PUBLIC RECORD

Dates: 19/05/2026 - 04/06/2026

Doctor:	Dr Magdalene Idu EKPIKEN
GMC reference number:	6161395
Primary medical qualification:	MB BS 2005 University of Ibadan

Type of case	Outcome on facts	Outcome on impairment
Misconduct	Facts relevant to impairment found proved	Fitness to practise impaired

Summary of outcome

Suspension, 6 months
Review directed
Immediate order of suspension

Tribunal:

Legally Qualified Chair	Ms Jane Kilgannon
Lay Tribunal Member:	Mr David Raff
Registrant Tribunal Member:	Dr Gillian Livesey

Tribunal Clerk:	Olivia Gamble - 19/05/2026, 26 May 2026 – 29 May 2026, 01/06/2026 – 03/06/2026 Ciara Fogarty - 20/05/2026 Matt O'Reilly - 21/05/2026 – 22/05/2026 Fiona Johnston - 04/06/2026

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Ms Laura Bayley Counsel, Counsel/KC, instructed by the MDS
GMC Representative:	Mr Ciaran Rankin, 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.

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 02/06/2026

Background

1. Dr Ekpiken qualified in 2005 with an MBBS from University of Ibadan in Nigeria. At the time of the events which are the subject of the hearing, Dr Ekpiken was working under a fixed-term contract as a salaried GP at Merrow Park Surgery in Guildford ('the Practice').

2. The Allegation that has led to Dr Ekpiken's hearing relates to alleged misconduct. It is alleged by the General Medical Council (GMC), that between January and May 2024, Dr Ekpiken failed to provide good clinical care and make accurate records in relation to five patients.

3. The initial concerns were raised with the GMC on 22 May 2024 by Dr Ekpiken's employer after the Practice Manager at the Practice received a complaint from a Health Visitor, who alleged that Dr Ekpiken had performed an inadequate 6-week baby check on a patient. As a result of this complaint, the Practice Manager undertook an audit of Dr Ekpiken's work since joining the Practice in August 2023. Concerns were further identified in other appointments and, subsequently, the matters were referred to the GMC.

The Outcome of Applications made during the Facts Stage

4. The Tribunal granted the GMC's application, made pursuant to Rule 35(4) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), for all of the patient names in this case to be anonymised. The GMC informed the Tribunal that there is now no automatic anonymisation for witnesses at MPT hearings and anonymity applications are required for all witnesses involved.

5. Mr Rankin, Counsel on behalf of the GMC, submitted that this is a situation where additional safeguards are reasonable and proportionate. Mr Rankin stated that this case concerns the medical treatment of patients (including children) and therefore involves private and sensitive medical information relating to these patients. He submitted that any identification of these patients could result in unnecessary intrusion into private lives and could expose personal medical matters that are not relevant to the wider public interest in the case. Mr Rankin submitted that granting this application would have no prejudicial effect on Dr Ekpiken. Ms Bayley, counsel for Dr Ekpiken, made no objection to the application.

6. The Tribunal accepted Mr Rankin's submissions that it was appropriate to grant anonymity to the patient witnesses to protect their privacy and that doing so would not prejudice Dr Ekpiken. It therefore determined to grant this application.

The Allegation and the Doctor's Response

7. The Allegation made against Dr Ekpiken is as follows:

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

Patient A

1. On 23 January 2024, you undertook a telephone consultation of Patient A via Patient A's partner, and you failed to:
    a. adequately assess Patient A in that you did not arrange for a physical examination to determine how serious her condition was, involving:
        i. the assessment of physiological observations such as:
            1. temperature; **Admitted and found proved**
            2. pulse rate; **Admitted and found proved**
            3. blood pressure; **Admitted and found proved**
            4. oxygen saturation; **Admitted and found proved**
            5. respiratory rate; **Admitted and found proved**
        ii. a detailed respiratory system examination to assess for signs of a serious chest infection or pneumonia; **Admitted and found proved**

b. make an accurate record of your examination of Patient A in that you did not record relevant and important features of her presentation such as that Patient A:
   i. was confused; Admitted and found proved
   ii. had a headache; Admitted and found proved
   iii. had chest pain; Admitted and found proved
   iv. had blood in her sputum; Admitted and found proved
   v. had a high temperature. Admitted and found proved

Patient B

2. On 8 March 2024, you undertook a 6-8 week screening examination of Patient B and you failed to:
   a. adequately examine Patient B in that you did not examine Patient B's:
      i. heart and chest with a stethoscope; To be determined
      ii. eyes with an ophthalmoscope; To be determined
   b. make an accurate record of your examination of Patient B in that you recorded that you had examined Patient B's:
      i. heart; To be determined
      ii. eyes, To be determined
      within Patient B's medical records.

3. You did not examine Patient B's:
   a. heart; To be determined
   b. eyes. To be determined

4. You included information within Patient B's medical records which was untrue. To be determined

5. You knew that the information included within Patient B's medical records was untrue. To be determined

6. Your actions as set out at paragraphs 2b and 4 were dishonest by reason of paragraphs 3 and 5. To be determined

Patient C

7. On 8 March 2024, you undertook a 6-8 week postnatal assessment of Patient C and you failed to make an accurate record of your examination of Patient C in that you recorded that you had:
   a. taken a substantive history from Patient C; To be determined
   b. undertaken an examination of Patient C's abdomen, To be determined within Patient C's medical records. To be determined

8. You did not:
   a. take a substantive history from Patient C; To be determined
   b. undertake an examination of Patient C's abdomen. To be determined

9. You included information within Patient C's medical records which was untrue. To be determined

10. You knew that the information included within Patient C's medical records was untrue. To be determined

11. Your actions as set out at paragraphs 7 and 9 were dishonest by reason of paragraphs 8 and 10. To be determined

Patient D

12. On 7 May 2024, you undertook a 6-8 week screening examination of Patient D and you failed to:
   a. adequately examine Patient D in that you did not examine Patient D's:
      i. heart and chest with a stethoscope; Admitted and found proved
      ii. eyes with an ophthalmoscope; Admitted and found proved
   b. make an accurate record of your examination of Patient D in that you recorded that you had examined Patient D's:
      i. heart; Admitted and found proved
      ii. eyes, Admitted and found proved
      within Patient D's medical records.

