PUBLIC RECORD

Dates: 08/09/2022 - 21/09/2022
19/12/2022 – 21/12/2022

Medical Practitioner's name:	Dr Izunna UZOKWE
GMC reference number:	5151372
Primary medical qualification:	MB BS 1982 University of Nigeria

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment not found proved	Not impaired

Summary of outcome

Warning not considered

Tribunal:

Legally Qualified Chair	Ms Chitra Karve
Lay Tribunal Member:	Ms Gail Mortimer
Medical Tribunal Member:	Dr Candida Borsada

Tribunal Clerks:	Ms Jennifer Lane (8 – 21 September 2022) Mr Michael Murphy (19 – 21 December 2022)

Attendance and Representation:

Medical Practitioner:	Present and not represented (not present or represented 21 December 2022)
Medical Practitioner's Representative:	N/A
GMC Representative:	Mr Christopher Hamlet, 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 - 20/12/2022

Background

1. Dr Uzokwe qualified in 1982 with an MBBS from the University of Nigeria. At the time of the events Dr Uzokwe was practising as a Locum Consultant Psychiatrist at Cambridge and Peterborough NHS Foundation Trust ('the Trust'), where he worked between April 2019 and August 2019.

2. The Allegation that has led to Dr Uzokwe's hearing can be summarised as Dr Uzokwe failing to provide adequate care to four patients, Patient A, B, C, and D, between 15 May and 8 August 2019.

3. It is also alleged that Dr Uzokwe made a dishonest statement to Patient D in order to encourage the patient to share information; that Dr Uzokwe made inappropriate statements about a patient to a colleague; and when consulting with Patient F, used information he was aware of relating to Patient F's paranoiac beliefs in an inappropriate manner.

4. The initial concerns were raised with the GMC on 20 August 2019 by Dr G, Medical Director at the Trust, who completed a Fitness to Practise Referral Form in which she raised the following concerns:

- Dr Uzokwe stopped a depot medication for a patient with longstanding psychotic illness and discharged the patient to a GP. Dr Uzokwe did not prescribe any further oral medication;
- Dr Uzokwe dishonestly purported that a patient would have to undertake a drugs test if he did not provide details of his substance misuse;

- Dr Uzokwe told a patient with delusions about the Police that he worked for them, showing him a Police visitor ID badge, causing great distress to the patient and a breakdown in therapeutic relationship with the team;
- Dr Uzokwe diagnosed a patient with Bipolar and then 4 weeks later changed the diagnosis to mood disorder and discharged the patient with minimal communication and offering no alternative action;
- Dr Uzokwe had made significant medication changes with little explanation or discussion with the team.

5. Dr G advised that an internal investigation would be carried out and said that Dr Uzokwe's contract had been ended with immediate effect on 15 August 2019.

The Outcome of Applications Made during the Facts Stage

6. 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 make amendments to the Allegation and withdraw a number of subparagraphs. The Tribunal's full decision on the application is included at Annex A.

7. The Tribunal granted Dr Uzokwe's application, made pursuant to Rule 34 of the Rules, for additional documents to be placed before the Tribunal. The Tribunal's full decision on the application is included at Annex B.

8. The Tribunal also considered Dr Uzokwe's application, made pursuant to Rule 17(2)(g) of the Rules for no case to answer in respect of all the remaining paragraphs of the Allegation. The Tribunal determined to grant the application in respect of paragraph 1(b)(ii) only. The Tribunal's full decision on the application is included at Annex C.

The Allegation and the Doctor's Response

9. The Allegation made against Dr Uzokwe is as follows:

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

1. On 15 May 2019 and/or 8 August 2019 you consulted with Patient A and on one or more occasion you failed to:

    a. carry out an adequate assessment of Patient A in that you did not consider/clarify Patient A's:

        i. hypothyroidism; To be determined.

        ii. vitamin D deficiency; To be determined.

        iii. iron deficiency; To be determined.

        iv. recent thyroid function tests; To be determined.

        v. degree of anxiety or depression; To be determined.

        vi. views on her body image; To be determined.

        vii. active thoughts related to her previous eating disorder; To be determined.

    b. appropriately diagnose Patient A in that you:

        i. did not fully elucidate Patient A's underlying symptoms; To be determined.

        ii. ~~did not fully justify the emotionally unstable personality disorder diagnosis;~~ Withdrawn following successful 17(2)(g) application.

        iii. did not take into account Patient A's zopiclone dependency or use of benzodiazepines; To be determined.

        iv. did not establish the severity of Patient A's depression; To be determined.

        v. did not include the diagnosis of hyperthyroidism or of vitamin D deficiency; To be determined.

vi. diagnosed Patient A with an adjustment disorder without justification; To be determined.

c. document:

i. an objective and/or agreed treatment goal; To be determined.

~~ii. Patient A's request for re-diagnosis;~~ Withdrawn following 17(6) application.

~~iii. any request from Patient A for dialectical behaviour therapy, or to join a vagus nerve stimulation trial;~~ Withdrawn following 17(6) application.

~~iv.~~ii. Patient A's hypothyroidism diagnosis; To be determined.

d. adequately manage Patient A in that you:

i. reduced Patient A's benzodiazepine intake without:

1. medical supervision; To be determined.

2. seeking advice from a drug and alcohol consultant; To be determined.

3. considering referring Patient A for cognitive behavioural therapy; To be determined.

ii. did not explain in Patient A's notes the rationale for your treatment including why you had prescribed 25mg of quetiapine; To be determined.

~~iii. offered to prescribe medication in exchange for keeping an activity diary;~~ Withdrawn following 17(6) application.

~~iv.~~iii. failed to conduct blood screening, in view of Patient A's hypothyroidism and Vitamin D deficiency; To be determined.

~~e. refer Patient A for further investigation of her hypothyroidism;~~
Withdrawn following 17(6) application.

~~f.~~ e. adequately prescribe to Patient A in that you did not adopt a structured withdrawal regime for zopiclone with the consent of Patient A. To be determined.

2. On 3 July 2019 you consulted with Patient B and you:

a. failed to carry out an adequate assessment of Patient B in that you did not:

i. obtain an adequate history including a failure to take note of Patient B's:

1. psychiatric history; To be determined.

2. admission of 2016 when he presented with thought disorder and bizarre command hallucinations; To be determined.

3. referential delusions; To be determined.

4. first appointment with Huntingdon Adult Locality Team ('HALT') on 25 February 2019; To be determined.

ii. carry out an adequate mental state examination in that you did not:

1. specify any symptoms of depression other than sleep, weight and appetite changes; To be determined.

2. mention Patient B's anxiety in his notes; To be determined.

3. carry out an adequate suicide risk assessment including a failure to refer to or factor in previous suicide attempts; To be determined.

iii. take into account a recent assessment of Patient B which suggested he suffered from a psychotic illness and not a mood disorder; To be determined.

b. failed to appropriately diagnose Patient B in that you failed to take into account:

i. some of Patient B's history; To be determined.

ii. a recent assessment of Patient B which suggested Patient B suffered from a psychotic illness and not a mood disorder; To be determined.

c. failed to implement an appropriate treatment plan in that you did not:

i. take into account Patient B's misgivings about coming off depot antipsychotic medication; To be determined.

ii. discuss with the secondary care team the change in Patient B's treatment plan; To be determined.

d. failed to appropriately prescribe to Patient B in that you:

i. stopped Patient B's depot medication; To be determined.

ii. did not offer and/or discuss alternative medication options having stopped depot medication; To be determined.

iii. did not include the following in the decision-making process:

1. Patient B; To be determined.

2. the previous clinician; To be determined.

3. the secondary care team; To be determined.

4. Huntingdon Adult Locality Team; To be determined.

iv. did not liaise with Patient B's GP with regards to the administering of tapering depot injection medication despite express advice

from the Community Mental Health Team that you do so; To be determined.

e. inappropriately discharged Patient B when:

i. Patient B's emerging symptoms of tardive dyskinesia necessitated Patient B remaining under the care of secondary services until the symptoms had resolved; To be determined.

ii. Patient B had a history of command hallucinations; To be determined.

f. failed to appropriately communicate with Patient B's GP in that:

i. your discharge letter to the GP failed to include a crisis contingency plan; To be determined.

ii. you did not discuss the major change in Patient B's medication. To be determined.

3. You reviewed Patient C and on 23 July 2019 you:

a. changed Patient C's diagnosis from Bipolar disorder to Unspecified Mood Disorder which was inappropriate because;

i. it was based upon your belief that Patient C was seeking a diagnosis for financial gain; To be determined.

ii. there was no, or no adequate formulation or rationale as to how you ruled out the diagnosis of Bipolar disorder; To be determined.

iii. there was evidence of previous episodes of continuous elevated mood fitting the hypomanic criteria, for more than a four-day period in Patient C's history; To be determined.

b. failed to take appropriate management action in that you did not:

i. consider alternative prescribing options; To be determined.

ii. discuss Patient C's needs with either Patient C or the allocated Community Psychiatric Nurse; To be determined.

iii. consider a referral to a Clinical Psychologist to clarify the diagnosis; To be determined.

c. inappropriately discharged Patient C without considering the:

~~i. view expressed by a member of the community team who had assessed Patient C over a number of home visits;~~ Withdrawn following 17(6) application.

~~ii.~~ i. views of the Community Practice Nurse; To be determined.

d. failed to appropriately communicate with Patient C in that you:

i. informed patient C of the change of diagnosis by telephone; To be determined.

ii. did not fully explain to Patient C the alteration in his diagnosis. To be determined.

4. On 23 July 2019 you consulted with Patient D and you:

a. failed to adequately record Patient D's history including a failure to adequately document:

i. Patient D's complaints; To be determined.

ii. Patient D's history of mental disorder; To be determined.

iii. your rationale to change Patient D's medication; To be determined.

b. failed to adequately assess Patient D in that you did not consider:

i. Patient D's mental wellbeing; To be determined.

ii. the significance of the bilateral shooting pains in Patient D's legs; To be determined.

iii. Patient D's forensic history; To be determined.

c. failed to appropriately refer Patient D:

i. to appropriate organisations for support; To be determined.

ii. regarding patient D's leg pain; To be determined.

d. failed to appropriately diagnose Patient D in that you:

i. failed to sufficiently investigate Patient D's symptoms to establish the:

1. extent of Patient D's grieving; To be determined.

