tribunal raised the issue of whether he had sent apologies to the neurosurgical team. He stated that he had tried his best to explain to the March 2026 Tribunal that this issue was addressed at the 2025 Tribunal hearing. Dr Anigala stated that he had apologised to Dr C at the time and also asked Dr C to extend his apologies to colleagues and staff affected. He stated that he could not apologise to the neurosurgical team as he never spoke to any neurosurgeon, nor would he start to explore who was the neurosurgeon on call at the time.

22. Dr Anigala stated that the last issue raised by the March 2026 Tribunal was his clinical engagement and CPD points during his suspension. Dr Anigala referred to the non-patient contact clinical activities with Daisy Hill Hospital, which had included teaching and presentations, as well as online learning and renewal of some modules and lectures organised by his locum agency. Dr Anigala provided a list of the CPD points he has obtained from June 2025 to May 2026 and of the clinical engagement undertaken between 20 March and 27 May 2026. He provided a certificate of completion of a half day workshop within his local Trust on *'Fairer Feedback Conversation'* on 23 April 2026 that had been organised by the GMC. He also provided a certification of completion of eLearning (4 hours) entitled *'Clinical Record Keeping Training Course'* provided by The Health & Safety Group Ltd dated 3 May 2026. Dr Anigala provided written reflections on both courses.

23. The Tribunal also had regard to a letter dated 18 March 2026 from Dr E, Clinical Director Emergency Medicine at Daisy Hill Hospital. He stated that Dr Anigala had remained engaged with the department, actively looked for opportunities to share his experience and learning, and had delivered teaching sessions. Dr E stated that, if Dr Anigala was reinstated, they *"would look forward to continuing to work with him and providing support during his ongoing learning journey"*.

Oral Evidence

24. Dr Anigala also gave oral evidence at the hearing. Dr Anigala was asked whether there was anything he would like to say to the neurosurgeons now as he had implicated them at the time. Dr Anigala stated that he should apologise to them, that he will have the opportunity to formally apologise to them as he is due to work with them in the future, and that he will do so. Dr Anigala stated that he thought that because he did not speak to anyone he would not be able to apologise to anyone but he did convey to Dr C at the time to extend his apologies to everyone that was affected. Dr Anigala stated that, after the March 2026

Tribunal hearing, he thought he should do more and properly apologise to the neurosurgical team for implicating them.

25. Dr Anigala was asked about what the risks are for keeping poor or dishonest records. He stated that record keeping is a cornerstone of medical practice and also a component of the GMC's Good medical practice guidelines. Dr Anigala stated that it was an obligation for every doctor to maintain good record keeping and he was deeply disappointed with himself and sorry for creating the confusion during the March 2026 Tribunal hearing. He stated that his attention had been on delivering the presentation. Dr Anigala stated that poor record keeping creates confusion and a risk of unsafe practice/of exposing patients to risk. He stated that he deeply apologised for the confusion created the last time and was clear as to the seriousness of record keeping.

26. Dr Anigala was asked if he was in the same situation in terms of the index Allegation whether he would act any differently. He stated that he would act differently and that, if faced with the same situation, he will take a step back and reflect before making a decision. Dr Anigala stated that he will be open and transparent and not take the same steps that he took the last time.

27. Dr Anigala was asked about the mentorship he had received. He spoke about the support he had received from Daisy Hill Hospital where the ongoing clinical engagement had been possible and the personal support from Dr E with help on how to approach his written reflections/preparation for this hearing and on how to approach future situations.

28. Dr Anigala was referred to his reflection on the Clinical Record Keeping course. He had listed the date as 03/05/2025 and confirmed this was a typographical error and that it should have been 03/05/2026.

Submissions

Submissions on behalf of the GMC

29. Ms Chapman, Counsel on behalf of the GMC, submitted that Dr Anigala's fitness to practise remains impaired.

30. Ms Chapman stated that the 2025 Tribunal made it clear that the misconduct was considered to be particularly serious as it involved dishonesty and a lack of candour with

aggravating features present, such as deflecting blame onto another medical professional. She stated that the seriousness was not disputed by Dr Anigala. Ms Chapman submitted that what was changeable was the potential risk to the public and the public interest, taking into account what has changed since.

31. Ms Chapman referred to the outstanding issue that the March 2026 Tribunal had identified which was said to be a lack of evidence of insight into record keeping accuracy. She submitted that the Tribunal must make its own assessment as to risk in light of the current circumstances and decide whether Dr Anigala's fitness to practise remains impaired.
Ms Chapman submitted that it was for Dr Anigala to satisfy the Tribunal of his current fitness to practise without restriction. She stated that the burden is on the practitioner at a review hearing to demonstrate they have fully acknowledged why past professional performance was deficient and sufficiently addressed the past impairment.

