PUBLIC RECORD

Dates: 29/04/2024 - 03/05/2024

Medical Practitioner's name:	Dr Christian ADINDU
GMC reference number:	7550508
Primary medical qualification:	MB BS 1994 University of Lagos

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

Summary of outcome
Suspension, 3 months

Tribunal:

Legally Qualified Chair:	Mr Simon Bond
Lay Tribunal Member:	Ms Liz Ord
Medical Tribunal Member:	Dr Leigh-Anne Hill

Tribunal Clerk:	Miss Emma Saunders

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Lee Gledhill, Doctors Defence Service
GMC Representative:	Mr Ryan Donoghue, Counsel

Attendance of Press / Public
In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly in private.

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 and Impairment - 01/05/2024

Hearing in Private

1. The Tribunal agreed, in accordance with Rule 41 of the General Medical Council (GMC) (Fitness to Practise Rules) 2004 as amended ('the Rules'), that parts of this hearing should be heard in private where the matters under consideration are confidential, namely where they involve XXX. As such, this determination will be read in private but a redacted version will be published following the conclusion of this hearing, with those matters relating to XXX removed.

FACTS

Background

2. Dr Adindu qualified in 1994 from the University of Lagos. He worked in a number of roles in Nigeria before moving to the United States in 2001 where he studied for the USA Medical Licensing exams and then worked as an Instructor of Anatomy and Physiology at Ivy Tech State College from January 2005 before becoming an Assistant Professor and then Lecturer from December 2011. Dr Adindu worked as a senior medical doctor in Nigeria from February 2012 before emigrating to the United Kingdom in 2016. He studied for the GMC Professional and Linguistic Assessments Board (PLAB) test and has been registered with the GMC since 2017.

3. Dr Adindu held a number of locum posts between 2017 and 2018 before starting General Practitioner (GP) training in 2018. The GP training programme involves undertaking the Royal College of General Practitioners (RCGP) examination process. The issues that form the basis of this hearing took place in 2020 when Dr Adindu was working as a ST3 GP Registrar at the Fordington Surgery, Dorchester, where he worked from February 2020 to February 2021. He subsequently worked at the Abbey View Medical Centre, Shaftesbury, on ST3 extension from February 2021 to February 2022. He completed his GP training in March 2022 and obtained a salaried GP role from April 2022 at the Abbey View Medical Centre, which is part of The Blackmore Vale Partnership. He continues to work there, as well as completing additional locum GP work in practices near his home and working as an Out Of Hours GP locally on Saturdays.

The allegations

4. The allegations that have led to Dr Adindu's hearing relate to his conduct in respect of the records of three patient consultations that he submitted as part of his Recorded Consultation Assessment (RCA), which is part of the RCGP examination process.

5. The RCGP examination is undertaken over the course of three years and, upon passing the examination, a doctor would receive their RCGP licence which is their licence to practise as a GP. There are three components to the RCGP examination: the RCA, Workplace Based Assessments, and the Applied Knowledge Test (AKT). At the time of the concerns, Dr Adindu had failed the AKT on three occasions and this was his first attempt at the RCA.

6. The RCA part of the examination consists of the doctor submitting recordings of 13 real consultations with patients. The examiners take account of the first 10 minutes of each recording. The RCA had replaced the Clinical Skills Assessment in the Summer of 2020 due to the Covid pandemic.

7. As part of the MRCGP Examination Recorded Consultation Assessment Policy, the recordings must not be edited (in accordance with section 2.20 of that policy): *"Individual consultations must be recorded continuously; the camera should not be turned off during the consultation and the recording must not be edited"*. Candidates had to upload their cases onto the FourteenFish platform and tick a box to confirm that the recordings had not been edited and that the relevant patients had consented to the recordings.

8. It was alleged by the GMC that, on 29 September 2020, Dr Adindu held a consultation with Patient A and had falsely recorded in the patient's written notes that he told Patient A of cauda equina symptoms, and that Patient A should report to the emergency department if they developed such symptoms.

9. It was also alleged by the GMC that, on 8 November 2020, Dr Adindu submitted the recordings of consultations with Patients A and B as part of his RCA. Patient A's case related to lower back pain and Patient B's case related to tinnitus. It was alleged that Dr Adindu inserted audio into:

- Patient A's recording by saying *"especially numbness or incontinence"* (or words to that effect) when he knew that these issues had not been discussed with Patient A; and into
- Patient B's recording by saying *"I'm happy with your blood pressure that we have checked, that is within normal"* (or words to that effect).

10. The GMC also alleged that Dr Adindu had made a number of other edits to the recordings of his consultations with Patients A and B. It was alleged that Dr Adindu knew that recordings should not be edited and that he had made a declaration that he had not made any edits to the recordings.

11. Further, it was alleged that, when submitting a recording of his consultation with Patient C, Dr Adindu entered the patient's age as 70 when he knew that the patient was 61.

12. It was alleged by the GMC that Dr Adindu had been dishonest by making edits to the recordings of his consultations with Patients A, B and C. Further the GMC alleged that Dr Adindu had been dishonest when he made a record in Patent A's notes about discussing cauda equina symptoms and about Patient A reporting to the emergency department if such symptoms developed.

How the concerns were raised

13. The initial concerns were raised by two RCGP assessors during the RCA marking exercise on 27 November 2020. In correspondence on 3 December 2020 from Dr E, RCGP Chief Examiner, to Dr D, Postgraduate Dean of HEE Wessex, they stated that over-dubbing had been reported by two RCGP examiners. The assessors had raised concerns that Dr Adindu had dubbed over two submitted recordings where red flag questions had been missed.

14. Red flag questions are questions to identify serious conditions that must not be missed in the consultation. Certain symptoms are a warning sign that the patient may have a more serious condition such that, if the red flag question is not asked or the information is not acted upon, it could have very serious consequences for the patient.

15. On 3 December 2020 Dr D had emailed Mr F, Head of School of Primary Care (General Practice) for Health Education England ('HEE') Wessex, to report the matter. Mr F undertook a local investigation into the concerns and sent his findings to Dr D on 26 April 2021. Matters were subsequently referred to the GMC.

16. As part of the local investigation, Mr F had spoken with Dr G, Dr Adindu's trainer, on 7 December 2020. Dr G told Mr F that Dr Adindu had given an explanation that he had edited the recordings for his own education and had sent the two recordings in for assessment by accident. Dr G said that they told Dr Adindu to keep hold of the recordings but that Dr Adindu had told them that he had already deleted them. In a conversation with Dr Adindu on 6 January 2021, Mr F stated that Dr Adindu explained that he had used WavePad, an editing

software, to add in comments to some of his submissions for education purposes and that he had submitted the edited recordings by mistake.

17. Because of the apparent editing identified during the marking exercise, Dr Adindu received a score of zero for the RCA. He has since passed the examination and he completed his GP training in March 2022.

The Outcome of Preliminary Applications

18. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the Rules, for amendment to paragraphs 4(c), 5(b) and 6(b) of the Allegation. The Tribunal's full decision on the application is included at Annex A.

19. The Tribunal granted Dr Adindu's application, made pursuant to Rule 34(1) of the Rules, for the admission of further evidence. A number of reasonable adjustments were also requested in respect of Dr Adindu. The Tribunal determined that these would be appropriate. The Tribunal's full decision on the application is included at Annex B.

20. The Tribunal granted Dr Adindu's application, made pursuant to Rule 34(13) and (14) of the Rules, for two testimonial witnesses to give evidence remotely. The Tribunal's full decision on the application is included at Annex C.

The Allegation and the Doctor's Response

21. The Allegation made against Dr Adindu is as follows:

That being registered under the Medical Act 1983 (as amended):

Patient A

1. On 29 September 2020 you held a consultation with Patient A and you recorded that you had told Patient A:

a. of cauda equina symptoms;
Admitted and found proved

b. to report to the emergency department if he developed cauda equina symptoms.
Admitted and found proved

2. You knew that you did not:

a. discuss cauda equina symptoms with Patient A;
Admitted and found proved

b. tell Patient A to report to the emergency department if he developed cauda equina symptoms.
Admitted and found proved

3. On 8 November 2020 you submitted a recording of your consultation with Patient A ('Recording 1') as part of your Recorded Consultation Assessment ('RCA') examination, and you:

a. had inserted an audio recording into Recording 1 at or around 00:10:04 of you stating *'especially numbness or incontinence'*, or words to that effect;
Admitted and found proved

b. had made one or more edits to the audio of Recording 1 at or around the times as set out in schedule 1;
Admitted and found proved

c. made a declaration that you had not made any edits to Recording 1.
Admitted and found proved

4. You knew that:

a. recordings submitted as part of the RCA examination must not be edited;
Admitted and found proved

b. you had not discussed numbness or incontinence with Patient A;
Admitted and found proved

c. you had inserted the audio recording as described at paragraph ~~3.b.~~ 3.a. ;
Amended under Rule 17(6)
Admitted and found proved

d. you had made one or more edits to the audio of Recording 1.
Admitted and found proved

Patient B

5. On 8 November 2020 you submitted a recording of your consultation with Patient B ('Recording 2') as part of your RCA examination, and you:

a. had inserted an audio recording into Recording 2 at or around 00:08:22 of you stating *'I'm happy with your blood pressure that we have checked, that is within normal* , or words to that effect;
Admitted and found proved

b. had made one or more edits to the audio of Recording 2 at or around the times as set out in schedule 2;
Amended under Rule 17(6)
Admitted and found proved

c. made a declaration that you had not made any edits to Recording 2.
Admitted and found proved

6. You knew that:

a. recordings submitted as part of the RCA examination must not be edited;
Admitted and found proved

b. you had inserted the audio recording as described at paragraph ~~5.b.~~ 5.a. ;
Amended under Rule 17(6)
Admitted and found proved

c. you had made one or more edits to the audio of Recording 2.
Admitted and found proved

Patient C

7. On 8 November 2020 you submitted a recording of your consultation with Patient C ('Recording 3') as part of your RCA examination, and you entered Patient C's age as 70.
Admitted and found proved

8. You knew that Patient C was not 70 years of age.
Admitted and found proved

9. Your actions as set out in paragraph:

a. 1 were dishonest by reasons of paragraph 2;
Admitted and found proved

b. 3.a. were dishonest by reason of paragraphs 4.a. , 4.b. , and 4.c. ;
Admitted and found proved

c. 3.b. were dishonest by reason of paragraphs 4.a. and 4.d. ;

Admitted and found proved

d. 3.c. were dishonest by reason of paragraphs 4.a. , 4c. , and 4.d. ;
Admitted and found proved

e. 5.a. were dishonest by reason of paragraphs 6.a. and 6.b. ;
Admitted and found proved

f. 5.b. were dishonest by reason of paragraphs 6.a. and 6.c. ;
Admitted and found proved

g. 5.c. were dishonest by reason of paragraphs 6. a. , 6.b. , and 6.c. ;
Admitted and found proved

h. 7 were dishonest by reason of paragraph 8.
Admitted and found proved

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. To be determined

The Admitted Facts

22. At the outset of these proceedings, through his legal representative, Mr Gledhill, Dr Adindu made admissions to the entirety of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced all paragraphs of the Allegation as admitted and found proved.

