Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 20/02/2020 - 03/03/2020

Medical Practitioner's name: Dr Idris OKEWOLE

GMC reference number: 6130860

Primary medical qualification: MB BS 1989 University of Lagos

Type of case
New - Misconduct

Outcome on impairment
Impaired

Summary of outcome
Conditions, 9 months.
Review hearing directed

Immediate order imposed

Tribunal:

Legally Qualified Chair	Miss Gillian Temple-Bone
Lay Tribunal Member:	Ms Susan Disley
Medical Tribunal Member:	Dr Anita Clay

Tribunal Clerk:	Mr Laurence Millea

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Ghazan Mahmood, Counsel, instructed by MPS
GMC Representative:	Mr David Toal, 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 - 26/02/2020

Background

1. Dr Okewole qualified in 1989 with an MB BS from the University of Lagos, going on to complete his postgraduate training at University College Hospital, Ibadan, Nigeria between 1994 and 1999, after which he practised as a specialist in Obstetrics and Gynaecology from 1999 to 2005. Dr Okewole came to the UK in 2005 on an overseas Doctors Training scheme and was registered on the GMC list of Registered Medical Practitioners with full registration in October 2006.

2. Dr Okewole obtained membership of the Royal College of Obstetrics and Gynaecology in 2008. After undertaking postgraduate training in the UK under the East Midlands North Deanery he obtained a Certificate of Completion of Training ('CCT') and became a consultant in January 2014. He was entered onto the Specialist Register of Obstetrics and Gynaecology on 7th July 2014. In addition to undertaking advanced training in this speciality, in 2015 Dr Okewole obtained a Masters in Medical Education Science from the University of Nottingham.

3. At the time of the events relating to Patient A, Dr Okewole was practising as a Locum Consultant Obstetrician & Gynaecologist at Milton Keynes University Hospital. At the time of the events relating to Patient B, Dr Okewole was practising as a Locum Consultant Obstetrician & Gynaecologist at Lister Hospital, Stevenage.

4. Dr Okewole has been employed as a Consultant in Obstetrics and Gynaecology at Noble Hospital on the Isle of Man since January 2018.

5. The allegation that has led to Dr Okewole's hearing can be summarised as concerns in regard to the assessment and treatment he provided to Patients A and B.

6. It is alleged that, on 4 September 2017, Dr Okewole failed to adequately examine Patient A. It is further alleged that Dr Okewole initially plotted a measurement on Patient A's growth chart without having carried out an adequate examination, and that his actions - in so doing - were dishonest. A concern was recorded on 4 September by Patient A's midwife, and a local complaint was made by Patient A on 5 September.

7. It is alleged that on 17 November 2017, Dr Okewole was instructed to remove a right sided labial polyp from Patient B. He in fact removed a left sided labial cyst ('the Procedure') on Patient B. It is alleged that he failed to obtain informed consent for the Procedure, failed to carry out an adequate pre-operative discussion to check he knew the exact site of the symptomatic lesion and agree that removal was justified, failed to examine Patient B before any form of anaesthetic was administered, inappropriately carried out the Procedure, failed to liaise with other members of the medical team, and failed to carry out an adequate post-operative discussion with Patient B.

8. The initial concerns were raised with the GMC on 11 December 2017 when Patient A reported her account of events to the GMC following a local investigation by Milton Keynes University Hospital Trust. During the course of GMC investigations, Mr Okewole's employers, East and North Hertfordshire Trust (ENHT) were contacted, and details of the clinical incident in November 2017 relating to Patient B and the local investigation were reported.

The Outcome of Applications Made during the Facts Stage

9. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to amend paragraph 1(a) of the allegation. This application was not opposed by Mr Mahmood, Counsel on behalf of Dr Okewole, and the Tribunal determined that there would be no injustice to the doctor in agreeing the amendment.

10. During this stage of proceedings, parties were consulted on a proposed amendment to the wording of paragraph 1(b) of the Allegation, put forward by the Tribunal pursuant to Rule 17(6) of the Rules. The Tribunal determined to amend this paragraph accordingly and full details of the Tribunal's decision are included in Annex A.

The Allegation and the Doctor's Response

11. The Allegation made against Dr Okewole is as follows:

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

Patient A

1. On 4 September 2017 you consulted with Patient A and you failed to adequately examine Patient A in that you did not:

    a. palpate Patient A's abdomen ~~to assess if the:~~

        ~~i. fetus was lying longitudinally;~~

        ~~ii. presenting part in the pelvis was the head or breech;~~

Amended under Rule 17(6), To be determined

b. ~~subsequent to palpation measure the symphysis-fundal height ('SFH') using a tape measure~~.

in your first examination of Patient A's abdomen measure the symphysis-fundal height ('SFH') using a tape measure
Amended under Rule 17(6), Admitted and found proved

2. On 4 September 2017 you initially plotted a measurement on Patient A's growth chart without having carried out the actions detailed at paragraphs 1a-b. **To be determined**

3. You knew you had not measured the SFH appropriately when you initially plotted the measurement. **To be determined**

4. Your actions as described at paragraph 2 were dishonest by reason of paragraph 3. **To be determined**

Patient B

5. On 17 November 2017 you carried out the removal of a left sided labial cyst ('the Procedure') on Patient B and you:

   a. failed to obtain informed consent for the procedure;
   Admitted and found proved

   b. failed to carry out an adequate pre-operative discussion in that you did not ask Patient B to identify the lesion to check that you knew the exact site of the symptomatic lesion and agree that removal was justified; **Admitted and found proved**

   c. failed to examine Patient B before any form of anaesthetic was administered; **Admitted and found proved**

   d. inappropriately carried out the Procedure:

      i. despite your omission as outlined in paragraph 5a;
      Admitted and found proved

      ii. when it should have been stopped once you could not identify a right sided labial polyp; **Admitted and found proved**

      iii. when the left sided cyst had not displayed features of suspicious of malignancy; **Admitted and found proved**

e. failed to liaise either directly or indirectly with other members of the medical team, either in relation to:

   i. not identifying a right sided labial polyp; **Admitted and found proved**

   ii. the findings of the Procedure; **Admitted and found proved**

f. failed to carry out an adequate post-operative discussion in that you did not:

   i. ask that Patient B waited until you could discuss your findings and why the Procedure was completed under general anaesthetic; **Admitted and found proved**

   ii. ensure that Patient B understood the nature of the Procedure completed; **Admitted and found proved**

   iii. offer information to Patient B to clarify why this alternative action had been felt to be clinically indicated. **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

12. At the outset of these proceedings, through his counsel, Mr Mahmood, Dr Okewole 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.

The Facts to be Determined

13. In light of Dr Okewole's response to the Allegation made against him the Tribunal is required to determine whether on 4 September 2017 Dr Okewole failed to palpate Patient A and use a tape measure in order to appropriately measure the fundal height of the foetus prior to recording the measurement on Patient A's growth chart, and whether in doing so he dishonestly made this record, knowing he had failed to carry out the appropriate examination and measurement.

Factual Witness Evidence

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

- Patient A, in person;
- Nurse C, Lead Midwife for Safeguarding at Milton Keynes University Hospital until February 2018, in person.

