MPTS Medical Practitioners Tribunal Service

Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 12/02/2024 - 29/02/2024

Medical Practitioner's name:	Dr Ewere ONYEKPE
GMC reference number:	7027794
Primary medical qualification:	Vrach 2003 Kharkov Medical University

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

Summary of outcome
Suspension, 6 months

Tribunal:

Legally Qualified Chair	Mr Tanveer Rakhim
Lay Tribunal Member:	Dr Matthew Fiander
Medical Tribunal Member:	Dr Deborah Brooke

Tribunal Clerk:	Ms Keely Crabtree

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr James Counsell, KC, instructed by Mr Gareth Gibson, Weightmans
GMC Representative:	Ms Rosalind Emsley-Smith, 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 - 20/02/2024

Background

1. Dr Onyekpe qualified in 2003 at Kharkov State Medical University.

2. Dr Onyekpe commenced his clinical practice in Nigeria, mostly within the Nigerian Army medical structure, before moving to the United Kingdom (UK) in 2008 and undertaking a Master's degree in public health at the London School of Hygiene and Tropical Medicine. Dr Onyekpe passed the Professional and Linguistic Assessments Board test (PLAB) in 2010 and, from summer 2010 he began full-time medical practice in the UK.

3. Dr Onyekpe initially worked at the Liverpool Heart and Chest Hospital before working at the North Middlesex Hospital as an SHO and then as a Trust Registrar for six years, before briefly working in Basildon as a specialty doctor. In 2016, he entered a formal training program and began work as an ST1 in Emergency Medicine and completed ST3 training in 2019. Thereafter Dr Onyekpe decided to take a year off from training, undertaking locum registrar work.

4. Dr Onyekpe was employed as a locum registrar at the Whittington Hospital ("the Hospital"), where the index events took place, from August 2019 until November 2019, and then March 2020 to the end of June 2020. He was working a 60-hour week, five days per week, working exclusively on nights.

5. Dr Onyekpe was later employed by the Royal Free London NHS Foundation Trust (the 'Trust') from August 2020 as a specialty trainee in emergency medicine.

6. It is alleged that in June and July 2020, Dr Onyekpe engaged in an improper emotional relationship with Patient A, behaved inappropriately and/or unprofessionally with Patient A and engaged in a sexual relationship with her. It is alleged that Patient A was vulnerable at all material times by reason of her medical history/conditions, and/or her personal circumstances. It is further alleged that Dr Onyekpe knew or ought to have known that Patient A was vulnerable or likely to be vulnerable.

7. On 3 August 2020, Dr Onyekpe was arrested on suspicion of raping Patient A on 10 June 2020. The police decided to take no further action against Dr Onyekpe in regard to the rape allegation. On 4 August 2020 the Metropolitan Police disclosed the fact of Dr Onyekpe's arrest to the GMC. The following day, Dr Onyekpe made the same disclosure to the GMC.

The Outcome of Applications Made during the Facts Stage

8. The Tribunal was asked to determine a preliminary issue (in accordance with rule 17(2)(a) of the Fitness to Practise Rules 2004) as to the admissibility of some of the evidence which the GMC wished to put before it. The contested evidence consisted of Patient A's hospital records of the 10 June 2020 and her GP records. The Tribunal determined that the GP records would not be adduced into evidence, but the hospital records in relation to 10 June 2023 would be admitted into evidence. The Tribunal's full decision on the application is included at Annex A.

9. The Tribunal refused the GMC's further application, made pursuant to Rule 34(1) of the Rules, to admit Patient A's GP records into evidence. The Tribunal's full decision on the further application is included at Annex B.

The Allegation and the Doctor's Response

10. The Allegation made against Dr Onyekpe is as follows:

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

1. At all material times:
    a. Patient A was vulnerable by reason of her:
        i. medical history/conditions, and/or; **To be determined**

ii. personal circumstances; **To be determined**

b. you knew or ought to have known that Patient A was vulnerable or likely to be vulnerable. **To be determined**

2. On 5 June 2020, you consulted with Patient A in your capacity as a doctor in Emergency Medicine and you performed an intimate examination on Patient A. **Admitted and found proved**

3. On 6 June 2020, you engaged in an improper emotional relationship with Patient A, in that on one or more occasion, as set out in Schedule 1, whilst you were still on shift you sent to Patient A`s personal mobile telephone number, from your personal mobile telephone number, WhatsApp messages which were both inappropriate and unprofessional. **Admitted and found proved**

4. On one or more occasion on 8 June 2020, as set out in Schedule 2, you behaved inappropriately and/or unprofessionally towards Patient A, in that you engaged in WhatsApp message communication with Patient A via her private mobile telephone number in which you:
   a. gave her medical advice on the symptoms with which she presented on 5 June 2020; **Admitted and found proved**
   b. diverted the topic of conversation from medical to private matters; **Admitted and found proved**
   c. discussed both your and her private life; **Admitted and found proved**
   d. called her 'pretty'; **Admitted and found proved**
   e. stated to her: 'You can pick and choose. Anyone you want'. **Admitted and found proved**

5. Your conduct as set out at paragraph 4, subparagraphs b-e, was sexually motivated. **Admitted and found proved**

6. Between 9 June 2020 and 25 July 2020, on one or more occasion as set out in Schedules 3 and 4, you behaved inappropriately and/or unprofessionally towards Patient A, in that you: **Admitted and found proved**
   a. gave her medical advice regarding the clinical issues for which you had not treated her since 5 June 2020; **Admitted and found proved**
   b. used an inappropriate method (WhatsApp messaging) to give that medical advice; **Admitted and found proved**

c. failed to make a proper record in Patient A`s hospital records of the medical advice you gave to her. **Admitted and found proved**

7. Between 9 June 2020 and 25 July 2020, you engaged in a sexual relationship with Patient A as set out in Schedules 3, 4 and 5. **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

11. At the outset of these proceedings, through his counsel, Mr Counsell KC, Dr Onyekpe made admissions to some paragraphs and sub-paragraphs 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 these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Witness Evidence

12. Dr Onyekpe provided his own witness statement dated 29 January 2024 and also gave oral evidence at the hearing.

Documentary Evidence

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

- Self-referral by Dr Onyekpe, dated 5 August 2020;
- Notification e-mail from police, dated 20 August 2020 informing the GMC that no further action would be taken and indicating that first disclosure was made by the police on 4 August 2020;
- The Royal Free London NHS Foundation Trust Investigation Report, dated 7 November 2020;
- Signed statement of Dr Onyekpe as part of the Trust investigation, dated 8 October 2020;
- Email exchange dated 23 February 2021 regarding WhatsApp messages;

- Transcript of WhatsApp messages between Dr Onyekpe and Patient A;
- Extracts from hospital records of Patient A, dated 05 June 2020;
- Extracts from hospital records of Patient A, dated 10 June 2020;
- Witness statement of Dr Onyekpe's Responsible Officer, dated 23 November 2022.

14. The Tribunal also had the agreed admissions document from both advocates and a copy of the Allegations from Mr Counsell that showed all the paragraphs of the Allegation that were admitted. Finally, the Tribunal had sight of a set of hospital records relating to 10 June 2020, which were disclosed following the Tribunal's determination on the preliminary application as set out at Annex A.

The Tribunal's Approach

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

Vulnerability

16. The GMC in its opening of the case, referred the Tribunal to the Oxford dictionary definition of the word vulnerable, which states:

> *'the quality or state of being exposed to the possibility of being attacked or harmed, either physically or emotionally.'*

17. The GMC indicated, that by one interpretation of this definition, all patients are vulnerable because of the power imbalance inherent in the doctor / patient relationship.

18. Further, both parties directed the Tribunal to paragraphs 145 and 146 of the Sanctions Guidance (SG) as the appropriate definition, which uses the phrase 'particularly vulnerable' and gives examples of characteristics or circumstances which are likely to make some patients more vulnerable than others:

> *'**Vulnerable patients***

145 Where a patient is particularly vulnerable, there is an even greater duty on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of certain characteristics or circumstances, such as:

a presence of mental health issues
b being a child or young person aged under 18 years
c disability or frailty
d bereavement
e history of abuse or neglect.

146 Using their professional position to pursue a sexual or improper emotional relationship with a vulnerable patient is an aggravating factor that increases the gravity of the concern and is likely to require more serious action against a doctor.'

19. The Tribunal considered paragraphs 1(a) and 1(b) of the Allegation in relation to both of the above definitions.

20. The context in which the index events occurred were described by Dr Onyekpe. During May and June 2020 there were increased levels of presentation to the A&E Department of patients with mental health conditions. Dr Onyekpe was of the opinion that this was due to the COVID-19 pandemic restrictions.

21. On 5 June 2020 Patient A was brought to the Whittington Hospital A&E Department by ambulance. This was on the advice of her GP, who had been concerned that she might have a serious condition. She arrived at the Hospital at XXX.

22. The Hospital records show that Patient A was allocated to Dr Onyekpe at XXX, that he considered her to be fit for discharge at XXX and that she was discharged at 00:11 on 6 June 2020.

23. Dr Onyekpe examined Patient A, made a diagnosis of sciatica and prescribed pain-killing medication for her. His examination included an intimate examination. There was no criticism of Dr Onyekpe's clinical interaction and examination which were considered to be entirely appropriate.

24. It was Dr Onyekpe's unchallenged evidence that prior to Patient A leaving the Department she gave him her telephone number on a piece of paper while saying *'in case you want to be friends or anything'.*

25. Dr Onyekpe used this number to initiate contact with Patient A via WhatsApp on his personal mobile number at 01:06 on 6 June 2020 in which he expressed his hope that she was feeling better. This was followed by a brief exchange of messages.

26. On 8 June 2020, Patient A initiated a further exchange of messages which lasted almost an hour. The exchange included discussion about their private lives and Dr Onyekpe complimenting Patient A and giving her medical advice.

27. On 10 June 2020, Patient A was again brought to Whittington Hospital A&E Department by ambulance. She initiated a further exchange of messages with Dr Onyekpe which lasted some three and a half hours. The exchange soon became personal and highly sexualised. Dr Onyekpe and Patient A had consensual sexual intercourse in a hospital toilet cubicle.

28. Patient A had presented complaining of chest pain. Dr Onyekpe was on duty in the Department. Dr Onyekpe arranged for Patient A to be seen by a more senior colleague. He had no clinical interaction with Patient A. He told the Tribunal he was entirely unaware of her presenting complaint and its management.

29. Further messages of a sexual nature continued to be exchanged on 10 June 2020, with a final message from Patient A indicating that the pair had agreed to meet the next morning. On the morning of 11 June 2020, Dr Onyekpe went to Patient A's home and again had consensual sex with her.

30. Messages between Dr Onyekpe and Patient A continued intermittently until 24 July 2020. The messages continued to be highly sexualised, including web links to sexual videos sent by Dr Onyekpe. The messages were interspersed with medical advice given by Dr Onyekpe in response to Patient A referring to her painful health issues.

The Tribunal's Analysis of the Evidence and Findings

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

Paragraph 1(a)(i)

At all material times:
Patient A was vulnerable by reason of her medical history/conditions

Physical conditions

32. The Tribunal had regard to Patient A's medical record when she presented to the Hospital on 5 June 2020. The Tribunal noted that Dr Onyekpe had elicited the following information:

'XXX'

[…]

'XXX.'

33. The Tribunal also had regard to Dr Onyekpe's oral evidence. He explained that a referral to the pain team meant that Patient A's pain had not responded to the usual analgesic regimes. Dr Onyekpe recorded, *'With her pain team she is already on XXX infusions…'*

34. The Tribunal noted that Patient A's multiple diagnoses included painful long-term conditions. XXX.

35. The Tribunal concluded that Patient A's vulnerability by virtue of these multiple medical conditions was enduring and long standing.

36. The Tribunal further noted that after his examination of Patient A, Dr Onyekpe had diagnosed XXX as being the cause for her attendance at the A&E, which is a further long-standing painful condition.

Mental health conditions

37. The Tribunal then considered Patient A's mental health vulnerability and had regard to Dr Onyekpe's note that Patient A had a pre-existing diagnosis XXX. In his statement Dr

Onyekpe stated *'Whilst she informed me that she suffered from XXX, that is not an unusual presentation among patients attending the emergency Department. In relation to her other conditions, they did not raise any concerns with me that she was vulnerable'*.