13. You did not examine Patient D's:
   a. heart; Admitted and found proved
   b. eyes. Admitted and found proved

14. You included information within Patient D's medical records which was untrue.
Admitted and found proved

Patient E

15. On 7 May 2024, you undertook a 6-8 week postnatal assessment of Patient E and you failed to make an accurate record of your examination of Patient E in that you did not record that you had:
    a. conducted an intimate examination of Patient E; Admitted and found proved
    b. obtained Patient E's explicit consent to the intimate examination;
    Admitted and found proved
    c. offered to provide a chaperone during the intimate examination of Patient E;
    Admitted and found proved
    within Patient E's medical records.

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

The Admitted Facts

8. At the outset of these proceedings, through her Counsel, Ms Bayley, Dr Ekpiken made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the 'the Rules'. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

9. In light of Dr Ekpiken's response to the Allegation made against her, the Tribunal is required to determine the remaining parts of the Allegation, which relate only to Patients B and C.

Witness Evidence

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

- Patient C (assisted by an interpreter, in Urdu);

- Dr F, a GP Partner at the Practice.

11. The Tribunal was due to hear oral evidence from Patient E on 21 May 2026. The Tribunal determined that Patient E's oral evidence was no longer required as the alleged facts in relation to this patient were admitted by Dr Ekpiken. Patient E was therefore stood down.

12. Dr Ekpiken provided her own witness statement and also gave oral evidence at the hearing.

Expert Witness Evidence

13. The Tribunal received oral evidence from expert witness, Dr G.

Documentary Evidence

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

- Witness statement of Patient C – dated 12 December 2024;
- Witness statement of Patient E – dated 13 November 2024;
- Witness statement of Dr F – dated 26 May 2026;
- Various audio recordings of patient calls and related transcripts;
- Various medical records;
- Expert report of Dr G – dated 10 April 2025;
- Rule 7 response – dated 6 June 2025;
- Rule 7 bundle.

The Tribunal's Approach

15. In reaching its decision on the facts, the Tribunal will apply the civil standard of proof. This means that the Tribunal must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged. The burden of proof rests with the GMC and it is for the GMC to prove the case that it is presenting against the doctor. There is no burden on the doctor to prove or disprove anything.

16. The Tribunal will approach fact finding by firstly identifying agreed facts and evidence. To reach a decision on the disputed facts, the Tribunal will assess the evidence in the round.

It will consider what conclusions and inferences can be drawn from the documentary evidence. The Tribunal will then consider the available oral evidence and subject that evidence to critical scrutiny against the agreed facts and documentary evidence to consider a witness' reliability and credibility. The Tribunal should not decide reliability and credibility based on the demeanour of a witness alone.

The Tribunal's Analysis of the Evidence and Findings

17. The Tribunal has considered each outstanding paragraph of the Allegation and has evaluated the evidence to make its findings on the facts. At the outset of this hearing, Dr Ekpiken admitted the allegations in relation to Patients A, D and E. Therefore, the disputed allegations that remain (allegations 2 to 11) relate only to Patients B and C. Patient B is the child of Patient C and, at the relevant time, Patient B was approximately 6-8 weeks old.

18. The outstanding allegations all relate to Dr Ekpiken's conduct at two consecutive GP appointments, for Patients B and C, which took place on the morning of 8 March 2024. The Tribunal first focused on paragraphs 3a, 3b, 8a and 8b of the GMC's Allegation – namely, whether it is more likely than not that Dr Ekpiken did not examine Patient B's heart, did not examine Patient B's eyes, did not take a substantive history from Patient C (about her own health issues), and did not examine Patient C's abdomen.

19. The Tribunal considered the medical notes recorded by Dr Ekpiken in relation to these two consultations. Those medical notes, together with the written and oral evidence of Dr F (based on the Practice records on the EMIS system), indicated that at 8:30am on the morning of 8 March 2024, the two consecutive appointments were booked for Patients B and C at 11:30am and 11:45am. They also indicated that the patients were called into the consultation at 11:19am and were recorded as having left the consultation at 11:57am. Although the Tribunal noted that those are not necessarily precise start and end times for the consecutive consultations (because it is open to the doctor to record a patient as having 'left' even some time after they have actually left the room), it found, on the balance of probabilities, that those recorded timings indicated that the consecutive consultations lasted altogether between 30 and 38 minutes.

20. The Tribunal noted the transcript of a telephone call, which was made by the Practice Manager at the Practice to Patient C on 22 May 2024 during the audit. The conversation was undertaken in English, without an Urdu interpreter. In response to questions put by the Practice Manager about the consecutive appointments on 8 March 2024, Patient C stated that Dr Ekpiken had not checked Patient B's eyes with an ophthalmoscope, had not checked

Patient B's heart, had not examined her abdomen, and that she wanted to tell Dr Ekpiken about her health problems including pain and swelling in her feet but was told to book another appointment.

21. The Tribunal has received written and oral evidence from Patient C as to her recollection of what took place on 8 March 2024. It also heard oral evidence of Dr Ekpiken's own account of the events.