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

- Dr D, Associate Specialist Anaesthetist, East & North Hertfordshire NHS Trust, dated 23 September 2019;
- Ms F, Deputy Divisional Quality Manager, East & North Hertfordshire NHS Trust, dated 4 October 2019;
- Nurse G, Nursing Team Leader in Theatres, East & North Hertfordshire NHS Trust, dated 21 October 2019 and;
- Mr H, Theatre Nurse, Lister Hospital, North & East Hertfordshire NHS Trust, dated 6 November 2019.

16. Dr Okewole provided his own witness statement, dated 23 January 2020 and also gave oral evidence at the hearing.

Expert Witness Evidence

17. The Tribunal also received evidence from 2 expert witnesses.

18. Dr I, on behalf of the GMC, provided an expert report, dated 15 March 2019 and a supplementary report dated 8 October 2019. Dr I is a Consultant in Obstetrics and Gynaecology and joined the Specialist Register of the General Medical Council in 2009. Dr I assisted the Tribunal in understanding the expected standards and best practice of practitioners within the field of obstetrics.

19. Professor K, on behalf of Dr Okewole, provided expert reports dated 4 December 2019 and 19 December 2019. Professor K is an Honorary Consultant Obstetrician & Gynaecologist. Professor K assisted the Tribunal in understanding the expected standards and best practice of practitioners within the field of obstetrics.

20. A joint statement of the experts was also provided, dated 6 February 2020.

Documentary Evidence

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

- Letter of complaint from Patient A to Milton Keynes University Hospital NHS Foundation Trust, dated 5 September 2017;
- Response letter from Dr Okewole, dated 22 September 2017;
- Letter from Milton Keynes University Hospital NHS Foundation Trust, dated 22 November 2017;
- Medical records of Patient A;
- Medical records of Patient B;
- Patient B's referral letter, dated 11 October 2017;
- Patient B's theatre record, undated;
- A number of testimonials on Dr Okewole's behalf, and;
- Colleague feedback report, dated 7 January 2020, and appraisal, dated 14 January 2020 for Dr Okewole.
- Youtube video from the Perinatal Institute on SFH measurement, dated August 2015;
- Slides from the Perinatal Institute on Customised Antenatal Growth Charts, published 2019;
- Guidance from NICE on antenatal care for uncomplicated pregnancies, published March 2008, and;
- Article on measuring SFH dated 2009, published by Clinical Obstetrics & Gynaecology journal

The Tribunal's Approach

22. Following submissions from both parties, the Legally Qualified Chair provided legal advice to the parties, emphasising the following points.

23. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Okewole 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.

24. The issue for the Tribunal to determine at this stage in relation to paragraphs 1, 2, 3 and 4 of the Allegation is whether Dr Okewole's conduct was dishonest, as alleged in paragraph 4. Dishonesty is a state of mind which, unless admitted, can only be inferred from conduct. In many cases a Tribunal is very well placed, with its experience of the world and common sense, to determine what is dishonest by ordinary decent standards. If the Tribunal considers that greater guidance as to "dishonesty" is necessary, it may consider the case of *Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67.*

25. In that case the Court held that the correct test of dishonesty is for the Tribunal :

(i) To ascertain (subjectively) the state of Dr Okewole's knowledge or belief as to the facts
The reasonableness or otherwise of his belief is a matter of evidence going to whether he genuinely held the belief but it is not a requirement that the belief must be reasonable; and

(ii) To then consider whether that conduct was honest or dishonest by applying the (objective) standards of ordinary decent people.

26. There is no requirement that Dr Okewole must appreciate that what he has done was, by those standards, dishonest.

27. In this case the Tribunal should take into consideration Dr Okewole's good character. He qualified as a doctor in 1989, has practised in the UK since 2005, and became a consultant in Obstetrics and Gynaecology in 2014. To date these two complaints are the only ones made against Dr Okewole.

The Tribunal's Analysis of the Evidence and Findings

28. 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

1(a)

29. The Tribunal was mindful of the evidence of both expert witnesses that palpation of the abdomen is necessary in order to adequately measure and plot foetal growth, and that a failure to do so would fall seriously below the standards expected of a registered practitioner.

30. In reaching its determination as to whether or not Dr Okewole palpated Patient A's abdomen, the Tribunal considered the evidence of both Patient A and Nurse C on the matter.

31. Patient A is a trained midwife. The Tribunal considered Patient A to be a largely credible witness, who provided clear answers which addressed the questions put to her. Her responses were on occasion emotional, but this was predominantly in response to sensitive matters and the Tribunal was not of the opinion that this substantially interfered with her recall of events. She maintained composure under cross-examination and responded clearly regarding her mental health and the triggers and management thereof. The Tribunal was assured that she is managing

these well and they are not significant factors in assessing her evidence and credibility as a witness in the matters before it.

32. The Tribunal, whilst acknowledging that some inconsistencies were present in her accounts of events, was of the opinion that her recollection and description that no palpation occurred was both consistent and compelling. As an experienced midwife undergoing a somewhat intimate clinical examination, she was well-placed to know whether such an examination took place or not and remained entirely consistent on this matter.

33. The Tribunal considered that Nurse C was also a largely credible witness, who is clearly passionate about her profession. At times during oral evidence her demeanour was defensive and somewhat combative, and the Tribunal did have some concerns about her objectivity as a witness given her statement that she is "an advocate" for her patients and her close and ongoing friendship with Patient A.

34. However, in light of the history of reports that Milton Keynes University Hospital had a high incidence of stillbirths which led to the involvement of the Care Quality Commission (CQC), the Tribunal concluded that her level of awareness and practice would be likely to be high and to a standard probably above average. The Tribunal was of the view that such concerns and the fact that she appeared to be defending one of her patients from criticism went some way in explaining her demeanour.

35. Despite this apparent bias and some inconsistencies within her evidence, and in comparison to Patient A's accounts, the Tribunal was of the view that her response in relation to the core allegation, namely that no palpation occurred and that no tape measure was used, was honest and consistent. It did not believe that she was attempting to fabricate responses or speculate on this matter.

36. The Tribunal noted that Nurse C confronted Dr Okewole immediately after the consultation and made her initial complaint about Dr Okewole's care on the same day as it occurred. In oral evidence she felt that the evidence was clear that Dr Okewole's practice in this instance was far from optimal and potentially posed a risk to pregnant mothers and unborn babies. The Tribunal was also mindful that it can be difficult for individuals to speak out regarding concerns of colleagues of higher rank or in senior positions, and that this culture has been strongly challenged in recent years. Patient A was allocated Nurse C (the Lead in Safeguarding) as midwife in part due to her mental health.

37. The Tribunal also considered the credibility and reliability of Dr Okewole as a witness. It was of the opinion that he is a credible person who gave consistent evidence but was not dogmatically rigid in his responses. He appeared open to answering questions and whilst appeared a little defensive under cross-examination, he provided calm and clear responses when questioned by the Tribunal.

38. Dr Okewole's responses to questions were consistent and he was willing to acknowledge fault in failing to use a tape measure before being prompted by Nurse C to do so, apologising and stating that this has not been repeated and will not occur again. During his oral evidence he also demonstrated some modesty when questioned about his record taking, admitting that often nurses and midwives do maintain more thorough records that doctors and/or consultants. The Tribunal noted that there were no concerns identified in relation to his record keeping, save for the specific allegations put before it.