38. The Tribunal considered that the relative frequency of XXX among A&E patients does not reduce its relevance to a patient's vulnerability. It is another disorder which is recognised to be long-standing, rather than transient, so vulnerability arising from this condition would be expected to be enduring. For Patient A this was part of a complex picture involving long-standing physical and mental conditions.

39. The Tribunal also considered whether Patient A's mental state may have been complicated by her regular medications. Dr Onyekpe described in his in oral evidence that Patient A's routine prescription comprised of six medications recorded by him, of which, he accepted, five medications have central actions (they affect the brain). He also accepted that four of the five medications had significant potential for dependency. In his oral evidence, Dr Onyekpe accepted that he had prescribed, and Patient A had received, diazepam, oramorph and dihydrocodeine and that these medications had the potential to influence her judgement on 5/6 June 2020.

40. The Tribunal concluded that the combination of her regular medication and the opiate administered in the A&E Department were likely to have affected both her mental state and her judgement. Although the precise impact of these medications cannot be determined they are more likely than not to have increased her vulnerability on the 5 June 2020.

41. Whatever the impact of the long-term prescription on Patient A's mental state, the Tribunal concluded that prescriptions for strong analgesics in combination indicated that Patient A's GP had recognised the extent and severity of her painful conditions.

42. With regard to the ambulance note of 5 June 2020 that Patient A was taking XXX, the Tribunal concluded that it might have been prescribed for XXX. However, Dr Onyekpe's evidence was that he had established that Patient A was not taking it at the time and the Tribunal accepted this.

43. In the Tribunal's analysis the combination of Patient A's mental condition, multiple long-standing painful physical disorders and the complications of her medications made her

particularly vulnerable on 5 June 2020 both in relation to the dictionary definition, and in relation to paragraphs 145 and 146 of the SG.

44. The Tribunal reached these conclusions based on the information that was available to Dr Onyekpe on 5 June 2020. The Tribunal considered that Patient A's vulnerability, by reason of her medical history/conditions increased by 10 June 2020 when she presented again at the A&E department of the Hospital. Thereafter, Patient A remained particularly vulnerable at all material times.

45. Accordingly, the Tribunal found paragraph 1(a)(i) of the Allegation determined and found proved.

Paragraph 1(a)(ii)

> ***At all material times:***
> ***Patient A was vulnerable by reason of her personal circumstances***

46. The Tribunal considered the content of the WhatsApp messages. The Tribunal understood that a complete record of the WhatsApp messages between Patient A and Dr Onyekpe is no longer available. It based its findings on the material provided to it.

47. The Tribunal did not accept that Patient A's message *that 'she had not been out for almost 3 years'* meant she was almost house bound, as this was stated in the context of a discussion on dancing and dating. The Tribunal decided not to attribute importance to the first message from Patient A ending with an '*X*', which is commonly used as an expression of a kiss, as this is also used in other contexts including amongst friends. The Tribunal was also not convinced that Patient A's use of the words such as '*baby*', '*honey*' and '*beautiful*' when referring to Dr Onyekpe, or saying that she missed him, showed vulnerability by reason of her personal circumstances.

48. The same was true for the message stating "*The past year I only leave to go hospital and appointments*", as this was set against the background of COVID-19 pandemic restrictions. The Tribunal did not have evidence from Patient A to clarify such messages and there was nothing in the messages to conclude that the reason she had not left home was due to her disabilities.

49. The Tribunal also had regard to Patient A's message stating that she had a XXX. It concluded that it is unaware of the context of any personal assistant.

50. In the circumstances, none of the above demonstrate that Patient A was vulnerable by reason of her personal circumstances.

51. The Tribunal acknowledged that the first breach of boundaries was made by Patient A when she handed Dr Onyekpe her telephone number and said *'in case you want to be friends or anything'.* The Tribunal was of the view that Patient A was an active participant in the exchanges between them.

52. The Tribunal considered whether Patient A may have engaged in the sexualised exchanges primarily or exclusively in order to remain engaged with a medical practitioner who she hoped could alleviate her pain. The Tribunal had regard to two examples of the many WhatsApp messages as follows:

> *'[08/06/2020, 14:27:18] [Patient A]*
>
> *I know, but the XXX is the worst, I been dealing with this pain for so many years, but the XXX get worst , I get them pain every month in the same place in my XXX*
>
> *[23/06/2020, 12:11:41] [Patient A]*
>
> *… Please tell me a name of a pain killer that will take this pain away . I canâ€™t take this like been in bed.'*

53. The Tribunal has analysed Patient A's communications including her comments as reported by Dr Onyekpe when she handed him her telephone number. The Tribunal was of the view that the messages show a level of need, especially, but not solely, in relation to her seeking help with her pain through medications and other interventions. However, the Tribunal also noted that much of the messages had a sexual content from both Dr Onyekpe and Patient A.

54. The Tribunal concluded that at all material times Patient A was not vulnerable by reason of her personal circumstances both in relation to the dictionary definition and in relation to paragraphs 145 and 146 of the SG.

55. The Tribunal therefore concluded, that taken together, the GMC had not discharged its burden of proof, that at all material times, Patient A was vulnerable by reason of her personal circumstances.

56. Accordingly, the Tribunal found paragraph 1(a)(ii) of the Allegation not proved.

Paragraph 1(b)

> ***you knew or ought to have known that Patient A was vulnerable or likely to be vulnerable.***

6 June 2020

57. The Tribunal took into account the information that was available to Dr Onyekpe on 5 June 2020, from his clinical note and that of the ambulance crew. In his evidence Dr Onyekpe was clear that he had reviewed the ambulance record prior to seeing Patient A. The Tribunal accept that Dr Onyekpe's sole concern was to establish the cause of her symptoms and exclude the serious condition mentioned by her GP. There were clear indications of her vulnerability on the information considered by Dr Onyekpe on 5 June 2020 such that he ought to have known that her medical history/conditions made her particularly vulnerable both within the meaning of the dictionary definition and paragraphs 145 and 146 of the SG. The Tribunal finds that on 6 June 2020 Dr Onyekpe ought to have known that Patient A was vulnerable but did not know the degree of her particular vulnerability.

8 June 2020

58. The Tribunal concluded that Dr Onyekpe should have known that Patient A was vulnerable on 5/6 June 2020 by reason of her long-standing medical history/conditions. The Tribunal next considered whether the events that followed would have led to Dr Onyekpe having actual knowledge of the vulnerability.

59. The Tribunal had regard to the messages prior to Patient A and Dr Onyekpe' s encounter on 10 June 2020. The Tribunal accepted that Dr Onyekpe's reply that Patient A was lucky to have a XXX indicated that he did not appreciate that the XXX that Patient A refers to may have been required to assist her with her vulnerability.

60. However, there were other messages where Patient A's vulnerability had been highlighted including the following on 8 June 2020:

[08/06/2020, 14:12:45] [Patient A] :
XXX

[08/06/2020, 14:19:17] [Patient A] :
I really donâ€™t leave the house , when I XXX give me years of stress . And I still fell that I am not safe going out by myself

[08/06/2020, 14:23:05] [Patient A] :
Sad when that pain happens , XXX need to help me up …

[08/06/2020, 14:24:16] [Patient A] :
Never though of it , I will try everything to get out of all this pain, when I have a brake from the global pain, them my XXX stop working

[08/06/2020, 14:24:54] [Patient A] :
I canâ€™t wait to get the injections in my XXX
[08/06/2020, 14:27:18] [Patient A] :

I know , but the XXX is the worst , I been dealing with this pain for so many years , but the XXX get worst , I get them pain every month in the same place in my XXX

61. The Tribunal considered that Dr Onyekpe had been alerted to Patient A's vulnerabilities by the above. They are further evidence that Dr Onyekpe should have known that Patient A was vulnerable. The Tribunal concluded that prior to Patient A's second presentation at the A&E Department on 10 June 2020, Patient A had provided Dr Onyekpe with more evidence of her vulnerability which he ought to have recognised made her particularly vulnerable both within the meaning of the dictionary definition and paragraphs 145 and 146 of the SG.

<u>10 June 2020</u>

62. In the Tribunal's assessment, Patient A's reattendance at the A&E Department on 10 June 2020 of itself increased substantially her vulnerability. It was Dr Onyekpe's evidence that when he and Patient A had consensual sex in the hospital toilet cubicle, he knew nothing of her presentation or what medication she may have been administered. The Tribunal noted that there was no evidence that Dr Onyekpe had taken any steps to clarify her vulnerability. Dr Onyekpe ignored the reason for Patient A returning to A&E, when it was obvious to him

that something was not right in terms of her health and that she was vulnerable. Nonetheless, he engaged in sexualised messages and had consensual sex with Patient A knowing that she was vulnerable.

Subsequent to 10 June 2020

63. The Tribunal read the WhatsApp messages sent between Patient A and Dr Onyekpe after the 10 June 2020 and concluded that there was nothing in them which reduced Patient A's vulnerability, nor detracted from the Tribunal's finding that Dr Onyekpe's knew that she was vulnerable on 10 June 2020. It therefore found that Dr Onyekpe knew that Patient A was particularly vulnerable from 10 June 2020 to 25 July 2020 both in relation to the dictionary definition of vulnerability and in relation to paragraphs 145 and 146 of the SG.

64. The Tribunal therefore concluded that Dr Onyekpe knew or ought to have known that Patient A was vulnerable or likely to be vulnerable.

65. Accordingly, the Tribunal found paragraph 1(b) of the Allegation determined and found proved.

The Tribunal's Overall Determination on the Facts

66. The Tribunal has determined the facts as follows:

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

1. At all material times:
   a. Patient A was vulnerable by reason of her:
      i. medical history/conditions, and/or; **Determined and found proved**
      ii. personal circumstances; **Not proved**
   b. you knew or ought to have known that Patient A was vulnerable or likely to be vulnerable. **Determined and found proved**

2. On 5 June 2020, you consulted with Patient A in your capacity as a doctor in Emergency Medicine and you performed an intimate examination on Patient A. **Admitted and found proved**

3. On 6 June 2020, you engaged in an improper emotional relationship with Patient A, in that on one or more occasion, as set out in Schedule 1, whilst you were still on shift you sent to Patient A`s personal mobile telephone number, from your personal mobile telephone number, WhatsApp messages which were both inappropriate and unprofessional. **Admitted and found proved**

4. On one or more occasion on 8 June 2020, as set out in Schedule 2, you behaved inappropriately and/or unprofessionally towards Patient A, in that you engaged in WhatsApp message communication with Patient A via her private mobile telephone number in which you:
   a. gave her medical advice on the symptoms with which she presented on 5 June 2020; **Admitted and found proved**
   b. diverted the topic of conversation from medical to private matters; **Admitted and found proved**
   c. discussed both your and her private life; **Admitted and found proved**
   d. called her 'pretty'; **Admitted and found proved**
   e. stated to her: 'You can pick and choose. Anyone you want'. **Admitted and found proved**

5. Your conduct as set out at paragraph 4, subparagraphs b-e, was sexually motivated. **Admitted and found proved**

6. Between 9 June 2020 and 25 July 2020, on one or more occasion as set out in Schedules 3 and 4, you behaved inappropriately and/or unprofessionally towards Patient A, in that you: **Admitted and found proved**
   a. gave her medical advice regarding the clinical issues for which you had not treated her since 5 June 2020; **Admitted and found proved**
   b. used an inappropriate method (WhatsApp messaging) to give that medical advice; **Admitted and found proved**
   c. failed to make a proper record in Patient A`s hospital records of the medical advice you gave to her. **Admitted and found proved**

7. Between 9 June 2020 and 25 July 2020, you engaged in a sexual relationship with Patient A as set out in Schedules 3,4 and 5. **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**

Determination on Impairment - 22/02/2024

67. 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 Onyekpe's fitness to practise is impaired by reason of misconduct.

The Evidence

68. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

Submissions

69. On behalf of the GMC, Ms Emsley-Smith submitted that Dr Onyekpe's fitness to practise is currently impaired by reason of his misconduct.

70. Ms Emsley-Smith outlined the staged approach to misconduct and impairment.

71. Ms Emsley-Smith submitted that Dr Onyekpe's misconduct would be considered deplorable by fellow medical practitioners.