22. Patient C recalls the consecutive consultations as having been very brief, lasting around 7-10 minutes in total. In her witness statement she said that the only checks of Patient B undertaken by Dr Ekpiken were to look at him without his clothes on, and to weigh him together with Patient C. Patient C said that she attempted to tell Dr Ekpiken about her own health issues but that Dr Ekpiken did not examine her and said she had to come back another day. In her oral evidence Patient C initially stated that Dr Ekpiken had examined Patient B's heart with a stethoscope on *'one side'* of his body. However, after a break and re-reading her witness statement, she retracted that statement and confirmed her previous recollection that Dr Ekpiken did not examine Patient B's heart with a stethoscope. In her oral evidence Patient C also confirmed that no history was taken from her in relation to her own health issues and that no examination was made of her abdomen. Patient C's recollection was that Dr Ekpiken was not interested in listening to Patient C's health concerns and told her to instead make an appointment for another day.

23. Dr Ekpiken's recollection is that she completed a full 6–8-week check for Patient B, including examining the baby's eyes with an ophthalmoscope and chest and heart with a stethoscope, took a full history from Patient C and examined Patient C's abdomen. In oral evidence she said that she could remember the consecutive consultations, including carrying out an examination of Patient C's abdomen with her lying on the couch clothed, but with her abdomen exposed for the examination.

24. The Tribunal considered all of the evidence presented to it. It noted the following:

a) Dr Ekpiken's account is consistent with the medical notes she made on the day. Dr Ekpiken's notes about Patient C's history were detailed and included reference to matters that she could not have known about without having asked Patient C detailed questions on the day. For example, detail was included about Patient B being born prematurely at 39 weeks, Patient C having low iron and tiredness throughout pregnancy, Patient C initially having tried to breastfeed Patient B but that now he was bottle fed, Patient C having had urinary incontinence problems and having made an

appointment to see a physiotherapist on 12 March 2024 about this, and Patient C currently having supra-pubic pain and tiredness. The detailed notes also included Dr Ekpiken arranging follow-up tests for Patient C, a urine sample and blood tests, that are consistent with Patient C having reported tiredness and supra-pubic pain and were recorded to have been arranged to rule out a possible urinary tract infection. This recorded history, current symptoms and arrangement of follow-up diagnostic tests would also be consistent with Dr Ekpiken having decided that it was appropriate to carry out an examination of Patient C's abdomen;

b) Dr Ekpiken's notes for Patients B and C were made contemporaneously in that Patient C's notes were made at 11:24am, during the consultation itself, and Baby B's notes were completed later in the day at around 4pm. The Tribunal was satisfied that the notes were contemporaneous and considered that this increased their reliability. It took into account Dr F's evidence that she herself would not consider a note made later on the same day to be non-contemporaneous such that it would need to be labelled as retrospective;

c) Dr Ekpiken's evidence about going to discuss Patient B's immunisations with the Practice Nurse and subsequently booking the immunisations during the consecutive consultations with Patients B and C (because Patient B's premature birth meant that the immunisations could not happen on the same day as the 6-8 week baby check) was consistent with the medical records showing that Patient B's immunisations did, in fact, take place approximately one week later;

d) Dr Ekpiken's account is consistent with the Tribunal's finding above that the likely length of the appointment was around 30 - 38 minutes, which would have given sufficient time, based on the evidence of Dr G, for the examinations of Patients B and C to have been undertaken, and the substantive history to be taken from Patient C, as set out in the medical notes recorded by Dr Ekpiken;

e) Patient C's first account of what happened was not given contemporaneously, which, in the Tribunal's view, lessens its reliability. Her account was given approximately 10 weeks later in a telephone conversation when the Practice Manager contacted Patient C as part of an audit the surgery was undertaking. The Tribunal was of the view that, having had regard to all of Patient C's evidence, Patient C's recollection of the consultation may well have been impacted by the gap in time between the 8 March 2024 consultation and this conversation with the Practice Manager. During that intervening period, Patient C had attended a number of other medical

appointments at the surgery (for herself and for Patient B). At the start of the conversation with the Practice Manager, Patient C wasn't entirely clear which appointment was being referred to. Furthermore, the Tribunal also considered that, having listened to the recording of the call in question and carefully read the transcript of that conversation, the Practice Manager's questions were, at some points, leading. The Tribunal also bore in mind that although Patient C seemed to broadly follow the conversation, English is not her first language and no interpreter was present. The Tribunal noted that an interpreter was needed for Patient C to fully participate in this MPT hearing. The Tribunal found that these further features of the way in which Patient C's initial account of the 8 March 2024 consultations was taken further lowered its reliability;

f) In her oral evidence, Patient C had changed her account about whether Patient B's heart was examined with a stethoscope. In her conversation with the Practice Manager, and in her witness statement, she had stated that Patient B's heart was not checked by Dr Ekpiken. However, in her oral evidence to the Tribunal, she first said that the chest was examined with a stethoscope and then later in her oral evidence, following a break and having re-read her witness statement, she later changed her account back to saying that there had been no examination with a stethoscope. The Tribunal found that inconsistency in Patient C's account indicated that she did not have a firm and reliable recollection of that part of the 8 March 2024 consultations;

g) The Tribunal accepted Ms Bayley's submission that it was improbable that, during a 6-8 week baby check appointment and 6 week post-natal check lasting in total approximately 30 – 38 minutes, Dr Ekpiken would ask for the baby's clothes to be removed (which it is agreed happened) but then do nothing more than look at the baby from afar and weigh them.

25. Having regard to the above, the Tribunal overall preferred the evidence of Dr Epikpen as to what had happened at the consecutive consultations for Patients B and C on 8 March 2024. It considered that, on the balance of probabilities, it is more likely than not that the examinations in question did happen during the consultations with Patients B and C, and that substantive history of Patient C was taken by Dr Ekpiken.

26. The Tribunal considered that Dr Ekpiken had been frank in her admission of other failures in relation to Patients A, D, and E, but had been consistent in denying the matters alleged by the GMC in respect of Patients B and C. Dr Ekpiken's explanation for this was that

she clearly remembered the consultation with Patients B and C. The Tribunal noted that her admissions in relation to the other matters were offered early in the regulatory proceedings.