39. When questioned by the Tribunal, Dr Okewole stated that he did not believe that he was nervous and made a mistake due to being in the presence of two experienced midwives, although did not discount the possibility. The Tribunal was of the opinion that this reflected an honesty and that he was genuinely considering and replying to the queries put to him.

40. Dr Okewole was consistent in asserting that he had palpated Patient A's abdomen. The Tribunal was of the opinion that either he truly believed that he did palpate her abdomen at the time or that he could not recall it but had persuaded himself over time that he must have done so because this would be his usual practice.

41. Dr Okewole indicated that the diagram of the consultation room he provided in November 2019 reflected his memory. Patient A and Nurse C' memories, he indicated, might be more accurate because Nurse C continued to work at this location.

42. Despite accepting that Dr Okewole was honestly providing his recollection of events, it did not attribute sufficient weight to his testimony to discount the evidence of Patient A and Nurse C. When considering the version of events provided by Dr Okewole against those of Patient A and Nurse C, the Tribunal concluded that on the balance of probabilities no palpation of Patient A's abdomen occurred. The likelihood of two experienced midwives mistaking a palpation for anything else is significantly less likely than Dr Okewole forgetting to conduct the palpation in a momentary lapse and proceeding as if he had, in line with his usual practice.

43. In addition, the concerns and accounts of Patient A and Nurse C are reflected in contemporaneous statements and reports raised immediately after the events occurred.

44. The Tribunal therefore accepted the accounts of Patient A and Nurse C that no palpation occurred and found this paragraph of the allegation proved.

1(b)

45. This paragraph of the Allegation was admitted by Mr Mahmood, on Dr Okewole's behalf, and therefore determined as admitted and found proved.

Paragraph 2

46. In light of the Tribunal's finding that Dr Okewole failed to palpate Patient A's abdomen or measure the SFH with a tape measure in the first instance, the Tribunal determined that it must follow that he initially plotted the measurement without having carried out these actions.

Paragraph 3

47. The Tribunal, having determined that Dr Okewole failed to palpate Patient A's abdomen, considered whether he knew that he had not measured the SFH appropriately when initially plotting the measurement on the growth chart.

48. The Tribunal took into account Dr Okewole's good character and the positive testimonials provided on his behalf, and also the absence of any such complaints about his practice before or since the allegations before this Tribunal. The Tribunal found Dr Okewole to be open and honest in his oral evidence, which was largely consistent with his earlier written accounts.

49. The evidence of both expert witnesses was that the use of a tape measure is recommended good practice for plotting the growth of foetuses from 26 to 28 weeks. The 28 week check provides the baseline for the growth chart. In none of the guidance to which the Tribunal was referred was there any mention of the use of finger breadths to measure SFH.

50. The Tribunal took into consideration Dr Okewole's immediate acknowledgement when challenged by Nurse C that he had not used a tape measure and that he invited Patient A back to the couch for a second examination using a tape measure. It also took into consideration Dr Okewole's evidence that his usual practice was to use finger breadths and a tape measure to assess SFH; that the tape measure was likely to have been to hand on the trolley within the consultation room; his vehement denial that he had plotted the chart knowing he'd failed to use a tape measure.

51. The Tribunal, in accepting Dr Okewole's evidence that his usual practice in the UK since 2005 had been to use finger breadths and tape measure, which is his current practice, accept that the most likely explanation is that he simply forgot to use a tape measure.

52. The Tribunal noted that Dr Okewole was not trained in use of these specific growth charts (namely NHS customised GROW charts) save through online learning and observing senior colleagues. The Tribunal also noted from Dr Okewole's oral evidence, he rarely examines patients at 28 weeks to check the growth of the foetus, or plots their measurements on the chart. This is usually a task performed by midwives, a view endorsed by Professor K.

53. If Dr Okewole believed he had palpated the foetus and taken a measurement, he would of course have recorded that on the growth chart.

54. His explanation for pausing prior to plotting the chart was that he had been trying to accurately record a measurement of 27 weeks and 4 days, which the Tribunal accepted.

55. The Tribunal accepted that Dr Okewole's standard practice is to palpate and use a tape measure to plot foetal growth, but that in the circumstances of this case he failed to do so. The Tribunal accepted that Dr Okewole had thought he had palpated Patient A's abdomen and was making an appropriate measure.

56. The Tribunal found Dr Okewole to be a credible witness and his errors regarding Patient A to have been genuine mistakes. Those errors were serious. He failed to palpate Patient A or use a tape measure on the first examination. He entered a plot on the growth chart having failed to palpate or use a tape measure. These are all basic steps for a consultant of his expertise to have conducted.

Paragraph 4

57. The Tribunal noted that all witnesses agreed in evidence that on 4 September 2017, Dr Okewole was not obliged to examine Patient A, or take any measurements, or listen to the foetal heart. The purpose of the consultation was to decide whether Patient A was to have an elective C-section or not.

58. No motive for the alleged dishonesty has been suggested. The Tribunal was unable to identify a reason Dr Okewole made such an error. It accepted that this was an accidental failure in this case and he was not intentionally dishonest in his actions.

59. The Tribunal has therefore determined that Dr Okewole's actions at paragraphs 1-3 above were not dishonest, and has therefore found Paragraph 4 not proved in relation to paragraphs 1, 2 and 3.

Paragraph 5

60. These paragraphs were all admitted by the doctor at the outset of proceedings and therefore were determined as admitted and found proved in their entirety.

The Tribunal's Overall Determination on the Facts

61. The Tribunal has determined the facts as follows:

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

Patient A

1. On 4 September 2017 you consulted with Patient A and you failed to adequately examine Patient A in that you did not:

   a. palpate Patient A's abdomen ~~to assess if the:~~

      ~~i. fetus was lying longitudinally;~~

      ~~ii. presenting part in the pelvis was the head or breech;~~
      Amended under Rule 17(6), Determined and found proved

   b. ~~subsequent to palpation measure the symphysis-fundal height ('SFH') using a tape measure~~.

      in your first examination of Patient A's abdomen measure the symphysis-fundal height('SFH') using a tape measure
      Amended under Rule 17(6), Admitted and found proved

2. On 4 September 2017 you initially plotted a measurement on Patient A's growth chart without having carried out the actions detailed at paragraphs 1a-b. **Determined and found proved**

3. You knew you had not measured the SFH appropriately when you initially plotted the measurement. **Not proved**

4. Your actions as described at paragraph 2 were dishonest by reason of paragraph 3. **Not proved**

Patient B

5. On 17 November 2017 you carried out the removal of a left sided labial cyst ('the Procedure') on Patient B and you:

a. failed to obtain informed consent for the procedure; **Admitted and found proved**

b. failed to carry out an adequate pre-operative discussion in that you did not ask Patient B to identify the lesion to check that you knew the exact site of the symptomatic lesion and agree that removal was justified; **Admitted and found proved**

c. failed to examine Patient B before any form of anaesthetic was administered; **Admitted and found proved**

d. inappropriately carried out the Procedure:

    i. despite your omission as outlined in paragraph 5a; **Admitted and found proved**

    ii. when it should have been stopped once you could not identify a right sided labial polyp; **Admitted and found proved**

    iii. when the left sided cyst had not displayed features of suspicious of malignancy; **Admitted and found proved**

e. failed to liaise either directly or indirectly with other members of the medical team, either in relation to:

    i. not identifying a right sided labial polyp; **Admitted and found proved**

    ii. the findings of the Procedure; **Admitted and found proved**

f. failed to carry out an adequate post-operative discussion in that you did not:

    i. ask that Patient B waited until you could discuss your findings and why the Procedure was completed under general anaesthetic; **Admitted and found proved**

    ii. ensure that Patient B understood the nature of the Procedure completed; **Admitted and found proved**

    iii. offer information to Patient B to clarify why this alternative action had been felt to be clinically indicated. **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 - 02/03/2020