32. Ms Chapman referred to the new material before the Tribunal from Dr Anigala. She stated that the GMC agreed that the material demonstrated Dr Anigala has remained engaged with professional development and remediation during the suspension period. He has undertaken further CPD relevant to the concerns identified by the March 2026 Tribunal and continued to participate in developmental teaching, workshops and handover meetings on a non-patient facing basis. Ms Chapman stated that there was also supportive statements provided by senior colleagues confirming Dr Anigala's continued engagement with the department and remediation activities. Ms Chapman also referred to the letter from Dr D in relation to the attendance note issue which the Trust had reviewed and did not feel there had been any dishonesty.

33. Ms Chapman stated that, in terms of insight and remediation, the GMC noted that the further reflections demonstrated some progression in insight and acknowledgement of the concerns identified by the March 2026 Tribunal. She referred to certain sections of Dr Anigala's reflections, including where he stated, *"I do understand this concern raised, and pointing it out highlighted that I still have a lot work to do towards archiving a full and complete remediation"*. Ms Chapman submitted that this demonstrated recognition that remediation remained incomplete on the part of Dr Anigala. She stated that Dr Anigala also accepted some responsibility in relation to the attendance sheet issue and referred to the clinical record keeping course undertaken. She submitted that these were positive developments and evidence of continued engagement with remediation but it was the GMC's position that the reflections remain largely general in nature. Ms Chapman submitted that the material focused significantly on Dr Anigala's remediation journey and ongoing

efforts to improve but provided limited detail as to how similar circumstances will be managed differently in future. She submitted that, while the further material demonstrates progression and continued engagement, it did not yet provide sufficient reassurance that the concerns relating to probity and record keeping have been fully addressed, or that the risk of repetition has materially reduced. She stated that this was similar to the position at the last review hearing.

34. Ms Chapman referred to the point about the apology for the neurosurgical team. She stated that, in oral evidence at this hearing, Dr Anigala has said he plans to apologise but, despite being asked, he did not set out what the apology would be. Ms Chapman also submitted that the issue regarding the attendance record that troubled the March 2026 Tribunal had not been sufficiently addressed. She submitted that, while there had been recognition of what went wrong, there was still a sense in the reflection of Dr Anigala minimising the importance of this issue, despite the focus of the March 2026 Tribunal on it. Ms Chapman stated that the March 2026 Tribunal linked this issue to concerns regarding the importance of inaccurate record keeping, which was one of the components of the misconduct. She submitted that those findings had not really been addressed in Dr Anigala's evidence and that deeper insight was required. Ms Chapman stated that, even when there is no actual or intended dishonesty, inaccurate records may cause others to have that impression which could affect the reputation of the profession and the doctor themself. She stated that a colleague had been concerned enough to report the matter to a senior colleague who then met with Dr Angiala, which was evidence that this was perceived to be a serious matter. She submitted that this remained unaddressed and, in oral evidence, Dr Anigala was unable to identify any risks of inaccurate record keeping when specifically asked.

35. Ms Chapman submitted that it was the GMC's position that aspects of the concerns identified by the 2025 and March 2026 Tribunals remain relevant. She stated that the reflections continued to place significant emphasis on Dr Anigala's remediation journey and the impact of proceedings on himself, with limited detail of reflection on the dishonest conduct itself and the wider professional impact. Ms Chapman submitted that the work on specific areas requested by the March 2026 Tribunal were still somewhat lacking and could have been developed further even with the suspension in place. She submitted that, overall, the evidence demonstrated continued engagement with remediation and some developing insight but the concerns relating to dishonesty and record keeping had not yet been sufficiently addressed such that a low risk remains to all three limbs of the overriding

objective. Ms Chapman submitted that insight and remediation is currently not present to the degree required for Dr Anigala to return to unrestricted practice at this stage.

Submissions on behalf of Dr Anigala

36. Ms Maudsley, Doctors Defence Service, referred to the index events that were the subject of the 2025 Tribunal hearing, including that:

> *"The Tribunal accepted that Dr Anigala had acknowledged his fault and expressed genuine remorse and regret for his actions. Dr Anigala had provided evidence of developing insight and had taken considerable steps towards remediation, including reflecting on the causes and consequences of his conduct. The Tribunal further noted that whilst continuing to practise at Daisy Hill Hospital, where he remained a respected member of the clinical team, there had been no further incidents since the Events."*

37. Ms Maudsley referred to conclusions of the March 2026 Tribunal, including:

> *"the Tribunal reached the view that Dr Anigala had addressed the concerns about his dishonest actions sufficiently, and that there was a low risk of him repeating his misconduct. The Tribunal determined that the level of risk is therefore reduced from medium to low*
>
> *…*
>
> *The Tribunal had identified a specific area of focus – record keeping - on which Dr Anigala needed to provide and demonstrate evidence of insight."*