23. Dr Adindu had made full admissions in his response to the Rule 7 Allegation, and then subsequently in response to the Rule 15 Allegation in February 2024.

24. On 18 April 2024, Dr Adindu wrote to the GMC (and to NHS England c/o the GMC). He stated that he wished to express his profound apologies for his wrongdoing. Dr Adindu stated that he was deeply sorry for all of the inconvenience that his actions had caused the GMC and NHS England and that he took full responsibility. He stated that he understood that his behaviour was unacceptable and fell below the standards expected of him. Dr Adindu stated that he understood the need for the GMC and NHS England to have taken the matter very seriously. He said that he was sorry to have acted in a way that undermined the profession and, to a large extent, public trust. He stated that he had learnt valuable lessons to prevent a reoccurrence of his wrongdoing, that he deeply regretted his actions, and that he would never repeat them.

IMPAIRMENT

25. 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 Adindu's fitness to practise is impaired by reason of misconduct.

The Evidence

Documentary Evidence

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

- Correspondence from Mr F as part of the local investigation he conducted, including email correspondence with Dr D and Dr G;
- Transcripts of the consultations with Patients A to C;
- Copies of relevant patient records;
- Various screenshots of the FourteenFish portal and an audit trail of the cases submitted for the RCA by Dr Adindu;
- MRCGP Examination Recorded Consultation Assessment Policy, RCGP examination requirements and RCGP examination marking criteria;
- Character references on behalf of Dr Adindu from Ms I, the Practice Support Manager at the Abbey View Medical Centre, and Ms H, IT Manager at the Abbey View Medical Centre;
- Dr Adindu's appraisal documentation for the year 2022/23, along with colleague and patient feedback summaries from January 2023;
- Dr Adindu's Curriculum Vitae;
- Continuing Professional Development (CPD) certificates for probity and ethics courses, namely a module on insight completed on 13 March 2023 and a module on remediation completed on 25 May 2023.

Expert Witness Evidence

27. The Tribunal also received written evidence from an expert witness on behalf of the GMC, Mr J. This was in the form of an Audio Analysis Report dated 3 May 2022 from Clarity Forensic Services. Mr J was asked by the GMC to review the recordings in respect of Patients A and B.

28. Mr J is registered with the Engineering Council as an Incorporated Engineer, holds a BSc in Electronics, and an Intermediate City and Guilds in Telecommunications. He is also a

Member of the Institute of Engineering and Technology. Mr J stated that he has listened to and analysed many hours of audio recordings associated with police and legal investigations.

29. Within his report, Mr J stated that, in his opinion, the recordings of Dr Adindu's consultations with Patients A and B had both been tampered with in that a section of speech had been edited into them in some way. He stated that both recordings exhibited sudden changes in the noise floor, '*gain*' and clipped words/sounds that he would not expect to hear in a recorded conversation. Mr J stated that this was strong support for the contention that the recordings had been edited or manipulated in some way at various points. He expressed the opinion that the recordings should not be relied upon to represent a true record of the consultations that had taken place.

Witness Evidence

30. The Tribunal received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Mr F, whose witness statements were dated 22 October 2021 and 11 January 2023. He provided detail of the RCA examination process and information about the local investigation undertaken as referred to above;
- Dr K, MRCGP Clinical Lead for IT systems for the RCGP. His witness statement was dated 14 March 2023. He provided a statement to outline the information provided by Dr Adindu as part of the RCA, in particular Dr Adindu's completion of the declaration screens for each case submitted, in which Dr Adindu confirmed that he had not made any edits to the recordings; and
- Mr L, software developer and company director of FourteenFish Limited. His witness statements were dated 21 January 2022 and 16 August 2022. Mr L provided information about how submissions are uploaded via the FourteenFish portal. He clarified that he was not a forensic expert and stated that he had confirmed to the RCGP on 14 September 2021 that it was not possible for him to tell whether or not Dr Adindu's audio files had been edited.

31. For the purposes of the impairment stage, the Tribunal was also provided with a witness statement dated 21 September 2023 from Ms M, Programme Manager for the Professional Standards Team within NHS England South West Medical Directorate. Ms M provided information that the relevant Responsible Officers had been updated about Dr Adindu at various points and that the outcome of the GMC process was awaited.

32. Dr Adindu provided written reflections and also gave oral evidence at the hearing on 29 April 2024.

33. Within his written reflections, Dr Adindu spoke about the impact of his actions on the role of the GMC and the trust the public has in the medical profession. He stated that he understood how serious the Allegation was and apologised for his actions. Dr Adindu said that he deeply regretted his actions and that nothing like this would ever happen again.

34. Dr Adindu provided a written summary of his mindset at the time in question, but emphasised that this was not an excuse for what he had done. He said that the incident occurred during the height of the Covid pandemic when there had been a lot of anxiety. Dr Adindu stated that there had also been conflicting information at that time about Covid death rates for those from a BAME background, XXX. He stated that his anxieties were such that he wore two masks at that time and, in his written reflections, stated *"I didn't know if that was going to be the day that I picked up the Covid and never went back home"*.

35. Dr Adindu stated that the index matters happened due to XXX and very poor judgement. He was isolated at the time as he had been working away from home as part of his GP training. Dr Adindu acknowledged that, with hindsight, he should just have asked to postpone the exam. He said that his actions had made everything worse. He also XXX and spoke about the impact of his actions on his family. He said that he only had himself to blame.

36. Dr Adindu expanded on these matters during his oral evidence. He stated that he had received a recommendation (as part of the standard practice for a candidate who has failed an exam) to engage with Professional Support Welfare (PSW). He spoke about his initial reluctance to engage with support but confirmed that he eventually did so, XXX. Dr Adindu stated that XXX but that his African background meant that he was reluctant to show any form of weakness. XXX. Dr Adindu provided written notes of an exam support meeting that he had with the PSW on 1 March 2021. XXX.

37. Within his oral evidence, Dr Adindu repeated his apology and stated that he was contrite and ashamed of what he had done. He spoke about the work that he does as a GP and the importance of the trust placed in doctors by patients.

38. Dr Adindu prepared three posters that he showed to the Tribunal during his oral evidence. He stated that the first poster demonstrated how many patients he sees each week and as a realisation of the opportunity he has been given to serve as a GP. He asked that the GMC allow him to continue to have the opportunity to serve. The second poster stated *"How*

did I get here?" and included reference to Dr Adindu having failed the AKT test on three occasions, the difficult Covid-19 pandemic, isolation and time away from his family, XXX. Dr Adindu stated that he understood that there would be other stresses in the future, but that he was now in a place where there would be no repeat of his wrongdoing. The third poster referred to his personal circumstances XXX.

39. Dr Adindu stated that he appreciated the far-reaching consequences of his actions in relation to the trust placed in doctors by the public. He told the Tribunal that he realised the implications associated with a doctor having passed an exam as a result of cheating. Dr Adindu referred to a number of real life situations that he had encountered in his clinical practice and how his thinking had developed as a result of the index concerns.

40. In addition, the Tribunal received evidence from the following witnesses on Dr Adindu's behalf:

- Mr N, Advanced Nurse Practitioner at the Abbey View Medical Centre. He provided a character statement for Dr Adindu dated 14 August 2023 and gave evidence to the Tribunal on 29 April 2024. He spoke positively about Dr Adindu describing him as an *"ideal role model"*. Within his statement, Mr N said that he had no concerns about Dr Adindu's competence or integrity. Mr N said he was aware of a number of patients who had expressed their gratitude to Dr Adindu for the care and attention that had shown them; and
- Dr O, GP Partner at The Blackmore Vale Partnership. He provided a character statement on 6 June 2023 and gave evidence to the Tribunal on 30 April 2024.

41. Dr O confirmed that he had known Dr Adindu for two years and four months at the date of his statement of 6 June 2023. Dr O said that Dr Adindu had started as his ST3 trainee in February 2021 and then started work as a salaried doctor at Blackmore Vale following qualification in April 2022. Dr O confirmed that he had read the Allegation. He stated:

> *"I have had a very close working relationship with [Dr Adindu] as I was his trainer for over a year. I have then worked with him in my role as a partner at the practice whilst he has been a salaried doctor here. In my opinion he is a very committed and kind Doctor. I have seen a lot of evidence of his interaction with patients during joint surgeries on a weekly basis during his training and on many other occasions when he has called me in to see patients with him. He is extremely professional during his consultations and very aware of patient confidentiality. He has shown high levels of integrity and professionalism in all of his actions at the practice. There [has] been a lot of positive feedback about him from colleagues and patients. Clinically I have seen a*

huge amount of evidence that he is competent and no evidence to the contrary. [He] has been an absolute delight to work with during his time here. During his training he shared with me the difficulties he had with the RCA submissions and some of this was probably related to his status as an international medical graduate. He found this extremely challenging and stressful due to linguistic and cultural obstacles. He is absolutely mortified and very regretful about the actions which he took and ever since then has been particularly mindful and careful to respect GMC regulations. I am absolutely confident he will be an excellent professional and follow the guidelines to the letter for the rest of his career. I would fully support his application to remain registered with the GMC. There have been absolutely no further issues since the initial allegations."