72. Ms Emsley-Smith stated that whilst there is no statutory definition of impairment, the Tribunal would be assisted by the guidance provided by Dame Janet Smith in her *Fifth Shipman Report* adopted by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 (Admin)*. Ms Emsley-Smith submitted that the following apply as regards to Dr Onyekpe's past conduct:

> *'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;'*

73. Ms Emsley-Smith submitted that Dr Onyekpe had breached Good medical practice (GMP), in particular paragraphs 1, 21 and 53. She submitted that Dr Onyekpe had: failed to ensure that the care of Patient A remained his primary concern; given medical advice to Patient A by inappropriate means; failed to record the advice given to Patient A and had pursued a sexual relationship with her. Further Ms Emsley-Smith submitted that the evidence pointed to a certain determination on Dr Onyekpe's part to pursue that sexual relationship.

74. Ms Emsley-Smith submitted that this was a case where each aspect of Dr Onyekpe's conduct had been so egregious that a finding of current impairment was required, notwithstanding the passage of time since the index events. Ms Emsley-Smith submitted that the misconduct was prolonged in the sense that the messages spanned from early June to the end of July 2020, and it appeared that they only stopped because there was no response to the final messages from Patient A.

75. Ms Emsley-Smith submitted that this was not a case where there had been a temporary lapse in judgment on the part of Dr Onyekpe. His misconduct continued throughout this period, notwithstanding that Dr Onyekpe knew at the earliest possible stage that he should not be doing what he was doing because of his professional obligations.

76. Ms Emsley-Smith reminded the Tribunal of Dr Onyekpe's oral evidence that even standing on the front doorstep of Patient A's home, he reflected upon the fact that he should not be doing what he was doing. She stated that notwithstanding that temporary moment of reflection, Dr Onyekpe knocked on the door and continued in any event.

77. Ms Emsley-Smith submitted that Dr Onyekpe's misconduct was in the face of vulnerability on the part of Patient A, which he should have recognised. She submitted that Dr Onyekpe had violated a fundamental rule governing the doctor and patient relationship by engaging in a sexual relationship with Patient A.

78. Ms Emsley-Smith submitted that a finding of impairment was required to bring Dr Onyekpe's attention and the attention of the public to the profound unacceptability of his behaviour and the importance of the rules that he had violated. This is for the purpose of declaring the expected professional standards, and to promote public confidence in the profession. Therefore, she submitted that a finding of impairment was required.

79. On behalf of Dr Onyekpe, Mr Counsell submitted that Dr Onyekpe fully appreciated the gravity of his behaviour as he had told the Tribunal in his oral evidence. Mr Counsell stated that it was for the Tribunal to make the decision on misconduct, but Dr Onyekpe had not instructed him to suggest that his conduct would not amount to serious professional misconduct.

80. With regard to impairment, Mr Counsell stated that the Tribunal will hear in due course that Dr Onyekpe had done a lot of work to address his behaviour. He said that in the summer of 2020 onwards, Dr Onyekpe had been lucky enough to have the support of his wife and for a while had managed to obtain further work. Additionally, he submitted that that Dr Onyekpe had excellent testimonials, which the Tribunal will consider at stage 3 of the hearing.

81. Mr Counsell stated that in due course he would be inviting the Tribunal to give this evidence considerable significance. Mr Counsell told the Tribunal that he was not instructed to make any positive submissions on impairment.

The Relevant Legal Principles

82. 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.

83. In approaching its 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 misconduct which finding lead to a finding of impairment.

84. In deciding whether Dr Onyekpe's fitness to practise is impaired, the Tribunal has exercised its own judgement and borne in mind the statutory overarching objective of the GMC set out in Section 1(1B) of the Medical Act 1983 to:

> *'a. Protect, promote and maintain the health, safety and well-being of the public,*
> *b. Promote and maintain public confidence in the medical profession, and*
> *c. Promote and maintain proper professional standards and conduct for members of that profession.'*

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

86. The Legally Qualified Chair (LQC) gave detailed legal advice, accepted by both parties, in relation to misconduct and impairment.

The Tribunal's Determination on Impairment

Misconduct

87. The Tribunal was informed at an earlier stage by Mr Counsell that he had a bundle of relevant materials, which included Dr Onyekpe's appraisals, reflections and references. Mr Counsell told the Tribunal that it was not his intention to call any witnesses for stage 2 and that Dr Onyekpe did not intend to give evidence until stage 3. At the end of the facts stage, the Tribunal questioned Mr Counsell's decision not to provide the remediation bundle at the impairment stage. Mr Counsell said he would reflect upon this.

88. An email was sent into the Tribunal from Dr Onyekpe's solicitors after the decision on the facts was handed down. This set out the intention to not place any further evidence of remediation before the tribunal at stage 2, as it was considered that as per *Yeong v GMC [2009] EWCHC 1923 [Admin]* the Tribunal may make a finding of impairment in cases where a doctor engaged in a sexual relationship with a patient, notwithstanding the extent to which the doctor may have been able to demonstrate remediation. The Tribunal was told that 'good evidence of remediation' would be provided and that this is 'highly relevant' for the Tribunal's consideration at Stage 3.

89. The Tribunal noted the decision made by Dr Onyekpe and his representatives. The Tribunal was not without any evidence on the matters of insight and remediation, as it had Dr Onyekpe's witness statement and his oral evidence, which were provided at the facts stage.

90. The Tribunal first considered whether the facts found proved amounted to a sufficiently serious departure from the standards of conduct reasonably expected of Dr Onyekpe as a registered medical practitioner, so as to amount to misconduct.

91. The Tribunal noted that the misconduct which the Tribunal has found proved related to Dr Onyekpe's care of, and behaviour towards, a single individual, namely Patient A.

92. The Tribunal had regard to the fact that Dr Onyekpe had engaged in an improper emotional relationship with Patient A, behaved inappropriately and/or unprofessionally with Patient A and engaged in a sexual relationship with her. The Tribunal also had regard to the fact that Patient A was vulnerable at all material times by reason of her medical history/conditions and that Dr Onyekpe knew or ought to have known that Patient A was vulnerable or likely to be vulnerable.

93. The Tribunal had regard to GMP, in particular paragraphs 1, 21 and 53, which state:

> *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.*
>
> *21 Clinical records should include:*
>
> *a relevant clinical findings*
>
> *b the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
>
> *c the information given to patients*
>
> *d any drugs prescribed or other investigation or treatment*
>
> *e who is making the record and when.*
>
> *53 You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.*

94. The Tribunal had regard to paragraph 53 of GMP and the guidance referenced within that paragraph, namely *Maintaining a professional boundary between you and your patient (2013)* GMC guidance. The Tribunal noted that Patient A had been discharged at 00:11 and the first WhatsApp message was sent by Dr Onyekpe at 01:06. Having had regard to the

Maintaining a professional boundary between you and your patient (2013) GMC guidance, the Tribunal accepted that when Dr Onyekpe sent the first WhatsApp message to Patient A she was, by then, his former patient.

95. The Tribunal had regard to paragraphs 8 and 13 of the *Maintaining a professional boundary between you and your patient (2013)* GMC guidance which states:

> *Former patients*
>
> *8 Personal relationships with former patients may also be inappropriate depending on factors such as:*
>
> *a. the length of time since the professional relationship ended…*
> *b. …*
> *c. whether the patient was particularly vulnerable at the time of the professional relationship, and whether they are still vulnerable…*
> *d. …*
>
> *13 Whatever your specialty, you must not pursue a personal relationship with a former patient who is still vulnerable…*

96. With respect to the length of time since the professional relationship ended (8a), the Tribunal noted that whilst there had only been a single consultation with Patient A, the WhatsApp message was sent within an hour of Patient A leaving the A&E Department.

97. The Tribunal has concluded that the combination of Patient A’s regular medication and the opiate administered in the A&E Department were likely to have affected both her mental state and her judgement. Although the precise impact of these medications cannot be determined, they are more likely than not to have increased her vulnerability on the 5 June 2020 and Dr Onyekpe should have known this. The Tribunal also noted that the relationship continued on 10 June 2020 and beyond when Dr Onyekpe did know that she was vulnerable.

98. With respect to whether the Patent A was particularly vulnerable at the time of the professional relationship, and whether she was still vulnerable (8c) the Tribunal had concluded that the combination of Patient A’s mental condition, multiple long-standing painful physical disorders and the complications of her medications made her particularly vulnerable on 5 June 2020, both in relation to the dictionary definition, and in relation to paragraphs 145 and 146 of the SG. The Tribunal has also concluded that Patient A’s

vulnerability, by reason of her medical history/conditions had increased as of 10 June 2020 when she presented again at the A&E department of the Hospital.

99. Accordingly the Tribunal considered that Dr Onyekpe's conduct was particularly inappropriate in view of paragraphs 8a, 8c and 13 of the *Maintaining a professional boundary between you and your patient (2013)* GMC as well as paragraph 53 of the GMP.

100. The Tribunal had regard to the duties of a doctor as set out in the preamble to GMP, under the heading 'Maintaining trust' which states, *'Never abuse your patients' trust in you or the public's trust in the profession'* and paragraph 1 of GMP. The Tribunal concluded that Dr Onyekpe's conduct (spanning almost seven weeks) as set out at paragraphs 3 to 7 inclusive of the Allegation in the context of paragraph 1(a)(i) and 1(b) demonstrated a failure to prioritise the care of Patient A whom he had met initially in the context of a professional relationship. He pursued a sexual relationship with a former patient who was vulnerable, which in the Tribunal's judgement, is a serious abuse of his former patient's trust and the public's trust in the profession and he was not acting with integrity. The Tribunal considered that this also amounted to serious misconduct.

101. The Tribunal had regard to paragraph 21 of GMP. The Tribunal was of the view that the medical advice given to Patient A by Dr Onyekpe was generic and in response to Patient A's obvious distress due to her pain. The Tribunal concluded that the failure to record this medical advice was a breach of GMP, however, it did not consider that it amounted to serious misconduct.

102. In summary, the Tribunal was satisfied that there was serious misconduct which engaged the preamble and paragraphs 1 and 53 of GMP, as well as paragraphs 8a and 8c and 13 of the *Maintaining a professional boundary between you and your patient (2013)* GMC guidance.

103. The Tribunal concluded that the facts found proved amounted to a serious falling short of the standard expected of a medical practitioner. The Tribunal was of the view that fellow members of the medical profession would consider Dr Onyekpe's behaviour deplorable and seriously below the standard expected.

104. The Tribunal therefore concluded that Dr Onyekpe's conduct as found proved amounted to serious misconduct.

Impairment

105. Having found that the facts found proved amounted to misconduct, the Tribunal went on to consider whether Dr Onyekpe's fitness to practise is currently impaired by reason of that misconduct.

106. The Tribunal noted that there were no specific submissions made on Dr Onyekpe's behalf at this stage of the hearing but that relevant submissions would be made at the sanction stage. Mr Counsell conceded that the Tribunal was likely to make a finding of impairment. However, the decision on impairment remained a matter for the Tribunal's judgement.

107. The Tribunal noted Dr Onyekpe's witness statement dated 29 January 2024, as follows:

> *'My comments on my behaviour*
>
> *34. My actions represented a serious breach of my professional boundaries. They breached professional standards of conduct and are a source of lasting shame and regret.*
>
> *35. I am deeply sorry for my conduct and how my actions undermined the reputation of the profession. I am passionate about working as a doctor and I am deeply sorry to have let patients and colleagues down through my actions. I have extensively reflected on my actions, how I came to undermine my own professional boundaries, and to reinforce those to ensure that I never compromise those again. In the time which has elapsed since, I have put in writing my reflections on these events and have attended courses on boundaries. I am advised that I should provide the tribunal with all this information at stage 3. What is key for me, going forwards, is continued awareness of my failings that have led to this case and the coping mechanisms that I have identified to prevent such incidents from happening again.'*

108. The Tribunal also noted Dr Onyekpe's oral evidence, that the boundaries course that he had attended did not address the vulnerability of patients. However, he said that he had been able to reflect on his own vulnerabilities and upon what had led to him breaching this boundary.

109. The Tribunal considered whether Dr Onyekpe's misconduct was remediable, has been remedied and whether there was a likelihood of repetition.

110. The Tribunal considered that in terms of the risk of repetition Dr Onyekpe's misconduct was capable of remediation with the appropriate work.

111. The Tribunal did not make adverse findings against Dr Onyekpe because of his denial that she was vulnerable, but this meant that it had no evidence before it about his insight into her vulnerability. The Tribunal concluded that there remains a risk of repetition.

112. The Tribunal found that Dr Onyekpe had placed Patient A at risk of harm, had breached fundamental tenets of the medical profession and brought the profession into disrepute. On the evidence before it, the Tribunal concluded that there remains a risk of repetition.