2. phase of grief Patient D was in; To be determined.

ii. failed to revisit the depressive elements of Patient D's presentation; To be determined.

e. failed to devise an appropriate treatment plan in that your treatment plan did not take into account Patient D's significant vulnerability with regards to relapse and alcohol reinstatement; To be determined.

f. failed to appropriately prescribe to Patient D, in the context of Patient D's reported depressive history, in that you:

i. stopped Patient D's quetiapine; To be determined.

ii. reduced Patient 'D's zopiclone; To be determined.

g. showed Patient D a piece of paper ('the Paper') and told him to sign the Paper in preparation for ~~was~~ a drug screen test or words to that effect, in order to elicit information from Patient D regarding his substance misuse; Amended following Rule 17(6) application.

h. knew that that the Paper was not associated with a drug screen test. Amended following Rule 17(6) application.

5. Your actions as described at paragraph 4.g. were dishonest by reason of paragraph 4.h. To be determined.

~~6. On or around 24 July 2019 you spoke with Dr E, your manager, regarding Patient D and you inappropriately:~~

~~a. stated that 'drug addicts often lie' or words to that affect;~~ Withdrawn following 17(6) application.

~~b. described Patient D as a drug addict.~~ Withdrawn following Rule 17(6) application.

~~7.~~6. On or around 1 August 2019 you consulted with Patient F and you:

a. showed Patient F your police visitors ID badge; To be determined.

b. told Patient F that you could call the police to establish if they were carrying out investigations. To be determined.

~~8.~~7. You carried out the actions at paragraph 7 ~~6~~ when you knew that Patient F suffered from a recurrent paranoiac theme of being wanted by the police. Amended following Rule 17(6) application.

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

The Facts to be Determined

10. Dr Uzokwe did not make any admissions to the outstanding subparagraphs of the Allegation. In light of this, the Tribunal is required to determine whether Dr Uzokwe failed to provide adequate care to four patients, was dishonest in his consultation with Patient D, and used information he was aware of relating to Patient F's paranoiac beliefs in an inappropriate manner.

Witness Evidence

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

- Ms H, Community Psychiatric Nurse, the Team, by video link;
- Patient D, by video link.

12. Dr Uzokwe provided his own witness statement, dated 11 June 2022 and also gave oral evidence at the hearing.

Expert Witness Evidence

13. The Tribunal also received evidence from an expert witness, Dr I, Locum Consultant in Adult Psychiatry. Dr I had been instructed by the GMC to review the medical records of Patients A, B, C, D and F, along with other documents, in order to report on the standard of care received by each patient whilst under the care of Dr Uzokwe.

14. Dr I provided his expert report, dated 4 November 2020, and an email dated 3 August 2022. He provided a further supplementary report dated 5 September 2022 and gave oral evidence at the hearing.

Documentary Evidence

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

- Datix Incident Forms for Patient D, dated 3 September 2019 and 11 October 2019;
- Datix incident relating to all incidents, dated 6 September 2019;
- Medical records for Patients A, B, C and D;
- Patient A's letter of complaint, dated 20 August 2019;
- Clinic Letters to Patient A's GP dated 29 May 2019 and 12 August 2019;
- Clinic Letter to Patient B's GP dated 5 July 2019;
- Clinic Letters to Patient C's GP dated 22 July 2019 and 23 July 2019; and
- Clinic Letter to Patient D's GP dated 25 July 2019.
- RiO notes (mental health team notes) for Patients A, B, C and D.

16. The Tribunal also received a number of testimonials in support of Dr Uzokwe from his colleagues, patients and their families.

The Tribunal's Approach

17. 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 Uzokwe 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.

The Tribunal's Analysis of the Evidence and Findings

18. 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.

Patient A

Paragraph 1(a)(i)

19. The Tribunal first considered the evidence relating to Patient A. It is clear from the evidence that Dr Uzokwe saw Patient A on 15 May 2019 at the request of PRISM, and that appointment lasted an hour.

20. There was some confusion in the timeline as to whether this appointment was a full assessment. Dr Uzokwe, in his evidence, and in Patient A's notes stated that the appointment was an outpatient review. Dr I, the expert, refers to this appointment as a first assessment throughout his report. The Tribunal considered that there is evidence that a full assessment was carried out in February 2019, with a view to conducting a review in three months, which would make the May 2019 appointment a review. The Tribunal therefore determined the appointment in May 2019 was a review.

21. The Tribunal considered the duties of a psychiatrist during a review. Dr I in his oral evidence, stated that a review could be '*checking on medication, checking on the patient, or a follow up appointment*'. He also stated that a full assessment would take much longer than a review and would go into full history of the presenting complaint, past history, forensic

history, substance abuse history as well as social background. Dr Uzokwe agreed with Dr I's evidence on this point.

22. Dr Uzokwe stated that there is no time to consider other medical complaints such as hypothyroidism in a review appointment, and that the patient should discuss those issues with their GP. He also gave evidence of a shared care agreement in which if the psychiatry team were concerned that there could be a medical issue, such as hypothyroidism, they could raise it with the GP who would then investigate and vice versa. The Tribunal was of the view that had Patient A been presenting symptoms of hypothyroidism that had not previously been checked, then Dr Uzokwe would have had a duty to refer this to the GP. However, this was not a new complaint, and there is evidence that Dr Uzokwe was aware of her history at the time of the appointment, as he notes in his letter that she was taking *'Levothyroxine 100mcg'*, which is a drug used to treat hypothyroidism.

23. The Tribunal concluded that Dr Uzokwe did not have a duty to carry out an assessment of Patient A's hypothyroidism, and therefore there was no failure to clarify or consider Patient A's hypothyroidism.

24. Accordingly, the Tribunal found paragraph 1(a)(i) not proved.

Paragraph 1(a)(ii)

25. The Tribunal was of the view that it was reasonable for Dr Uzokwe to conclude that Patient A's GP was monitoring and treating her vitamin D deficiency, under the shared care agreement. The shared care arrangement would ensure Patient A was being monitored for these conditions and therefore Dr Uzokwe did not have that duty as part of the review process.

26. Accordingly, the Tribunal found paragraph 1(a)(ii) not proved.

Paragraph 1(a)(iii)

27. The Tribunal noted that Dr Uzokwe stated in his notes that Patient A was currently taking '*Ferrous Sulphate 200mg*' which is a medication used to treat iron deficiency. It was

clear from this that Dr Uzokwe was aware of and did consider Patient A's iron deficiency, although he does not explicitly state this in his records.

28. Therefore, the Tribunal found paragraph 1(a)(iii) not proved.

Paragraph 1(a)(iv)

29. The Tribunal was of the view that it was reasonable for Dr Uzokwe to conclude that Patient A's GP was monitoring and appropriately treating her hypothyroidism with Levothyroxine, under the shared care agreement. Therefore, Dr Uzokwe did not have that duty as part of the review process.

30. Accordingly, the Tribunal found paragraph 1(a)(iv) not proved.

Paragraph 1(a)(v)

31. The Tribunal did not receive any evidence directly from Patient A. Consequently, it has no basis on which to consider Patient A's degree of anxiety or depression at the time of the appointment with Dr Uzokwe. It noted that Dr Uzokwe does discuss Patient A's anxiety and depression in his letter to the GP following the review. Therefore, the Tribunal cannot find that Dr Uzokwe failed to consider Patient A's degree of anxiety or depression.

32. Accordingly, the Tribunal found paragraph 1(a)(v) not proved.

Paragraph 1(a)(vi)

33. The Tribunal took into account the clinic letter to the GP surgery, dated 29 May 2019, in which Dr Uzokwe stated:

> *'… good appetite with body image disturbance and no disturbance in form and content of thought.'*

34. The Tribunal has no evidence before it from Patient A to clarify what is meant by body image issues. Dr Uzokwe clearly mentioned body image disturbance in his letter to Patient A's GP, which implies he did discuss that with Patient A. Further it noted that Patient A was not

referred for an assessment because of body image issues. The Tribunal was of the view that, in the absence of any other evidence, it cannot conclude that the GMC has proved their case for this sub-paragraph.

35. Therefore, the Tribunal found paragraph 1(a)(vi) not proved.

Paragraph 1(a)(vii)

36. The Tribunal noted there was no evidence in the presented material of any active eating disorder, nor could it see any past diagnosis of an eating disorder. Dr Uzokwe reviewed Patient A after she had elective gastric bypass surgery and had lost a significant amount of weight. The Tribunal noted that there is mention of issues relating to the gastric bypass, medication causing weight gain, and significant weight loss, but there was no evidence of significant presenting factors in Patient A's mental health history to suggest an eating disorder. It also took into consideration that Dr Uzokwe is not a specialist in eating disorders. With all of these factors in mind, the Tribunal could not conclude that there was a failure to consider whether Patient A had active thoughts relating to a previous eating disorder.

37. Accordingly, the Tribunal found paragraph 1(a)(vii) not proved.

Paragraph 1(b)(i)

38. The Tribunal have already determined that this appointment was a review rather than a full assessment. It also clear that Dr Uzokwe did conduct a mental state examination in which he asked Patient A about her suicidal thoughts, self-harming and her substance misuse.

39. Dr I stated in a follow up email to his report, dated 3 August 2022, that this was a *''stand-alone' criticism rather than a systemic failing'.* Dr I also stated that there can be disagreements between clinicians, because patients may present differently to different consultants.

40. The Tribunal was of the view that there was significant information available in Patient A's records for Dr Uzokwe to consider which could direct him to potential underlying symptoms, which he does ask her about, and documents in his assessment of her mental

state. The Tribunal therefore does not find that there was a failure to elucidate underlying symptoms.

41. Accordingly, the Tribunal found paragraph 1(b)(i) not proved.

Paragraph 1(b)(iii)

42. The Tribunal noted that Dr Uzokwe, in his letter to the GP, did take into account Patient A's Zopiclone dependency and did advise her to reduce her intake.

43. The Tribunal could find no evidence of Patient A using benzodiazepines. The Tribunal considered the evidence of Dr I, who stated that Zopiclone was a benzodiazepine. Dr Uzokwe challenged this during Dr I's oral evidence, and it was accepted that Dr I had incorrectly referred to Zopiclone as a benzodiazepine.

44. Accordingly, the Tribunal found paragraph 1(b)(iii) not proved.

Paragraph 1(b)(iv)

45. The Tribunal noted that Dr Uzokwe did make a note of Patient A's symptoms of depression, which he then repeated in his letter to Patient A's GP. Dr Uzokwe also included his assessment of suicide risk in his letter. Patient A in her complaint says he had not considered it. The Tribunal did not hear any evidence from Patient A, so could only give limited weight to her statements in the written complaint. On that basis, the Tribunal was of the view that this paragraph of the Allegation could not be found proved.