27. The Tribunal considered the submissions made on behalf of the GMC in terms of Dr Ekpiken's account, noting that it was submitted by Mr Rankin that Dr Ekpiken had changed her account in relation to when the medical notes were made for Patient B. The Tribunal noted that, in her oral evidence, Dr Ekpiken had initially told the Tribunal that, although time-stamped at 15:56, she had inputted Patient B's medical notes that morning during the consultation with Patients B and C. It was only after hearing Dr F's evidence that this would be impossible on the Practice's IT system that Dr Ekpiken changed her position and accepted that she must have inputted Patient B's medical notes some hours after the appointment, at around 4pm.

28. The Tribunal considered that it was more likely than not that this was a case of poor recollection on Dr Ekpiken's part due to the passage of time. The Tribunal noted that this was a routine 6–8-week baby check, which was relatively unremarkable. It considered that this was in stark contrast with the consultation with Patient D, which had very unusual features, including the baby having a 'jerking episode' during the appointment itself.

29. The Tribunal considered that the routine nature of the appointment with Patient B, along with the passage of time, and the fact that the notes for Patient C appear to have been made during the consultation itself, mean that it is more likely than not that this discrepancy and change in Dr Ekpiken's evidence is the result of poor memory of when she made Patient B's notes rather than any deliberate attempt to mislead the Tribunal in that regard.

30. In respect of Patient C's account of events, the Tribunal took the view that Patient C was in no way seeking to mislead or present a false account of events in her evidence to the Tribunal. There was no evidence that she had any such motivation, nor was there any evidence that she might have any reason to have had such motivation. The Tribunal found that Patient C was doing her best to remember what had happened on 8 March 2024. However, Patient C had misremembered some of the details of the appointment due to the passage of time, as well as other factors. The Tribunal bore in mind that Patient C was experiencing significant health issues at the relevant time, some of which Dr Ekpiken may not have been able to fully address during the appointment. The Tribunal considered that Patient C's frustration over being told that she would need to make a follow-up appointment on another day to discuss these health issues may have also impacted upon her recollection of the rest of the events of the appointment. Overall, the Tribunal took the view that Patient C's memory of the consultations was less reliable than the memory of Dr Ekpiken, whose

account of the consultations had been largely consistent with the contemporaneous medical records and had not changed over time (except in relation to the timing of making Patient B's notes).

31. Given its findings, the Tribunal found that Dr Ekpiken did examine Patient B's heart and eyes, did take a substantive history from Patient C and did undertake an examination of Patient C's abdomen. As a result, it found paragraphs 3a, 3b, 8a and 8b not proved.

32. Given those findings, the Tribunal found that Dr Ekpiken had not:

a. failed to adequately examine Patient B;
b. failed to make an accurate record of her examination of Patient B;
c. included untrue information within Patient B's medical records;
d. failed to make an accurate record of her examination of Patient C;
e. included untrue information within Patient C's medical records.

33. Accordingly, it found allegations 2, 4, 7 and 9 not proved, and allegations 5, 6, 10 and 11 fell away.

The Tribunal's Overall Determination on the Facts

34. The Tribunal has determined the facts as follows:

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

Patient A

1. On 23 January 2024, you undertook a telephone consultation of Patient A via Patient A's partner, and you failed to:
    a. adequately assess Patient A in that you did not arrange for a physical examination to determine how serious her condition was, involving:
        i. the assessment of physiological observations such as:
            1. temperature; **Admitted and found proved**
            2. pulse rate; **Admitted and found proved**
            3. blood pressure; **Admitted and found proved**
            4. oxygen saturation; **Admitted and found proved**
            5. respiratory rate; **Admitted and found proved**
        ii. a detailed respiratory system examination to assess for signs of a serious chest infection or pneumonia; **Admitted and found proved**

b. make an accurate record of your examination of Patient A in that you did not record relevant and important features of her presentation such as that Patient A:

i. was confused; Admitted and found proved
ii. had a headache; Admitted and found proved
iii. had chest pain; Admitted and found proved
iv. had blood in her sputum; Admitted and found proved
v. had a high temperature. Admitted and found proved

Patient B

2. On 8 March 2024, you undertook a 6-8 week screening examination of Patient B and you failed to:

a. adequately examine Patient B in that you did not examine Patient B's:
i. heart and chest with a stethoscope; Found not proved
ii. eyes with an ophthalmoscope; Found not proved

b. make an accurate record of your examination of Patient B in that you recorded that you had examined Patient B's:
i. heart; Found not proved
ii. eyes, Found not proved
within Patient B's medical records.

3. You did not examine Patient B's:
a. heart; Found not proved
b. eyes. Found not proved

4. You included information within Patient B's medical records which was untrue. Found not proved

5. You knew that the information included within Patient B's medical records was untrue. Found not proved

6. Your actions as set out at paragraphs 2b and 4 were dishonest by reason of paragraphs 3 and 5. Found not proved

Patient C

7. On 8 March 2024, you undertook a 6-8 week postnatal assessment of Patient C and you failed to make an accurate record of your examination of Patient C in that you recorded that you had:

a. taken a substantive history from Patient C; **Found not proved**

b. undertaken an examination of Patient C's abdomen, **Found not proved**

within Patient C's medical records. **Found not proved**

8. You did not:

a. take a substantive history from Patient C; **Found not proved**

b. undertake an examination of Patient C's abdomen. **Found not proved**

9. You included information within Patient C's medical records which was untrue. **Found not proved**

10. You knew that the information included within Patient C's medical records was untrue. **Found not proved**

11. Your actions as set out at paragraphs 7 and 9 were dishonest by reason of paragraphs 8 and 10. **Found not proved**

Patient D

12. On 7 May 2024, you undertook a 6-8 week screening examination of Patient D and you failed to:

a. adequately examine Patient D in that you did not examine Patient D's:

i. heart and chest with a stethoscope; **Admitted and found proved**

ii. eyes with an ophthalmoscope; **Admitted and found proved**

b. make an accurate record of your examination of Patient D in that you recorded that you had examined Patient D's:

i. heart; **Admitted and found proved**

ii. eyes, **Admitted and found proved**

within Patient D's medical records.