42. In his oral evidence, Dr O stated that he had worked with Dr Adindu on a one-on-one basis for 18 months when he was Dr Adindu's GP trainer. Dr O said that there had been nowhere for Dr Adindu to hide during this period. Dr O explained that he would do joint surgeries where he would watch Dr Adindu seeing patients and vice versa. Dr O stated that he had also interrogated Dr Adindu's notes on a random basis during his training. Dr O told the Tribunal that he could give no greater compliment than giving a trainee a job at the practice once the trainee's training had completed. He said that he had seen absolutely no evidence of any other professional or clinical difficulties in relation to Dr Adindu, either before or since the incident.

43. Dr O stated that Dr Adindu's clinical skills were superb. He said that Dr Adindu was highly professional, got on well with all of the team, and was thoughtful and compassionate with patients. Dr O stated that they he had held many discussions with Dr Adindu about the index issues and that Dr Adindu completely understood that his conduct had been unacceptable and could not be repeated. Dr O stated that Dr Adindu was mortified and regretful of his actions; Dr O expressed the view that Dr Adindu had really good insight into his misconduct and realised that his actions could not be 'brushed under the table'. Dr O stated that Dr Adindu works hard and sees a lot of patients; he added that Dr Adindu was working well and has consistently done so for all of the years that Dr O has worked with him.

Submissions

Submissions on behalf of the GMC

44. Mr Donoghue, Counsel on behalf of the GMC, referred the Tribunal to a number of paragraphs of Good Medical Practice (2013) ('GMP'), including:

"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.

...

19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

...

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

…

71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any 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."

45. Mr Donoghue submitted that the above provisions of GMP were all engaged in this case and that Dr Adindu's actions were in breach of these provisions. He submitted that paragraph 65 of GMP was central to this case given the proved dishonesty that engages considerations around public trust in the profession and public confidence in the profession.

46. Mr Donoghue submitted that the Tribunal would be assisted by assessing Dr Adindu's conduct by reference to four separate actions, summarised as:

a) Dr Adindu dishonestly submitting the edited recording of the consultation with Patient A and declaring that the recording had not been edited;
b) Dr Adindu dishonestly recording that he had discussed the symptoms of cauda equina syndrome with Patient A and had advised Patient A to attend the emergency department if such symptoms developed;
c) Dr Adindu dishonestly submitting the edited recording of the consultation with Patient B and declaring that the recording had not been edited; and
d) Dr Adindu dishonestly submitting the recording of the consultation with Patient C as related to a patient who was over the age of 65.

47. Mr Donoghue submitted that Dr Adindu's actions in these four areas were in breach of the various provisions of GMP listed above. He also submitted that honesty is a

fundamental tenet of the medical profession and that dishonesty is always serious such that it easily meets the definition of serious professional misconduct.

48. Mr Donoghue submitted that there were a number of factors present in this case that made Dr Adindu's dishonesty more serious. He stated that, whilst closely related in time, Dr Adindu's actions included four separate and distinct instances of dishonesty, and the editing of the recordings was sophisticated in nature. Mr Donoghue stated that Dr Adindu's actions were deliberate and intended to secure an advantage in the RCGP examination. He stated that Dr Adindu had been required, prior to submission, to tick a box confirming the recordings had not been edited.

49. Mr Donoghue submitted that the dishonesty had the potential to present a risk to patients if it had not been detected, in that Dr Adindu could have secured a score that his consultations did not merit. He stated that the editing of the recordings had only come to light due to it being identified by the RCGP examiners and, when initially challenged about the editing of the recordings, Dr Adindu had insisted that he had edited the recordings for his own educational purposes and had submitted the recordings in error.

50. Mr Donoghue submitted that the allegations found proved in this case involved Dr Adindu acting in a way that fell far below the standards expected of medical practitioners. He submitted that, with reference to case law, Dr Adindu's actions would be considered deplorable by fellow medical professionals and would attract opprobrium, such that they meet the definition of serious misconduct.

51. In terms of impairment of fitness to practise, Mr Donoghue submitted that the principles of GMP breached in this case were of a fundamental nature and of vital importance to the medical profession as a whole. He stated that Dr Adindu's actions also involved a breach of a fundamental tenet of the medical profession - that of honesty.

52. Mr Donoghue submitted that Dr Adindu's actions were such that they engaged all three limbs of the overarching objective. He submitted that Dr Adindu's actions potentially presented a risk to patients, as they involved him seeking to obtain a qualification which would have qualified him to treat patients alone as a GP, when his actual examination performance may not have warranted this. They were also such that they were very likely to bring the medical profession into disrepute and undermine public confidence in the profession. Further, Mr Donoghue submitted that, in relation to professional standards, the working relationship between doctors is heavily reliant upon the trust that individual doctors place in each other to do the right thing and work within the GMC's guidance. He submitted that Dr Adindu's actions were very likely to have undermined that trust.

53. Mr Donoghue referred to relevant case law and submitted that dishonesty was always a serious instance of misconduct and was not easily remediable, such that it would be an unusual case where dishonesty was not found to impair fitness to practise. Mr Donoghue submitted that, whilst there was a scale to be applied to such cases, a finding of impairment was generally required in the public interest for cases of serious dishonesty such as in this case.

54. In terms of insight and remediation, Mr Donoghue stated that the GMC accepted that Dr Adindu had made full admissions to the Allegation, had apologised for his actions, and had presented some documentary evidence demonstrating insight and relevant remediation.

55. Mr Donoghue submitted that there were areas of the case in which the Tribunal may have been assisted by more detailed reflections being provided by Dr Adindu, such as the potential risks his actions presented to members of the public, the impact of his actions upon his colleagues in the medical profession and also in relation to the importance of maintaining accurate medical records (as relevant to Patient A). Mr Donoghue stated that the GMC accepted that Dr Adindu was generally able to analyse and express the impact of his actions in these areas in his oral evidence, and that this evidence supported the insight demonstrated in the written documents.

56. Mr Donoghue submitted that the weight to be attached to insight and remediation was a matter for the Tribunal. He submitted that the facts of the case were such that only limited weight could be attached to insight and remediation at this stage, given the seriousness of the misconduct, which is difficult to remediate.

57. Mr Donoghue submitted that, whilst Dr Adindu has provided evidence of mitigation, in terms of the circumstances prevailing at the time, such mitigation was more relevant to the sanction stage of proceedings. He therefore submitted that, in terms of impairment, the balance in this case must fall down in favour of maintaining public confidence in the profession and the upholding of proper professional standards. Mr Donoghue submitted that it was on this basis that a finding of impairment was required in this case.

Submissions on behalf of Dr Adindu

58. Mr Gledhill, Doctors Defence Service, stated that Dr Adindu accepted that his conduct constituted serious professional misconduct and that his fitness to practise is currently impaired.

59. Mr Gledhill referred to the background to this case and to Dr Adindu's evidence about not performing well in his previous exams. Mr Gledhill stated that this was a contributing factor to what occurred in that Dr Adindu had wanted to demonstrate that he could perform well in consultations with patients. He stated that Dr Adindu had wrongly made edits that he should never have done and which he fully acknowledged fairly quickly. Mr Gledhill stated that, from that moment, Dr Adindu had embraced the acceptance of his wrongdoing and had made full admissions in response to the Rule 7 and 15 Allegations.

60. Mr Gledhill submitted that Dr Adindu was a man who, having made admissions from the outset, was able to embark on a journey of reflection and remediation. He submitted that this was at a very advanced stage. Mr Gledhill referred to the evidence of Dr O who had endorsed this and who has known, and worked closely with, Dr Adindu for some considerable time. Mr Gledhill submitted that Dr O has closely observed Dr Adindu and has formed the view that Dr Adindu is somebody who is a very able doctor, who can be relied upon and who has made contributions to Dr O's Practice. Mr Gledhill stated that the Practice gave Dr Adindu a job in the full knowledge of the concerns and he submitted that Dr O clearly has great confidence in Dr Adindu.

61. Mr Gledhill submitted that Dr Adindu was very ashamed of what he had done. He stated that Dr Adindu had apologised publicly at this hearing and had also sent an apology to the GMC and to NHS England. Mr Gledhill said he understood that the GMC had forwarded the apology letter to the person at NHS England who had made the complaint to the GMC.

62. Mr Gledhill submitted that Dr Adindu had sought to make amends in a number of ways, both through his commitment to medicine generally but also through his apology. Mr Gledhill stated that Dr Adindu was terribly ashamed of his actions. He submitted that this was palpable in Dr Adindu's demeanour when he gave evidence. Mr Gledhill stated that, if he could, Dr Adindu would undo what he had done but he cannot do this, and so Dr Adindu has done his best to explain himself.

63. Mr Gledhill submitted that the Tribunal should be cautious in finding that Dr Adindu's written reflections were not very detailed and he referred to the evidence regarding XXX. Mr Gledhill submitted that it was quite clear from the documentation as a whole, including the certificates of attendance on courses, that Dr Adindu had done a great deal of work. Mr Gledhill stated that Dr Adindu had clearly discussed matters with Dr O and, in oral evidence, had done his best to articulate his feelings. Mr Gledhill submitted that Dr Adindu had done very well in responding to matters put to him during oral evidence. Mr Gledhill submitted that the Tribunal could be confident that Dr Adindu really does appreciate the impact of his actions on patients, colleagues, public confidence, and on medicine more generally. He

submitted that Dr Adindu had sought to articulate his recognition of these issues in terms of the examples he gave of patients who have needed his support. Mr Gledhill stated that Dr Adindu was very aware of the impact of his conduct on his own ability to provide this support and continuity of care moving forward in the light of the potential sanctions. Mr Gledhill submitted that Dr Adindu felt deep sorrow and regret for this because medicine and helping people is his passion.