46. Therefore, the Tribunal found paragraph 1(b)(iv) not proved.

Paragraph 1(b)(v)

47. The Tribunal noted that the Allegation states the 'diagnosis of hyperthyroidism' which is incorrect. It should have stated 'hypothyroidism'. The GMC made no attempt to amend this paragraph of the Allegation.

48. The Tribunal has already set out that it was not Dr Uzokwe's duty to diagnose Patient A with medical complaints such as hypothyroidism or vitamin D deficiency. As this was a mental health review, Dr Uzokwe had no duty to include a diagnosis.

49. The Tribunal therefore found paragraph 1(b)(v) not proved.

Paragraph 1(b)(vi)

50. The Tribunal first considered the letter sent to Patient A's GP in August 2019, in which it states:

> *'Diagnosis*
> *Recurrent depressive disorder with traits of emotionally unstable personality disorder*
> *Adjustment disorder'* (emphasis in original)

51. The Tribunal noted that adjustment disorder does not appear as a diagnosis in the GP letter sent after the previous review appointment in May 2019 which suggests Dr Uzokwe made the diagnosis following the August 2019 appointment.

52. In his oral evidence Dr Uzokwe directed the Tribunal to his RiO notes as the justification for this diagnosis. Patient A had had a recent visit with her sister which had gone badly. However, there is no clear link in the GP letter or RiO note to that event which directly justifies making such a diagnosis. Therefore, the Tribunal considered that there is sufficient evidence that Dr Uzokwe did not appropriately diagnose in that he did not justify the diagnosis of an adjustment disorder.

53. Accordingly, the Tribunal found paragraph 1(b)(vi) proved.

Paragraph 1(c)(i)

54. The Tribunal was of the view that the notes Dr Uzokwe made could have been more complete. This was also stated by Dr I in his email subsequent to his 4 November 2020 report. However, the Tribunal noted that the appointment was a review and not a full assessment. As indicated previously, there is a note that indicates advice was given to Patient A to cut down on Zopiclone at both the May and August appointments.

55. Therefore, the Tribunal found paragraph 1(c)(i) not proved.

Paragraph 1(c)(ii)

56. This issue has also been referred to under paragraph 29 above. The Tribunal does not consider that Dr Uzokwe had a duty to consider the Patient's hypothyroidism. It was under treatment by the GP and Dr Uzokwe had listed the drug that Patient A had been prescribed to treat the hypothyroidism. Under the circumstances, the Tribunal does not find paragraph 1(c)(ii) proved.

Paragraphs 1(d)(i)(1), 1(d)(i)(2) and 1(d)(i)(3)

57. The Tribunal has already established in its consideration of paragraph 1(b)(iii) that there is no evidence that Patient A was taking a benzodiazepine. It is apparent to the Tribunal that zopiclone has been incorrectly documented as a benzodiazepine within the Allegation.

58. Accordingly, the Tribunal found paragraphs 1(d)(i)(1), 1(d)(i)(2) and 1(d)(i)(3) not proved.

Paragraph 1(d)(ii)

59. The Tribunal accepted that the rationale for prescribing 25mg of quetiapine is not in Patient A's notes. It also accepted that this is not a standard medication used to treat depression. Dr Uzokwe explained in his oral evidence, that the prescription was below the recommended dose, and was meant to help to reduce Patient A's anxiety and ultimately to help reduce her zopiclone use. He did not document this in his notes about Patient A. The Tribunal finds little in Dr I's evidence relating to this part of the Allegation, although it notes that in his email, which gives further clarification of some of the points in his report, he says *'It may be that Dr Uzokwe felt quetiapine would help reduce Patient A's self-harming'*.

60. The Tribunal noted that Dr Uzokwe was a psychiatric consultant and does not consider that consultants have a duty to document all reasons for medication changes following an assessment or review. The Tribunal accepted Dr Uzokwe's evidence on this point but was of the view that it would have been helpful if he had documented the rationale for the changes.

61. Therefore, the Tribunal found paragraph 1(d)(ii) not proved.

Paragraph 1(d)(iii)

62. The Tribunal, having read the relevant material and taken evidence from both Dr I and Doctor Uzokwe reached the view that arranging blood screening relating to Patient A's hypothyroidism and vitamin D deficiency was the responsibility of Patient A's GP under the shared care agreement. The patient was already receiving treatment for both illnesses.

63. Accordingly, the Tribunal found paragraph 1(d)(iii) not proved.

Paragraph 1(e)

64. The Tribunal first considered the opinion of Dr I. Dr I was of the view that Dr Uzokwe should have adopted a structured withdrawal of Zopiclone with Patient A, rather than just request for her to reduce the number she was taking. However, this view was formed on the basis that zopiclone is a benzodiazepine.

65. Dr Uzokwe accepted in his oral evidence that had zopiclone been a benzodiazepine, then he would have undertaken a structured withdrawal. Zopiclone, however, is not a benzodiazepine. With regards to consent, it was a known fact that Patient A was purchasing additional Zopiclone online and taking well over the maximum recommended dosage, and so likely would not have responded positively to a structured withdrawal at that time. Consequently, Dr Uzokwe decided not to stop the prescription outright, and advised Patient A to cut down. The Tribunal was of the view that Dr Uzokwe had considered that the best option at the time was to request Patient A reduce the number of Zopiclone she was taking. Patient A acknowledged in her complaint letter dated 20 August 2019 that she had '*managed to cut down on my Zopiclone intake since my last visit'.*

66. In this context, the Tribunal found paragraph 1(e) not proved.

Patient B

Paragraphs 2(a)(i)(1) 2(a)(i)(2), 2(a)(i)(3) and 2(a)(i)(4)

67. The Tribunal took into consideration that this appointment was a review, following an early assessment in February 2019. Further, it noted that Dr Uzokwe does not specifically recall Patient B.

68. There were some issues with the documentation for Patient B, and as such the Tribunal was unsure if it had all of the information before it to make a full judgement. It is clear from the GP letter that further notes were taken, but the Tribunal has not been supplied with them. Dr Uzokwe stated in his evidence that he would have made notes, that were not before the Tribunal, and that he had no access to the relevant IT system for procuring the said notes.

69. The Tribunal noted that a very thorough patient history was taken at the initial assessment of Patient B by another psychiatrist in February 2019. The Tribunal therefore does not accept that Dr Uzokwe had a duty to carry out a further full assessment at this stage. The Tribunal was of the view that Dr Uzokwe had an obligation to review Patient B, and how she presented on the day of her appointment. The Tribunal therefore found that, taking into account the recent historical information already available in Patient B's files and the fact that this was a review, the assessment of Patient B was adequate.

70. Therefore, the Tribunal found paragraphs 2(a)(i)(1) 2(a)(i)(2), 2(a)(i)(3) and 2(a)(i)(4) not proved.

Paragraphs 2(a)(ii)(1), 2(a)(ii)(2) and 2(a)(ii)(3)

71. The Tribunal noted that Dr Uzokwe, during his oral evidence, was concerned that large parts of Patient B's RiO notes were not in evidence. He explained to the Tribunal that there were other sections of that online note, including one called risk assessment, and another called '*cluster five*' that would have had more information and that were not included in the evidence. He said that part of the history was often found in the risk assessment.

72. The Tribunal has seen a RiO note which does indeed have a long section called risk assessment, although this is not for this particular paragraph of the Allegation. The Tribunal

has also seen an extract of the RiO notes where there are hyperlinks to different parts of the clinical notes, including one for risk assessment. The Tribunal therefore was of the view that it does not have before it a complete record of the clinical note for Patient B with regard to 3 July 2019, and is unable on the balance of probabilities to make a finding of whether Dr Uzokwe performed an adequate mental state examination. It reminded itself that it is the task of the GMC to prove its case.

73. Accordingly, the Tribunal found paragraphs 2(a)(ii)(1), 2(a)(ii)(2) and 2(a)(ii)(3) not proved.

Paragraph 2(a)(iii)

74. The Tribunal noted that it is documented in February 2019, that there had been a psychotic illness diagnosis in 2016. Dr Uzokwe stated in evidence that he did not change Patient B's diagnosis from the one made in 2016, although he did suggest that it needed to be reviewed along with medication Patient B was taking. It appears to the Tribunal that is what Dr Uzokwe did. He also noted the historic diagnosis of psychotic depression in his letter to the GP following the appointment which describes '*Severe depression with psychotic symptoms now resolved*'. The Tribunal is unable therefore to find that Dr Uzokwe did not take into account the previous assessment of Patient B in his review.

75. Accordingly, the Tribunal found paragraph 2(a)(iii) of the Allegation not proved.

Paragraph 2(b)(i) and 2(b)(ii)

76. The Tribunal took into account that a full assessment of Patient B was completed in February 2019 by another Psychiatrist. The appointment with Dr Uzokwe was one of a series of regular reviews. The Tribunal was of the view that Dr Uzokwe was not diagnosing at this review appointment. Further it noted that the diagnosis of psychotic illness had been made in 2016 and had already been taken into consideration and was noted by Dr Uzokwe in his letter to the GP following the review.

77. Accordingly, the Tribunal found paragraphs 2(b)(i) and 2(b)(ii) of the Allegation not proved.

Paragraph 2(c)(i)

78. The Tribunal considered a note from a nurse, dated 1 July 2019, in Patient B's notes. This note indicated that there had been a discussion about stopping Patient B's depot antipsychotic medication. In that note, it is stated that Patient B expressed concerns about the plans to reduce then stop her medication. While there is nothing in the notes from 3 July 2019 or the follow up GP letter that states that Dr Uzokwe took her misgivings into account, it is clear that the patient and Dr Uzokwe had had a discussion about this at some point prior to the review on 3 July 2019.

79. The Tribunal found paragraph 2(c)(i) of the Allegation not proved.

Paragraph 2(c)(ii)

80. The Tribunal first considered whether Dr Uzokwe had a duty to discuss the changed treatment plan with the secondary care team. Dr Uzokwe in his oral evidence stated that he did not have to discuss every time he stopped a patient's medication. The Tribunal can find no duty for an experienced consultant to discuss changes to treatment plans with the secondary care team.