13. You did not examine Patient D's:

a. heart; **Admitted and found proved**

b. eyes. **Admitted and found proved**

14. You included information within Patient D's medical records which was untrue.
Admitted and found proved

Patient E

15. On 7 May 2024, you undertook a 6-8 week postnatal assessment of Patient E and you failed to make an accurate record of your examination of Patient E in that you did not record that you had:

a. conducted an intimate examination of Patient E; Admitted and found proved
b. obtained Patient E's explicit consent to the intimate examination;
Admitted and found proved
c. offered to provide a chaperone during the intimate examination of Patient E;
Admitted and found proved

within Patient E's medical records.

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

Determination on Impairment - 03/06/2026

35. 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 Ekpiken's fitness to practise is impaired by reason of misconduct.

Submissions

Submissions on behalf of the GMC

36. On behalf of the GMC, Mr Rankin submitted that Dr Ekpiken's admissions relate to serious failings. Mr Rankin further submitted that the doctor attempted to minimise and or deflect when asked to explain how the errors arose. Mr Rankin stated that the only reason the concerns came to light was due to a complaint received from a patient and he noted that without this intervention, the potential risks to young babies may have gone undetected. Mr Rankin submitted that the GMC expert, Dr G, opined that Dr Ekpiken's actions fell seriously below the standard expected.

37. Mr Rankin drew the Tribunal's attention to paragraphs of Good Medical Practice ('GMP') that the GMC submit Dr Ekpiken has breached. In terms of context for the Tribunal to consider, Mr Rankin submitted that in this case, this could be the working environment, time constraints and Dr Ekpiken's own personal circumstances at the time. However, Mr Rankin reminded the Tribunal that Dr Ekpiken has herself acknowledged that a busy day is not an excuse for her failings.

38. Mr Rankin submitted that Dr Ekpiken has apologised and expressed regret for her shortcomings, acknowledging that her practice has been deficient, noting that they arose from unintentional oversight, flawed judgment under pressure, and a need for greater consistency and structure in her clinical approach. Mr Rankin stated that Dr Ekpiken says she has developed genuine insight into her failings and taken proactive, sustained steps to remediate them along with undertaking targeted training. However, Mr Rankin submitted that concerns should remain about the doctor's remediation as she said herself in evidence that she has started along this path but not yet finished it.

39. Mr Rankin submitted that there are some factors that aggravate the already high level of seriousness. Those being, that the poor performance was persistent and repeated, the doctor's behaviour in relation to record keeping undermined a system designed to protect the public and she has shown a reckless disregard to professional standards as she did not follow professional guidance. Mr Rankin stated that when taking these factors into account, the matters found proved fall at the higher end on the spectrum of seriousness.

40. Mr Rankin submitted that, with the admissions at the start of these proceedings, the doctor has accepted where she has gone wrong and has produced some evidence about the steps she has taken to prevent future concerns. However, despite this, Mr Rankin submitted that the GMC do not consider the doctor's insight to be fully complete.

41. In terms of remediation, Mr Rankin submitted that, for a doctor to remediate, it is important that they have insight into the concern. Mr Rankin asked the Tribunal to ask itself: has she actively addressed the concerns about her behaviour and performance? Mr Rankin submitted that Dr Ekpiken has given evidence about what she has done and provided some objective evidence of remediation in the form of courses undertaken.

42. Mr Rankin submitted that all three elements of public protection are engaged in this case. He submitted that, as the GMC submit that the departure from the professional standards indicates a starting point of a high level of seriousness, it means that the starting point for assessing current and ongoing risk to public protection will be high.

43. Mr Rankin submitted that the Guidance suggests that a decision on risk should be weighted to reflect this and a conclusion that the doctor poses a current and ongoing risk to public protection will usually be needed. He submitted that Dr Ekpiken's fitness to practise is currently impaired by reason of her misconduct.

Submissions on behalf of Dr Ekpiken

44. Ms Bayley, on behalf of Dr Ekpiken submitted that the allegations found proved had been admitted in their entirety. Ms Bayley stated that Dr Ekpiken understands that her actions were a serious lapse in conduct and a significant departure from the standards expected of a medical practitioner, accepting the conclusions of Dr G's report in full. She submitted that Dr Ekpiken has not sought to minimise the seriousness of her conduct. She therefore accepts that her conduct amounted to serious professional misconduct.

45. Ms Bayley invited the Tribunal to find that the misconduct in this case falls at the lower end of the spectrum of seriousness. She stated that the regulatory concerns are clinical failures which do not equate in their level of seriousness to those matters listed in the Guidance as being likely to be found to be at the higher end of the spectrum of seriousness. Ms Bayley accepted on Dr Ekpiken's behalf that the degree of repetition across the matters found proved could be considered to be aggravating factor, but she submitted that it was not enough to move these matters into a higher category of seriousness.

46. Ms Bayley invited the Tribunal to find that Dr Ekpiken's misconduct is capable of being remedied.

47. Ms Bayley submitted that Dr Ekpiken genuinely and deeply regrets her actions, which are a matter of deep personal and professional shame and anguish. She drew the Tribunal's attention to Dr Ekpiken's repeated apologies offered to the Tribunal, the public and most significantly, the patients involved. They were genuine and heartfelt. Ms Bayley stated that Dr Ekpiken's remorse was also reflected in her early admissions to the allegations and misconduct.