64. Mr Gledhill reminded the Tribunal that Dr Adindu was asked about his future, to which Dr Adindu replied that he would continue to work for another 17 years if the Tribunal were to allow this. Mr Gledhill stated that Dr Adindu was going to focus on his patients and develop greater knowledge and abilities in relation to being able to provide a local service giving injections to the knee that was a service currently very slow in its delivery. Mr Gledhill submitted that this was evidence of a man who was working in the public interest.

65. Mr Gledhill stated that the Courts have said on occasion that it is important to return a member of the profession back to practise in the public interest. In terms of current impairment, Mr Gledhill stated that this was on a much narrower basis than it might have been. He referred to the cases of *Grant* and *Yeong v GMC* [2009] EWHC 1923 (Admin), in that there will be occasions where impairment of fitness to practise must be found as a matter of public policy, to uphold public confidence in the profession, and where to make no such finding would have an adverse impact on public confidence in the profession and the GMC/MPTS. Mr Gledhill stated that that was the position here, in the light of all of the remediation undertaken and the insight demonstrated.

66. Mr Gledhill submitted that, in relation to sitting exams, there were suitable mechanisms in place that were not available previously should Dr Adindu take any further exams. He stated that Dr Adindu took a course to help him pass the RCA and that he managed to do so without any repetition of any further dishonest conduct. Mr Gledhill submitted that, indeed, there had been no evidence of any dishonest conduct outwith the index events in Dr Adindu's 30 year career. He submitted that Dr Adindu was a man of previous good character and there had been no repetition.

67. Mr Gledhill stated that cultural differences had been one issue explored during the hearing. He stated that Dr Adindu had explained that it was frowned upon to show vulnerabilities in Nigeria. Mr Gledhill stated that Dr Adindu's cultural heritage was perhaps a contributory factor in him not being able to seek help earlier. He submitted that Dr Adindu was now in a place where he is able to speak to others. Mr Gledhill stated that Dr O was confident in Dr Adindu being able to come to him to have discussions.

68. Mr Gledhill referred to the additional testimonial evidence, including the oral evidence of Mr N. He submitted that they were also an endorsement of Dr Adindu, namely that there were no signs of repetition and that Dr Adindu is a very able practitioner. Mr Gledhill also referred the Tribunal to the appraisal material and submitted that Dr Adindu seems to be someone who has learnt his lesson, learnt a lot about himself, and who was confident that they would never repeat the misconduct again.

69. Mr Gledhill submitted that Dr Adindu's new insight into his learning needs would be especially important moving forward. XXX. Mr Gledhill submitted that, XXX, the Tribunal could be confident that this was a helpful point in Dr Adindu's personal journey of remediation.

The Relevant Legal Principles

70. 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.

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

72. The Tribunal must determine whether Dr Adindu's fitness to practise is impaired today, taking into account Dr Adindu'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.

73. The Legally Qualified Chair (LQC) gave legal advice to the Tribunal. He referred to the comments of Lord Clyde in the case of *Roylance v GMC [No 2]* [2000] 1 AC 311, that 'misconduct' is:

> *"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."*

74. The LQC also referred to the principles that Lord Justice Elias, after review of the authorities, derived in *Remedy UK Ltd v GMC* [2010] EWHC 124.

75. The LQC referred to the comments by Dame Janet Smith in the Fifth Shipman Report, as to four reasons why a decision maker might conclude that a doctor is unfit to practise or that their fitness to practise is impaired, namely:

> *"(a) that the doctor presented a risk to patients, (b) that the doctor had brought the profession into disrepute, (c) that the doctor had breached one of the fundamental tenets of the profession and (d) that the doctor's integrity could not be relied upon. Lack of integrity might or might not involve a risk to patients. It might or might not bring the profession into disrepute. It might be regarded as a fundamental tenet of the profession."*

76. The LQC referred to the comments of Mrs Justice Cox in *CHRE v NMC & Grant* [2011] EWHC 927 (Admin), in that:

> *"In determining whether a practitioner's fitness to practise is impaired… The relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidences in the profession would be undermined if a finding of impairment were not made in the particular circumstances."*

77. The LQC also referred to the approach set out by Dame Janet Smith in the Fifth Shipman Report, as referred to in *Grant*, as follows:

> *"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/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 is liable to act dishonestly in the future."*

78. The LQC also referred to the case of *PSA v Health and Care Professions Council & Ghaffar* [2014] EWHC 2723, where it was said that a finding of impairment did not necessarily

follow from a finding of dishonesty. However, whilst each case will turn on its facts, it would be an unusual case in which dishonesty was not found to impair fitness to practise.

79. The LQC stated that, in applying these principles, the Tribunal must take into account our overarching objective which is to protect the public. This objective includes to:

a protect and promote the health, safety and wellbeing of the public;
b promote and maintain public confidence in the medical profession; and
c promote and maintain proper professional standards and conduct for the members of the profession.

80. The Tribunal should consider the overarching objective as a whole, not giving excessive weight to any one limb.

The Tribunal's Determination on Impairment

Misconduct

81. The Tribunal first considered whether Dr Adindu's actions amounted to misconduct.

82. In reaching its determination, the Tribunal reminded itself of the admitted facts in this case. It considered the edits and additions made by Dr Adindu to the recordings of his consultations with Patients A and B, and the declaration that Dr Adindu had ticked at the time to confirm that he had not made any edits to the recordings. The Tribunal also had regard to:

- Dr Adindu's notes in Patient A's medical records about cauda equina symptoms when Dr Adindu knew that he had not discussed that matter with Patient A; and
- Dr Adindu's confirmation that Patient C's was 70 when Dr Adindu knew this was not the case.

83. The Tribunal also took account of the allegations of dishonesty, as set out at paragraph 9 of the Allegation, in respect of these matters.

84. The Tribunal noted that Dr Adindu had admitted the Allegation, including in his responses to the Rule 7 and 15 stages. Dr Adindu had also accepted that his actions amounted to serious misconduct, and that his fitness to practise is currently impaired. The Tribunal took into account that, when the concerns were first raised with him by Dr G, Dr Adindu suggested that he had made the edits to the recordings for educational purposes

and submitted them by mistake. Dr Adindu had also told Mr F that he had submitted the recordings by mistake.

85. Having considered the admitted facts, the Tribunal concluded that Dr Adindu's actions represented a departure from the principles of GMP, namely paragraphs 1, 19, 65 and 71, as quoted in full above. It determined that paragraph 19 of GMP was engaged in relation to the amendment of Patent A's medical records and that the other paragraphs related to all of the concerns. The Tribunal had particular regard to paragraph 65 of GMP, which states:

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

86. The Tribunal had regard to the seriousness of Dr Adindu's actions. The admitted facts include eight instances of dishonesty, namely Dr Adindu's gathering and submission of evidence for his RCA examination. The index events took place within the same context and within a limited time period. The Tribunal considered that there had been a degree of sophistication and planning by Dr Adindu in that he had made the edits using WavePad software. The Tribunal was of the view that Dr Adindu was well aware that he was not permitted to make the edits, had been clearly warned that edits should not be made and had ticked a declaration to confirm that he had not made any edits. The Tribunal found that, in making the edits, Dr Adindu had breached the requirements of the RCA and of those relevant paragraphs of GMP referred to above.

87. The Tribunal took into account that, in addition to making edits of the recordings, Dr Adindu had dishonestly added information to Patient A's medical records about cauda equina symptoms which he had not discussed with Patient A.

88. The Tribunal also considered, as acknowledged by Dr Adindu in his oral evidence, the potential risk to patient care had Dr Adindu passed the RCA and achieved a licence to practise as a GP when this may not have been warranted.

89. The Tribunal also noted the pressures that Dr Adindu was under at the time of the index events. Those events had taken place during the height of the Covid-19 pandemic; Dr Adindu had been particularly vulnerable to Covid-19 being of a BAME background XXX. In addition, he had been working some distance away from his family whilst training and he explained that passing the RCA would have enabled him to be reunited with his family. The Tribunal accepted Dr Adindu's evidence about the particular obstacles he faced in relation to his exams, namely:

- he had failed the AKT on three occasions and was only permitted four attempts at passing;
- English is not Dr Adindu's first language, which was of particular concern given the oral and time limited nature of the RCA;
- XXX; and
- XXX.

90. The Tribunal took the view that these factors, whilst providing relevant context for the index events, did not diminish the seriousness of Dr Adindu's misconduct.

91. The Tribunal has concluded that Dr Adindu's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct that was serious.

Impairment by reason of misconduct

92. The Tribunal, having found that the facts found proved amounted to misconduct, went on to consider whether Dr Adindu's fitness to practise is currently impaired by reason of his misconduct.

93. In respect of insight, the Tribunal had regard to Dr Adindu's evidence, including his reflective statement, the three posters he had produced as a visual aid of his reflections, the apology letter, and his oral evidence. The Tribunal concluded that Dr Adindu was extremely remorseful about his actions and clearly understood the nature of what he had done. The Tribunal determined that Dr Adindu has reflected very well on his misconduct and described in detail the various impacts of his actions. The Tribunal did not accept the GMC's criticisms of Dr Adindu's reflective statement. It took into account XXX and that English is not his first language. The Tribunal took the view that, in his oral evidence, Dr Adindu had articulated very clearly the extent of the impact of his actions on patients, colleagues and the wider public interest. For example, he gave (albeit anonymous) examples of patient situations which had highlighted to him the gravity of his misconduct and its impact upon the trust that his patients would have in him if they were aware of his dishonest actions.

94. The Tribunal found Dr Adindu's oral evidence to be convincing, powerful and consistent with his written reflections. He was genuinely remorseful and contrite and, at times, visibly upset when reflecting upon his misconduct. The Tribunal considered that the written and verbal apologies given by Dr Adindu were sincere and expressed his remorse and regret at his actions.