113. The Tribunal therefore concluded that a finding of impairment is necessary in order to protect, promote and maintain the health, safety and wellbeing of the public; maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

114. The Tribunal determined that Dr Onyekpe's fitness to practise is impaired by reason of his misconduct on each of the three limbs of the overarching objective as in the above paragraph.

Determination on Sanction - 28/02/2024

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

The Evidence

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

117. At stage three of the hearing (sanctions), the Tribunal received further evidence on behalf of Dr Onyekpe including the following within the evidence bundle:

- Reflective statement of Dr Onyekpe;
- Curriculum vitae (CV) of Dr Onyekpe;
- Maintaining Professional Boundaries Course Certificate dated 6-8 October 2020;
- Dr Onyekpe's reflections following completion of the Maintaining Professional Boundaries Course;
- Maintaining Professionalism – The Fourth Day Certificate;
- Values in Practice Course Certificate ;
- Dr Onyekpe's reflection following Values in Practice Course;
- Letter of completion - Medical Ethics Course, Dr B dated 3 March 2023;
- Dr Onyekpe's reflections following completion of the Medical Ethics Course dated 3 March 2023;
- Further reflections on the ethics course completed;
- Dr Onyekpe's appraisal, following the meeting with Dr D on 17 December 2021 and appraisal covering November 2020 to September 2021;
- Dr Onyekpe's appraisal, following the meeting with Dr D on 25 November 2022 and appraisal covering October 2021 to September 2022;
- Example of Chaperone Logs between 24 November 2022 and 7 January 2023;
- Letter from Dr Onyekpe's wife;
- Letters from Pastor E dated 11 November 2021 and 4 January 2023;
- Email from Mr F (sent 8 July 2020 prior to knowledge of index concerns);
- Additional testimonial bundle.

118. Dr Onyekpe provided a further witness statement dated 22 February 2024 and also gave oral evidence.

119. The Tribunal also received a witness statement and oral evidence from Dr D dated 22 February 2024.

Submissions

Submissions by the GMC

120. In the course of her submissions on behalf of the GMC, Ms Emsley-Smith referred the Tribunal to relevant paragraphs in the 'Sanctions Guidance' (SG). In summary, Ms Emsley-Smith submitted that the appropriate and proportionate sanction in this case was one of erasure.

121. Ms Emsley-Smith reminded the Tribunal that the primary purpose of sanction was to protect and promote the health, safety and wellbeing of the public, promote and maintain public confidence in the medical profession and promote and maintain proper professional standards and conduct for members of the profession. Ms Emsley-Smith stated that the purpose of any sanction was not to punish a doctor, however, there would be occasions where a punitive effect was inescapable. Further, that the reputation of the profession as a whole is more important than the interests of any individual doctor. Ms Emsley-Smith submitted that the Tribunal should reflect very carefully on paragraph 17 of the SG when deciding upon the sanction in this case.

122. With regard to the mitigating factors of this case, Ms Emsley-Smith stated that Dr Onyekpe had admitted the majority of the allegations he faced before this Tribunal, and the totality of the allegations he had faced before a previous Tribunal. However, Dr Onyekpe had an ongoing blind spot regarding his own knowledge of Patient A's vulnerability and consequently, the inherently exploitative nature of their relationship.

123. Ms Emsley-Smith reminded the Tribunal of its stage two decision, that Dr Onyekpe's conduct in this case is remediable. However, the broad question, she submitted, was how is the damage to the reputation of the profession remedied?

124. Ms Emsley-Smith reminded the Tribunal of Dr D's evidence, that in his view Dr Onyekpe had learned from his mistake. However, she invited the Tribunal to use caution as she submitted that he had formed this view an hour after meeting with Dr Onyekpe and the allegations were not discussed. However, she acknowledged that Dr D maintained his view when he became aware of the Allegation and stated that he would have still offered Dr Onyekpe employment had he known about Patient A's vulnerability. Ms Emsley-Smith cautioned the Tribunal on the weight to attach to Dr D's evidence because he appeared to be saying that as the MPTS had made a judgement that Dr Onyekpe can continue to practise with conditions, what was good enough for the GMC, was good enough for Dr D.

125. With regard to the aggravating factors of this case, Ms Emsley-Smith submitted that after reading the WhatsApp messages, it was clear that Dr Onyekpe used his position as a

doctor to pursue a sexual and improper emotional relationship with Patient A which is a highly relevant feature.

126. Ms Emsley-Smith reminded the Tribunal of paragraphs 145 and 146 of the SG, that where a patient is particularly vulnerable, there was an even greater duty on a doctor to safeguard a patient. She submitted that using one's professional position to pursue a sexual or improper emotional relationship with a vulnerable patient was an aggravating factor that increases concern and that it was more likely to require more serious action against a doctor. Ms Emsley-Smith submitted that one only need look at the WhatsApp messages to come to the conclusion that Dr Onyekpe used his position as a doctor and this was a primary feature in the development of the interaction between them.

127. Ms Emsley-Smith reminded the Tribunal of paragraph 147 of the SG, which requires the Tribunal to determine whether Dr Onyekpe's conduct amounts to predatory behaviour. She submitted that the facts relevant to this were that on 8 June 2020, it was Dr Onyekpe who diverted the conversation between himself and Patient A to personal matters. Further, on 10 June 2020, despite taking steps to avoid contact with Patient A in the A&E Department, within the hour Dr Onyekpe was messaging Patient A about sex. Then 20 minutes thereafter, he messaged Patient A, telling her in explicit terms that he wanted sexual contact with her before she left the hospital. Ms Emsley-Smith stated that at this point it had been determined as a fact that Dr Onyekpe knew that Patient A was particularly vulnerable. He also knew that she was back in the A&E Department for a second time within a week but made no inquiry as to the reason why she was back as this was not important to him. Further, that his obligations to his fellow doctors on shift with him in the Department, seemingly in that moment, were not important to him. Ms Emsley-Smith stated that Dr Onyekpe also had no regard to his obligation to other patients in the Department.

128. Ms Emsley-Smith stated that on 11 June 2020, Dr Onyekpe visited Patient A at her home and there was no medical reason to do so. She stated that Dr Onyekpe had countless opportunities over the course of the seven-week period to do the right thing.

129. Ms Emsley-Smith submitted that his stage three evidence suggested that Dr Onyekpe was using a vulnerable patient to provide him with some escapism from the stresses and trauma affecting him at the time.

130. With regard to the range of sanctions, Ms Emsley-Smith submitted that this case was too serious to take no action, and this was an unrealistic option. She submitted that the

imposition of conditions would not send the required message to the public and the profession regarding the standards to be expected from medical professionals.

131. With regard to suspension, Ms Emsley-Smith stated that this would be inadequate to address Dr Onyekpe's serious misconduct and his deliberate disregard for the principles as set out in GMP. She submitted that there has been a blatant abuse of trust in this case both in relation to Patient A and the public's trust in the profession. Ms Emsley-Smith submitted that the fact that Patient A was vulnerable increased the gravity of concern.

132. Ms Emsley-Smith submitted that the only way to remedy the damage to the reputation of the profession which has occurred as a consequence of Dr Onyekpe's decisions and conduct, would be to erase his name from the medical register.

Submissions by the Defence

133. On behalf of Dr Onyekpe, Mr Counsell submitted that Dr Onyekpe entirely accepts responsibility for his misconduct. Further, he reminded the Tribunal that it occurred nearly four years ago, and that Dr Onyekpe had accepted responsibility at the earliest opportunity. Mr Counsell submitted that Dr Onyekpe has always acknowledged that his behaviour transgressed professional boundaries and that he had let everybody down, including himself, his family and his colleagues. Mr Counsell referred the Tribunal to the statement Dr Onyekpe made to the Trust in 2020. Mr Counsell stated that Dr Onyekpe had never tried to deflect the blame onto Patient A.

134. Mr Counsell stated that it had been suggested for the first-time, during GMC sanction submissions, that Dr Onyekpe's behaviour could be considered as predatory. Mr Counsell submitted that this was not a case of a doctor preying on a patient, notwithstanding that the Tribunal has found that he should have realised and did realise that Patient A was vulnerable. Mr Counsell said that this suggestion had never been put to Dr Onyekpe (although this was disputed by Ms Emsley-Smith), nor did it form part of the Allegation. Mr Counsell stated that from the outset, it had been Patient A that had initiated the conversations and that when Dr Onyekpe visited her at her home, he did so at her express invitation.

135. Mr Counsell referred the Tribunal to the WhatsApp messages with Patient A. He stated that the conduct was wrong because of the doctor/patient relationship but that there was complete acceptance of responsibility. Mr Counsell questioned why a doctor of this quality would allow himself to behave in this way. He stated that Dr Onyekpe was a family

man with a supportive wife and referred to the various testimonials that spoke of Dr Onyekpe as a man with integrity. Mr Counsell referred XXX and mentoring sessions that have been completed and to the events that Dr Onyekpe has experienced. He stated that, perhaps in the reflections, there is acceptance of his lack of emotional intelligence to process what had happened to him. Mr Counsell stated that, whatever else the Tribunal may think, the reflections were very honest and highly self-critical.

136. Mr Counsell stated that the GMC accepted that the relationship was entirely consensual. He referred to the rape allegation and Dr Onyekpe's arrest in the presence of his wife XXX, as well as the investigation by the GMC and the Trust. Mr Counsell stated that Dr Onyekpe entirely cooperated with those processes. He stated that Dr Onyekpe wrote a letter of apology to the Trust and had the courage to write a letter to his previous colleagues to apologise and try to explain. Mr Counsell submitted that not many doctors would do this and try to explain themselves. He also referred to the boundaries courses completed by Dr Onyekpe. Mr Counsell drew the Tribunal's attention to Dr Onyekpe's sessions with a pastor and referred to the pastor's comments that Dr Onyekpe is a man of impeccable standing who made a mistake, reappraised himself, and is now more self-aware and emotionally intelligent. Further, that Dr Onyekpe has developed the tools of self-regulation.

137. He also referred the Tribunal to the letter from Dr Onyekpe's wife and submitted that this showed evidence of Dr Onyekpe's improvements as she stated that her husband had moved away from his macho image and now addresses his own vulnerabilities.

138. Mr Counsell stated that the Responsible Officer's report showed that Dr Onyekpe had scrupulously complied with the interim conditions, received good appraisals, and excellent feedback from patients and colleagues. Mr Counsell drew the Tribunal's attention to relevant sections of the positive testimonials provided on behalf of Dr Onyekpe.

139. Mr Counsell referred to Dr Onyekpe's written reflections and submitted that Dr Onyekpe was now able to step away and recognise when he was stressed or tired and had developed tools to deal with this. He would now ask for help.

140. In relation to the appropriate sanction, Mr Counsell submitted that it was clearly in the public interest that behaviour of this kind should not be tolerated, and this was why Dr Onyekpe did not seek to contest impairment. Mr Counsell submitted that, in this case, an excellent doctor should be kept within the profession and that the years of further

employment without any other issues had shown that Dr Onyekpe was a doctor of great value to the profession. Mr Counsell again referred to the various positive testimonials.

141. Mr Counsell referred to paragraph 109 of the SG, in relation to erasure, and submitted that this included the word 'may' when considering the factors that indicate erasure is appropriate. He stated that the Tribunal had discretion even in those listed circumstances. Mr Counsell submitted that, particularly given the level of insight demonstrated, the Tribunal could legitimately say that this case does not reach the level of seriousness such that erasure was necessary. He submitted that the appropriate sanction in this case was one of suspension. Mr Counsell referred to the relevant paragraphs of the SG in respect of suspension. He reminded the Tribunal of its finding that the misconduct was capable of being remedied. He submitted that the misconduct was not likely to be repeated, there was no evidence of repetition of similar behaviour, and no evidence that demonstrated that remediation was unlikely to be successful.

142. Mr Counsell submitted that the Tribunal can be satisfied that Dr Onyekpe did have insight and did not pose a significant risk of repeating the behaviour. Further, he stated that, the Tribunal was entitled to take into account the fact that Dr Onyekpe had gone through this process, had already completed a suspension period of six months and had lost his employment. Mr Counsell stated that, as a matter of common fairness, account should be taken of the punitive and deterrent effect of already having been deprived of the ability to practise for a period under suspension. He also stated that it may also be appropriate to take into account periods of suspension insofar as the sanction is intended to mark the gravity of the offence and send out a message. Mr Counsell clarified that he was not suggesting that the Tribunal should not impose a period of suspension, but that these factors should be taken into account and that they tip the balance away from erasure in what is an exceptional case. He suggested that the 'message' would be sent out without the need for erasure in this truly exceptional case given the lengthy period of suspension already served and the fact that Dr Onyekpe has lost his job. Mr Counsell referred to the relevant paragraphs of the SG regarding the length of suspension.