48. Ms Bayley stated that Dr Ekpiken has found the MPTS process difficult and stressful. She submitted that her misconduct has clearly been challenging to confront, however, the doctor's oral and written evidence demonstrates that Dr Ekpiken has accepted full responsibility and accountability for her misconduct. She has been open and honest about her ongoing journey to developing insight. It has taken time and work, research, training and

reflection to bring Dr Ekpiken to a position where, today, she has developing insight into her misconduct. Ms Bayley also asked the Tribunal to note that Dr Ekpiken has been subject to an investigation by her regulator for two years. She has engaged throughout these proceedings, attending every day of the hearing. She has given evidence before the Tribunal, and accepted responsibility and accountability for her failures.

49. Ms Bayley submitted that Dr Ekpiken has taken concrete steps to understand the triggers for her behaviour and improve her personal and professional skills, in line with the principles of Good Medical Practice. Ms Bayley submitted that Dr Ekpiken has undertaken targeted and relevant training, which she has also reflected upon at length. Ms Bayley further submitted that Dr Ekpiken's insight has developed substantially and meaningfully over time, to the point that she has demonstrated the ability to look objectively at her conduct and consider the impact of her misconduct upon those involved, the wider medical profession and the public. Ms Bayley stated that the doctor's insight is developing but not yet embedded. Ms Bayley stated that, as well as the targeted training courses and general CPD undertaken by Dr Ekpiken, she has also undertaken a period of shadowing with GP colleagues in 2025. Ms Bayley stated that, as she has been away from practice for some time, Dr Ekpiken intends to undertake a 'return to practice course' to ensure her clinical skills and knowledge are up to date and that she is capable of safe and effective practice.

50. Ms Bayley stated that Dr Ekpiken recognises that, despite the steps that she has already taken, there is more work to do in order to fully remediate her misconduct. On that basis, Ms Bayley stated that a finding of current impairment of fitness to practise is not challenged.

51. Ms Bayley submitted that the Tribunal can be assured that the conduct admitted and found proved is remediable, is in the process of being remedied to the point that it is highly unlikely to be repeated. Ms Bayley accepted, however, that due to the nature and seriousness of the matters admitted and found proved, the public interest is likely to be engaged and a finding of current impairment of fitness to practise may be considered necessary in the public interest.

The Relevant Legal Principles

52. There is no burden or standard of proof at this stage of the proceedings and the decision on impairment is a matter for the Tribunal's judgement alone. The Tribunal will only make a finding of impaired fitness to practise where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more

of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are: to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

53. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first, whether the facts found proved were serious enough to amount to the statutory ground of misconduct; and second, whether that misconduct poses a current and ongoing risk to public protection requiring restrictive action in response and therefore leading to a finding of impaired fitness to practise.

54. To assess whether Dr Ekpiken poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal will consider the steps set out in the Guidance:

- Where on the spectrum of seriousness does the conduct lie?
- What is the impact of any relevant context known about the doctor and their working environment?
- How has the doctor responded and what does this tell us about how the doctor might act in the future?

The Tribunal's Determination on Impairment

Misconduct

55. The Tribunal first considered whether Dr Ekpiken's conduct amounted to misconduct.

56. In relation to Patient A, the Tribunal considered GMP 2013 because that was the version of GMP in force at the time of Dr Ekpiken's telephone consultation with Patient A / Patient A's partner (23 January 2024). In relation to Patients D and E, the Tribunal referred to GMP 2024 because that was the version of GMP in force at the time of Dr Ekpiken's face to face consultations with Patients D and E (7 May 2024). It also had regard to a document, produced by Mr Rankin, Counsel for the GMC, which provided a comparison of the potentially relevant standards across the two versions of GMP.

57. In relation to paragraph 1 of the Allegation (relating to Patient A), the Tribunal considered the following standards from GMP 2013 to be engaged in this case:

7 You must be competent in all aspects of your work, including management, research and teaching

8 You must keep your professional knowledge and skills up to date

15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient
b promptly provide or arrange suitable advice, investigations or treatment where necessary
c refer a patient to another practitioner when this serves the patient's needs

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

21 Clinical records should include:

a relevant clinical findings
b the decisions made and actions agreed, and who is making the decisions and agreeing the actions
c the information given to patients
d any drugs prescribed or other investigation or treatment e who is making the record and when

58. In relation to paragraphs 12 and 13 of the Allegation (relating to Patient D), the Tribunal considered the following standards from GMP 2024 to be engaged in this case:

1 You must be competent in all aspects of your work including, where applicable, formal leadership or management roles, research and teaching.

6 You must provide a good standard of practice and care. If you assess, diagnose, or treat patients, you must work in partnership with them to assess their needs and priorities. The investigation or treatment you propose, provide or arrange must be

based on this assessment, and on your clinical judgement about the likely effectiveness of the treatment options.

7 In providing clinical care you must:

a. *Adequately assess a patient's condition(s), taking account of their history, including*
   i. *Symptoms*
   ii. *Relevant psychological, spiritual, social, economic, and cultural factors*
   iii. *The patient's views, needs, and values*
b. *Carry out a physical examination where necessary*
c. *Promptly provide (or arrange) suitable advice, investigation or treatment where necessary*
d. *Propose, provide or prescribe drugs or treatment (including repeat prescriptions) only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment will meet their needs*
e. *Propose, provide or prescribe effective treatment based on the best available evidence*
f. *Follow our more detailed guidance on professional standards, Good practice in prescribing and managing medicines and devices, if you prescribe*
g. *Consult colleagues or seek advice from your supervising clinician, where appropriate*
h. *Refer a patient to another suitably qualified practitioner when this serves their needs.*

69 You must make sure that formal records of your work (including patients' records) are clear, accurate, contemporaneous and legible.

59. In relation to paragraphs 14 and 15 of the Allegation (relating to Patient E), the Tribunal considered the following standards from GMP 2024 to be engaged in this case:

1 You must be competent in all aspects of your work including, where applicable, formal leadership or management roles, research and teaching.