95. The Tribunal also found the comments of Dr O helpful in terms of Dr Adindu's insight, which included:

> *"[Dr Adindu] is absolutely mortified and very regretful about the actions which he took and ever since then has been particularly mindful and careful to respect GMC regulations. I am absolutely confident he will be an excellent professional and follow the guidelines to the letter for the rest of his career."*

96. In addition, Dr O, during his oral evidence, stated that he and Dr Adindu had had many discussions about the index issues. Dr O described Dr Adindu's actions as out of character and stated that Dr Adindu completely understood that his misconduct had been unacceptable and could not be repeated. Dr O told the Tribunal about the close relationship he had with Dr Adindu, first as trainer/trainee and then as colleagues. Dr O felt that Dr Adindu has really good insight into his misconduct. The Tribunal accepted Dr O's evidence and considered that Dr O was in a good position to comment on Dr Adindu's insight given their close working relationship over a number of years. It also accepted Dr O's evidence that Dr Adindu's misconduct was out of character.

97. The Tribunal determined, overall, that Dr Adindu had demonstrated a high level of insight into his actions. He did not see himself as a victim and was fully able to recognise the nature and impact of his misconduct and how he would prevent a recurrence. The Tribunal noted that Dr Adindu did not try to shy away from his misconduct or to mitigate it. The Tribunal found it difficult to see what more Dr Adindu could do in terms of his insight.

98. The Tribunal then went on to consider whether Dr Adindu's conduct was remediable, whether it had been remediated, and any likelihood of repetition. Whilst it appreciated that non-clinical matters may be harder to remediate, the Tribunal agreed that his actions were, in principle, remediable.

99. The Tribunal had regard to the probity and ethics modules on insight and remediation that Dr Adindu had completed in 2023, the appraisal and feedback documentation, and the positive character statements provided on Dr Adindu's behalf.

100. The Tribunal noted that, during his oral evidence, Dr Adindu had provided examples of how he had applied his learning and reflections to his clinical work. He gave the example of a patient who had asked him to provide a sick note so that she could avoid a breathalyser test; Dr Adindu had refused the patient's request as a result of the principles he had learned during the probity and ethics course and his wider reflections. The Tribunal regarded this as

good evidence that Dr Adindu had reflected upon his learning and was able to apply it in practice not only to himself but in other situations which require a doctor to be open and honest.

101. The Tribunal took the view that Dr Adindu's actions, while serious, occurred within a particular context and limited timeframe, in relation to the admission of evidence for his RCA examination. As noted above, Dr Adindu faced particular pressure as a result of Covid-19, his family circumstances and the obstacles he faced - as noted above - to successfully pass the RCA.

102. The Tribunal considered that, in terms of any future exam taking, Dr Adindu has now addressed XXX. A number of 'access provisions' had been identified for Dr Adindu and would be in place in the event that he is required to take exams in the future. The Tribunal concluded that the particular circumstances that Dr Adindu faced at the time of the index events were highly unlikely to repeat themselves.

103. The Tribunal noted that Dr O stated that Dr Adindu's clinical skills were superb, that Dr Adindu was highly professional, worked well with all of the team, and was thoughtful and compassionate with patients. Further, Dr O had told the Tribunal that Dr Adindu regularly sees a lot of patients and has dealt with his caseload well in all of the years that Dr O has worked with him. The decision by Dr O's Practice to offer Dr Adindu a job upon qualification, notwithstanding the Allegation, was a powerful endorsement.

104. Having regard to the risk of repetition, the Tribunal noted that there has been no repetition of the misconduct, either before or since the index concerns. Given the good level of Dr Adindu's insight and remediation and the absence of the particular context in which the misconduct occurred, the Tribunal was satisfied that the risk of repetition was negligible. It was as satisfied, as it could be, that Dr Adindu will not repeat his misconduct.

105. Whilst the Tribunal was impressed by Dr Adindu's insight and remediation, it nevertheless found that his actions constituted serious misconduct that included dishonesty.

106. The Tribunal considered that limbs *b* to *d* of the test set out by Dame Janet Smith as set out in *Grant*, as quoted above, were applicable in this case in that Dr Adindu had brought the medical profession into disrepute, had breached one of the fundamental tenets of the medical profession, and has admitted that he acted dishonesty.

107. The Tribunal concluded that a finding of impairment was necessary in order to uphold limbs *b* and *c* of the overarching objective, namely, to promote and maintain public

confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of the professions.

108. In the light of all of the above, the Tribunal determined that Dr Adindu's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 03/05/2024

109. Having determined that Dr Adindu'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

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

Submissions

Submissions on behalf of the GMC

111. Mr Donoghue submitted that suspension was the appropriate sanction in this case.

112. Mr Donoghue stated that the GMC recognised that the decision as to the appropriate sanction was a matter for the Tribunal exercising its own independent judgement. He referred to various paragraphs from the Sanctions Guidance (5 February 2024) ('the SG'), including paragraph 14 which sets out that *"the main reason for imposing sanctions is to protect the public"*. Mr Donoghue also referred to paragraph 17 of the SG, which states:

> *"Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession... Although the tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor."*

113. Mr Donoghue submitted that the above considerations were particularly important in this case, where the second and third limbs of the overarching objective, particularly the maintenance of public confidence and trust in the profession, are engaged.

114. In terms of mitigating factors, Mr Donoghue stated that insight and remediation are best viewed as a sliding scale, with full insight and remediation at one end and no insight or remediation at the other end. He submitted that the Tribunal had reflected in its impairment determination that Dr Adindu has demonstrated insight into the actions that have brought him before the Tribunal. In particular:

a) Dr Adindu admitted his misconduct from an early stage in the GMC investigation;
b) Dr Adindu provided written reflections, which identified the seriousness of his misconduct and, in particular, its potential impact upon public confidence in the medical profession;
c) Dr Adindu's oral evidence expanded upon his written reflections and demonstrated an understanding of the risk to patients that could have arisen, had his actions not been identified by the RCA examiners. The Tribunal found this evidence to be *"convincing, powerful and consistent with his written reflections"*; and
d) Dr Adindu apologised to both the GMC and NHS England, by way of his letter sent on 18th April 2024. The Tribunal noted that Dr Adindu was extremely remorseful about his actions and that his apologies were sincere.

115. Mr Donoghue stated that, on the whole, the Tribunal has found Dr Adindu to have a high level of insight into his misconduct and that he has also demonstrated evidence of remediation in the form of the probity and ethics course undertaken. Mr Donoghue submitted that Dr Adindu should be considered to fall at the top end of the scale of insight and remediation referred to above and that this therefore acted as a mitigating factor.

116. Mr Donoghue stated that Dr Adindu should be considered of previous good character and referred to the testimonial evidence provided on behalf of Dr Adindu. He stated that the testimonials provided mitigation as they spoke of Dr Adindu's clinical competence, his general character and his position as a valued colleague. Mr Donoghue stated that, as the SG makes clear, the weight to be attached to this evidence was a matter for the Tribunal to determine. He submitted, however, that the more serious the concerns that have been found then the less weight that could be attached to testimonials and character evidence when determining sanction.

117. Mr Donoghue referred to the personal and professional stressors that Dr Adindu was under at the time of his misconduct. These included Dr Adindu being away from his family during the Covid-19 pandemic and the difficulties he was experiencing undertaking the RCGP assessments. Mr Donoghue stated that the Tribunal had accepted this evidence and therefore these pressures could also act as a mitigating factor in this case.

118. Mr Donoghue stated that the Tribunal had heard that Dr Adindu obtained his primary medical qualification in Nigeria and had been working there for some years, prior to conducting his GP training in the UK. He stated that the Tribunal has therefore heard evidence as to the potential impact of cultural factors. Mr Donoghue submitted that the core principles engaged in this case, such as honesty and the need for accurate records, were not such that Dr Adindu's actions could be explained by reference to differing applicable standards in another jurisdiction. He submitted that, in any event and as made in clear at paragraph 28 of the SG, *"doctors are expected to familiarise themselves with the standards and ethical guidance that apply to practising in the UK"*. Mr Donoghue stated that if the Tribunal accepted Dr Adindu's evidence that he was reluctant to engage with and seek help for his educational needs and his study difficulties at the time of the misconduct, then it would be relevant for the Tribunal to consider the evidence that has been given as to whether this may have been affected by cultural factors. Mr Donoghue submitted that, if so, this would be a relevant mitigating factor.

119. Mr Donoghue stated that the passage of time since the index events, now some three and a half years ago, without further incident also acted as a mitigating factor in this case. He stated that Dr Adindu had continued to work as a GP and, with reference to Dr O's evidence, no other concerns have been raised.

120. Mr Donoghue stated that, whilst the GMC did not submit that any of the specific aggravating factors listed in the SG apply in this case, there were a number of factors that increased the seriousness of Dr Adindu's misconduct, in particular:

a) the Tribunal noted that Dr Adindu's actions include eight instances of dishonesty;
b) the Tribunal considered that the editing of the recordings involved a degree of sophistication;
c) Dr Adindu's actions in editing the recordings, and amending the medical records, were deliberate and intended to secure Dr Adindu an advantage in the RCGP examination;
d) the Tribunal has also noted that Dr Adindu was aware that it was not permitted for candidates to edit the recordings they were submitting;
e) the Tribunal also found that Dr Adindu's actions breached the requirements of the RCA and various provisions of GMP;
f) as Dr Adindu acknowledged, his dishonesty had the potential to present a risk to patients had it not been detected; and
g) when initially challenged regarding the editing of the consultations, Dr Adindu insisted that he had edited the recordings for his own educational purposes and had submitted the recordings in error.