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

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. Dr Okewole provided a second witness statement, dated 27 February 2020 and gave additional oral evidence at this stage of the hearing. In addition, the Tribunal received further evidence as follows on behalf of Dr Okewole:

- reflective statement prepared by Dr Okewole, undated;
- a number of Continuous Professional Development ('CPD') certificates, various dates 2018 to present;
- a number of reflection documents on CPD and courses attended, various dates 2018 to present;
- patient feedback report, dated 7 January 2020;
- colleague feedback report, dated 7 January 2020 with attached reflections;
- patient feedback report, dated 6 December 2018 with attached reflections;
- audit of record keeping, dated 10 January 2020;
- appraisal summary, dated 14 Janaury 2020, and;
- list of additional reading materials

Submissions

3. On behalf of the GMC, Mr Toal, Counsel, submitted that the GMC's position is that Dr Okewole's Fitness to Practise is currently impaired owing to his misconduct.

4. Mr Toal submitted that when all the determined facts of the case are taken into account, both expert witnesses agree that Dr Okewole's actions fell seriously below the standards expected of a registered practitioner and a Consultant in Obstetrics and Gynaecology. The fact that this finding applies to both Patient A and Patient B illustrates the seriousness of Dr Okewole's misconduct and has resulted in stress to both patients. This is exacerbated in the case of Patient A owing to her vulnerability and anxieties in regard to her birth plan.

5. Mr Toal reminded the Tribunal that although it had found that Dr Okewole's actions were genuine mistakes in its determination on the facts, it explicitly stated that they were nevertheless serious errors.

6. Mr Toal submitted that these failures on the part of Dr Okewole have brought the reputation of the profession into disrepute, and both colleagues and ordinary members of the public would regard his actions as wholly inappropriate.

7. Mr Toal submitted that whilst Dr Okewole has undertaken a great deal of remediation in these matters, his fitness to practise remains impaired. Despite what has happened in relation to Patient A, Dr Okewole has admitted that he has continued using the finger breadth method of measuring SFH, albeit in conjunction with a tape measure. It is only at this stage of proceedings following his oral evidence at the facts stage, and that of the expert witnesses, that he has acknowledged that this method was a factor in his failings in the care of Patient A. He then conceded that this makes it more likely that he would forget to also use a tape measure. The Tribunal should not consider this aspect of his failures remediated but that he remains impaired on this matter.

8. Mr Toal submitted that for the reasons outlined, if a finding of impairment was not made this would both damage public confidence in the profession, and significantly undermine the upholding of proper standards. A finding of current impairment is therefore necessary to reaffirm clear standards of professional conduct and uphold public confidence in the profession.

9. On behalf of Dr Okewole, Mr Mahmood, Counsel, submitted that in light of the admissions made by Dr Okewole, his efforts to gain and demonstrate insight and undertake the necessary actions to remediate, the Tribunal should determine that he is no longer impaired.

10. Mr Mahmood submitted that, as stated by the Tribunal in its determination on the facts, Dr Okewole's failures in relation to Patient A were momentary lapses and did not reflect any pattern of similar behaviour or misconduct. Dr Okewole has clearly demonstrated the necessary insight and remediation in relation to his shortcomings in the care of Patient A, and his acceptance that it is not appropriate to use the finger breadth method to assess SFH completes his insight in relation to this aspect of the Allegation.

11. Mr Mahmood submitted that Dr Okewole has fully accepted his responsibility in the failures relating to Patient B's care, and whilst there are extenuating circumstances in that there were errors, failures and gaps in the surgical journey which were beyond Dr Okewole's control, he fully accepts responsibility for his actions. Dr Okewole has clearly expressed how ashamed and deeply remorseful he is for his actions and accepts the seriousness of them. Through his CPD activities and reflection he has demonstrated full remediation on these matters.

12. Mr Mahmood submitted that no such issues or concerns have arisen in Dr Okewole's many years of practice prior to these events, which occurred over two and a half years ago, and there have been no such issues or concerns raised since. The events before the Tribunal are two separate and isolated events where Dr Okewole made honest mistakes in his care for these patients, and do not reflect a pattern of behaviour or broader issues with his competency or practice.

13. Mr Mahmood submitted that through his efforts to gain full insight and remediate these matters, Dr Okewole has sought to share his experiences and knowledge with fellow colleagues and provide an example to junior colleagues. In fact, he now teaches and advises junior colleagues on the importance of informed consent, using himself as an example and sharing his experiences and learnings, to the benefit of the profession.

14. Mr Mahmood submitted that the risk of repetition is low, there is no significant risk to patient safety going forward and that Dr Okewole has demonstrated full insight and remediation, so whilst he accepts that Dr Okewole's fitness to practise was impaired, but reminded the Tribunal that it must consider whether he remains impaired as of today. In light of all the facts of the case and the great efforts Dr Okewole has made to remediate and mitigate, the Tribunal should therefore determine that he is not currently impaired.

The Relevant Legal Principles

15. 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.

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

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

18. The Legally Qualified Chair provided legal advice, which was agreed by the parties. This included the following:

(i) There is no legal test for determining impairment to practise. It is a matter entirely for the Tribunal to decide, as a matter of judgment, whether the Doctor's fitness is impaired in the light of the evidence before it. The authorities provide some guidance as to the correct approach to determining the issue and identify some of the relevant factors to be taken into account.

(ii) The courts have said that four reasons for unfitness tend to recur and on the facts of some cases more than one of them will apply, as set out in *Council for Healthcare Regulatory Excellence v. NMC and Paula Grant [2011] EWHC 927 (Admin):*

"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

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

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

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

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

(iii) Other relevant questions which the Tribunal may consider helpful to ask itself, on the authorities, are:

a) What insight does Dr Okewole demonstrate of the conduct found proven?

b) Is the conduct remediable?

c) Has it been remedied?

d) What is the likelihood of repetition?

The Tribunal's Determination on Impairment

Misconduct

Patient A

19. Both expert witnesses were in agreement that a failure to palpate prior to measuring the SFH, set out at paragraph 1(a), fell seriously below the standards expected of a Consultant in Obstetrics and Gynaecology. The Tribunal did find that he did not palpate prior to measuring the SFH. In regard to paragraphs 1(b) and 2

there was disagreement. Dr I held the view that in respect of each paragraph Dr Okewole's conduct fell seriously below the standards expected of a Consultant. Professor K held the view that it fell below but not seriously below those standards.

20. The Tribunal considered the differing views of the experts. It noted that when considering the need to palpate the patient's abdomen to identify the lie of the foetus, Dr I stated this is crucial even at 28 weeks, to accurately assess the SFH measurement. Professor K said it was not important at 28 weeks of pregnancy but would be after 32 weeks.