81. The Tribunal also noted that there is evidence that Dr Uzokwe did discuss the plan to stop Patient B's medication with the secondary care team, as noted by a nurse in Patient B's notes from 1 July 2019 referred to in the paragraph above. This stated:

> *'I had a discussion with Dr Izu re: XXX depot. Dr Izu suggested reducing XXX's depot from 100 mg to 50 mg then stopping it, as she's complaint (sic) with meds and not psychotic.'*

82. In all the circumstances, the Tribunal cannot find that Dr Uzokwe failed to discuss the change in treatment plan as it is clear from the notes that he did.

83. Accordingly, the Tribunal found paragraph 2(c)(ii) not proved.

Paragraph 2(d)(i)

84. Dr Uzokwe was clear in his oral evidence that it was inappropriate to continue antipsychotic medication when it was no longer required. The Tribunal could find no evidence that Patient B was still experiencing psychotic symptoms, and discussions about reducing and stopping the medication had been ongoing for a considerable period of time, involving other clinicians. Further, Patient B was experiencing side effects from the medication, such as tardive dyskinesia. The Tribunal could not find that the GMC had proved its case that Dr Uzokwe had inappropriately stopped the medication.

85. Accordingly, the Tribunal found paragraph 2(d)(i) not proved.

Paragraph 2(d)(ii)

86. Dr Uzokwe stated in evidence it was recorded in the patient's notes that Patient B was no longer experiencing psychotic symptoms and thus, in his view, there was no need to offer an alternative medication. The Tribunal accepted his evidence that as a consultant Dr Uzokwe is able to make that decision, and that there was no duty on him that he had to consider any alternative.

87. Accordingly, the Tribunal found paragraph 2(d)(ii) not proved.

Paragraph 2(d)(iii)(1), 2(d)(iii)(2), 2(d)(iii)(3) and 2(d)(iii)(4)

88. The Tribunal took into account the evidence before it, particularly the notes from 1 July 2019, in which it is stated by a nurse that:

> *'I had a discussion with Dr Izu re: XXX depot. Dr Izu suggested reducing XXX's depot from 100 mg to 50 mg then stopping it, as she's complaint (sic) with meds and not psychotic. We also agreed to have an Outpatient review.*
>
> *OPR booked for 03/07/2019 at 12 pm, XXX informed and agreed to attend. I also informed her about plan with depot, she was apprehensive about stopping it, but agreed to have a discussion at review.'*

89. It is clear from this note that Dr Uzokwe did discuss stopping the medication with members of the nursing team within the secondary care team (HALT), and Patient B was aware of the plan.

90. Dr Uzokwe indicated in his oral evidence that the team held meetings in which cases were discussed, two or three times per week. He expressed that while there was an element of shared care and multi team working he, as consultant, ultimately had to make the decisions on his patients. The Tribunal does not have any evidence before it from any other members of the team to dispute this.

91. The Tribunal can find no duty that Dr Uzokwe as an experienced consultant should have to include Patient B's previous clinician, or the rest of the secondary care team in the decision-making process when reviewing and changing medications. He did in fact discuss it with HALT in any event.

92. Accordingly, the Tribunal found paragraphs 2(d)(iii)(1), 2(d)(iii)(2), 2(d)(iii)(3) and 2(d)(iii)(4) not proved.

Paragraph 2(d)(iv)

93. The Tribunal had regard to the report produced by Dr I, which states:

> *'…nor did he fully discuss the case with the team as reported in the witness statement by the team manager'*

94. The Tribunal was not provided with the statement referred to by Dr I, nor was it provided any other evidence to support this paragraph of the Allegation. The Tribunal has already found that Dr Uzokwe did discuss this patient with the community mental health team (HALT). As the evidence relating to this paragraph of the Allegation has not been adduced, the Tribunal cannot find this paragraph proved.

95. Therefore, the Tribunal found paragraph 2(d)(iv) not proved.

Paragraph 2(e)(i)

96. The Tribunal first considered the evidence of Dr I. In his oral evidence, he stated that if a patient shows signs of tardive dyskinesia, then the patient should remain under the care of secondary services until the symptoms have resolved.

97. Dr Uzokwe, in his evidence, stated that it can be many years before symptoms of tardive dyskinesia fully resolve, and that it would be inappropriate on that basis to keep a patient under his care indefinitely. Dr Uzokwe, when asked if he would act the same way if he was given the opportunity again, was firm in his '*yes*'. He also stated that a GP can monitor the symptoms of tardive dyskinesia.

98. The Tribunal weighed up the evidence of both Dr I and Dr Uzokwe, and found it preferred Dr Uzokwe's evidence. There was documentary evidence to show that there had been a plan in place for several months to discharge Patient B. The Tribunal therefore determined it was not inappropriate to discharge her, and have her GP monitor the ongoing tardive dyskinesia. The letter to the GP refers to the symptom.

99. Accordingly, the Tribunal found paragraph 2(e)(i) of the Allegation not proved.

Paragraph 2(e)(ii)

100. The Tribunal noted that there was no evidence in the material before it that Patient B was still suffering from command hallucinations at the time of the consultation with Dr Uzokwe, nor had she been for some time. From the RiO notes it is clear that the plan for several months had been to discharge Patient B, and it was therefore not inappropriate in those circumstances.

101. Accordingly, the Tribunal found paragraph 2(e)(ii) of the Allegation not proved.

Paragraph 2(f)(i)

102. The Tribunal considered whether Dr Uzokwe had a duty to include a crisis contingency plan. The Tribunal does not consider that there is a duty for psychiatrists to give a GP crisis contingency plans unless there is a particular need for it. The Tribunal has noted that the patient received a letter with detailed advice about managing any crises or emergencies and where to go for help from the service. Dr Uzokwe's letter to the GP, dated 5

July 2019, provides a brief history of the patient, a full list of medication including stopped medication and a report of the review. It ends with a plan, but not a crisis plan.

103. Having found that Dr Uzokwe did not have a duty to include a crisis contingency plan in his discharge letter, the Tribunal found paragraph 2(f)(i) of the Allegation not proved.

Paragraph 2(f)(ii)

104. The Tribunal first considered whether Dr Uzokwe had a duty to discuss the change in medication with Patient B's GP. In the letter to the GP as referred to above, Dr Uzokwe did inform the surgery about the change of Patient B's medication. Given the fact that Dr Uzokwe is a consultant psychiatrist, it was his prerogative to change medications as he saw fit, and there was therefore no duty for him to discuss the change to medication with Patient B's GP. Dr Uzokwe made the changes after an assessment of Patient B, which he then communicated to the GP in his letter.

105. Accordingly, the Tribunal found paragraph 2(f)(ii) of the Allegation not proved.

Patient C

106. The Tribunal received limited evidence in respect of Patient C. Dr Uzokwe had no recollection of this patient. He was seen by Dr Uzokwe on 23 July 2019.

107. The Tribunal had some concerns about the documentary evidence provided by the GMC in relation to this patient. Dr Uzokwe adamantly denied writing a letter dated 23 July 2019 presented as his in the documentary evidence, which changed Patient C's diagnosis from '*Bi-Polar disorder to Unspecified Mood disorder*'. Dr Uzokwe stated in his oral evidence that a diagnosis of bi-polar disorder is a diagnosis for life once given and he would never, as an experienced consultant, alter such a diagnosis.

108. Dr Uzokwe pointed to another letter to Patient C's GP, dated 22 July 2019, which he said was likely to have been written by him as it was in his style, although he queried a highlight at the top of that letter which stated it had been amended. This letter of 22 July 2019 does not change Patient C's diagnosis.

109. The Tribunal noted that the letter dated 22 July 2019 was entirely different in style and content to the 23 July 2019 letter and also different to the RiO notes purportedly made by Dr Uzokwe on 18 July 2019. The Tribunal noted that the RiO notes bore similarity to the contents of the (denied) 23 July 2019 letter, in that they state a diagnosis of Mood disorder, and mention potential financial gain. The Tribunal further noted that it had seen a number of letters by Dr Uzokwe to various patients' GPs, and none of them bore any resemblance in style to the letter of 23 July 2019 which purportedly was written by Dr Uzokwe and changed Patient C's diagnosis.

110. In the letter dated 22 July 2019, which Dr Uzokwe accepted was written by him although he was concerned about the note of amendment, Dr Uzokwe stated the diagnosis was of Bi-Polar disorder in remission, and listed actions for Patient C:

> *'Further Plan*
> *1. Advised to cut down on alcohol.*
> *2. Advised to inform the DVLA of his diagnosis.*
> *3. Continue to work with Care Co-ordinator.'* (emphasis in original)

111. Dr Uzokwe, in his oral evidence, told the panel that the two letters could not be reconciled along with the RiO notes, and posited that the information recorded in RiO and the 23 July 2019 letter could potentially have related to a different patient. The Tribunal was also of the view that there were significant inconsistencies in the evidence before it, which raised concerns about the validity of the RiO notes and the 23 July 2019 letter. It noted another version of the 22 July 2019 letter in the accompanying documentation, this one was largely the same as the one adduced by the GMC except it did not have the 'amendment' heading.

112. Given the unreliable evidence, the Tribunal determined that it could not make a finding in respect of any of the paragraphs of the Allegation relating to Patient C.

113. Accordingly, the Tribunal found paragraph 3 of the Allegation not proved in its entirety

<u>Patient D</u>

Paragraph 4(a)(i)

114. The Tribunal first considered the wording of this paragraph of the Allegation. It was of the view that the phrase 'Patient D's complaints' in the paragraph was ambiguous and so it determined that it should view it as meaning the presenting complaints. The Tribunal could see that Dr Uzokwe documented Patient D's bilateral leg pain and his recent bereavement in his patient notes and in his letter to the GP.

115. The Tribunal was of the view that the GMC has failed to adequately particularise what is meant by 'complaints'. It appears in the notes that the presenting complaints were pain in the legs, substance misuse, recent bereavement, and deteriorating mental health. These complaints are noted by Dr Uzokwe in both Patient D's notes and in his letter to the GP.

116. Dr Uzokwe was clear in his evidence that this was a review of Patient D, not a full assessment. Patient D was a known patient, which corroborated this evidence. The Tribunal could not find that anything further could have been done to elaborate on Patient D's presenting complaints, as noted by Dr I, in his opinion of the material that HALT already knew existed.

117. Therefore, the Tribunal found paragraph 4(a)(i) of the Allegation not proved.

Paragraph 4(a)(ii)

118. The Tribunal took account of Dr Uzokwe's letter to the GP following the review as well as Patient D's notes. In both, Dr Uzokwe has set out Patient D's diagnoses, his past alcohol abuse, and his current substance misuse. Given that this appointment was a review, the Tribunal finds that a sufficient history of Patient D's mental health disorder was adequately documented.