69 You must make sure that formal records of your work (including patients' records) are clear, accurate, contemporaneous and legible.

60. The Tribunal considered the evidence of the expert, Dr G, that these were serious failings, conduct that fell seriously below the standard expected of a registered medical practitioner.

61. Taking into account the nature and extent of Dr Ekpiken's failings, in important areas of clinical practice – adequate assessments and accurate record keeping, and the expert opinion of Dr G, the Tribunal concluded that each of the matters admitted and found proved was serious enough to amount to the statutory ground of misconduct.

Is there a legal basis for considering impairment?

62. Having found misconduct, the Tribunal was satisfied that there was a clear legal basis to proceed to consider whether Dr Ekpiken's fitness to practise is currently impaired. The Tribunal therefore moved to the impairment stage.

Where on the spectrum of seriousness does the allegation lie?

63. The Tribunal considered the nature and seriousness of the misconduct in this case.

64. The Tribunal had regard to paragraphs 28 and 31 of Part B of the Guidance, which provided that:

> *'28. Allegations that usually fall at the lower end of the spectrum of seriousness and due to their nature are more likely to be easily remediable include, but are not limited to:*
>
> - *Clinical failings, including where a doctor has acted without regard for patients' rights or feelings provided this is not a wilful disregard of their wishes….'*
>
> *'31. Allegations that are likely to fall at the higher end of the spectrum of seriousness include, but are not limited to:*
>
> - *Clinical failings that are not considered to be easily remediable, including those amounting to gross negligence or recklessness about a risk of serious harm to patients…'*

65. The Tribunal found that the clinical failings in this case fell between the lower and higher ends of the spectrum of seriousness. The failings were serious, in that they related to

fundamental areas of practice and had put patients at a risk of serious harm. However, this was not a case where the evidence indicated that the doctor's failures had been deliberate or undertaken with a reckless or grossly negligent disregard for those risks.

66. The Tribunal determined that Dr Ekpiken's misconduct fell in the mid-range of the spectrum of seriousness as a starting point.

67. The Tribunal identified one aggravating feature, namely, that Dr Ekpiken's misconduct was repeated across three separate patients. The Tribunal concluded, however, that this single aggravating feature was not so serious as to move the misconduct from the mid-range to the higher end of the spectrum of seriousness.

What is the impact of any relevant context known about Dr Ekpiken and her working environment?

68. In terms of context, the Tribunal considered that there was nothing exceptional in Dr Ekpiken's role or work environment at the relevant times that materially impacted on its assessment of the seriousness of the misconduct. The Tribunal noted that Dr Ekpiken is an experienced GP and there was no submission from Dr Ekpiken, nor evidence before the Tribunal, to indicate that she was working in an unusually difficult work environment. The Tribunal did consider Dr Ekpiken's oral evidence about her personal XXX issues and XXX. However, as accepted by Ms Bayley on Dr Ekpiken's behalf, whilst this did provide helpful background context, the Tribunal found that it was not a feature that reduced the level of the seriousness of the misconduct.

69. The Tribunal therefore concluded that the misconduct fell within the mid-range of the spectrum of seriousness. That therefore indicated a medium starting point for assessing risk to public protection.

How has Dr Ekpiken responded to the Allegation?

70. The Tribunal accepted that Dr Ekpiken's remorse is genuine and meaningful. She had expressed regret throughout her Rule 7 response and in her oral evidence to the Tribunal.

71. The Tribunal found that Dr Ekpiken had demonstrated developing insight. She had made early admissions to the matters found proved, and she had demonstrated through her Rule 7 response, reflection statement, and in her oral evidence that she understood the nature of her failings, and the impact that her failings would have had on others (including

the patients themselves, her colleagues, and public confidence in the wider profession). The Tribunal also noted that Dr Ekpiken had provided evidence of a small number of appropriately targeted training courses and reflections on those, alongside certificates for CPD courses of more general application. The Tribunal considered that this was evidence of a good start, but that the targeted training was relatively limited in duration, the reflections upon it somewhat generic, and some time had now elapsed since the training was undertaken.

72. The Tribunal heard evidence that Dr Ekpiken has undertaken unpaid shadowing in a clinical setting. The Tribunal found this to be positive but noted that Dr Ekpiken had not provided any documentary evidence of that shadowing.

73. The Tribunal noted the testimonials provided. They were all recent, and came from people who have known the doctor for a number of years. They all provided very positive feedback on Dr Ekpiken's personal qualities. However, none of the testimonials had ever worked with Dr Ekpiken and so none could assist the Tribunal as to Dr Ekpiken's performance in a clinical setting, whether in the past or since the misconduct in question.

74. The Tribunal took account of the fact that Dr Ekpiken has been out of practice as a doctor for some time now and that her skills and knowledge may therefore have deteriorated. It also noted Dr Ekpiken's own acceptance was that she still has 'work to do' and that her remediation is not complete.

75. Overall, the Tribunal was of the opinion that, whilst Dr Ekpiken has begun her journey to develop insight and remediation into her misconduct, there was still a considerable amount of work to be done in that regard. Accordingly, the Tribunal determined that insight and remediation were incomplete and so there is risk to public protection.

<u>The Tribunal's decision as to whether Dr Ekpiken poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment</u>

76. The Tribunal reviewed its conclusions on the previous paragraphs. It found that Dr Ekpiken's misconduct fell within the mid-range of the spectrum of seriousness, and that although some progress has been made in terms of insight and remediation, those are incomplete and so a risk to public protection remains.

77. At this point, the Tribunal had reference to the guidance provided by Dame Janet Smith in the Fifth Shipman Report, as adopted by the *High Court in CHRE v NMC & Grant*

(2011) EWHC 927 (Admin.) Dame Smith sets out some features that are likely to be present when impairment is found. These are where the doctor has in the past or is liable in the future to:

a. act so as to put a patient or patients at unwarranted risk of harm.
b. bring the medical profession into disrepute.
c. breach one of the fundamental tenets of the medical profession; and/or
d. act dishonestly.