21. Professor K described Dr I's view in his oral evidence as "*very extreme*" regarding the importance of assessing the lie of the foetus at 28 weeks. Professor K was asked about this in cross-examination by Mr Toal for the GMC and said:

> *"I don't think there is good evidence for identifying the lie before you take SFH in the early stages pregnancy".*

22. It was suggested to him that Dr I says it is important. Professor K responded:

> *"yes, she has a view that it should be done with 100% certainty. She has a very extreme view that every lie of the foetus is crucial at that gestation".*

In re-examination Professor K stated:

> *"I know from my colleagues who do clinics I expect there will be some who don't examine the lie at 28 weeks. I find it very difficult to have a clinician say that the lie of the foetus is crucial at 28 weeks because it will alter the SFH because, no it won't".*

Asked how does Dr I's view accord with others he answered:

> *"there's a spectrum."*

23. The Tribunal notes that palpating for the "lie of the baby" does not form part of the charges against Dr Okwole that it has to consider. In hearing the experts' evidence, the Tribunal recognised the differing views of Dr I and Professor K in regard to the need to identify a baby's lie at 28 weeks gestation. Dr I was of the view that it was crucial in keeping with her programme to reduce stillbirths through the early identification of babies with low birth weight at 28 weeks. Professor K was of the view that it was not crucial and indeed not important at that early gestation. He indicated that neither he nor his colleagues would routinely identify a baby's lie at 28 weeks. The Tribunal notes that there is a spectrum of views.

24. The Tribunal concluded that within that spectrum Dr I was clearly strongly opinionated about the degree of care which was required and necessary to minimise

the risk of stillbirths. Professor K's views seemed more measured, reflecting his practice and that of his colleagues.

25. Where the experts differed in their views as to whether Dr Okewole's behaviour was below or seriously below the standard expected of a Consultant in Obstetrics and Gynaecology, the Tribunal preferred the opinion of Professor K. The Tribunal acknowledged that Dr I's view may align with best or optimum practice, but determined that Dr Okewole's actions should be assessed against the standards expected of and demonstrated by his peers. To hold him to higher standards than those expected of a competent fellow practitioner would be unjust.

26. In relation to paragraphs 1(b) and 2 of the Allegation, the Tribunal finds that Dr Okewole's failure to use a tape measure, and plotting a measurement on Patient A's growth chart fell below the standards expected.

Patient B

27. The two expert witnesses agreed that Dr Okewole's failure to obtain informed consent for the procedure which he carried out on Patient B, the Procedure itself and the lack of post-operative discussion with Patient B at paragraphs 5(a), (d) and (f) of the allegation, fell seriously below the standards expected of a Consultant in Obstetrics and Gynaecology.

28. The expert witnesses regarded Dr Okewole's conduct in paragraphs 5(b) and (c) of the Allegation as falling below the expected standards of a Consultant in Obstetrics and Gynaecology, but not seriously.

29. The expert witnesses regarded Dr Okewole's conduct regarding paragraph 5(e) of the Allegation as falling below the standards expected of a Consultant in Obstetrics and Gynaecology, but not seriously. Their opinion depended upon the Tribunal finding that Dr Okewole did believe that he had removed the lesion on the appropriate side and that the error lay with the typed letter.

30. The Tribunal found Dr Okewole to be honest. When Dr Okewole could not find the right sided labial polyp his evidence is that he looked at the referral letter. That letter, he asserted, contained an inaccuracy recording 'the polyp was excised' when it was clearly not and hence the need for surgery. Having found no polyp on the right side but a cyst on the left side, Dr Okewole's evidence was that he concluded the letter stating 'right' was in error and he proceeded to remove the left sided cyst.

31. The Tribunal notes that there is no supporting evidence that Dr Okewole looked at the referral letter during the procedure. The GMC did not challenge Dr Okewole's evidence in regard to his assertions of inaccuracies regarding the words "right", "excised" or the fact that Dr Okewole removed a cyst and not a polyp. The

letter does include the word "excised" which is inconsistent with the request for surgery. The Tribunal find that he did believe the reference to "right" was an error in the referral letter.

32. The Tribunal finds that Dr Okewole's actions fell seriously below the standards expected of a Consultant in Obstetrics and Gynaecology on four of the charges in relation to Patient A and Patient B, and below the standards expected in regard to five of the charges.

33. The Tribunal has therefore concluded that Dr Okewole's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

34. The Tribunal having decided that the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct, Dr Okewole's fitness to practise is currently impaired.

CURRENT IMPAIRMENT

35. In reaching its determination on whether Dr Okewole's fitness to practise is currently impaired the Tribunal has borne in mind all three limbs of the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act), namely:

i) to protect, promote and maintain the health, safety and well-being of the public,
ii) to promote and maintain public confidence in the medical profession, and,
iii) to promote and maintain proper professional standards and conduct for members of that profession.

36. Dr Okewole's misconduct engaged all three limbs of the overarching objective. His conduct demonstrated he could have posed a risk to the public's wellbeing, that he undermined public confidence in the medical profession and in the maintaining of standards within the profession.

37. The Tribunal's opinion was that Dr Okewole's conduct was in breach of the expected duties of a doctor. It noted that it was his general practice to use the finger breadth method, when examining for SFH measurement. Dr Okewole's knowledge was out of date regarding the measuring of SFH as a means to reduce stillbirths and he had not appreciated the importance of not using finger breadths to assess foetal size. Doctors must keep their skills up to date.

38. The Tribunal were mindful of the following paragraphs of GMP:

> ***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.*
>
> ***7.*** *You must be competent in all aspects of your work, including management, research and teaching.*
>
> ***8.*** *You must keep your professional knowledge and skills up to date.*
>
> ***11.*** *You must be familiar with guidelines and developments that affect your work.*
>
> ***15.*** *You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> > ***a.*** *adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
> >
> > *…*
>
> ***19.*** *Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*

39. The Tribunal noted that in relation to Patient B, Dr Okewole failed to obtain adequate consent before the Procedure or communicate his actions to remove a left labial cyst to Patient B afterwards. He failed to communicate in the operating room with the operating team, his inability to identify the right sided polyp. In short, he failed to communicate effectively with colleagues and Patient B.

40. The Tribunal considered the following paragraphs of GMP in relation to these matters:

> ***16.*** *In providing clinical care you must:*
>
> *…*
>
> ***d.*** *consult colleagues where appropriate*
>
> *…*

> ***17.*** *You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.*
>
> ***49.*** *You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:*
>
> > ***a.*** *their condition, its likely progression and the options for treatment, including associated risks and uncertainties*
> >
> > *…*
>
> ***32.*** *You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.*
>
> ***35.*** *You must work collaboratively with colleagues, respecting their skills and contributions.*
>
> ***68.*** *You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.*

41. The Tribunal considered Dr Okewole's insight into the matters before it: his attendance at courses acquiring considerably more CPD than would be required in a single year; his remediation through his reflective statement and reflections during courses he attended and of the lectures he has delivered; his oral evidence during the proceedings.

42. The Tribunal concluded that Dr Okewole has insight in relation to nearly all aspects of his misconduct. He has clearly demonstrated reflection and undertaken CPD in relation to communication, consent, managing difficult interactions, and an online GAP training in the growth of babies.