119. Accordingly, the Tribunal found paragraph 4(a)(ii) of the Allegation not proved.

Paragraph 4(a)(iii)

120. The Tribunal noted that Patient D was presenting with deteriorating mental health and a very recent bereavement, along with continued symptoms of substance misuse and bilateral leg pains.

121. Dr I opined that Dr Uzokwe's decision to reduce medication under these circumstances was a significant change and the Tribunal accepted his point that the change did need explanation in his notes about the patient and/or letter to the GP.

122. Accordingly, the Tribunal found paragraph 4(a)(iii) of the Allegation proved.

Paragraph 4(b)(i)

123. The Tribunal found that it is very clear on the face of the notes and the letter to Patient D's GP that Dr Uzokwe did consider Patient D's mental wellbeing, remarking on his low mood, current bereavement and other matters which went to his mental health.

124. Therefore, the Tribunal found paragraph 4(b)(i) of the Allegation not proved.

Paragraph 4(b)(ii)

125. The Tribunal found that there was evidence that Dr Uzokwe had considered the significance of Patient D's bilateral leg pains as he had pointed out the complaint to Patient D's GP in his letter. It considers that this is sufficient evidence of consideration.

126. Further, Dr Uzokwe had explained there was shared care of patients, and that something like this would have been picked up by Patient D's GP and appropriately dealt with. The Tribunal considered this to be a reasonable explanation.

127. Accordingly, the Tribunal found paragraph 4(b)(ii) of the Allegation not proved.

Paragraph 4(b)(iii)

128. The Tribunal first considered whether Dr Uzokwe had a duty to consider the forensic history in a review of a patient. It did not find that a psychiatrist carrying out a review on a

patient, would have a duty to document the full history, forensic or otherwise in their assessment.

129. Further, there is no evidence, in any event, that Dr Uzokwe did not consider Patient D's forensic history, as he would have had access to that information. The Tribunal noted that the forensic history was taken some years back, and therefore could not find the GMC had proved its case in respect of this paragraph.

130. Therefore, paragraph 4(b)(iii) of the Allegation is not proved.

Paragraph 4(c)(i)

131. The Tribunal first considered whether there was a duty for Dr Uzokwe to refer Patient D for bereavement support at this stage.

132. Dr I stated under cross examination by Dr Uzokwe that he accepted that exploring a very recent bereavement was not something one would bring up as a topic, however it would be reasonable to offer ways of support, for example the organisation Cruse. Dr Uzokwe stated in his oral evidence that it was too soon after the bereavement to refer Patient D for support, and in any event organisations such as Cruse Bereavement Support ('Cruse') would not accept a referral '*until after six months*'.

133. The Tribunal agreed that it would not have been appropriate to refer someone with so recent a bereavement to organisations such as Cruse. On that basis, it could not find that there was a failure to appropriately refer Patient D.

134. Accordingly, the Tribunal found paragraph 4(c)(i) not proved.

Paragraph 4(c)(ii)

135. The Tribunal was of the view that it was not clear in Dr I's report whether his opinion was that Dr Uzokwe should have made a referral for the leg pains to the relevant specialist himself or made a referral to the GP to investigate and refer to a specialist.

136. The Tribunal first considered whether Dr Uzokwe should have referred Patient D to a specialist himself. Dr Uzokwe indicated that referrals of this sort would normally be undertaken by a GP and not a psychiatrist, and the Tribunal accepted that as a consultant psychiatrist there was no duty on Dr Uzokwe to make a referral to a specialist. The Tribunal was of the view that it was more likely that it would have been the responsibility of the GP to make the referral.

137. The Tribunal also considered Dr I's evidence that Dr Uzokwe should have referred the matter to Patient D's GP. It noted that Dr Uzokwe had included the bilateral leg pain in his letter to the GP. Although it was not expressly mentioned as a referral, the Tribunal considers this would be sufficient to alert the GP to the issue, and for the GP to then arrange appropriate investigation into the issue.

138. Therefore, on either view of the evidence, the Tribunal cannot find paragraph 4(c)(ii) proved.

Paragraphs 4(d)(i)(1) and 4(d)(i)(2)

139. The Tribunal first considered whether it was appropriate to pathologize grief as a mental health problem in itself. Dr Uzokwe stated in his oral evidence, that grief is a natural process and he pointed out the very short period of time, within 2 weeks, since Patient D had experienced his loss.

140. The Tribunal noted that Dr I suggested that some further investigation should have taken place to establish the extent of Patient D's grieving. However, under cross examination, Dr I accepted that it would not be appropriate so soon after the loss. The Tribunal agrees with both Dr Uzokwe and Dr I that it was far too early to probe further at this stage.

141. Further, it is not clear to the Tribunal what is meant by '*phase of grief*'. Clearly by any common reading of the situation, this would have been a very early stage of grief due to the very recent bereavement, and therefore considers that there was no duty at this stage for Dr Uzokwe to 'diagnose' Patient D's 'stage of grief'.

142. Accordingly, the Tribunal found paragraphs 4(d)(i)(1) and 4(d)(i)(2) of the Allegation not proved.

Paragraph 4(d)(ii)

143. The Tribunal was of the view that the GMC had not explained what was meant by '*failed to revisit the depressive elements*'. Dr Uzokwe clearly did assess Patient D and took into account his recent bereavement and associated low mood. The Tribunal can find no evidence of any failure with respect of this paragraph.

144. Therefore, the Tribunal found paragraph 4(d)(ii) of the Allegation not proved.

Paragraph 4(e)

145. The Tribunal noted that Dr Uzokwe did refer to Patient D's past use of alcohol in his treatment plan and therefore there is no evidence that he failed to take Patient D's vulnerability into account. Dr Uzokwe stated in the letter to the GP that Patient D had maintained abstinence for almost three years. For all these reasons, the Tribunal cannot find there was a failure to take this into consideration.

146. Therefore, the Tribunal found paragraph 4(e) of the Allegation not proved.

Paragraph 4(f)(i) and 4(f)(ii)

147. The Tribunal has already agreed that the decision to change Patient D's medication during this particular difficult time of his life was unusual.

148. However, the Tribunal took into consideration that Dr Uzokwe altered the dosage of Zopiclone to abide by NICE guidelines, as Patient D was on an unusually high dosage, well beyond the maximum that should be prescribed. Dr Uzokwe stated that he was doing his '*due diligence*' by reducing Patient D's Zopiclone with a view to stopping it in the near future.

149. Further, Dr Uzokwe explained in his oral evidence that the quetiapine dose that Patient D was on was a subtherapeutic amount (accepted by Dr I) and that it should not be used alongside the antipsychotic drugs that he was already on. The Tribunal, while acknowledging the unusual timing of the medication changes, could not find that following prescribing guidelines was a failure to appropriately prescribe to Patient D.

150. Accordingly, the Tribunal found paragraphs 4(f)(i) and 4(f)(ii) of the Allegation not proved.

Paragraph 4(g)

151. The Tribunal took into account Patient D's oral and written evidence. He told the Tribunal that there had been a piece of paper, that he could not recall what was on the paper but was told to sign it as part of a mandatory drug screen test. It also took into account Dr Uzokwe's evidence which was that he asked Patient D '*If I tested your urine, what am I likely to find?*' or words to that effect, but that drug screening was not mandatory, nor did he have a testing kit available. Dr I stated that if Dr Uzokwe had in fact done something like that as suggested by Patient D, that would be a 'bizarre' way of trying to find out if the patient was taking drugs. Dr I also stated that it was often difficult to get an honest account of drug misuse from patients who were drug dependent.

152. The Tribunal considered that there were significant inconsistencies in Patient D's evidence. It noted that Patient D had not raised the issues with his usual consultant, who had written a long note to Dr Uzokwe on 6 August 2019. This note was about Dr Uzokwe's decision to stop Patient D's medication. There is no mention of a drug screen test in this note.

153. Further, the Tribunal found it difficult to reconcile the evidence given by Patient D that he was asked to sign a piece of paper but has no recollection at all of what was on that paper. The Tribunal has no other evidence of this paper's existence.

154. Having taken evidence from Dr I on this point, where he accepted the difficulties in getting patients to admit their drug relapses, the Tribunal found that the words used at that appointment were more likely to be along the lines of what Dr Uzokwe suggested *'if I tested your urine what am I likely to find?'*. The Tribunal acknowledged that Patient D may have felt manipulated into answering questions about his drug use during that appointment.

155. The Tribunal has further noted that despite the fact that Patient D had a support worker with him in the consultation room at the time, there is no corroborative statement from that professional to support this allegation.

156. The Tribunal was satisfied that it was more likely than not that Dr Uzokwe stated words to the effect of '*If I tested your urine, what am I likely to find?*' but not that he produced a piece of paper which he made Patient D sign.

157. Therefore, the Tribunal found paragraph 4(g) of the Allegation not proved.

Paragraph 4(h)

158. Having found subparagraphs 4(g) not proved, the Tribunal subsequently found paragraph 4(h) of the Allegation also not proved.

Paragraph 5

159. Having found subparagraphs 4(g) and 4(h) not proved, the Tribunal subsequently found paragraph 5 of the Allegation also not proved.

Patient F

Paragraphs 6(a) and 6(b)

160. The Tribunal carefully considered the witness statement of Ms H and the accompanying documents (RiO notes and Datix). The Tribunal took particular note of the RiO notes that she made which were more contemporaneous than her witness statements. It also considered Ms H's oral evidence and Dr Uzokwe's own evidence. The consultation had taken place on or around 1 August 2019.

161. The Tribunal was concerned about the quality of the evidence before it in relation to this paragraph of the Allegation. The Tribunal did not receive a witness statement from Patient F, or Patient F's sister who was also present during the consultation.

162. The Tribunal took into account that the Datix incident which purportedly recorded this incident was opened and reported on 9 September 2019. Ms H was unable to explain why this form was created on this date, as opposed to on or around the 1 August 2019, stating in her oral evidence that it was a '*little bit baffling*' and a '*bit of a mystery*'. She referred to her entry in RiO, which is dated as created on 7 August 2019, and updated 8 August 2019, and was puzzled as to why it had those dates if the appointment was on or

close to 1 August 2019. She told the Tribunal her usual practice was to write up the notes within hours of the appointment or issue, not days. She agreed that she may have made a mistake about the date of the actual appointment which could have been nearer 7th August 2019.