The Tribunal's Determination on Sanction

143. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal alone, exercising its own judgement. In reaching its decision, the Tribunal has taken GMP and the SG into account and has, at all times, borne in mind the overarching objective.

144. The Tribunal reminded itself that the main reason for imposing any sanction is to protect the public and that sanctions are not imposed to punish doctors, even though they may have a punitive effect. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Onyekpe's interests with the public interest.

Context

145. The Tribunal reminded itself of the course of events of the Allegation involving Dr Onyekpe. Whilst it was common ground between parties that Dr Onyekpe's relationship with Patient A was consensual, Dr Onyekpe had been arrested for rape. The police did not take this matter further and Dr Onyekpe was released without charge.

146. Dr Onyekpe had lost his ST4 training post, which was scheduled to begin in August 2020, which meant that his training for a consultant post was interrupted.

147. The Tribunal was informed by the parties that Dr Onyekpe had an MPTS Fitness to Practise ('FTP') hearing in January 2023 and was given a sanction of suspension for 6 months. At the time Dr Onyekpe had established himself at Medway NHS Foundation Trust as a speciality doctor for two years with a view to pursuing a CESR route to a consultant post. He resigned from his post due to his suspension. Having completed his sanction of a 6-month suspension, Dr Onyekpe was told that he would have a further MPTS FTP hearing because the Professional Standards Authority (PSA) had successfully appealed the MPTS decision. This was on the grounds that the GMC had failed to take into account the vulnerability of Patient A within the Allegation.

148. While waiting for the outcome of the PSA appeal to the High Court, Dr Onyekpe was subject to conditions on his medical licence imposed by the MPTS interim orders Tribunal (IOT). The IOT conditions remained on Dr Onyekpe' s registration, but despite this, colleagues at Medway Maritime Hospital were keen for him to return. Unfortunately, his name had been removed from the medical register so this was not possible. He has been unable to find work since. Ms Emsley-Smith informed the Tribunal that Dr Onyekpe's name had been removed (temporarily) due, it seems, to an error by the MPTS.

149. The Tribunal acknowledges that the above events have had both a professional and personal impact upon Dr Onyekpe.

150. The Tribunal noted that at his first MPTS FTP hearing, Dr Onyekpe made full admissions to the Allegation in its entirety and took full responsibility for his actions. Dr Onyekpe had cooperated fully with the NHS investigation and with his regulator, the GMC.

151. During this MPTS FTP hearing, Dr Onyekpe has maintained his admissions to the Allegation from the outset. However, he did not accept the additional paragraphs dealing with Patient A's vulnerability at the time of the index events. Notwithstanding his acceptance of Patient A's vulnerability during his oral evidence, this matter remained to be determined at the fact stage.

152. The Tribunal determined that Patient A was vulnerable at all material times. In his oral evidence at stage three of this hearing Dr Onyekpe stated that at the time of the index events his judgement had been clouded. However, he now accepts that Patient A had been vulnerable at all material times, a concession that he attributed to the remediation work he had completed, which included the reading/study of matters surrounding vulnerability and reflections about himself. Dr Onyekpe accepted that he had taken advantage of Patient A's vulnerability but maintained that he did not do so knowingly.

153. The Tribunal had earlier found that Dr Onyekpe's misconduct was capable of remediation with the appropriate work. At stage two of the hearing, the Tribunal did not have the benefit of the evidence it now has before it.

154. The Tribunal considered that the evidence bundle that Dr Onyekpe adduced at stage three of the hearing was extensive and included reflections on boundaries courses that he had completed. It included details and reflections about a further one day course that Dr Onyekpe had attended on medical ethics.

155. The Tribunal considered the contents of the bundle, addressing extra pieces of work done by Dr Onyekpe. The Tribunal acknowledged that Dr Onyekpe had reflected thoughtfully about the benefits of this remediation work in terms of his own breaches and also his ethical obligations.

156. The Tribunal was of the view that Dr Onyekpe's remedial work was profound. He had engaged wholeheartedly in every aspect of it. There were numerous examples to assist the Tribunal in concluding this view and they included the following:

'No matter where regulators go they cannot see what individuals internalise and they can never fully understand what it means for a individual like myself to loathe looking in the mirror where in the isolation and quiet of self reflection you have to deal with the person you have become (even if by past actions) and marry that with who you thought you were and the distance in between those two concepts…Hence, I was happy to note he accepted that although I had failed in my conduct there was no impression of a deficit in moral perception or reasoning. Having failed to act morally I was keen to accept this and seek ways to redress not only the concerns of a wider community scrutinising my actions but looking (internally) for deeper reasons that allowed for a detour when moral action was demanded of me.'

'What was stark was the clarity in black and white that again showed [my] *moral deficiency at the time. What was clear was my continued attempts to address them and own these mistakes. What was hopeful was the overarching sense of a consciousness that prevailed within me exuding a catalytic posture to continue self improvement and maintaining self awareness with a focus on emotional intelligence. So often, well-being is used as a gimmick but it is clear that without it (it also exist in guidance and statutory rules) I will be far less a competent physician and dare I say a wholesome person.'*

157. This was an unusually comprehensive set of remediation documents. The Tribunal was satisfied by Dr Onyekpe's own examination of the reasons for breaching the professional boundary. The material demonstrated a consistently reflective and detailed examination of himself as Dr Onyekpe described his thoughts on the effects of his actions on his work, both in terms of breaching boundaries as well as his ethical obligations. The extent and depth of his remediation assisted the Tribunal in concluding that the risk of repetition was now very low. In his oral evidence, Dr Onyekpe stated that his approach was to go further than the formal coursework. He undertook the ethical course with Dr B on a one-to-one basis. XXX. He therefore sought the assistance of Pastor E, with whom he continues to have ongoing XXX.

158. The Tribunal considered the risk of repetition was significantly reduced given the detailed remediation and the level of insight achieved by Dr Onyekpe. The Tribunal found that Dr Onyekpe had engaged in fearless and profound reflections. The Tribunal accepted his evaluations of the changes he has made as being genuine. Dr Onyekpe continues to undertake remedial work.

159. The Tribunal considered carefully Dr Onyekpe's more recent acceptance of Patient A's vulnerability and his having taken advantage of it albeit whilst maintaining that he did not do so knowingly. The Tribunal acknowledged that Dr Onyekpe's resilience was likely to have been affected by working solely night shifts during the Covid-19 pandemic. Dr Onyekpe provided a detailed insight including on his *'post-colonial'* upbringing, working 60 hours per week, permanent night shifts and working in the first year of the Covid-19 pandemic. He described XXX and his sense of being isolated and undervalued. The Tribunal also had regard to Dr Onyekpe's particular family circumstances at the time.

160. The Tribunal accept the above evidence and the pressure Dr Onyekpe was under. XXX. The Tribunal noted Dr Onyekpe was isolated, working long hours, on permanent night shifts, in the first stage of the Covid-19 pandemic lockdown and accepted that these circumstances affected his judgment. The Tribunal noted Dr Onyekpe's evidence about how he felt appreciated when Patient A was grateful and thanked him. It noted that Dr Onyekpe focussed on his similarities with Patient A, instead of recognising her particular vulnerabilities. The Tribunal had found that he ought to have recognised these and from 10 June 2020, that he was indeed aware of them.

161. The Tribunal was assisted by the evidence of Dr Onyekpe's developed insight and emotional intelligence. In relation to Patient A's vulnerability, Dr Onyekpe had conceded, that with what he now knows, Patient A was vulnerable. This was prior to the findings by this Tribunal. Notwithstanding the finding by the Tribunal, having now had the benefit of documentary and oral evidence, the Tribunal considered that this behaviour was a departure from his usual behaviours. Dr Onyekpe had talked about his core values and why he had crossed the boundary at the time. Taking into account the context at the time, as well as the remediation and reflections since, the Tribunal considers that the risk of repetition is low.

<u>Predatory behaviour</u>

162. The Tribunal considered the GMC's submission that Dr Onyekpe's conduct had been predatory. In doing so it had regard to paragraph 147 of the SG.

163. The Tribunal noted that following a totally appropriate and well-documented clinical examination by Dr Onyekpe, Patient A had initiated the first breach of boundaries. The Tribunal concluded that there was no evidence of premeditation by Dr Onyekpe. The Tribunal was also satisfied that Dr Onyekpe's behaviour was not predatory but was in response to

Patient A taking the first step, which had not been prompted by Dr Onyekpe. The Tribunal did not conclude that his behaviour was predatory.

Abuse of position

164. The Tribunal concluded that Dr Onyekpe's conduct (spanning almost seven weeks) demonstrated a failure to prioritise the care of Patient A, whom he had met initially in the context of a professional relationship. He pursued a sexual relationship with a former patient who was vulnerable, which in the Tribunal's judgement, was a serious abuse of his former patient's trust. It was also a breach of his employer's trust and of the public's trust in the profession.

Vulnerability

165. The Tribunal has found that Patient A was vulnerable at all material times. The Tribunal noted that the events took place after Dr Onyekpe ceased to be Patient A's treating clinician, albeit the time gap was very short. On 10 June 2020, Patient A was no longer his patient, but she was a patient at the A&E Department where Dr Onyekpe was on shift at the time. The Tribunal also considered that after 10 June 2020, as Dr Onyekpe and Patient A's relationship continued, there was nothing to negate her vulnerability, and Dr Onyekpe's knowledge of her vulnerability continued thereafter.

166. The Tribunal had no evidence as to the impact of Dr Onyekpe actions on Patient A. However, it was now common ground between the parties that she was vulnerable and that Patient A may have felt that Dr Onyekpe had taken advantage of her.

167. Before considering what action, if any, to take in respect of Dr Onyekpe's registration, the Tribunal considered the aggravating and mitigating factors in this case.

Aggravating Factors

168. The Tribunal considered the following to be aggravating factors:

- Dr Onyekpe's inappropriate behaviour occurred over a seven-week period;
- Dr Onyekpe's abuse of his professional position;
- Patient A was vulnerable at all material times;

- Dr Onyekpe ought to have been aware of Patient A's vulnerability from the outset and from 10 June 2020 onwards he did know that she was vulnerable;
- On the 10 June 2020, Dr Onyekpe engaged in text messages with Patient A for a period of three hours and had sexual intercourse in the hospital toilet cubicle whilst he was on duty in the A&E department.

Mitigating Factors

169. The Tribunal considered the following to be mitigating factors in this case:

- There have been no previous adverse findings against Dr Onyekpe as a medical practitioner;
- Dr Onyekpe is otherwise a person of good character;
- Dr Onyekpe has been completely candid with the investigations conducted by the NHS, the police, the GMC and also with his subsequent employer;
- Dr Onyekpe has expressed genuine remorse and apologised for his behaviour;
- Dr Onyekpe was under some stress at the time working 60 hours weeks, exclusively at night, during the Covid-19 pandemic;
- Almost four years had passed since the event in question with no evidence of any repetition;
- Dr Onyekpe has taken extensive steps to reflect on his misconduct, to remediate and develop insight. Therefore any repetition of his misconduct is highly unlikely.

Testimonials

170. The Tribunal noted that the testimonials provided on Dr Onyekpe's behalf had been written with full knowledge of the Allegation, including Patient A's vulnerability. There were earlier testimonials provided before the last MPTS FTP hearing, but it was noted that the testimonials had been updated to reflect awareness of the vulnerability allegation.

171. The Tribunal noted that a number of the authors had experience of Dr Onyekpe's work extending back several years. The testimonials all comment positively on Dr Onyekpe's relationships with patients. Further, they provide evidence which the Tribunal accepts that Dr Onyekpe had been fastidious in complying with the conditions imposed on his registration in relation to chaperones and the recording of his use of them.

172. Dr D also gave oral evidence at the hearing to support his testimonial and expand upon his witness statement. He retained his positive assessment of Dr Onyekpe's character and professionalism. Dr D understood the seriousness of the finding. He expressed how much staff have missed Dr Onyekpe and stressed that he had saved many lives. Dr D stated that doctors like Dr Onyekpe are in short supply, the NHS requires doctors like him and that he felt sad for the patients who missed out in not having Dr Onyekpe look after them. His evidence was highly complimentary about Dr Onyekpe's capabilities, and he stated that such doctors are '*hard to train and hard to come by*'.