43. Dr Okewole has shared his experiences with his colleagues and used his mistakes as examples in guiding and educating junior colleagues, and has lectured on record keeping and consent. The Tribunal considered that this represents insight, remediation and a modesty on Dr Okewole's part that he is able to both learn from his mistakes, and share his experiences openly for the benefit of the profession.

44. Dr Okewole states he has accepted the findings of the Tribunal and does not seek to undermine them. Although he has not admitted paragraph 1(a) of the Allegation, his failure to palpate, the Tribunal were provided with some assurance that he has nonetheless gained insight and demonstrated remediation in relation to this paragraph of the Allegation.

45. In his oral evidence, Dr Okewole described to the Tribunal how his current practice is to explain each step and procedure to the patient when undertaking foetal assessments, so there is no risk of confusion on the part of the patient as to what has occurred. This process also serves as a form of examination checklist.

46. The Tribunal considered whether Dr Okwole's misconduct was remediable, had been remedied and the likelihood of repetition. It concluded that his misconduct was remediable because it concerns clinical skills, not behavioural nor attitudinal issues. Through his insight, training, use of procedures and practice his misconduct regarding Patient B is fully remediated. The complaints made over two years ago were isolated incidents with no complaints before or since. He has repeatedly expressed considerable remorse from the first incident onwards. The likelihood of repetition is low and the risk to patient safety in the future minimal.

47. However, the Tribunal has residual concern that Dr Okewole has continued to use the finger breadth method of measuring SFH, albeit in conjunction with a tape measure. This was in evidence during the impairment stage of the hearing when Dr Okewole accepted that he last used the finger breadth method at his last antenatal clinic. He told the Tribunal he now intended to stop his practice of using the finger breadth method. On questioning from the Tribunal he acknowledged to the Tribunal that the use of the finger breadth method increased the likelihood that he might forget to use the tape measure.

48. The Tribunal appreciated his honesty in admitting that he had still been using the finger breadth method. The Tribunal acknowledges that it is an unusual occurrence of Dr Okewole to make the first assessment of a low risk patient, as Patient A was, at 28 weeks gestation. He has now reflected on the evidence of the expert witnesses and his own standard of practice. However, the Tribunal is not of the opinion that his behaviour can be considered fully remediated in this regard as it remains untested.

49. The Tribunal was of the view that this aspect of Dr Okewole's misconduct is fully remediable. His admission represents the necessary insight to remediate. Due to the timing of his acceptance that he should not use the finger breadth method, remediation has not yet been demonstrated in his antenatal clinical examinations.

50. The Tribunal recognises the need to uphold proper professional standards and to maintain public confidence in the profession. This would be undermined if a finding of impairment were not made.

51. The Tribunal has therefore determined that Dr Okewole's fitness to practice is impaired by reason of misconduct.

Determination on Sanction - 03/03/2020

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

The Evidence

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

Submissions

3. On behalf of the GMC, Mr Toal, Counsel, submitted that the position of the GMC is that a period of suspension is the suitable and proportionate sanction to impose in the circumstances of this case, with the length of suspension to be left to the Tribunal's discretion.

4. Mr Toal submitted that there are no exceptional circumstances in this case that could justify the Tribunal taking no action, and the imposition of undertakings or conditions on Dr Okewole's registration would not sufficiently mark the seriousness of his misconduct, as found by this Tribunal in its determinations on facts and impairment.

5. Mr Toal submitted that a period of suspension would be the appropriate and proportionate response to the findings of this Tribunal and reflects that Dr Okewole's misconduct was serious, but not fundamentally incompatible with continued registration. For this reason, the GMC is not seeking erasure or inviting the Tribunal to do so in this case.

6. On behalf of Dr Okewole, Mr Mahmood, Counsel, submitted that a 3 month period of conditions would be the proportionate and appropriate sanction in this case, and would meet the concern and address the gap set out in its impairment determination.

7. In his submissions, Mr Mahmood accepted that there are no exceptional circumstances in this case which would justify the Tribunal taking no action following its finding of impairment.

8. Mr Mahmood submitted that in light of the mitigating and aggravating factors of the case and the limited and narrow scope of current impairment identified by the tribunal, a period of conditions would be sufficient. These would adequately mark the seriousness of Dr Okewole's misconduct and also provide a route for him to address the outstanding concern of the Tribunal, namely that he will discontinue his use of the finger breadth method when measuring SFH.

9. Mr Mahmood submitted that as a Senior Consultant, the imposition of conditions requiring supervision of Dr Okewole could be unworkable and jeopardise Dr Okewole's position, and that this would certainly be the case were a period of suspension to be imposed. Whilst sanctions may be punitive, that is not their intent, and to do so would be wholly disproportionate given the Tribunal's finding that only one aspect of his misconduct remains to be remediated.

The Tribunal's Approach

10. The Tribunal received legal advice from the Chair which was accepted by each party. The Tribunal has taken into account the statutory overarching objective. It has considered each limb separately and has not given excessive weight to any one limb. It noted that the purpose of imposing sanctions is to protect the public and not to be punitive, albeit that a sanction may have a punitive effect.

11. It has applied the principle of proportionality and has sought to balance the interests of the doctor against the public interest but it has noted that if the public interest demands a particular sanction and no other, that sanction must be imposed. In *Bolton v Law Society* [1994] 1 WLR 512, the court held that, "*the reputation of the profession is more important than the fortunes of any one individual member. Membership of a profession brings many benefits, but that is a part of the price*".

12. The Tribunal first identified the aggravating and mitigating features of the case. In the light of those features and its findings generally, it then considered each sanction in turn, starting with the least restrictive. Throughout its consideration, it took account of the relevant paragraphs of the Sanctions Guidance (2019) ('SG') and GMP.

The Tribunal's Determination on Sanction

<u>Mitigating Factors</u>

13. The Tribunal considered the mitigating features in this case.

<u>Patient A</u>

- Dr Okewole invited Patient A for a second examination when the issue was raised with him;

- He apologised to the patient in a letter addressed to a consultant in the hospital dated 22 September 2017;
- He admitted his failure to use the tape measure at the first examination and was found to be truthful in giving evidence;
- He has expressed remorse throughout;
- He has now demonstrated insight into all matters in relation to this patient;
- He completed a growth assessment protocol (GAP) e-learning training and intends to attend a future RCOG Northern Professional Development Conference, which includes consent and foetal growth monitoring;
- His good character with no previous history of complaints;
- This was an isolated incident;
- The positive testimonials provided on Dr Okewole's behalf.

Patient B

- There were issues/inconsistencies in the referral letter;
- The theatre time that day overran, beginning at 13.30 and ending at 18.40 such that there was a time pressure;
- He had recorded that he intended to follow up with the patient the same day, prior to the theatre overrunning;
- He has attended training in consent, communication and record keeping;
- He has put in place a new checklist for himself for pre-operative care to ensure no repetition;
- He admitted his misconduct from the start and was found truthful in evidence;
- He has demonstrated insight through training and reflection on his conduct;
- Dr Okewole has demonstrated full remediation in relation to this patient;
- There have been no complaints since against Dr Okewole;
- The positive testimonials and appraisal of Dr Okewole's work by colleagues, and positive patient feedback.