121. Mr Donoghue referred to paragraphs of the SG regarding dishonesty, including paragraph 124, which states:

> *"Although it may not result in direct harm to patients, dishonesty related to matters outside the doctor's clinical responsibility (eg providing false statements or fraudulent claims for monies) is particularly serious. This is because it can undermine the trust the public place in the medical profession. Health authorities should be able to trust the integrity of doctors, and where a doctor undermines that trust there is a risk to public confidence in the profession. Evidence of clinical competence cannot mitigate serious and/or persistent dishonesty."*

He submitted that the guidance supported the position that, in this case, Dr Adindu's dishonesty is of an increased seriousness on the scale of dishonesty cases as it involved actions equivalent (with reference to paragraph 125 of the SG) to submitting false or inaccurate information and also involved falsifying patient records.

122. Mr Donoghue submitted that the mitigation advanced in this case must be considered in the light of the position that dishonesty of this nature is not easily remediable and that the principles of public trust and confidence in the medical profession should remain at the forefront of the Tribunal's considerations.

123. In terms of the available sanctions, Mr Donoghue submitted that there were no exceptional circumstances that would justify the taking of no action in this case. He submitted that, whilst there were mitigating factors relating to the circumstances at the time of the index events, the seriousness of the misconduct in this case was not such that those circumstances could justify the taking of no action by way of sanction.

124. With regard to conditions, Mr Donoghue referred to relevant paragraphs of the SG, including paragraph 81 of the SG, which states that conditions might be most appropriate in cases involving the doctor's health, involving issues around the doctor's performance, where there is evidence of shortcomings in a specific area of the doctor's practice, or where a practitioner lacks the necessary knowledge of English to practise medicine without direct supervision. Mr Donoghue submitted that Dr Adindu's case was not of the same kind as the examples mentioned in that paragraph of the SG. Mr Donoghue submitted that, whilst Dr Adindu does have insight into his misconduct and would likely comply with any conditions imposed, a period of retraining or supervision was not the most appropriate way of dealing with the nature of the misconduct in this case. Mr Donoghue submitted that, in any event, the imposition of conditions was not a sanction that would appropriately promote and

protect the need to uphold public confidence in the profession and uphold proper professional standards.

125. Mr Donoghue referred to a number of paragraphs of the SG regarding suspension, including paragraph 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 (ie 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)."*

He submitted that Dr Adindu's misconduct was sufficiently serious such that action must be taken to maintain public confidence in the profession.

126. Mr Donoghue submitted, with reference to paragraph 97 of the SG, that Dr Adindu's case involved a number of serious breaches of GMP but that the conduct falls short being fundamentally incompatible with continued registration. He stated that remediation would likely be successful, there was no evidence of repetition of the misconduct, and the Tribunal has deemed the risk of repetition to be negligible.

127. Mr Donoghue submitted that a period of suspension was the most appropriate sanction in this case. He submitted that suspension would appropriately mark the seriousness of Dr Adindu's conduct and sufficiently protect public confidence in the profession and uphold proper professional standards.

128. Mr Donoghue stated that the GMC did not advance any submissions as to the length of any suspension and leaves this matter to the Tribunal's discretion. He stated that the GMC did not suggest that a review hearing was necessary in this case.

Submissions on behalf of Dr Adindu

129. Mr Gledhill referred to the mitigation referenced by Mr Donoghue and said, as far as it was relevant, he adopted those submissions. Mr Gledhill also referenced his own submissions in respect of impairment and noted that the Tribunal had been supportive of those submissions in some respects, including that Dr Adindu has changed his approach to ensure that the misconduct is unlikely to be repeated. Mr Gledhill referred to the Tribunal's

comments at impairment that the risk of repetition was negligible, which suggests that it is an infinitesimally small risk.

130. Mr Gledhill stated that Dr Adindu has said he was very sorry for what has taken place and he reminded the Tribunal of the apology letter that Dr Adindu submitted. Mr Gledhill also submitted that Dr O's evidence showed that he really does believe in Dr Adindu. Mr Gledhill stated that Dr Adindu is clearly a very able clinician.

131. Mr Gledhill referred to the case of *Lusinga v Nursing And Midwifery Council* [2017] EWHC 1458 (Admin), and stated that there was some useful commentary by the relevant Judge in relation to the imposition of a suspension for dishonesty, namely:

> *"This is in my judgment par excellence a case where the public interest requires the safe return to practice of a competent nurse... The guidance does not differentiate between different forms of dishonesty, and takes one of the most serious forms of dishonesty (fraudulent financial gain) as the paradigm, without alluding to the possibility that dishonest conduct can take various forms; some criminal, some not; some destroying trust instantly, others merely undermining it to a greater or lesser extent."*

132. Mr Gledhill stated that the public interest could run two ways. It was not only about removing doctors to protect the public, but also about carefully balancing the statutory overarching objectives against the equally important need to ensure that we have sufficient qualified doctors in the community that we can trust and rely upon. Mr Gledhill submitted that the remediation and insight demonstrated by Dr Adindu meant that this case could quite properly be disposed of by a period of suspension. He submitted that suspension would send a message to both the public and the profession - and indeed to Dr Adindu - that the index conduct was wholly unacceptable, not to be repeated, and will be marked with a response.

133. Mr Gledhill acknowledged that taking no action would be inappropriate in this case. He submitted that, in the light of the Tribunal's findings on impairment, it seemed that a period of conditions did not appear to be necessary. Mr Gledhill submitted that erasure of Dr Adindu's name from the medical register would be a step too far. He submitted that Dr Adindu's case was not one where his conduct was fundamentally incompatible with the practice of medicine, particularly in the light of the wide-ranging analysis that Dr Adindu undertook as part of his remediation. Mr Gledhill submitted that Dr Adindu was clearly a doctor who saw the impact of his actions on his patients, and recognised that his misconduct had undermined his own ability to be able to deliver the care that he wanted to provide.

134. Mr Gledhill stated that it was clear from Dr Adindu's demeanour that he deeply understood how inappropriate it was for any doctor to be dishonest in any circumstances. Mr Gledhill stated that Dr Adindu, when explaining some of the mitigating features, was not advancing those matters as an excuse and was instead seeking to explain the situation he was in. Mr Gledhill submitted that, as the Tribunal has acknowledged, Dr Adindu has taken great steps to improve his circumstances in a number of ways.

135. Mr Gledhill submitted that erasure or a lengthy period of suspension would have an impact on Dr Adindu's patients and Practice. He stated that GPs are in short supply and that Dr Adindu's absence from the Practice will have longer term consequences.

136. Mr Gledhill stated that it was utterly wrong for a doctor to edit audio that is intended for submission for assessment. He stated that Dr Adindu did not seek to excuse that conduct but did seek to persuade the Tribunal that the conduct occurred in a very narrow period of time in an otherwise unblemished career of some 30 years.

137. Mr Gledhill referred to the unique circumstances of the misconduct and submitted that they were very unlikely to ever come about in the same way. He referenced the importance of a doctor being honest in every way and referred to the examples given by Dr Adindu as to how he would deal with issues in the future. Mr Gledhill submitted that Dr Adindu was a man that could be trusted moving forward. He stated that Dr Adindu was insightful and that Dr O was confident that Dr Adindu understood the importance of upholding the standards of the profession.

138. Mr Gledhill referred to Dr Adindu's personal circumstances and stated that there will be hardship for XXX as a result of any erasure or lengthy suspension. Mr Gledhill stated, with reference to case law, that it was appreciated that the personal fortunes of any one doctor was less important in this consideration, but submitted that it might still be relevant to the Tribunal's considerations with regard to proportionality and length of suspension.

139. Mr Gledhill referred to the relevant paragraphs of the SG regarding suspension, including paragraph 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."*

He submitted that Dr Adindu's current position fell squarely within the suspension criteria and not in the erasure criteria.

140. Mr Gledhill submitted that the length of any suspension should be relatively short. He invited the Tribunal to conclude that a review hearing is not required in this case due to the steps that have been taken as recorded by the Tribunal in its impairment determination. Mr Gledhill submitted that there were no clinical competence concerns, no ongoing remediation needs, and Dr Adindu's insight was sufficiently developed.

141. Mr Gledhill also referred to the statement provided by Ms M. He submitted that this showed that an independent person had been kept abreast of what had been going on and there were no other concerns raised about Dr Adindu.

142. In terms of the length of suspension, Mr Gledhill submitted that it was important to mark the seriousness of the departure from GMP but that the length of suspension could have a dramatic effect if it was longer than it needed to be. He referred to Dr Adindu's personal circumstances and also stated that it was preferable, and in the public interest, to get a doctor back to work as soon as possible. Mr Gledhill suggested that a period of suspension of two to three months would meet the requirements of the overarching objective in balancing the mitigating features of this case against the seriousness of the misconduct. He submitted that members of the public who knew the details of this case would feel that this time period was right and proper in all of the circumstances.

The Tribunal's Determination on Sanction

143. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own judgement.

144. In reaching its decision, the Tribunal has taken account of the SG and of the overarching objective. It has borne in mind that the purpose of the sanctions is not to be punitive, but to protect patients and the wider public interest, although they may have a punitive effect.

145. The LQC stated that, in the case of *Bawa-Garba v GMC* (2018) EWCA Civ 1879, the Court of Appeal held that the SG should always be consulted by panels, but that it is no more than non-statutory guidance, the relevance of which depends upon the precise circumstances of the particular case. The Court went on to say that, if having considered the particular facts and features of the case, the SG points clearly in the direction of a particular sanction, the panel must explain in the determination why that sanction is not to be imposed.

146. The LQC also referred to the case of *GMC & The Professional Standards Authority for Health and Social Care v Bramhall* [2021] EWHC 2109, where the court held that if a Tribunal departs from the SG, it has a duty to state more clear, substantial and specific reasons for the departure, than if the SG was being followed. Generalised assertions that a registrant's actions are not fundamentally incompatible with continued registration, and that erasure is not proportionate or appropriate, are inadequate. In *Bramhall* the Court stated that unusual facts or features of a case and public prominence made it especially important that a careful, structured, and transparently accessible approach to regulatory decision-making is demonstrably taken.