163. Further, there was a mistake that Ms H admitted to in the Datix incident forms from the outset, for which she earlier apologised to a Trust investigator. This was the section relating to the outcome following Patient F's appointment with Dr Uzokwe, in that she stated he had been admitted to hospital as a result of the consultation, when he had not. This was clarified in an email between Ms H and the Trust investigator, dated 9 September 2019, which perhaps coincidentally is the same date as the date on the Datix incident.

164. The Tribunal noted that in Ms H's RiO note, which was produced more or less contemporaneously, she does state that Dr Uzokwe '*produced a photographed police ID card*' and '*said he could call the police to establish if they were investigating*' which she repeats in her witness statement but does not mention that Patient F was upset during this conversation. She does state however that Patient F was upset in her witness statement to the GMC, dated 17 February 2022.

165. The Tribunal cannot be confident in the evidence provided, given the significant inconsistencies. The Tribunal also noted Dr Uzokwe's denial that he would never offer to contact the police or produce a police ID card to a patient with delusions that he was being pursued by the police. The Tribunal took into account at this point Dr Uzokwe's good character and did not consider that there were sufficient grounds for it to meet the evidential burden that the GMC have to prove what would be a highly unusual behaviour from a consultant psychiatrist with a long and unblemished career.

166. Accordingly, the Tribunal found paragraphs 6(a) and 6(b) not proved.

Paragraph 7

167. Having found subparagraphs 6(a) and 6(b)not proved, the Tribunal subsequently found paragraph 7 of the Allegation also not proved.

The Tribunal's Overall Determination on the Facts

168.The Tribunal has determined the facts as follows:

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

1. On 15 May 2019 and/or 8 August 2019 you consulted with Patient A and on one or more occasion you failed to:

   a. carry out an adequate assessment of Patient A in that you did not consider/clarify Patient A's:

      i. hypothyroidism; Not proved.

      ii. vitamin D deficiency; Not proved.

      iii. iron deficiency; Not proved.

      iv. recent thyroid function tests; Not proved.

      v. degree of anxiety or depression; Not proved.

      vi. views on her body image; Not proved.

      vii. active thoughts related to her previous eating disorder; Not proved.

   b. appropriately diagnose Patient A in that you:

      i. did not fully elucidate Patient A's underlying symptoms; Not proved.

      ii. ~~did not fully justify the emotionally unstable personality disorder diagnosis;~~ Withdrawn following successful 17(2)(g) application.

      iii. did not take into account Patient A's zopiclone dependency or use of benzodiazepines; Not proved.

      iv. did not establish the severity of Patient A's depression; Not proved.

v. did not include the diagnosis of hyperthyroidism or of vitamin D deficiency; **Not proved.**

vi. diagnosed Patient A with an adjustment disorder without justification; **Determined and found proved**

c. document:

i. an objective and/or agreed treatment goal; **Not proved.**

~~ii. Patient A's request for re-diagnosis;~~ **Withdrawn following 17(6) application.**

~~iii. any request from Patient A for dialectical behaviour therapy, or to join a vagus nerve stimulation trial;~~ **Withdrawn following 17(6) application.**

~~iv.~~ii. Patient A's hypothyroidism diagnosis; **Not proved.**

d. adequately manage Patient A in that you:

i. reduced Patient A's benzodiazepine intake without:

1. medical supervision; **Not proved.**

2. seeking advice from a drug and alcohol consultant; **Not proved.**

3. considering referring Patient A for cognitive behavioural therapy; **Not proved.**

ii. did not explain in Patient A's notes the rationale for your treatment including why you had prescribed 25mg of quetiapine; **Not proved.**

~~iii. offered to prescribe medication in exchange for keeping an activity diary;~~ **Withdrawn following 17(6) application.**

~~iv.~~iii. failed to conduct blood screening, in view of Patient A's hypothyroidism and Vitamin D deficiency; Not proved.

~~e. refer Patient A for further investigation of her hypothyroidism;~~
Withdrawn following 17(6) application.

~~f.~~e. adequately prescribe to Patient A in that you did not adopt a structured withdrawal regime for zopiclone with the consent of Patient A. Not proved.

2. On 3 July 2019 you consulted with Patient B and you:

a. failed to carry out an adequate assessment of Patient B in that you did not:

i. obtain an adequate history including a failure to take note of Patient B's:

1. psychiatric history; Not proved.

2. admission of 2016 when he presented with thought disorder and bizarre command hallucinations; Not proved.

3. referential delusions; Not proved.

4. first appointment with Huntingdon Adult Locality Team ('HALT') on 25 February 2019; Not proved.

ii. carry out an adequate mental state examination in that you did not:

1. specify any symptoms of depression other than sleep, weight and appetite changes; Not proved.

2. mention Patient B's anxiety in his notes; Not proved.

3. carry out an adequate suicide risk assessment including a failure to refer to or factor in previous suicide attempts; Not proved.

iii. take into account a recent assessment of Patient B which suggested he suffered from a psychotic illness and not a mood disorder; Not proved.

b. failed to appropriately diagnose Patient B in that you failed to take into account:

i. some of Patient B's history; Not proved.

ii. a recent assessment of Patient B which suggested Patient B suffered from a psychotic illness and not a mood disorder; Not proved.

c. failed to implement an appropriate treatment plan in that you did not:

i. take into account Patient B's misgivings about coming off depot antipsychotic medication; Not proved.

ii. discuss with the secondary care team the change in Patient B's treatment plan; Not proved.

d. failed to appropriately prescribe to Patient B in that you:

i. stopped Patient B's depot medication; Not proved.

ii. did not offer and/or discuss alternative medication options having stopped depot medication; Not proved.

iii. did not include the following in the decision-making process:

1. Patient B; Not proved.

2. the previous clinician; Not proved.

3. the secondary care team; Not proved.

4. Huntingdon Adult Locality Team; Not proved.

iv. did not liaise with Patient B's GP with regards to the administering of tapering depot injection medication despite express advice

from the Community Mental Health Team that you do so; **Not proved.**

e. inappropriately discharged Patient B when:

i. Patient B's emerging symptoms of tardive dyskinesia necessitated Patient B remaining under the care of secondary services until the symptoms had resolved; **Not proved.**

ii. Patient B had a history of command hallucinations; **Not proved.**

f. failed to appropriately communicate with Patient B's GP in that:

i. your discharge letter to the GP failed to include a crisis contingency plan; **Not proved.**

ii. you did not discuss the major change in Patient B's medication. **Not proved.**

3. You reviewed Patient C and on 23 July 2019 you:

a. changed Patient C's diagnosis from Bipolar disorder to Unspecified Mood Disorder which was inappropriate because;

i. it was based upon your belief that Patient C was seeking a diagnosis for financial gain; **Not proved.**

ii. there was no, or no adequate formulation or rationale as to how you ruled out the diagnosis of Bipolar disorder; **Not proved.**

iii. there was evidence of previous episodes of continuous elevated mood fitting the hypomanic criteria, for more than a four-day period in Patient C's history; **Not proved.**

b. failed to take appropriate management action in that you did not:

i. consider alternative prescribing options; **Not proved.**

ii. discuss Patient C's needs with either Patient C or the allocated Community Psychiatric Nurse; **Not proved.**

iii. consider a referral to a Clinical Psychologist to clarify the diagnosis; Not proved.

c. inappropriately discharged Patient C without considering the:

~~i. view expressed by a member of the community team who had assessed Patient C over a number of home visits;~~ Withdrawn following 17(6) application.

~~ii.~~ i. views of the Community Practice Nurse; Not proved.

d. failed to appropriately communicate with Patient C in that you:

i. informed patient C of the change of diagnosis by telephone; Not proved.

ii. did not fully explain to Patient C the alteration in his diagnosis. Not proved.

4. On 23 July 2019 you consulted with Patient D and you:

a. failed to adequately record Patient D's history including a failure to adequately document:

i. Patient D's complaints; Not proved.

ii. Patient D's history of mental disorder; Not proved.

iii. your rationale to change Patient D's medication; Determined and found proved.

b. failed to adequately assess Patient D in that you did not consider:

i. Patient D's mental wellbeing; Not proved.

ii. the significance of the bilateral shooting pains in Patient D's legs; Not proved.

iii. Patient D's forensic history; Not proved.

c. failed to appropriately refer Patient D:

i. to appropriate organisations for support; **Not proved.**

ii. regarding patient D's leg pain; **Not proved.**

d. failed to appropriately diagnose Patient D in that you:

i. failed to sufficiently investigate Patient D's symptoms to establish the:

1. extent of Patient D's grieving; **Not proved.**

2. phase of grief Patient D was in; **Not proved.**

ii. failed to revisit the depressive elements of Patient D's presentation; **Not proved.**

e. failed to devise an appropriate treatment plan in that your treatment plan did not take into account Patient D's significant vulnerability with regards to relapse and alcohol reinstatement; **Not proved.**

f. failed to appropriately prescribe to Patient D, in the context of Patient D's reported depressive history, in that you:

i. stopped Patient D's quetiapine; **Not proved.**

ii. reduced Patient 'D's zopiclone; **Not proved.**

g. showed Patient D a piece of paper ('the Paper') and told him to sign the Paper in preparation for ~~was~~ a drug screen test or words to that effect, in order to elicit information from Patient D regarding his substance misuse; **Amended following Rule 17(6) application. Not proved.**

h. knew that that the Paper was not associated with a drug screen test. **Amended following Rule 17(6) application. Not proved.**

5. Your actions as described at paragraph 4.g. were dishonest by reason of paragraph 4.h. **Not proved.**

~~6. On or around 24 July 2019 you spoke with Dr E, your manager, regarding Patient D and you inappropriately:~~

~~a. stated that 'drug addicts often lie' or words to that affect;~~ Withdrawn following 17(6) application.

~~b. described Patient D as a drug addict.~~ Withdrawn following Rule 17(6) application.

~~7.~~6. On or around 1 August 2019 you consulted with Patient F and you:

a. showed Patient F your police visitors ID badge; Not proved.
b. told Patient F that you could call the police to establish if they were carrying out investigations. Not proved.

~~8.~~7. You carried out the actions at paragraph 7 ~~6~~ when you knew that Patient F suffered from a recurrent paranoiac theme of being wanted by the police. Amended following Rule 17(6) application. Not 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 - 21/12/2022

169. 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 Uzwoke's fitness to practise is impaired by reason of misconduct.