Aggravating Factors

14. The Tribunal considered the aggravating features in this case.

Patient A

- It was a failure to correctly undertake a basic procedure;
- He appeared to be unfamiliar with plotting the patient's SFH measurement on the GROW chart;
- He did not follow the good practice recommended of using a tape measure to determine SFH at the outset but relied upon his use of finger breadths, an out of date method not recommended in this country since 2000;

- Dr Okewole's late recognition at the impairment stage that the finger breadth method should no longer be used and that its use could cause him to forget to use a tape measure.

Patient B

- He failed to examine the patient pre-operatively even after she had put him on notice that the polyp was very small;
- He conducted an invasive procedure without obtaining adequate consent, and failed to immediately report this to the patient;
- A failure to work collaboratively with colleagues or raise concerns that there was no right polyp apparent but there was a left cyst.

No action

15. The Tribunal first considered taking no action in this case. It determined that this would be wholly inappropriate given the finding of serious misconduct and in light of the overarching objective. This opinion was also reflected in the submissions of both parties.

Conditions

16. The Tribunal then went on to consider the sanction of conditions. In doing so, it was mindful of the following paragraphs of the SG:

> ***81*** *Conditions might be most appropriate in cases:*
>
> ***…***
>
> ***b*** *involving issues around the doctor's performance*
>
> ***c*** *where there is evidence of shortcomings in a specific area or areas of the doctor's practice*
>
> ***…***
>
> ***82*** *Conditions are likely to be workable where:*
>
> ***a*** *the doctor has insight*
>
> ***…***
>
> ***c*** *the tribunal is satisfied the doctor will comply with them*
>
> ***…***

> ***84*** *Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:*
>
> > ***a*** *no evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage*
> >
> > ***b*** *identifiable areas of their practice are in need of assessment or retraining*
> >
> > ***c*** *willing to respond positively to retraining, with evidence that they are committed to keeping their knowledge and skills up to date throughout their working life, improving the quality of their work and promoting patient safety (Good medical practice, paragraphs 7–13 on knowledge, skills and performance and paragraphs 22–23 on safety and quality)*
> >
> > ***d*** *willing to be open and honest with patients if things go wrong (Good medical practice, paragraphs 55 and 61)*
> >
> > ***…***
>
> ***85*** *Conditions should be appropriate, proportionate, workable and measurable.*
>
> ***88*** *The tribunal should consider whether the conditions imposed should take effect immediately, taking into account any evidence received and any submissions made by the parties. The tribunal should explain fully the reasons for its decision.*
>
> ***89*** *The tribunal should clearly set out the objectives of the conditions so the doctor knows what is expected of them. This is also important to help tribunals at future review hearings understand the original findings and the exact proposals to respond to them, and to evaluate whether the issues have been resolved.*

17. The Tribunal was of the opinion that conditions would allow Dr Okewole to continue to improve his practice while addressing the outstanding concern, namely his use of the finger breadth method in the measurement of SFH.

18. The Tribunal considered whether a period of conditions would address the key concerns in this case and uphold the overarching objective. A period of conditions would suitably address the outstanding aspect of Dr Okewole's practice,

for which full remediation has yet to be demonstrated. These proceedings and the findings made against Dr Okewole, when combined with the imposition of conditions to ensure his remediation is completed, would adequately serve to maintain public confidence and maintain standards within the profession.

19. A sanction of conditions would allow Dr Okewole to continue working whilst immediately applying his newfound insight when examining antenatal patients that he palpate the patient's abdomen and use a tape measure when measuring SFH. It noted that there is no identified risk to public safety. The Tribunal wants Dr Okewole to have the opportunity to amend his practice, refraining from using the finger breadth method and relying solely on a tape measure, or ultrasound as appropriate. The advantage of his applying current good practice will benefit the public.

20. The Tribunal determined that any period of conditions would need to be of sufficient length to allow Dr Okewole to demonstrate remediation, particularly given the infrequency with which he measures SFH at 28 weeks.

21. The Tribunal also considered that conditions regarding Dr Okewole's misconduct towards Patient B would ensure that his newly adopted checklist for use with pre-operative patients could be demonstrated.

22. The Tribunal, conscious of the need to also reflect that Dr Okewole's misconduct undermined public confidence in the profession and brought the medical profession into disrepute, went on to consider whether a suspension would be more appropriate.

Suspension

23. The Tribunal then went on to consider the sanction of suspension. In doing so, it was mindful of the following paragraphs of the SG:

> ***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 (ie for which erasure is more likely to be the appropriate sanction because the*

tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

24. The Tribunal noted that a period of suspension would mark the seriousness of Dr Okewole's misconduct. In its determination on impairment it found that public confidence in the profession would be undermined if Dr Okewole were not found impaired, and an appropriate and proportionate sanction is also necessary to uphold public confidence.

> ***93*** *Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated.*
>
> ***95*** *In such cases, to protect the public, the tribunal might wish to impose a period of suspension. The suspension will need to be reviewed and therefore a review hearing should be directed. Such a direction should indicate in broad terms the type of action and evidence of remediation (such as complying with any invitations from the GMC to undergo a performance assessment or English language assessment) which, if carried out during the period of suspension, may help the tribunal's evaluation at and subsequent review hearing. However, the tribunal should bear in mind that during the period of suspension the doctor will not be able to practise*
>
> ***97*** *Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> > ***a*** *A serious breach of Good Medical Practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors*
> >
> > ***...***
> >
> > ***e*** *No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
> >
> > ***f*** *No evidence of repetition of similar behaviour since incident.*
> >
> > ***g*** *The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.*

25. The Tribunal considered whether a period of suspension would address its concerns. Whilst this would mark the seriousness of Dr Okewole's misconduct and send a signal to the profession, it would prevent him from practising and would mean that for any period of suspension he would not be able to demonstrate or put into effect the remediation of his use of the finger breadth method in measuring SFH. In addition there would be no monitoring of his change of practice.

26. The Tribunal also balanced the need to maintain public confidence in the profession and the wider public interest, namely that a period of suspension would deprive the public of an otherwise competent practitioner.

27. The Tribunal was also mindful of the fact that as a Senior Consultant, any period of suspension could have a significant impact on Dr Okewole's position, and potentially jeopardise his position. Whilst this would not be deliberately punitive and the Tribunal would not seek to lessen a proportionate sanction to prevent this, it is nonetheless a consideration.

Erasure

28. The Tribunal determined that erasure would be extremely disproportionate in light of the fact that Dr Okewole's behaviour is largely remediated and the outstanding aspects are fully remediable, as well as due to the lack of patient safety concerns.

29. The Tribunal noted that the GMC did not seek erasure and to do so is not merited in this case.

<u>The Tribunal's Decision</u>

30. The Tribunal therefore determined to impose a nine month period of conditions on Dr Okewole's registration. The following conditions are applicable in this case:

1 He must personally ensure the GMC is notified of the following information within seven calendar days of the date these conditions become effective:

a The details of his current post, including:

i his job title
ii his job location
iii his responsible officer (or their nominated deputy)

b the contact details of his employer and any contracting body, including his direct line manager

c any organisation where he has practising privileges and/or admitting rights

d any training programmes he is in

e of the contact details of any locum agency or out of hours service he is registered with.