Aggravating and mitigating factors

147. The Tribunal identified the following aggravating factors in this case:

- The Tribunal referred to its comments at impairment that the admitted facts included eight instances of dishonesty relating to Dr Adindu's gathering and submission of evidence for his RCA examination. It was also mindful that the dishonesty was of different types in terms of the edits made to the audio of the consultations, the confirmation of Patient C's incorrect age, and the adding of information to Patient A's medical records about cauda equina symptoms.

- The Tribunal has found there to have been a degree of sophistication and planning by Dr Adindu in that he had made the edits using WavePad software. The Tribunal considered this to be an aggravating factor.

- The Tribunal was of the view that Dr Adindu was well aware that he was not permitted to make the edits, had been clearly warned that edits should not be made and had ticked a declaration to confirm that he had not made any edits. The Tribunal considered that Dr Adindu's actions in deliberately doing something that he knew was wrong, amounted to an aggravating factor.

- The Tribunal also considered that Dr Adindu's actions were motivated by his intention of trying to obtain an advantage in the RCA exam. The Tribunal took the view that, whilst Dr Adindu may have encountered a number of obstacles in taking the RCA, that did not justify his dishonesty.

- As noted in the Tribunal's determination on impairment, it considered the potential risk to patient care had Dr Adindu passed the RCA and achieved a licence to practise as a GP when this may not have been warranted.

- When initially challenged regarding the editing of the consultations, Dr Adindu stated that he had edited the recordings for his own educational purposes and had submitted the wrong recordings in error.

148. The Tribunal identified the following mitigating factors in this case:

- The Tribunal reminded itself of the finding in its impairment determination that Dr Adindu has demonstrated a high level of insight into his actions. He did not see himself as a victim, was fully able to recognise the nature and impact of his misconduct and how he would prevent a recurrence. The Tribunal endorsed Mr Donoghue's assessment of the Tribunal's position that Dr Adindu's insight fell at the top end of the scale. The Tribunal considered Dr Adindu's admissions from the Rule 7 stage, his written reflections, his apology letter to the GMC and NHS England, and his oral evidence that the Tribunal found to be *"convincing, powerful and consistent with his written reflections"*. Overall, the Tribunal found the insight displayed by Dr Adindu to be a mitigating factor and was also impressed by his steps to remediate.

- The Tribunal concluded that Dr Adindu's previous good character was also a mitigating factor in this case. There was no evidence of any other misconduct on Dr Adindu's part, either before or since the index concerns. The Tribunal had regard to the testimonial evidence presented to it, particularly the evidence of Dr O and Mr N, which endorsed Dr Adindu's good character. In addition, the Tribunal had regard to the statement provided by Ms M that provided further confirmation that there had been no further concerns and that the relevant Responsible Officer had confirmed in 2022 that she was happy for Dr Adindu to transfer and join their list in the South West at that time.

- The Tribunal also considered that the pressures that Dr Adindu had been under at the time of the index events was a mitigating factor in this case. It had accepted Dr Adindu's evidence about the particular obstacles he faced in relation to his exams, including that at the time of the index events XXX. Further the Tribunal took into account that it had taken some time for Dr Adindu to acknowledge or seek help for XXX as the result of a cultural resistance to showing weakness. The Tribunal was also mindful that the events took place during the height of the

Covid-19 pandemic, where Dr Adindu had been particularly vulnerable to Covid-19 being of a BAME background XXX. In addition, he had been working some distance away from his family whilst training and he explained that passing the RCA would have enabled him to be reunited with his family. Dr Adindu had also provided information to the Tribunal about the XXX around this time, which had resulted in XXX. The documentation set out that XXX. The Tribunal considered it likely that XXX added to the pressures faced by Dr Adindu at the time of the index events.

- The Tribunal also found that the lapse of time since the index events was a mitigating factor that it could properly take into account. It noted that approximately three and a half years had passed, without further incident, since Dr Adindu's misconduct.

149. The Tribunal balanced the aggravating and mitigating factors. In doing so it considered that Dr Adindu's dishonest misconduct had been serious, in that it had been repeated, sophisticated and deliberate. His dishonesty also had the potential to create a risk to patient safety, albeit there was no evidence that any harm had actually been caused. However, there were a number of powerful mitigating factors, not least the particular circumstances in which Dr Adindu found himself at the time of the index events, his otherwise good character and high level of insight. The Tribunal concluded that the misconduct, whilst serious, was out of character, had taken place in a particular context and was highly unlikely to be repeated.

150. The Tribunal had regard to Mr Donoghue's submissions in connection with paragraphs 27 and 28 of the SG. It agreed with Mr Donoghue's submission that the principles of honesty and accurate record keeping, are not such that Dr Adindu's actions could be explained by reference to differing standards in other countries. However the Tribunal noted that Dr Adindu had not advanced any such explanation for his conduct, albeit that differing cultural expectations were a matter raised by Dr O in his oral evidence.

151. The Tribunal also took into account Dr Adindu's oral evidence about XXX, XXX. He explained that XXX. It was suggested that a period of suspension or erasure might create financial hardship and disrupt those XXX arrangements. However, the Tribunal gave this evidence limited weight. It reminded itself that the overarching objective should be at the forefront of its deliberations and, in particular, the need to protect public confidence in the profession and uphold proper professional standards. As the SG makes clear, some of the available sanctions may have a punitive effect, but that is not the intention. In addition, the Tribunal noted paragraph 17 of the SG which states *"the reputation of the profession as a whole is more important than the interests of any individual doctor"*.

No action

152. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Adindu's case, the Tribunal first considered whether to conclude the case by taking no action.

153. The Tribunal determined that, in view of its findings on the facts and impairment, it would be neither appropriate, proportionate nor in the public interest to conclude this case by taking no action. It was unable to identify any exceptional circumstances such as to justify taking no action.

Conditions

154. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Adindu's registration. It has borne in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

155. The Tribunal noted that, with reference to paragraph 81 of the SG, conditions might be most appropriate in cases involving the doctor's health, where there is a lack of necessary knowledge of English, or involving issues around the doctor's performance. The Tribunal determined that these examples were not relevant to Dr Adindu's case.

156. The Tribunal, having regard to the seriousness of the misconduct, and the nature of dishonesty, determined that it was unable to formulate any workable or appropriate conditions that would adequately address the need to maintain public confidence and uphold proper professional standards and conduct for the members of the profession. The Tribunal determined that, in the light of its findings as to dishonesty and seriousness, the imposition of conditions would not be proportionate or sufficient to meet the public interest concerns.

Suspension

157. The Tribunal then went on to consider whether suspending Dr Adindu's registration would be appropriate and proportionate.

158. The Tribunal had regard to its findings in respect of misconduct and impairment, as well as the submissions provided by both parties. It also had regard to the aggravating and mitigating factors listed above and considered the paragraphs of the SG in relation to suspension, including 91 and 92 which are quoted above. The Tribunal noted, with reference

to paragraph 91 of the SG, that suspension can have 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"*.

159. The Tribunal also had regard to paragraph 93 of the SG, which states:

> *" Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions..."*

The Tribunal referred to its comments at the impairment stage that the risk of repetition was negligible. It had stated that it was as satisfied, as it could be, that Dr Adindu will not repeat his misconduct. The Tribunal also considered that Dr Adindu had clearly acknowledged his wrongdoing and made clear steps in terms of remediation. This remediation had included the probity and ethics modules on insight and remediation and Dr Adindu's ability to give examples, during oral evidence, of how he had applied his learning and reflections to his clinical work.

160. The Tribunal had regard to paragraph 120 of the SG:

> *"Good medical practice states that registered doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession."*

161. The Tribunal also considered paragraph 125 of the SG, which gives examples of dishonesty in professional practice. The paragraph includes reference to the example of *"falsifying or improperly amending patient records"* which would relate to the amendment to Patient A's medical records. The Tribunal accepted that there could be parallels between Dr Adindu's case and the examples given in paragraph 125 of *"submitting or providing false references"* or *"inaccurate or misleading information on a CV"*. As a result, the Tribunal concluded, by reference to paragraph 124 of the SG, that Dr Adindu's misconduct had been particularly serious.

162. The Tribunal determined that the following sections of paragraph 97 of the SG applied in this case:

> *"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.

...

e) No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f) No evidence of repetition of similar behaviour since [the] incident.

g) The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour."

163. The Tribunal has found that Dr Adindu's actions did amount to a serious breach of GMP and a departure from the principles expected of him. It concluded that any sanction lower than suspension would not be sufficient or appropriate in order to maintain confidence in the medical profession. The Tribunal determined that Dr Adindu's remediation efforts had been positive and, as already stated, that Dr Adindu has demonstrated a high level of insight into his actions and that the risk of repetition was negligible. The Tribunal considered that, taken together, these factors indicated that suspension was an appropriate sanction in this case.

164. The Tribunal considered whether erasure of Dr Adindu's name from the medical register would be necessary and appropriate. It had regard to paragraph 107 of the SG which states that a *"Tribunal may erase a doctor from the medical register in any case where this is the only means of protecting the public"*.

165. The Tribunal considered that the following sub-paragraphs of 109 of the SG were of relevance in this case:

"Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

a) A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.

b) A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.

...
d) Abuse of position/trust (see Good medical practice, paragraph 81: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').
...
h) Dishonesty, especially where persistent and/or covered up...
i) Putting their own interests before those of their patients..."

166. The Tribunal determined that Dr Adindu's misconduct, whilst a serious departure from the principles of GMP, was not fundamentally incompatible with continued registration. The Tribunal considered that it would be disproportionate to erase Dr Adindu's name from the medical register and found the factors at paragraph 97 of the SG to be more persuasive than those at paragraph 109.