The Outcome of Applications Made during the Impairment Stage

170. The Tribunal granted the GMC's application, made pursuant to Rule 31 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to proceed in Dr Uzwoke's absence. The Tribunal's full decision on the application is included at Annex D.

Submissions

171. On behalf of the GMC, Mr Hamlet reminded the Tribunal of the two-stage process for misconduct.

172. Mr Hamlet reminded the Tribunal of its findings on facts. He stated that paragraph 1(b)(vi) relating to Patient A, had been alleged in the context of wider allegations relating to

Patient A's care, which the Tribunal had not found proved. In the absence of criticisms in that wider context, what was left was simply a recording error. Mr Hamlet stated that in isolation this cannot be considered a serious failing amounting to serious professional misconduct.

173. Mr Hamlet stated that similarly in relation to paragraph 4(a)(iii), the criticism was that Dr Uzwoke had not explained his decision to reduce Patient D's medication, and the Tribunal had found this proved. There were no findings made with respect to allegations regarding Dr Uzwoke's wider treatment of Patient D. Mr Hamlet submitted that on the basis of the Tribunal's findings alone there remains a criticism in relation to Dr Uzwoke's history taking, which cannot be categorised as a serious failing.

174. Mr Hamlet submitted that, looking at the overall picture, these are two discrete criticisms of record making and history taking. It is the GMC's position that these remaining charges in isolation and also taken together do not reach the threshold of serious misconduct. Therefore, the GMC puts forward no case that Dr Uzwoke's fitness to practise is impaired.

The Relevant Legal Principles

175. 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.

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

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

The Tribunal's Determination on Impairment

Misconduct

Paragraph 1(b)(vi) of the Allegation

178. The Tribunal first considered if Dr Uzwoke's conduct in diagnosing Patient A with an adjustment disorder without documenting his justification amounted to misconduct. It bore in mind that there was no criticism of this diagnosis and that even though this was found proved it only amounts to a minor matter.

179. The Tribunal therefore concluded that this conduct did not fall so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

Paragraph 4(a)(iii) of the Allegation

180. The Tribunal next considered if Dr Uzwoke's conduct in failing to adequately document his rationale for changing Patient D's medication amounted to misconduct. It bore in mind that Dr Uzwoke was an experienced consultant, of good character, who made a decision to change a patient's medication which was accepted. The Tribunal accepted that Dr Uzwoke was working in a busy environment and that it would be unreasonable to expect a consultant of his experience to provide justification for changing a patient's medication on every occasion.

181. The Tribunal therefore concluded that this conduct also did not fall so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

The Tribunal's decision

182. Given the submissions made by the GMC and that no misconduct was found, the Tribunal determined that consideration of a warning was not necessary.

ANNEX A – 09/09/2022

17(6) Application

1. At the outset of proceedings, Mr Hamlet, on behalf of the GMC, made an application to amend paragraphs 1(c)(ii), 1(c)(iii), 1(d)(iii), 1(d)(e), 3(c)(i), 4(g), 4(h), 6 and the current paragraph 8 of the Allegation under Rule 17(6) of the General Medical Council ('GMC') (Fitness to Practise) Rules 2004 ('the Rules').

Submissions

On behalf of the GMC

2. Mr Hamlet submitted that the GMC were seeking to withdraw paragraphs 1(c)(ii), 1(c)(iii), 1(d)(iii) and 1(d)(e). He submitted that following a review of the evidence, the GMC were of the view that these subparagraphs of the Allegation could not be sustained as Patient A was not attending to give evidence before the Tribunal. Mr Hamlet further submitted that the GMC also sought to withdraw paragraph 3(c)(i), as it was a duplication of paragraph 3(c)(ii), and the entirety of paragraph 6, as the key witness Dr E is unavailable to give evidence before the Tribunal. He submitted that these withdrawals would narrow the case against Dr Uzokwe and would not therefore generate any injustice against him.

3. In respect of paragraphs 4(g) and 4(h), Mr Hamlet submitted that the application was being made to amend these subparagraphs as the current wording does not accurately reflect the account of Patient D. He submitted that the current wording does not make sense as it suggests that the paper handed to Patient D was a drug screen test, which does not accord with the account given by Patient D. He submitted that the proposed wording was not to change the essence of the Allegation but simply to correct the clumsy wording of the original and reflect what both Patient D and Dr Uzokwe understand that part of the Allegation to mean. He also stated that should the Tribunal agree to the withdrawal of paragraph 6, the following paragraphs of the Allegation would need to be renumbered accordingly. The proposed amendment was as follows:

> 4. On 23 July 2019 you consulted with Patient D and you:
> ...

g. showed Patient D a piece of paper ('the Paper') and told him **to sign** the Paper **in preparation for** ~~was~~ a drug screen test **or words to that effect,** in order to elicit information **from Patient D** regarding **his** substance misuse;

h. knew that that the Paper was not **associated with** a drug screen test.

…

~~8.~~7. You carried out the actions at paragraph ~~7~~6 when you knew that Patient F suffered from a recurrent paranoiac theme of being wanted by the police.

Dr Uzokwe

4. Dr Uzokwe did not raise any objections to the amendments being proposed by the GMC.

The Tribunal's decision

5. The Tribunal considered Rule 17(6) of the Rules which 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.'

6. The Tribunal first considered the withdrawals being proposed. It was of the view that the withdrawals would cause no injustice to Dr Uzokwe. The Tribunal accepted the application to withdraw these allegations, and adjusted the numerical order of the Allegations to reflect the withdrawals.

7. In relation to paragraphs 4 (g) and 4 (h), the Tribunal took into account that the change being proposed is to rephrase a badly written paragraph of the Allegation. The Tribunal noted that Dr Uzokwe indicated that he understands the new wording as more

accurately representing what he understood was the Allegation and that in any event he has not opposed the application.

8. As such, the Tribunal was of the view that to grant the amendment would cause no injustice to Dr Uzokwe. Accordingly, the Tribunal granted the application to amend paragraphs 4(g), 4(h) and the new paragraph 7 to read:

> 4. On 23 July 2019 you consulted with Patient D and you:
>
> …
>
> g. showed Patient D a piece of paper ('the Paper') and told him **to sign** the Paper **in preparation for** ~~was~~ a drug screen test **or words to that effect,** in order to elicit information **from Patient D** regarding **his** substance misuse;
>
> h. knew that that the Paper was not **associated with** a drug screen test.
>
> …
>
> ~~8.~~7. You carried out the actions at paragraph ~~7~~ 6 when you knew that Patient F suffered from a recurrent paranoiac theme of being wanted by the police.

ANNEX B – 08/09/2022

Application to admit further evidence

1. At the outset of proceedings, Dr Uzokwe made an application, pursuant to Rule 34 of the Rules, that documents he had submitted to the GMC be admitted as evidence at this stage.

Submissions

Dr Uzokwe

2. Dr Uzokwe submitted that, prior to the hearing, he had submitted a bundle of documents to the GMC, including testimonials, and these documents had not been provided to the Tribunal. He submitted that the bundle was relevant at this stage as it answered all the points in the Allegation in order to support his case.

On behalf of the GMC

3. Mr Hamlet, on behalf of the GMC, submitted that the GMC was opposed to the bundle being admitted as evidence at this stage of proceedings. He submitted that the GMC had reviewed the documents provided and were of the view that they were relevant to future stages of the hearing.

The Tribunal's decision

4. The Tribunal noted that it had a wide discretion under Rule 34(1) to admit any evidence that it considered fair and relevant to the case before it. The Tribunal first considered the issue of fairness in admitting Dr Uzokwe's further evidence bundle. It noted that the GMC was not against the Tribunal seeing the bundle at the appropriate stage of the hearing but had raised issues of relevancy at the Facts stage.

5. The Tribunal considered the issue of the relevance of the bundle. It noted that the bundle was submitted by Dr Uzokwe in response to the Allegation against him, and his submission that it was relevant at this stage. It also noted Mr Hamlet's reservations about the relevancy of the bundle at the Facts stage. However, he helpfully brought to the Tribunal's attention two statements which may assist at the Facts stage. It carefully considered fairness to both parties and determined that under the circumstances the Tribunal felt able to put the evidence that is not relevant out of its mind, and as such granted the application.

ANNEX C – 13/09/2022

17(2)(g) Application

1. At the close of the case on behalf of the GMC, Dr Uzokwe made an application pursuant to Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'). Rule 17(2)(g) states:

> *'the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should*

proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld'.

Submissions

Dr Uzokwe

2. Dr Uzokwe submitted that there was no case to answer in relation to the entire Allegation. He submitted that what was alleged was untrue, and that while he was not above making mistakes, in the case of these patients, there was no evidence that he had done so.

3. Dr Uzokwe highlighted to the Tribunal the evidence of the GMC Expert witness, Dr I, and the inaccuracies in the evidence of the other witnesses.

On behalf of the GMC

4. Mr Hamlet, on behalf of the GMC, submitted that there was a case to answer. He reminded the Tribunal of the purpose of halftime submissions was not to challenge the evidence, but to establish whether or not sufficient evidence has been presented that a Tribunal could potentially find the Allegation proved.

5. Mr Hamlet submitted that there is no paragraph of the Allegation unsupported by evidence. He reminded the Tribunal that it must assess the evidence at its highest and decide whether on that basis the Allegation should proceed further and be determined.

6. Mr Hamlet stated that, while Dr Uzokwe had made submissions that there was no case to answer on the basis that the Allegation was untrue, a position which Dr Uzokwe is entitled to, he is not entitled to challenge the Allegation as having no case to answer at this stage because he claims the evidence before the Tribunal is inaccurate. That would be for the Tribunal to decide, weighing up the evidence at the conclusion of the Facts stage. Accordingly, Mr Hamlet invited the Tribunal to dismiss the application.

The Tribunal's Approach

7. The Tribunal carefully considered the oral submissions of both Dr Uzokwe, and Mr Hamlet on behalf of the GMC. In reaching its decision, it had full regard to all the evidence

presented to date, both oral and documentary. It first determined that it accepted that the application of no case to answer was a valid one and should be considered. In so doing it considered the submission from Mr Hamlet that there were no grounds for the application and considered that as Dr Uzokwe was not represented, some leeway should be afforded him when he made applications if in so doing he was clear about what he was seeking. The Tribunal then considered the half time submission.