2 He must personally ensure the GMC is notified:

a of any post he accepts, before starting it

b that all relevant people have been notified of his conditions, in accordance with condition 6

c if any formal disciplinary proceedings against him are started by his employer and/or contracting body, within seven calendar days of being formally notified of such proceedings

d if any of his posts, practising privileges, or admitting rights have been suspended or terminated by his employer before the agreed date within seven calendar days of being notified of the termination

e if he applies for a post outside the UK.

3 He must allow the GMC to exchange information with any person involved in monitoring his compliance with his conditions.

4 a He must have a workplace reporter appointed by his responsible officer (or their nominated deputy).

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his workplace reporter

ii he has personally ensured that the GMC has been notified of the name and contact details of his workplace reporter.

5 a He must design a Personal Development Plan (PDP), with specific aims to address the deficiencies in the following areas of his practice:

- Examination of all ante-natal patients with specific reference to measuring SFH and plotting each patient's GROW chart;

- Ensuring any SFH measurement does not include the use of finger breadths;
- Maintaining up to date knowledge of the value of measuring SFH from 28 weeks onwards, and following current Good Practice Guidance including Saving Babies' Lives;
- He must keep a log detailing every case where he measures the SFH, with the method logged accordingly;
- Keeping a log of his practice of discussion and examination of patients pre-operatively; their consent; communicating with the theatre staff; his post-operative contact with the patient;
- He must give the GMC a copy of these logs on request;

b His PDP must be approved by his responsible officer (or their nominated deputy).

c He must give the GMC a copy of his approved PDP within three months of these substantive conditions becoming effective.

d He must give the GMC a copy of his approved PDP on request.

e He must meet with his responsible officer (or their nominated deputy), as required, to discuss his achievements against the aims of his PDP.

6 He must personally ensure the following persons are notified of the conditions listed at 1 to 5:

a his responsible officer (or their nominated deputy)

b the responsible officer of the following organisations:

i his place(s) of work, and any prospective place of work (at the time of application)

ii all of his contracting bodies and any prospective contracting body (prior to entering a contract)

iii any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application)

iv any locum agency or out of hours service he is registered with

v if any of the organisations listed at (i to iv) does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within that organisation. If he is

unable to identify that person, he must contact the GMC for advice before working for that organisation.

c the approval lead of his regional Section 12 approval tribunal (if applicable) - or Scottish equivalent

d his immediate line manager and senior clinician (where there is one) at his place of work, at least 24 hours before starting work (for current and new posts, including locum posts).

31. The Tribunal determined to direct a review of Dr Okewole's case. A review hearing will convene shortly before the end of the period of conditional registration, unless an earlier review is sought.

32. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Okewole to demonstrate how he has addressed the concerns of the Tribunal in relation to:

- his use of a tape measure;
- the implementation of his pre and post-operative patient care.

33. It therefore may assist the reviewing Tribunal if Dr Okewole provides copies of his PDP, and logs of supportive evidence together with any training material or guidance in this regard. Dr Okewole will also be able to provide any other information that he considers will assist.

Determination on Immediate Order - 03/03/2020

1. Having determined to impose conditions on Dr Okewole's registration for a period of nine months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Okewole's registration should be subject to an immediate order.

Submissions

2. On behalf of Dr Okewole, Mr Mahmood submitted that having reviewed the conditions set out in the Tribunal's determination on sanction, Dr Okewole is content for an immediate order to be imposed in this case.

3. On behalf of the GMC, Mr Toal submitted that the GMC supports the imposition of an immediate order in this case. Given the Tribunal's findings that the conditions will allow Dr Okewole to continue to practise whilst addressing and remediating the SFH measurement issue identified by the Tribunal, this would be in the best interests of the public and Dr Okewole himself.

The Tribunal's Determination

4. In reaching its decision the Tribunal referred to the relevant paragraphs of the SG. It exercised its own judgement and had regard to 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, is in the public interest, or is in the best interests of the practitioner. It also took into account the submissions made by Mr Mahmood, on behalf of Dr Okewole and Mr Toal, on behalf of the GMC.

5. The Tribunal had particular regard to the following paragraph of the SG, namely in relation to public protection and public interest:

> ***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.*

6. The Tribunal considered the submissions made by both parties, and acknowledged that the implementation of an immediate order was agreed by both parties, and would allow Dr Okewole to continue to practise whilst immediately beginning the implementation of measuring SFH in accordance with good practice and keeping the logs identified within the conditions.

7. The Tribunal noted that there are no patient safety concerns in this case, but that given the submissions of both parties and its findings at the earlier stages of proceedings, an immediate order would both uphold the overarching objective and allow Dr Okewole to continue practising while at the same time addressing the concerns of the Tribunal and implementing the necessary changes to his practice.

8. The Tribunal therefore determined that an immediate order was appropriate in this case.

9. This means that Dr Okewole's registration is subject to conditional registration from today. The substantive direction, as already announced, will take effect 28 days from today, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

10. There is no interim in order in place to revoke.

11. That concludes the case.

Confirmed
Date 03 March 2020 Miss Gillian Temple-Bone, Chair

ANNEX A – 27/02/2020

Application to Amend the Allegation

1. The Tribunal proposed an amendment to paragraph 1(b) of the Allegation under Rule 17(6) of the General Medical Council ('GMC') (Fitness to Practise Rules) 2004 as amended ('the Rules').

Rule 17(6) states:

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

2. The Tribunal noted that the current wording of the paragraph, presupposes palpation occurred when in fact the GMC case is that it did not. It proposed the following amendment to address this inconsistency.

b. ~~subsequent to palpation measure the symphysis-fundal height ('SFH') using a tape measure~~.

in your first examination of Patient A's abdomen measure the symphysis-fundal height('SFH') using a tape measure

3. The Tribunal accordingly heard submissions from the parties on the proposed amendment.

4. Mr Toal, Counsel on behalf of the GMC, submitted that the GMC oppose the amendment on the following grounds:

i. palpation is necessary for there to be any measurement of the SFH

ii. The GMC case is that there was no palpation at either the first or second examination of Patient A

iii. The proposed amendment suggests that the later use of the tape measure was adequate

5. Mr Toal submitted that the GMC position is that failure to palpate Patient A's abdomen or use a tape measure in recording the SFH both represent serious failings on the part of Dr Okewole and the Allegation reflects this position.

6. Mr Mahmood, on behalf of Dr Okewole, did not oppose the proposed amendment. He indicated that if the amendment was allowed, the amended paragraph of the Allegation would be admitted. The amendment would correct the factual error highlighted by the Tribunal and it would be appropriate to amend it in the manner proposed.

7. Mr Mahmood submitted that he had proposed such an amendment to the GMC earlier in proceedings but this was rejected. He also submitted that the GMC's case has never been that Dr Okewole had failed to palpate on two occasions, or that his use of a tape measure was inappropriate. The experts never explored whether the use of the tape measure on the second occasion was appropriate or not.

8. The Tribunal indicated that on the present wording if they found that no palpation had occurred then it would not be able to find Dr Okewole subsequently failed to use a tape measure.

9. Tribunal acknowledged that the GMC are not in favour of the proposed amendments but accepted the arguments put forward by Mr Mahmood why it should be amended.

10. Having heard from both parties, the Tribunal was satisfied that the proposed amendment to paragraph 1(b) of the Allegation would correct the factual error highlighted by the Tribunal and that the amendment could be made without injustice.

11. The Tribunal therefore determined to amend the Allegation accordingly.