173. It was noted that Dr D would be well placed to assess given he has line managed Dr Onyekpe, had conducted two appraisals with him, had interacted with him in the work environment on a regular basis and had a detailed knowledge of his practice. The Tribunal considered Dr D to have provided a valuable insight and assessment. It attached significant weight to this.

174. The Tribunal found that that Dr Onyekpe was a highly skilled, professional and well-regarded clinician. This was a consistent message from all those that had provided testimonials. The testimonial evidence also comment positively on the professionalism with which Dr Onyekpe conducts himself with patients.

175. The Tribunal has taken the above factors into account in considering the appropriate sanction under the SG. It considered each sanction in ascending order of severity, starting with the least restrictive.

No action

176. The Tribunal first considered whether to conclude the case by taking no action. Taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances. The Tribunal determined that there are no exceptional circumstances in this case and that it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

177. The Tribunal next considered whether to impose conditions on Dr Onyekpe's registration. It bore in mind that any conditions imposed would need to be appropriate, proportionate, workable, and measurable. In light of its findings, the Tribunal determined

that it would not be possible to formulate a set of appropriate or workable conditions which could adequately address Dr Onyekpe's misconduct. In any event, the Tribunal concluded that a period of conditional registration would not be a sufficient, appropriate, or proportionate sanction to satisfy the public interest.

Suspension

178. The Tribunal next considered whether it would be appropriate and proportionate to suspend Dr Onyekpe's registration.

179. The Tribunal considered the SG in relation to suspension including paragraphs 91 and 92, which state:

> *'91. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> *92. Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e. for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).'*

180. The Tribunal also had regard to paragraphs 97 of the SG which sets out some of the circumstances in which suspension may be the appropriate sanction. The Tribunal considered 97(a), (e), (f) and (g) to be engaged in this case:

> *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 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, e.g. because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f No evidence of repetition of similar behaviour since incident.

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

181. The Tribunal was in no doubt that Dr Onyekpe's misconduct was sufficiently serious that a message must be sent to the medical profession and the public that this behaviour is unacceptable and was required in order to uphold professional standards and public confidence.

182. Having had regard to the specific circumstances of this case, and having carefully balanced the aggravating and mitigating factors as set out above, the Tribunal was satisfied that Dr Onyekpe's misconduct was not fundamentally incompatible with continued registration and that erasing his name from the medical register would be disproportionate, punitive, and otherwise not in the public interest.

183. The Tribunal was satisfied that Dr Onyekpe has been completely candid with the investigations conducted by the NHS, the police, the GMC and also with his subsequent employer. Further, the Tribunal was satisfied that Dr Onyekpe's apologies and expressions of remorse are wholly genuine. This reflected not just his regret for having acted as he did, but also his determination not to let the profession down again.

184. In addition, the Tribunal noted that Dr Onyekpe has used the time since the index events to develop a high degree of insight which was evident in the oral and written evidence he gave to the Tribunal. There has been no repetition of Dr Onyekpe's misconduct, and the Tribunal was satisfied that Dr Onyekpe's full insight means repetition is highly unlikely. The Tribunal also had regard to the numerous testimonials provided from colleagues in support of Dr Onyekpe; these attested to his exceptional clinical skills, good standing amongst his colleagues and the keenness with which they seek his return.

185. The Tribunal therefore determined that a period of suspension would be an appropriate and proportionate sanction in this case. The Tribunal took into account the impact that this sanction may have upon Dr Onyekpe, his patients, and others who may rely upon his contribution to medicine. However, in all the circumstances the Tribunal concluded that Dr Onyekpe's interests are outweighed by the need to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of the profession.

186. The Tribunal determined that Dr Onyekpe's registration should be suspended for a period of 12 months.

187. The Tribunal was satisfied that a suspension of Dr Onyekpe's registration for this period will send a clear message to Dr Onyekpe, the profession, and the wider public that such behaviour was unbefitting of a registered medical practitioner and will be taken seriously.

188. The Tribunal was mindful that it was dealing with not only the finding in relation to paragraph 1 of the Allegation, but also the remaining paragraphs, which had been admitted in full at the outset. The Tribunal noted that these admissions had also been made by Dr Onyekpe at the January 2023 hearing, for which the previous MPTS had imposed a sanction of a 6-month suspension. It was noted that this suspension had been completed.

189. The Tribunal noted the guidance in *Mohammed Adil v GMC [2023] EWCA Civ 1261*, it was stated that '*it is a matter of common fairness that account should be taken of the punitive and deterrent effect of having already been deprived of the ability to practice for a period under temporary suspension orders… in fairness to the practitioner, he should be allowed to return to practice immediately, or within a lesser period, by reason of his already having been deprived of the ability to do so in the period prior to the imposition of the sanction*'.

190. In keeping with the guidance, the Tribunal took into account the 6-month suspension already served for the admission of the other parts of the Allegation, with the exception of paragraph 1 that had only been included for this current hearing. The Tribunal considered it would be fair for Dr Onyekpe to have the benefit of a reduction to reflect the suspension already served. Accordingly, the 12-month total suspension is reduced to 6 months, which reflects full credit for the 6-month period of suspension that has already been completed.

191. The Tribunal did consider whether erasure was appropriate. Whilst the misconduct was serious, the evidence of the remediation and insight meant that the risk of repetition was low. The Tribunal considered that the overarching objective was met with a sanction of suspension.

192. It was clear to the Tribunal that, since the index events, Dr Onyekpe has reflected at length into his misconduct, has taken steps to remediate it, and has demonstrated full insight into both its seriousness and its consequences.

193. The Tribunal therefore determined that in the circumstances of this case a review hearing is not necessary. The requirements to promote and maintain public confidence in the medical profession and to promote and maintain proper professional standards and conduct for members of the profession are met by the further suspension of Dr Onyekpe's registration.

194. In summary, Dr Onyekpe will be subject to a further 6-month suspension.

Determination on Immediate Order - 29/02/2024

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

Submissions

196. On behalf of the GMC, Ms Emsley-Smith submitted that an immediate order in this case was a necessity. She referred the Tribunal to the relevant paragraphs of the SG (172 and 173) dealing with immediate orders.

197. Ms Emsley-Smith submitted that immediate action must be taken to protect public confidence in the profession. She stated that Mr Counsell had referred the Tribunal to the case of *Ashton v GMC [2013] EWHC 943 (Admin)*. She submitted that there was nothing contained within that case which should cause the Tribunal any concern in terms of the necessity for an immediate order based on a public confidence in the medical profession. In any event that case was factually different.

198. On behalf of Dr Onyekpe, Mr Counsell stated that the effect of making an immediate order was to increase the length of the sanction by 28 days. It follows, therefore, that the default position is that there should not be an immediate order unless one is necessary to protect members of the public, was otherwise in the public interest or in the best interests of the doctor.

199. Mr Counsell referred the Tribunal to the case of *Ashton*, in particular paragraphs 77 to 81.

200. Mr Counsell stated that Dr Onyekpe's case was not one involving inadequate clinical care which may lead the Tribunal to conclude that there was a continuing risk to patient safety, it was quite the opposite.

201. Mr Counsell reminded the Tribunal of its decision in its sanction determination, that in the light of the extent of Dr Onyekpe's insight and the remediation he has done, the risk of repetition was very low and highly unlikely.

202. Mr Counsell stated this was a case where the need for an appropriate sanction was squarely to maintain public confidence and send out the message that this kind of deplorable behaviour cannot in any circumstances be tolerated. He stated that the Tribunal has already done this with respect to its decision and has carefully considered that a 12 month, reduced to six-month suspension was the appropriate sanction. He stated that imposing an immediate order would increase this to 13 months, reduced to 7 months.

203. Mr Counsell reiterated that there was no risk to patient safety. He stated that the Tribunal has seen from the evidence that it has heard and accepted that Dr Onyekpe is an excellent clinician who was hard working.

204. Mr Counsell reminded the Tribunal of Dr D's evidence to which the Tribunal attached considerable weight about the work that Dr Onyekpe was carrying out.

205. Mr Counsell submitted that it would be completely wrong for the Tribunal to consider that an immediate order was a necessity in this case as there are no grounds for one.

The Tribunal's Determination

206. In reaching its decision, the Tribunal has exercised its own judgement and has taken account of the principle of proportionality. The Tribunal has borne in mind that it may impose

an immediate order where it is satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest or is in the best interests of the practitioner. It has also considered the guidance given in paragraphs 172, 173, and 178 of the SG relating to immediate orders:

> 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.*

207. The Tribunal had regard to its previous determinations and the submissions made by Ms Emsley-Smith and Mr Counsell.

208. The Tribunal determined that it is not necessary to impose an immediate order to '*protect members of the public*', '*in the public interest*', or '*in the best interests of the doctor*'. It was not of the view that immediate action needed to be taken to protect public confidence in the medical profession, particularly given that there was a very low risk of repetition. The Tribunal was conscious of the seriousness of the misconduct but determined that this was adequately addressed by the substantive suspension.

209. In all the circumstances, the Tribunal determined not to impose an immediate order of suspension on Dr Onyekpe's registration.

210. This means that Dr Onyekpe's registration will be suspended from the Medical Register 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 Onyekpe does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

211. For the same reasons, the Tribunal also determined to revoke the interim order of conditions with immediate effect.

212. Case concluded.

ANNEX A – 12/02/2024
Application to exclude evidence

213. At the start of this hearing, the Tribunal was asked to determine a preliminary issue (in accordance with rule 17(2)(a) of the Fitness to Practise Rules 2004) as to the admissibility of some of the evidence which the GMC wished to put before it.

214. The contested evidence consisted of Patient A's hospital records of the 10 June 2020 and her GP records which were not available to Dr Onyekpe at the relevant times.

215. On behalf of Dr Onyekpe, Mr Counsell reminded the Tribunal of paragraph 1 of the Allegation, where it is alleged by the GMC that Patient A was 'vulnerable' by reason of her medical history/condition(s) and/or her personal circumstances and that Dr Onyekpe knew that she was vulnerable or ought to have known.

216. Mr Counsell stated that it is Dr Onyekpe's case that there was nothing in the information with which he was provided, either during the course of his examination of Patient A or his subsequent dealings with her, which alerted him to any vulnerability. Mr Counsell stated that knowledge of any vulnerability was important because if a doctor knew or ought to have known that a patient was vulnerable, that was likely to amount to an aggravating feature.

217. Mr Counsell stated that the GMC would like to put before the Tribunal all of Patient A's medical records, including hospital records and the whole of her extensive GP records for an 8-year period from January 2012 to June 2020.

218. Mr Counsell submitted that the Tribunal should exclude this evidence as being neither admissible nor relevant to the issues between the parties. Furthermore, to provide the whole of a patient's confidential and sensitive medical records to a court or tribunal in the absence of a good reason is in breach of that person's human rights.

219. Mr Counsell stated that the GMC had taken the decision not to call Patient A, and that if all the extraneous medical records are admitted, the GMC would presumably be inviting the Tribunal to draw inferences from their contents. Mr Counsell submitted that this was an exercise likely to lead to unfairness, in circumstances where the doctor is not able to explore with the patient the entries relied upon and in the absence of expert evidence to guide the

Tribunal on the issue of what inferences would be safe to draw. Even if the records were relevant and admissible, they should be excluded on that ground alone.

220. Mr Counsell reminded the Tribunal of Rule 34 (1) of the Rules, which provides:

> *'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.'*

221. He also referred the Tribunal to Article 8, of the European Convention on Human Rights ("ECHR"), headed '*Right to respect for private and family life*' which provides:

> *'Everyone has the right to respect for his private and family life, his home and his correspondence.*
>
> *There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.'*

222. Mr Counsell submitted that the Tribunal should conclude that the medical records, to which this doctor had no access at the time, should not form part of the evidence before it for three reasons.

223. Firstly, that the evidence was not relevant to the issue the Tribunal had to decide, namely, whether or not this doctor's misconduct was aggravated by what he knew or should have known about Patient A's vulnerability. Mr Counsell said that it was self-evident that Dr Onyekpe could not have assessed vulnerability from documents which he never saw. Nor could the GMC legitimately rely upon a submission that the extraneous records are relevant because they go to paragraph 1 (a) of the allegations because the GMC has already indicated that it does not rely on medical evidence to prove vulnerability. Furthermore, if there was a case on vulnerability, it arises out of 'personal communications' between the doctor and patient, rather than the patient's medical history or any medical condition from which she may have suffered.