8. The Tribunal reminded itself that at this stage of the proceedings it was not considering whether it would or would not find each paragraph in question proved but whether sufficient evidence had been adduced for there to be a case for Dr Uzokwe to answer. In considering whether or not sufficient evidence has been adduced to find some or all of the facts proved, the test to be applied by the Tribunal is as set out in *R v Galbraith* [1981] 2 All ER 1060 which states (with adapted wording for the Tribunal):

> How then should the Tribunal approach a submission of 'no case'?
>
> If there is no evidence that the fact alleged has been committed by the medical practitioner, there is no difficulty. The Tribunal will of course stop the case.
>
> (2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.
>
> (a) Where the Tribunal comes to the conclusion that the GMC evidence, taken at its highest, is such that a properly directed Tribunal could not properly find the fact proved upon that evidence, it is the Tribunal's duty, upon a submission being made, to stop the case in relation to that alleged fact.
>
> (b) Where however the GMC evidence is such that its strength or weakness depends on the view to be taken of a witness' reliability, or other matters which are generally speaking within the province of the Tribunal, and where on one possible view of the facts there is evidence upon which a Tribunal could properly find the fact proved, then the Tribunal should not make a direction of no case to answer.

9. The Tribunal also had regard to the case of *R (Tutin) v GMC* [2009] EWHC 553 (Admin) which confirms that the case of *Galbraith* applies to civil proceedings.

Tribunal's Decision

10. The Tribunal kept foremost in its mind that, at this stage, it was required to determine the sufficiency of the evidence taken at its highest and not to make any findings of fact. It then went on to consider each paragraph of the Allegation and the evidence it has been provided with so far.

Patient A

11. The Tribunal first considered whether there was sufficient evidence that a reasonable Tribunal could, on one view of the evidence when taken at its highest, properly find proved all of the subparagraphs at paragraph 1 of the Allegation, which relate to the care of Patient A.

12. The Tribunal noted that it does not have a statement from Patient A, and that the evidence is limited to Patient A's medical records, and the expert witness report. The Tribunal noted that, in general, there is some evidence before it to support the Allegation in respect of Patient A, and that the relative strength or weakness of the evidence will be the responsibility of the Tribunal when it considers its decision on the facts. There was one part of the Allegation relating to Patient A that did not meet this test, and this is explained below.

13. The Tribunal noted that paragraph 1(b)(ii) alleges that Dr Uzokwe made a diagnosis of emotionally unstable personality disorder which he did not fully justify. The Tribunal has had sight of Patient A's medical records which clearly state '*traits*' of emotionally unstable personality disorder. It also referred to the evidence of Dr I, who was firm in his oral evidence that stating that there were 'traits' of a personality disorder did not amount to a diagnosis of that disorder.

14. Paragraph 1(b)(ii) relates to Dr Uzokwe not fully justifying the diagnosis of emotionally unstable personality disorder. It is clear on the evidence of Dr I, and by the medical records that Dr Uzokwe did not make a diagnosis. On that basis, the Tribunal found that there is no case to answer in respect of paragraph 1(b)(ii).

Patient B

15. The Tribunal next considered whether there was sufficient evidence that a reasonable Tribunal could properly find proved the subparagraphs at paragraph 2 of the Allegation, which relate to the care of Patient B.

16. The Tribunal noted that it does not have a statement from Patient B, and that the evidence is limited to the medical record entries for this patient, and the expert witness report.

17. The Tribunal considered the evidence before it, which while limited, does provide support for the particulars of the Allegation. The Allegation relates to failures to obtain an adequate history, carry out an adequate mental state examination, appropriately diagnose Patient B, and appropriately prescribe medication. It also relates to an inappropriate discharge of Patient B from the service. The Tribunal referred to the medical records of Patient B, which albeit in some cases limited, do support the failures alleged, and also show that Patient B was discharged. The Tribunal bore in mind that at this stage, it was not considering whether this discharge was appropriate, nor did it have before it any evidence that set out Dr Uzokwe's duties to Patient B, which could attest to the alleged failures. However, these were matters to be considered at the Facts stage and not for an application for no case to answer.

18. The Tribunal therefore determined that in light of the evidence adduced by the GMC and taken at its highest, a reasonable Tribunal could, on one view of the evidence, find the particulars of paragraph 2 proved and did not uphold the application in respect of this paragraph.

Patient C

19. The Tribunal then went on to consider whether there was sufficient evidence that a reasonable Tribunal could properly find proved the subparagraphs at paragraph 3 of the Allegation, which relate to the care of Patient C.

20. The Tribunal noted that it does not have a statement from Patient C, and that the evidence is limited to the medical record entries for this patient, and the expert witness report.

21. The Tribunal heard detailed oral evidence from Dr I on the assessment of this patient. The Tribunal was of the view that this evidence, when considered alongside the medical records and taken at its highest, was sufficient to support the failures in care alleged by the GMC in respect of Patient C. Accordingly, it did not uphold the application in respect of paragraph 3.

Patient D

22. The Tribunal first considered whether there was sufficient evidence that a reasonable Tribunal could, on one view of the evidence when taken at its highest, properly find proved the subparagraphs at paragraph 4 of the Allegation and paragraph 5, which relate to the care of Patient D.

23. The Tribunal heard oral evidence from Patient D on the first day of the hearing. It also had before it a copy of Patient D's witness statement, Datix entries for Patient D, his medical records and the evidence of the expert witness.

24. The Tribunal determined that in taking the evidence pertaining to Patient D at its highest, there remains a case to answer in respect of all the subparagraphs of paragraph 4.

25. As paragraph 5 relates to paragraph 4, there must also be a case to answer in respect of this paragraph.

Patient F

26. The Tribunal then considered whether there was sufficient evidence that a reasonable Tribunal could, on one view of the evidence when taken at its highest, properly find proved subparagraphs at paragraph 6 of the Allegation, and paragraph 7, which relate to the care of Patient F.

27. The Tribunal noted that it does not have a statement from Patient F, and that the evidence is limited to the Datix entries for this patient, the evidence of Ms H, a Community Psychiatric Nurse at the Newtown Centre, and the expert witness report.

28. The Tribunal determined that in taking the evidence pertaining to Patient F at its highest, there remains a case to answer in respect of all the subparagraphs of paragraphs 6 and 7.

Conclusion

29. In summary, the Rule 17(2)(g) application is upheld in respect of:

a Paragraph 1(b)(ii)

30. The Rule 17(2)(g) application is not upheld in respect of

1 Paragraph 1(a)(i), 1(a)(ii) , 1(a)(iii), 1(a)(iv), 1(a)(v), 1(a)(vi), 1(a)(vii), 1(b)(i), 1(b)(iii), 1(b)(iv), 1(b)(v) 1(b)(vi), 1(c)(i), 1(c)(ii), 1(d)(i)(1), 1(d)(i)(2), 1(d)(ii), 1(d)(iii) and 1(e);

2 Paragraph 2(a)(i)(1), 2(a)(i)(2), 2(a)(i)(3), 2(a)(i)(4), 2(a)(ii)(1), 2(a)(ii)(2), 2(a)(ii)(3), 2(a)(iii), 2(b)(i), 2(b)(ii), 2I(i), 2I(ii), 2(d)(i), 2(d)(ii), 2(d)(iii)(1), 2(d)(iii)(2), 2(d)(iii)(3), 2(d)(iii)(4), 2(d)(iv), 2(e)(i), 2(e)(ii), 2(f)(i) and 2(f)(ii);

3 Paragraph 3(a)(i), 3(a)(ii), 3(a)(iii), 3(b)(i), 3(b)(ii), 3(b)(iii), 3(c)(i), 3(d)(i) and 3(d)(ii);

4 Paragraph 4(a)(i), 4(a)(ii), 4(a)(iii), 4(b)(i), 4(b)(ii),4(b)(iii), 4(c)(i), 4(c)(ii), 4(d)(i)(1), 4(d)(i)(2), 4(d)(ii), 4(e), 4(f)(i), 4(f)(ii), 4(g) and 4(h);

5 Paragraph 5;

6 Paragraph 6(a) and 6(b); and

7 Paragraph 7.

ANNEX D – 21/12/2022

Proceeding in Absence

1. Dr Uzwoke was present and fully engaged during stage one of the hearing but not present when the Tribunal's determination on facts was announced.

Submissions

2. Mr Hamlet submitted that Rule 31, which relates to proceeding in the absence of the doctor, applies just as readily now as it would have at the outset of proceedings had Dr Uzwoke not been present. He reminded the Tribunal that it has had the opportunity to hear from Dr Uzwoke at stage one when he provided his position in regard to the Allegation.

3. Mr Hamlet referred the Tribunal to the case of *R v Jones (2001) EWCA Crim 168* and *Adeogba (2016) EWCA Civ 162* in relation to proceeding in absence.

4. Mr Hamlet reminded the Tribunal that at the end of giving evidence and closing submissions at the Facts stage, Dr Uzokwe had told the Tribunal that he would not be attending any further stages of the hearing. He stated that he would be in Nigeria. Mr Hamlet submitted that Dr Uzwoke had made a clear and informed decision not to attend the remainder of the hearing.

5. Mr Hamlet stated that Dr Uzwoke has had the opportunity to engage fully during the fact-finding stage, which resulted in all but two of the charges being found not proved and therefore there could be little or no prejudice to him in proceeding in his absence.

6. Mr Hamlet reminded the Tribunal that Dr Uzwoke has not requested an adjournment and the Tribunal may consider that an adjournment would not be appropriate at this stage.

The Tribunal's decision

7. The Tribunal was mindful that the discretion to proceed in the absence of a doctor should be exercised with the utmost care and caution, balancing the interests of the doctor with the wider public interest. It considered the statutory overarching objective prior to making its decision.

8. In deciding whether to proceed with this hearing in Dr Uzwoke's absence, the Tribunal carefully considered all the information before it and the relevant case law.

9. The Tribunal noted that Dr Uzwoke had made it very clear that he would not attend the rest of the hearing as he would be in Nigeria and would be unable to attend the hearing virtually from there. The Tribunal noted that Dr Uzwoke did not request an adjournment at that time, and although he has engaged somewhat in correspondence with the GMC since the Facts stage, he has not requested an adjournment since. It considered that adjourning the hearing at this stage would serve no useful purpose and it has no indication that Dr Uzwoke would attend the hearing in the future.

10. In the circumstances, the Tribunal determined it was appropriate to proceed in Dr Uzwoke's absence because he has voluntarily absented himself, made no application for an adjournment and it is in the public's interest and that of Dr Uzokwe for this hearing to proceed.