38. Ms Maudsley submitted that Dr Anigala has taken on board the findings of the March 2026 Tribunal. She stated that Dr Anigala has reflected further and focused specifically, as requested, on record keeping. Ms Maudsley stated that Dr Anigala has attended relevant courses, including the workshop on *'Fairer Feedback Conversation'.* She stated that Dr Anigala has taken the recommendations onboard, that he wants to learn and improve, and that he will communicate better in future if he makes a mistake rather than trying to cover it up. Ms Maudsley also referred to the record keeping course undertaken. She submitted that Dr Anigala has learned from this and has a clear understanding of the risks in not keeping accurate records.

39. Ms Maudsley submitted that Dr Anigala had shown insight into the risk of not keeping accurate and honest records. She stated that the March 2026 Tribunal had noted some inaccuracies with record keeping that had the potential to be misleading but that the Hospital had looked into this and found no dishonest misconduct. Ms Maudsley referred to the letter from Dr D.

40. In terms of the apology to the neurosurgical team, Ms Maudsley submitted that Dr Anigala apologised to Dr C and asked him to extend the apologies to colleagues and staff. She stated that Dr Anigala could not apologise directly to the neurosurgical surgeons at RVH as he never spoke to them but that they were implicated and, in oral evidence, he has extended his apologies to them and intends to apologise more directly at the Coroner's inquest.

41. Ms Maudsley referred to the correspondence from Dr E, that they *"would look forward to continuing to work with him and providing support during his ongoing learning journey"*.

42. Ms Maudsley submitted that Dr Anigala has made attempts to address any shortcomings in his practice, and that he has reflected, apologised and shown insight. She stated that this matter had been a salutary lesson for Dr Anigala and submitted that he is unlikely ever to repeat the same misconduct. Ms Maudsley stated that, in oral evidence, Dr Anigala has said how he will act differently in the future and that he will be very transparent if things do go wrong. She stated that there had been no repetition of the misconduct.

43. Ms Maudsley stated that the March 2026 Tribunal had said the risk was low and submitted that the risk has now been removed and Dr Anigala's fitness to practise is no longer impaired.

The Relevant Legal Principles

44. Throughout the decision-making process, the Tribunal will bear in mind the overarching objective of the GMC and MPTS as set out in Section 1 of the Medical Act 1983 to protect the public, which is split into three distinct parts. It means that a Tribunal must act in way that: protects, promotes and maintains the health, safety and well-being of the public ('patient safety'); promotes and maintains public confidence in the medical profession

('public confidence'); and promotes and maintains proper professional standards and conduct for members of that profession ('uphold professional standards').

45. The Tribunal reminded itself that the decision of impairment is a matter for the Tribunal's judgement alone. As noted above, the March 2026 Tribunal set out the matters that a future Tribunal may be assisted by. This Tribunal is aware that it is for the doctor to satisfy it that he would be safe to return to unrestricted practice.

46. The Legally Qualified Chair (LQC) referred the Tribunal to the overall Guidance for MPTS Tribunals (24 November 2025), including steps 2(a) to (e) at Section three: MPT hearings, Part B: stage two - impairment. She stated that new guidance for review hearings in particular had been published but does not come into effect until June 2026. The LQC stated that the approach for this Tribunal when looking at impairment in this interim period was therefore as set out in MPTS Tribunal circular *'20/25: Guidance for review hearings starting on or after 24 November 2025'*. This included that:

> *"On review, the following questions should be used to inform the tribunal's assessment of whether a doctor poses any current and ongoing risk to public protection requiring restrictive action in response, and if so, what level of risk (low, medium or high):*
>
> > *i. What was the last assessment of current and ongoing risk to public protection resulting in the doctor's fitness to practise being found impaired? (Look back at the previous tribunal's findings)*
> > *ii. What has happened since the last assessment of risk and what impact does this have?*
> > *iii. How has the doctor responded to the previous tribunal's findings?*
> > *iv. Has the risk to public protection requiring restrictive action in response changed and if so, how?"*

47. This Tribunal must assess whether Dr Anigala poses any current and ongoing risk to one or more of the three parts of public protection requiring restrictive action in response. This Tribunal must determine whether Dr Anigala's fitness to practise is impaired today, taking into account his 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.

The Tribunal's Determination on Impairment

48. The Tribunal considered whether Dr Anigala's fitness to practise is currently impaired by reason of his misconduct.

What was the last assessment of current and ongoing risk to public protection resulting in Dr Anigala's fitness to practise being found impaired?