167. The Tribunal recognised that whilst some of the factors at paragraph 109 were engaged, the level of Dr Adindu's insight and remediation, the negligible risk of repetition and Dr Adindu's good character, indicated that suspension was the appropriate sanction rather than erasure. In addition, the Tribunal noted that, although the dishonesty was repeated, it took place in the context of particular pressures - as set out previously - and consisted of a series of connected actions, within a limited period of time, related to his submissions for the RCA exam. The index events took place some three and a half years ago and there had been no repetition of the misconduct. The Tribunal considered that there was a public interest in retaining a competent doctor who was well regarded by his patients and colleagues, as was the case here.

168. In all the circumstances, the Tribunal determined to impose a period of suspension on Dr Adindu's registration. It was of the view that suspension would have, as set out in paragraph 91 of the SG, a deterrent effect; it would send out a clear signal to Dr Adindu, the profession and the public about what is regarded as behaviour unbefitting a registered doctor. The Tribunal concluded that a period of suspension was necessary in order to promote and maintain public confidence in the medical profession and to promote and maintain proper professional standards and conduct for the members of the profession.

Length of suspension

169. The Tribunal had regard to paragraph 100 of the SG, which sets out the factors which are relevant when determining the length of suspension. They are:

"a. the risk to patient safety/public protection

b. the seriousness of the findings and any mitigating or aggravating factors...
c. ensuring the doctor has adequate time to remediate."

The Tribunal determined that *b* and *c* were particularly relevant in this case, albeit that Dr Adindu's conduct had had the potential to cause a risk to patient safety.

170. The Tribunal was mindful that, as at paragraph 101 of the SG, its *"primary consideration should be public protection and the seriousness of the findings"*. The Tribunal noted the seriousness of the admitted facts and the departure from the principles set out in GMP. The admitted facts had included eight instances of dishonesty, albeit that these actions were out of character and took place within the context of certain pressures and obstacles that the Tribunal has set out previously.

171. The Tribunal determined that a period of three months was appropriate in this case. It concluded that this time period was proportionate in terms of the misconduct found, as balanced with the other factors in the case. It also determined that this time period would be sufficient to uphold limbs *b* and *c* of the overarching objective. The Tribunal considered that a three month suspension would mark the seriousness of Dr Adindu's conduct whilst meeting the public interest in returning a highly competent and well regarded clinician to practise.

Whether to direct a review hearing

172. The Tribunal noted that neither party contended that a review hearing was necessary in this case, but it was recognised that this decision was a matter for the Tribunal's discretion.

173. The Tribunal had regard to the relevant paragraphs of the SG, including paragraph 163, that *"It is important that no doctor is allowed to resume unrestricted practice following a period of conditional registration or suspension unless the tribunal considers that they are safe to do so".*

174. The Tribunal, with reference to paragraph 164 of the SG, determined that Dr Adindu fully appreciated the gravity of his misconduct and there had been no repetition either before or since. It was clear to the Tribunal that Dr Adindu has a high level of medical skills and knowledge.

175. In all the circumstances, the Tribunal determined not to direct a review in Dr Adindu's case. The Tribunal concluded that the public interest would be met upon the expiration of the suspension without the need for a review given Dr Adindu's high level of insight and remediation, the negligible risk of repetition, and his high degree of clinical competence. The

Tribunal took the view that a review hearing would serve no useful purpose and it considered that Dr Adindu would be safe to return to unrestricted practice at the end of the period of suspension.

Determination on Immediate Order - 03/05/2024

176. Having determined to suspend Dr Adindu's registration for three months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Adindu's registration should be subject to an immediate order.

Submissions

177. Mr Donoghue stated that the GMC did not suggest that an immediate order was necessary in this case. He also confirmed that there is no interim order to be revoked.

178. Mr Gledhill stated that he had no submissions to make on behalf of Dr Adindu.

The Tribunal's Determination

179. In making its decision the Tribunal had regard to the relevant paragraphs of the SG, including:

> *"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.*
>
> *173. An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
> *...*
> *178. Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive*

direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect."

180. The Tribunal had regard to its determinations on facts, impairment and sanction. In all the circumstances, the Tribunal determined not to impose an immediate order of suspension on Dr Adindu's registration.

181. The Tribunal was of the view that an immediate order was not necessary to protect members of the public, was not otherwise in the public interest, nor was in Dr Adindu's best interests. The Tribunal concluded that, given its previous findings, it did not consider this to be a case where immediate action by way of an immediate order was required to protect public confidence in the medical profession.

182. This means that Dr Adindu's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless he lodges an appeal. If Dr Adindu does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

183. There is no interim order to revoke.

184. That concludes this case.

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ANNEX A - 01/05/2024

Application to amend the Allegation

185. On 29 April 2024 the Tribunal asked Mr Donoghue, Counsel on behalf of the GMC, whether the GMC wished to amend any particulars of the Allegation. In that regard the Tribunal raised a query about the wording of paragraphs 4(c) and 6(b) of the Allegation, and highlighted a typographical error at paragraph 5(b) of the Allegation.

186. Mr Donoghue made an application for amendment of the Allegation under Rule 17(6) of the General Medical Council (GMC) (Fitness to Practise Rules) 2004 as amended ('the Rules'), which states:

> *"(6) Where, at any time, it appears to the Medical Practitioners Tribunal that—*
> *(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and*
> *(b) the amendment can be made without injustice,*
> *it may, after hearing the parties, amend the allegation in appropriate terms."*

187. The amendments were to:

> *4. You knew that:*
> *...*
> *c. you had inserted the audio recording as described at paragraph ~~3.b.~~ 3.a. ;*
> *...*
> *5. On 8 November 2020 you submitted a recording of your consultation with Patient B ('Recording 2') as part of your RCA examination, and you:*
> *...*
> *b. had made one or more edits to the audio of Recording 2 at or around the times as set out in schedule 2;*
> *...*
> *6. You knew that:*
> *...*
> *b. you had inserted the audio recording as described at paragraph ~~5.b.~~ 5.a. ;*

188. Mr Gledhill, Doctors Defence Service, stated that this application was not opposed by Dr Adindu.

Tribunal's Decision

189. The Tribunal determined to grant the GMC's application for amendment to paragraphs 4(c), 5(b) and 6(b) of the Allegation. It determined that these amendments were corrections that it could properly make without injustice to either party.

ANNEX B - 01/05/2024

Application to admit further evidence / reasonable adjustments

190. This determination will be handed down in private. The Tribunal agreed, in accordance with Rule 41 of the Rules, that parts of this hearing should be heard in private where the matters under consideration are confidential, namely where they involve XXX. As such, this determination will be read in private but a redacted version will be published following the conclusion of this hearing, with those matters removed relating to XXX.

191. On 29 April 2024 Mr Gledhill made an application for the admission of further evidence under Rule 34(1) of the Rules, which states:

> *"The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law."*

192. Mr Gledhill also asked for a number of reasonable adjustments in respect of Dr Adindu.

193. The further evidence consisted of:

- a document setting out the result of discussions held during an exam support meeting that Dr Adindu attended on 1 March 2021. The document included reference to XXX and confirmed advice provided to him about how he could prepare himself for taking his forthcoming AKT exam;
- XXX;
- three posters that Dr Adindu wished to show to the Tribunal during his oral evidence; and
- a document setting out the admissions to the Allegation that Dr Adindu was to make at this hearing.

Submissions

194. Mr Gledhill stated that Dr Adindu had prepared three posters that he wished to use during his oral evidence to illustrate a number of matters, which were not controversial. He stated that it would be unusual for someone to present posters during a hearing but that it would put Dr Adindu at ease if he were able to do so. Mr Gledhill referred to the exam support meeting document and asked for a number of reasonable adjustments to be made XXX. These adjustments included:

- additional breaks;
- making allowances for Dr Adindu taking more time to answer questions; and
- Dr Adindu being able to make notes and making reference to the posters during his oral evidence.

195. Mr Gledhill stated that Dr Adindu functions well as a General Practitioner and that he was making this request as Dr Adindu only has one opportunity to present his evidence to the Tribunal.

196. Mr Donoghue stated that the application for the admission of further evidence and the reasonable adjustments request were not opposed.

Tribunal's Decision

197. The Tribunal had regard to Rule 34(1) of the Rules and the submissions of the parties. The Tribunal determined to grant the Dr Adindu's application for the admission of this further evidence. It concluded that the documentation was relevant and that it was fair for it to be admitted.

198. The Tribunal also determined that reasonable adjustments, such as additional breaks where required, would be appropriate in this case. They would be managed through the hearing as and when required.

ANNEX C - 01/05/2024

Application for two witnesses to give evidence remotely

199. On 29 April 2024 Mr Gledhill made an application for two witnesses (Mr N and Dr O) to give evidence remotely under Rule 34(13) and (14) of the Rules, which states:

"(13) A party may, at any time during a hearing, make an application to the Committee or Tribunal for the oral evidence of a witness to be given by means of a video link or a telephone link.

(14) When considering whether to grant an application by a party under paragraph (13), the
Committee or Tribunal must—

(a) give the other party an opportunity to make representations; (b) have regard to—
(i) any agreement between the parties, or
(ii) in the case of a Tribunal hearing, any relevant direction given by a Case Manager; and
(c) only grant the application if the Committee or Tribunal consider that it is in the interests of justice to do so."

Submissions

200. Mr Gledhill stated that both witnesses had given written testimonials on behalf of Dr Adindu, which were included in the current hearing documentation, and asked that they be permitted to give their evidence remotely.

201. Mr Donoghue stated that the application was not opposed by the GMC.

Tribunal's Decision

202. The Tribunal had regard to Rule 34(13) and (14) of the Rules and the submissions of the parties. The Tribunal determined to grant the Dr Adindu's application for the two testimonial witnesses to give evidence remotely. It concluded that this application should be granted in the interests of justice.

SCHEDULE 1

1. 00:01:56;

2. 00:03:34;

3. 00:03:50;

4. 00:04:37;

5. 00:10:07.

SCHEDULE 2

1. 00:01:44;

2. 00:05:49;

3. 00:06:44;

4. 00:07:17;

5. 00:08:26;

6. 00:09:04;

7. 00:09:17.