224. Mr Counsell stated that during the course of the preparation of this case, the GMC had indicated that it proposed to obtain expert evidence on this issue and instructed an expert by the name of Mr Sen, a Consultant in Emergency Medicine. However, on 13 December 2023, the GMC indicated that it did not propose to rely upon expert evidence. At a pre-hearing meeting on 11 January 2024, the GMC was asked why it was that it was not proposing to serve expert evidence, having earlier indicated that it would. The GMC representative replied that there had been a case conference with the expert. As a result, the Case Manager directed that the GMC should disclose discussions which had taken place between its expert and the GMC.

225. Mr Counsell stated that on 17 January 2024, the GMC sent an e-mail to those instructed by Dr Onyekpe as follows:

> *'I refer to the PHM which took place on 11 January 2024.*
>
> *I had expected to receive the PHM minutes from MPTS by now but I have not.*
> *During the PHM the Case Manager made a direction for the provision of clarification regarding expert evidence.*
>
> *In the absence of the minutes of the PHM, the GMC hereby provides the following clarification:*
> *During the conference [Dr G] was asked what documentation/medical records Dr O would have had available during the initial consultation with Patient A.*
>
> *Answer - the triage and ambulance notes. The fact of previous A&E visits.*
>
> *[Dr G] was asked what the medication was for (as listed in the notes).*
>
> *He provided an explanation.*
>
> *[Dr G] was asked how a Dr would assess whether a patient had a particular vulnerability during an A&E consultation.*
>
> *Answer - the issue of a patient's vulnerability comes forward as you start your conversations with the patient. If you are having normal discourse, it doesn't come up any further.*

[Dr G] was asked whether Patient A's pattern of annual attendance at A&E would be considered in any way peculiar/unusual.

Answer - no.

[Dr G] was not informed regarding the nature of the allegations Dr O was facing.

The GMC do not consider that these matters progress the GMC case; [Dr G] was not invited to reduce into writing what he had said.

Similarly, the GMC did not feel that [Dr G's] answers undermined the GMC case. While the history of anxiety (as noted on the records) is a feature the GMC will point to, the case on vulnerability arises out of the nature of Patient A's personal communication with Dr O.'

226. Mr Counsell stated that the email was significant because it confirmed that Dr Onyekpe would only have had available to him the 'triage and ambulance notes' and so would not have had the documents sought now to be introduced. In addition, the GMC was making it clear that its case on vulnerability arose out of '*the nature of Patient A's personal communications with Dr Onyekpe*.' The GMC was not, therefore proposing to rely upon other, mostly historic, medical records to prove vulnerability but to rely upon '*personal communications*', namely, the conversations and exchanges which took place between doctor and patient and the WhatsApp messages. Such communications, insofar as they are recorded, would be in the medical records and the WhatsApp messages which are in the bundle and to which objection is not taken.

227. Secondly, Mr Counsell submitted that to carry out a trawl through numerous GP records and other hospital records, none of which was available to this doctor, and then to invite this Tribunal to infer vulnerability was not a legitimate method of seeking to prove vulnerability, in circumstances where there was no expert evidence to provide the Tribunal with guidance on what inferences can safely be drawn, if any. Without such evidence the exercise would be an entirely speculative one and fraught with danger. By way of a hypothetical example, if the records showed that the patient had suffered a particular condition, in the absence of expert evidence, how was the Tribunal to assess whether such a condition might affect such matters as her independence, her mobility or her ability to carry out day-to-day activities and the extent to which it might have made her vulnerable at the time she was seen by Dr Onyekpe?

228. Mr Counsell submitted that not only was there no expert evidence but there was no factual witness to be asked about the entries to which the Tribunal may be taken. Given that the GMC was not going to call Patient A, nobody can ask her. Mr Counsell submitted that it was obviously unfair to seek to draw inferences from records, going back years, when the defence will have no opportunity to explore with Patient A the entries relied upon. Furthermore, Dr Onyekpe cannot deal with this because he was not aware of the records at the material times.

229. Mr Counsell submitted that in the absence of a witness to deal with this evidence, this becomes no more than an academic exercise which does not take the case further. It risks the Tribunal drawing inferences which it would not have drawn had it not been provided with such evidence.

230. Thirdly, Mr Counsell submitted that the GMC wished to put before this Tribunal a large quantity of sensitive material of a highly personal and intimate nature. A patient has a legitimate expectation of, and there is a strong public interest in, such information remaining private and confidential. Mr Counsell stated that before the Tribunal was provided with such sensitive material, it needed to be satisfied that there was a legitimate purpose for disclosing it. The wording of Article 8, ECHR, requires a balancing exercise to be carried out so that privacy rights are only infringed if it be shown to be necessary to do so. Mr Counsell submitted that there was no good reason here because the evidence does not go to any issue which might be said to aggravate this doctor's misconduct.

231. Mr Counsell submitted that the Tribunal should proceed to hear the case at Stage 1 on the basis of the evidence in the current hearing bundle and the GMC should not be able to rely upon Patient A's hospital records of the 10 June 2020 and her GP records.

232. On behalf of the GMC, Ms Emsley-Smith confirmed that the GMC are not calling Patient A to give evidence. This decision was made for a variety of reasons relating to Patient A and not solely or mainly because of the allegation that she made to the police. Ms Emsley-Smith stated that on 2 December 2023 Patient A provided her consent to the GMC to obtain her GP records.

233. Ms Emsley-Smith submitted that Dr Onyekpe had denied that he knew or ought to have known that Patient A was vulnerable or was likely to be vulnerable. It is agreed that relevant to that question will be all the information, from various sources, that he had

available to him during the course of his interactions with Patient A. Further, that Dr Onyekpe had also denied, as a fact, that Patient A was vulnerable.

234. Ms Emsley-Smith submitted that the evidence which goes to the issue of vulnerability is relevant to Allegation 1(a) irrespective of whether Dr Onyekpe had that information available to him. The medical records which are in dispute more fully reveal Patient A's medical history and conditions which the GMC asserts supports the allegation of vulnerability.

235. Ms Emsley-Smith submitted that it was not accepted that the GMC cannot legitimately rely on the submission that the records are relevant to allegation 1(a). She said that the email sent on the 17 January 2024 was for the purpose of disclosing a summary of the GMC's interaction with Dr G in the interests of ensuring the GMC's disclosure obligations were met. It was not intended to be a comprehensive articulation of the GMC's case on vulnerability and the GMC was not bound by or limited to the contents of that email when putting the case before the Tribunal.

236. Ms Emsley-Smith stated that the defence have had the additional medical records as part of the draft Hearing Bundle process since the 4 August 2022 (hospital records for 10 June 2020) and the 20 December 2023 (GP records). She said that the medical records simply provide information relating to Patient A's medical history and conditions.

237. Ms Emsley-Smith submitted that the records speak for themselves and do not require expert analysis or guidance on what inferences can safely be drawn from the entries. Further, that the Tribunal will be able to safely navigate the records and draw only those inferences which can be safely drawn from the face of the records.

238. Ms Emsley-Smith acknowledged that the GP records could be limited to an appropriate period prior to the allegation period.

The Tribunal's Decision

239. The Tribunal received and accepted the legal advice from the LQC.

240. The Tribunal noted the parties' joint position that the additional records do not need to be seen by the Tribunal in order for this decision to be made. The Tribunal was in agreement that a determination can be made on the preliminary application without seeing the additional

medical records. In assessing the additional medical records, the Tribunal first considered the GP records, then the hospital records for the attendance of 10 June 2020.

241. The Tribunal considered the availability of the medical notes already within the bundle, which included the hospital records of 5 June 2020 within the Accident and Emergency department of the hospital. These included the following;

- detailed record of the examination where the presenting complaints were listed, the patient's history was taken, her drug history was taken, her family social history was noted, the observations were noted and the diagnosis reached with the management plan;
- the attendance record including another copy of this bearing Dr Onyekpe's handwritten notes;
- records from the paramedics;
- nursing notes;
- record of the medication prescribed and given;
- computerised log of the patients attendance on 6 June 2020.

242. With respect to the GP records, the Tribunal noted these would not be available to those working in Accident and Emergency and there was no suggestion that Dr Onyekpe would have ever had access to these. He had only been provided with these, via GMC disclosure through his solicitors, in December 2023. They should only be disclosed if necessary and relevant. Given the detailed records that were available, including the detailed patient history taken and noted in the records, the Tribunal did not consider it necessary to have further medical records disclosed. Both advocates confirmed that there was nothing else of relevance in the GP records about Patient A's attendance at the hospital on 5/6 June 2020 other than a record that she had attended. There was no letter from the hospital to assist the Tribunal as to Patient A's condition on that occasion.

243. The Tribunal therefore had the detailed hospital records in relation to 5/6 June 2020 to assist it considering Allegation 1 with respect to Patient A's vulnerability at the material times. The Tribunal also had sight of the contemporaneous messages exchanged between Dr Onyekpe and Patient A between 6 June 2020 and 24 July 2020. Within these there were numerous mentions in relation to Patient A's health and indeed Dr Onyekpe had, in parts, entered into a discussion with her in relation to her health.

244. In light of the above, the Tribunal was not persuaded of the merits of looking at GP records which were not available to Dr Onyekpe. Importantly, the Tribunal understood it had to focus on whether Patient A was vulnerable at the material times and then consider whether Dr Onyekpe knew or ought to have known about any vulnerability. The Tribunal was mindful of the unfairness of adducing the GP records into evidence and the dangers of being invited to make inferences where Dr Onyekpe was unable to properly challenge the evidence. The Tribunal noted that Patient A was not going to give evidence and had not provided a statement. There are no other factual witness who might assist. Additionally, the GMC had elected, for various reasons, not to proceed in seeking to rely on Dr G as an expert. In those circumstances, the Tribunal was not persuaded that the GP records should be adduced into evidence and considered it was not necessary. To admit the GP records would lead to unfairness for Dr Onyekpe and there was no means to mitigate such unfairness.

245. In relation to the hospital records of 10 June 2020, the Tribunal had a copy of the attendance note. It was noted that the fuller record of Patient A's attendance on this date is within the additional material being sought to be adduced by the GMC as part of the medical records. The Tribunal considered these records to be relevant and it would be necessary to have sight of these records as Dr Onyekpe was working in the Accident and Emergency department at the material time. His evidence was that he arranged for Patient A to be seen by a more senior colleague, he was engaging in WhatsApp messages with her whilst they were both within the hospital that day, and he has accepted in the Trust investigation that he had met her at the hospital and had sex with her. Given the various interactions in relation to Patient A within the hospital, it was appropriate for the remainder of the records of 10 June 2020 to be put before the Tribunal. The Tribunal did not consider this to cause unfairness as part of the records were already within the exiting bundle, Dr Onyekpe's own case was that he influenced who the treating physician would be on the day, and it would be fair for him to be able to deal with any relevant materials when he is giving evidence.

246. The Tribunal therefore determined that the GP records would not be adduced into evidence, but the hospital records in relation to 10 June 2023 would be admitted into evidence.

ANNEX B – 15/02/2024

Application to admit evidence

247. On behalf of the GMC, Ms Emsley-Smith submitted that the evidence given by Dr Onyekpe justified a further application to admit the GP records into evidence.

248. This issue was raised once Dr Onyekpe's evidence was nearly complete. He had started giving evidence on the afternoon of the first day, with evidence in chief completed and the cross examination mostly complete. On the second day, the cross examination was completed and re-examination took place. The Tribunal then retired to consider any questions that it may have. Upon the hearing resuming, the application was made by Ms Emsley-Smith before the Tribunal could put its questions to Dr Onyekpe.

249. After the issue was raised, both parties addressed the Tribunal. The parties had previously agreed for the written determination on the preliminary application on the first day to be handed down at the end of Stage 1. However, the Tribunal considered it appropriate to provide its written determination, so as to inform the parties' further submissions. Accordingly, the written determination for the preliminary application was provided (Annex A). Ms Emsley Smith was allowed time that afternoon to take instructions but was not in a position to proceed.

250. On the third day, Ms Emsley Smith was provided further time to secure instructions. In the meantime, the advocates provided the Tribunal with a joint note of extracts from the evidence of Dr Onyekpe, which, it was submitted, was relevant to the second application. Ms Emsley-Smith provided written submissions. Upon resuming the hearing, both advocates provided oral submissions in relation to the application.