49. The Tribunal had regard to the conclusions of the March 2026 Tribunal, as summarised above. It noted that the March 2026 had reached the view that Dr Anigala "*had addressed the concerns about his dishonest actions sufficiently, and that there was a low risk of him repeating his misconduct*" and that the level of risk had reduced from medium to low (albeit at the higher end of the lower spectrum).

50. The Tribunal also noted that the March 2026 Tribunal had raised an issue with Dr Anigala's record keeping and concluded that Dr Anigala had *"not fully addressed the concerns relating to his actions which led to his appearing before these proceedings".*

51. The Tribunal had regard to the factors identified by the March 2026 Tribunal which may assist a future review, namely *"Evidence of Dr Anigala's insight into the Tribunal's findings in relation to his misconduct, particularly record keeping. This could include a personal reflections document".*

What has happened since the last assessment of risk and what impact does this have? and How has Dr Anigala responded to the March 2026 Tribunal's findings?

52. The Tribunal considered what has happened since the March 2026 Tribunal and how Dr Anigala has responded to the March 2026 Tribunal's findings.

53. The Tribunal was of the view that Dr Anigala's written reflections addressed the issues that the March 2026 Tribunal was keen to resolve. The Tribunal considered that Dr Anigala was candid in his initial reflections on the same day of the conclusion of the March 2026 Tribunal hearing when he stated that he understood the concern raised and that it had *"highlighted that I still have a lot work to do towards archiving a full and complete remediation"*. The Tribunal appreciated that Dr Anigala was upset regarding the decision of the March 2026 Tribunal but even in his immediate reflection he set out that he understood, acknowledged and was going to reflect further. The Tribunal was of the view that progress

has been made since this point and Dr Anigala has gone on to address the issues raised by the March 2026 Tribunal.

54. The Tribunal was clear that Dr Anigala has acknowledged and accepted the findings of the March 2026 Tribunal and has directed his CPD accordingly. He has completed a feedback course and a record keeping course to represent targeted CPD upon which he has then provided written reflections. The Tribunal noted that Dr Anigala has also given presentations about his experiences and imparted his knowledge to others, which the Tribunal considered were further positive steps in terms of his insight and development.

55. The Tribunal understood the attendance note/record keeping issue referred to by the March 2026 Tribunal. The Tribunal found the correspondence from Dr D to have been very reassuring as to how this matter had been dealt with by the Trust. He stated that *"We did not feel that there had been any dishonesty. The doctors who signed the attendance sheet had received the teaching".*

56. The Tribunal also had keen regard to Dr Anigala's oral evidence including his answers as to the informal mentorship and support he has received from Daisy Hill Hospital and Dr E. The Tribunal was impressed by Dr Anigala's ongoing commitment and felt that he has continued to engage with them in the best sense that he could while suspended. The Tribunal also had regard to the correspondence from Dr E which shows that Dr Anigala is well regarded and that he is spoken about in relation to his commitment, his ongoing journey, and that they are willing to support him.

57. The Tribunal also took account of Dr Anigala's evidence in which he answered questions about what he would do differently in the future and apologised again for the inaccuracy in the record keeping that came up at the March 2026 Tribunal hearing.

58. The Tribunal was satisfied that Dr Anigala has focused his insight and remediation and has done what was asked of him by the March 2026 Tribunal. The Tribunal determined that Dr Anigala has now remediated his behaviour and his insight is developed.

<u>Has the risk to public protection requiring restrictive action in response changed and if so, how?</u>

59. The Tribunal acknowledged that the index misconduct was serious. It appreciated that the March 2026 Tribunal found that Dr Anigala had "*addressed the concerns about his*

dishonest actions sufficiently" but had *"identified a specific area of focus - record keeping - on which Dr Anigala needed to provide and demonstrate evidence of insight"*.

60. The Tribunal has had regard to all of the evidence before it now and the positive steps taken by Dr Anigala including the full insight and remediation now shown. The Tribunal was satisfied that Dr Anigala has now addressed the issues raised by the March 2026 Tribunal. It determined, in all the circumstances, the risk of repetition of the misconduct is so negligible that it is highly unlikely to be repeated. The Tribunal also determined that, due to all of the evidence before it, the risk to public protection has now been removed in terms of the three parts of public protection: patient safety, public confidence and upholding professional standards

61. The Tribunal has therefore determined that Dr Anigala's fitness to practise is no longer impaired by reason of misconduct.

62. The Tribunal took the view that the current order of suspension on Dr Anigala's registration should remain in place until it expires (on 12/06/2026) to reflect the findings of the 2025 Tribunal and March 2026 Tribunals to ensure public confidence is maintained, and the need to uphold professional standards is fulfilled.