Submissions by the GMC

251. In relation to the previous determination (Annex A), Ms Emsley-Smith submitted:

- although the determination did not specifically use the word 'relevant', she had interpreted certain parts of the determination as a conclusion by the Tribunal that the GP records were not relevant to paragraph 1(a) of the Allegation. She acknowledged she may be the only person who had interpreted it this way.
- the Tribunal determined that it would not be fair to admit the GP records because of '*the dangers of being invited to make inferences where Dr Onyekpe was unable to properly challenge the evidence*'.

- the Tribunal also determined that the admission of the GP records would lead to unfairness for Dr Onyekpe and there was no means to mitigate such unfairness.

252. Ms Emsley-Smith submitted that the GP records are relevant to paragraph 1(a) of the Allegation. She submitted that the Tribunal should take care not to conflate the issues relevant to paragraph 1(b) of the Allegation when determining the relevance and fairness of admitting the GP records in relation to paragraph 1(a) of the Allegation.

253. Ms Emsley-Smith submitted that paragraph 1(a) of the Allegation relates only to whether, as a fact, Patient A was vulnerable. She stated that issues of knowledge are relevant only to paragraph 1(b) of the Allegation. Ms Emsley-Smith stated that paragraph 1(a) of the Allegation has not been formally admitted by Dr Onyekpe and so the Tribunal was required to determine the presence or absence of vulnerability at the material times. It is required to give reasons for any decision, including, if a finding of vulnerability was made, the nature of that vulnerability.

254. Ms Emsley-Smith submitted that Dr Onyekpe's evidence was that he accepted, with the benefit of hindsight, that Patient A's vulnerability was self- evident. She said that, in re-examination, Dr Onyekpe was asked whether he was aware at the time that this patient was particularly vulnerable and he had replied that he was not aware at the time. He was then asked whether he was aware at any stage that Patient A was vulnerable and he replied that with hindsight, and with the extra reading he had done, the scales would definitely tip in favour of vulnerability. It was then put to him that he was now aware of information about this patient that he could not have been aware of at the time. He accepted this and later stated in re-examination that the additional information was in the GP records.

255. Ms Emsley-Smith highlighted that the extra reading that informed Dr Onyekpe's assessment that Patient A was vulnerable was the GP records. She submitted that the Tribunal would need to see the GP records to assess fairly the extent to which Dr Onyekpe's apparent concession assists it in determining paragraph 1(a) of the Allegation and to assess whether Dr Onyekpe's concession was fair and formulated on reliable information.

256. Ms Emsley-Smith submitted that the effect of Dr Onyekpe's evidence was that he is asserting that the GP records paint a very different picture on vulnerability from what was known, or could have been known, by him at the time he was involved with Patient

A. Ms Emsley-Smith stated that for the Tribunal to assess the veracity of that assertion, it needs to see the GP records.

257. Ms Emsley-Smith noted the Tribunal's concerns about the danger of drawing inferences and the doctor being unable to challenge the evidence. She submitted that Dr Onyekpe's evidence in respect of the GP records has the effect of that concern falling away. Rather than Dr Onyekpe being unable to challenge the evidence, he had made it clear that he had been able to read, understand and assess the contents of the GP records and form a view of the patient's vulnerability based on the GP entries.

258. Ms Emsley-Smith submitted that the GP records do not require any expert analysis or any witness to speak to their contents. She stated that the records do not differ from any other set of GP records; they contain diagnoses, treatments and referrals. She said they are a contemporaneous record of the patient's symptoms and social circumstances. She stated that in this regard they represent corroborative evidence for information contained within the WhatsApp messages.

259. Ms Emsley-Smith reminded the Tribunal that part of its fact-finding function was to draw reasonable inferences from relevant evidence. She stated that the Tribunal will hear submissions at the conclusion of Stage 1 regarding what inferences can be drawn from the records and receive legal directions that speculation is not permitted, and the GMC are confident that, as a professional Tribunal, there will be no speculative findings of fact.

260. Ms Emsley-Smith stated that the Tribunal is capable, just as Dr Onyekpe was, of reading the GP records and drawing appropriate conclusions from their contents. She submitted that there was no longer any unfairness to Dr Onyekpe in the records being admitted. Ms Emsley-Smith invited the Tribunal to look at the GP records in determining this point and that only by seeing the records will it be able to assess the issue of fairness following what Dr Onyekpe has said about them in his evidence.

261. Ms Emsley-Smith stated that fairness not only applies to Dr Onyekpe but also to the GMC, and to the overall public interest. She stated that Dr Onyekpe has relied on the contents of the GP records as a basis upon which he says his hindsight has been informed. Ms Emsley-Smith submitted that it cannot be said to be fair for one party to rely on evidence and the other party be prohibited from relying on that same evidence.

262. Ms Emsley-Smith stated that the GMC have alleged that Patient A is

vulnerable by reason of her medical history. She submitted that the GP records are evidence of Patient A's medical history, they have been referred to in evidence and the public interest now requires that they be admitted in evidence.

Submissions by the Defence

263. On behalf of Dr Onyekpe, Mr Counsell opposed the application. He submitted that there was no change in circumstances and the GMC was essentially seeking a review in order to obtain a different outcome on a determined issue that had already been 'well-reasoned'.

264. He stated that it would be completely unfair at this late stage, during Dr Onyekpe's evidence, for the GP records to be admitted because nothing has changed since the GMC's previous application. He submitted that the issue had been determined with detailed reasons provided as paragraphs 30-33 of Annex A. He submitted that there are instances where it would be dangerous to draw inferences and gave the example of Dr Onyekpe's evidence in relation to citalopram: despite it being listed in the ambulance records it was stated by Dr Onyekpe that he had established with Patient A that she was not currently taking citalopram.

265. Mr Counsell submitted the issue arose out of questions raised by Ms Emsley-Smith in cross examination, which he followed up in re-examination. He submitted that if it is said by the GMC that the position had changed, then it was due to the cross examination by Ms Emsley-Smith and that this caused unfairness.

266. Mr Counsell submitted that Dr Onyekpe should know the allegations and the facts upon which they are based as per Rule 15(1)(a) of the Rules. He also submitted that the allegation in question is generic, it was unclear as to what facts are relied upon with respect to paragraph 1(a) of the Allegation and it was too late to remedy this. He went on to say that this was no longer a preliminary issue, the case was well advanced and Dr Onyekpe had almost completed his evidence. His concerns were that it is unclear how the new evidence would be introduced, the details within the records are extensive, it is unclear what specific consultation or medication the GMC would wish to rely upon and there would be no advance warning if this evidence was raised in closing submissions. He also submitted that if permission is granted to admit the GP records into evidence then there is likely to be a stage where the GP records are relied upon and the defence would require expert evidence, which would have been obtained already if there had been advance notice of the GP records being used in evidence.

267. Mr Counsell submitted that fairness requires that the GMC's application should fail. Finally, he submitted that irrespective of the relevance of the GP records the fairness requirement of the test would not be met.

268. Ms Emsley-Smith responded to Mr Counsell's submission by inviting the Tribunal to find that there was a change in the circumstances, paragraph 1(a) of the Allegation was denied and thus the particular questions arose for those reasons. She invited the Tribunal to look at the GP records to consider any concerns relating to whether an expert would be required by the defence.

The Tribunal's Decision

269. The Tribunal had already received and accepted the legal advice from the LQC on the admission of new evidence. The Tribunal reminded itself that Rule 34(1) stated as follows:

> *'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.'*

270. The Tribunal had already determined a similar application as set out in Annex A, a copy of which had been provided to both advocates. Both advocates had agreed that the Tribunal would have to be satisfied that the admission of the GP records would have to be both relevant and fair. It was common ground between the parties, and the Tribunal reminded itself, that satisfying one of these elements alone would not meet the test set out in Rule 34(1).

271. The Tribunal wished to clarify that in its original determination, at Annex A, it did not reach the conclusion that the GP records were irrelevant.

272. With respect to paragraph 1(a) of the Allegation, the Tribunal accepts that the GP records are relevant and considered that it may well be fair to admit them. However, the Tribunal was mindful that it also had to consider paragraph 1(b) of the Allegation; whether the GP records were relevant to what Dr Onyekpe knew, or ought to have known, at all material times and whether it was fair to admit them in relation to its consideration of paragraph 1(b) of the Allegation.

273. It is common ground between the parties that Dr Onyekpe did not have access to Patient A's GP records at the relevant times. The Tribunal concluded that the GP records were not necessarily relevant to its consideration of paragraph 1(b) of the Allegation. The Tribunal took into account that there was other evidence before it, which addresses determining both paragraphs 1(a) and 1(b) of the Allegation. This had been set out in paragraphs 29 and 31 of Annex A. The Tribunal had available to it the messages exchanged between Dr Onyekpe and Patient A where health was frequently discussed. It also had available to it the detailed hospital records, which were summarised in Annex A as:

- *detailed record of the examination where the presenting complaints were listed, the patient's history was taken, her drug history was taken, her family social history was noted, the observations were noted and the diagnosis reached with the management plan;*
- *the attendance record including another copy of this bearing Dr Onyekpe's handwritten notes;*
- *records from the paramedics;*
- *nursing notes;*
- *record of the medication prescribed and given;*
- *computerised log of the patient's attendance on 6 June 2020.*

274. The Tribunal bore in mind that it had the evidence set out above about Patient A's medical history in the form of these hospital records. These now included the hospital records in relation to 10 June 2020, which had been provided to the Tribunal following its determination on the preliminary application. The Tribunal is able to examine these records in relation both to Patient A's vulnerability and Dr Onyekpe knowledge thereof at all material times.

275. The Tribunal was mindful that fairness to both parties is paramount in its obligation to meet the overarching objective.

276. The Tribunal considered that any unfairness to the GMC in not admitting the GP records was mitigated in light of the detailed material that was now available to the Tribunal.
277. In considering unfairness to Dr Onyekpe, the Tribunal had outlined the concerns at the preliminary stage before the hearing commenced. This was reflected in paragraph 32 of Annex A, with there being no factual witnesses or experts to assist and the dangers of having

to draw inferences. The Tribunal had regard to the wider consequences as to the risks of admitting the GP records as illustrated by Mr Counsell's citalopram example.

278. The Tribunal considered this second application by the GMC and was persuaded that Dr Onyekpe's evidence amounted to a change of circumstances. However, in determining paragraph 1(a) of the Allegation, the Tribunal did not consider it needed to consider the source material of Dr Onyekpe's concession. This was because paragraph 1(a) of the Allegation could be considered by reference to other materials, which had already been outlined in detail. This continues to mitigate any potential unfairness to the GMC.

279. The Tribunal considered that the potential prejudice to Dr Onyekpe would be increased should the GP records be admitted. He was entitled, under Rule 15(1)(a), to know the facts that are relied upon with respect to paragraph 1(a) of the Allegation. Dr Onyekpe had all but completed his evidence with just the Tribunal's questions remaining.

280. The Tribunal has considered the impact of admitting the GP records, not in isolation, but in relation to both paragraphs 1(a) and 1(b) of the Allegation. It was of the view that any evidential value in admitting the GP records for paragraph 1(a) of the Allegation would likely lead to real unfairness during the Tribunal's consideration of paragraph 1(b) of the Allegation. In the Tribunal's judgement the risk of unfairness outweighs any evidential benefit of admitting the GP records.

281. The Tribunal was not satisfied that both elements of the test outlined in Rule 34(1) were met; whilst the records were relevant, the extent of potential prejudice was such that it would be unfair to admit the GP records into evidence. For the above reasons, the Tribunal refused the GMC's application.

Schedule 1

Messages passing between Dr Onyekpe and Patient A on 6 June 2020 in period 01:06:33 to 03:26:30

Disclosed - to be distributed in session

Schedule 2

Messages passing between Dr Onyekpe and Patient A on 8 June 2020 in period 13:32:29 to 14:28:26

Disclosed - to be distributed in session

Schedule 3

Messages passing between Dr Onyekpe and Patient A on 10 June 2020 in period 20:09:01 to 23:07:44

Disclosed - to be distributed in session

Schedule 4

Messages passing between Dr Onyekpe and Patient A in period 11 June 2020 to 24 July 2020

Disclosed - to be distributed in session

Schedule 5

Disclosed - to be distributed in session