78. The Tribunal found that Dr Ekpiken's misconduct breached fundamental tenets of the profession (adequate assessments and examinations, and accurate record keeping), putting patients at risk of serious harm. This has the potential to bring the medical profession into disrepute. Therefore, the Tribunal found that limbs a, b and c were engaged.

79. Given the risk to patients, the Tribunal concluded that there was a current and ongoing risk to public protection that required a finding that Dr Ekpiken's fitness to practise is impaired.

80. The Tribunal also considered the wider public interest. Given the nature and seriousness of Dr Ekpiken's misconduct – failing to adequately assess two patients, and failing to make accurate records for three patients – alongside Dr Ekpiken's incomplete journey towards full insight and remediation, the Tribunal determined that a finding of impaired fitness to practise was also required to uphold proper professional standards and to maintain public confidence in the medical profession.

81. The Tribunal considered that a finding of impairment was required to send a clear signal to Dr Ekpiken, the profession and the public that the nature of her misconduct was unacceptable.

82. Accordingly, the Tribunal determined that Dr Ekpiken's fitness to practise is currently impaired by reason of misconduct.

Determination on Sanction - 04/06/2026

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

The Evidence

84. The Tribunal has reviewed its findings at the facts and impairment stages and taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

85. The Tribunal received further evidence on behalf of the GMC including:

- An MPT determination dated 5 July 2018, finding Dr Ekpiken's fitness to practise impaired by reason of misconduct (clinical failures and dishonest record-keeping in relation to three patients) and imposing a period of suspension of 6 months;
- An MPT review determination dated 24 January 2019, finding Dr Ekpiken's fitness to practise no longer impaired; and
- A list of Dr Ekpiken's current interim conditions, in place since 13 August 2024.

86. On behalf of Dr Ekpiken, the Tribunal received a reflective letter dated 2 June 2026.

Submissions

Submissions on behalf of the GMC

87. On behalf of the GMC, Mr Rankin submitted that the appropriate sanction in this case is one of suspension.

88. Mr Rankin drew the Tribunal's attention to the Guidance. Given the Tribunal's finding that the level of risk is within the mid-range, he submitted that the sanctions banding within the Guidance indicated a sanction range of 24-36 months conditions to up to 6 months suspension.

89. Mr Rankin submitted that Dr Ekpiken has demonstrated only limited insight and remediation. Mr Rankin also drew the Tribunal's attention to Dr Ekpiken's previous fitness to practise history. He stated that the matters found proved on the previous occasion (2018) included clinical misconduct and making false records. Mr Rankin submitted that the repetition of similar clinical misconduct in this case aggravated the misconduct and took it to the top end of that mid-range band.

90. Mr Rankin submitted that conditions would not be workable in this case because conditions so stringent as to be tantamount to suspension would be required. He also suggested it would be very difficult for Dr Ekpiken to secure a GP position whilst subject to stringent conditions. Mr Rankin submitted that a period of suspension of up to 6 months duration would be appropriate and proportionate in light of the Tribunal's findings and the aggravating repetition of the clinical misconduct.

91. Mr Rankin submitted that erasure was not the proportionate response because suspension is sufficient to protect the public and because Dr Ekpiken's behaviour had not caused serious harm.

Submissions on behalf of Dr Ekpiken

92. Ms Bayley, on behalf of Dr Ekpiken, submitted that conditions would be an adequate sanction in this case.

93. Ms Bayley acknowledged that the previous determination, which related to misconduct that took place between January and September 2016, is likely to increase the Tribunal's assessment of ongoing risk to public protection. Ms Bayley suggested that the level of risk may be considered to increase from medium to medium/high and that a more restrictive sanction may be called for than would otherwise be considered proportionate.

94. Ms Bayley submitted that there are identifiable areas of Dr Ekpiken's practice which require further training, improvement and embedding, specifically history taking, telephone consultations and note keeping. Progress in these areas can be monitored and assessed. She submitted that Dr Ekpiken has demonstrated that she is willing and able to be open and honest if things do wrong and take steps to mitigate poor performance. Ms Bayley stated that Dr Ekpiken has demonstrated that she is committed to improving her practice, knowledge and skills, to improve the quality of her work and, ultimately, ensure patient safety.

95. Ms Bayley submitted that a period of restricted practice, with the aim that Dr Ekpiken should be able to safely return to unrestricted practice in the future, is a proportionate sanction in this case. She submitted that such a sanction would allow Dr Ekpiken time to further reflect, to take steps to apply for a return to practice course, or similarly rigorous and assessed course, that she is committed to completing. She submitted that it would also have a deterrent effect, sending a signal to the public and the profession that Dr Ekpiken's repeated behaviour is regarded as unbefitting of a registered doctor.

96. Ms Bayley invited the Tribunal to find that Dr Ekpiken is capable of demonstrating safe and effective practice once her remediation is complete. She submitted that in light of Dr Ekpiken's genuine remorse (expanded upon in her recent reflective letter), her targeted and relevant training, and her developing insight, the Tribunal should agree that her misconduct is capable of remediation.

97. Ms Bayley invited the Tribunal to find that a lengthy, stringent conditions of practice order would be appropriate and proportionate in this case. She submitted that workable and measurable conditions could be formulated to address the risks identified in this case. Ms Bayley submitted that, if the Tribunal considered that conditions were insufficient, a period of suspension of up to six months would be appropriate in order to allow Dr Ekpiken time to further reflect and take steps to prepare to enrol on an appropriate return to practice course.

98. In relation to the length of any sanction, Ms Bayley submitted that the Tribunal ought to take into account the time that Dr Ekpiken has spent subject to interim conditions as having contributed to addressing the wider public interest risks in this case.

99. In response to questions from the Tribunal, Ms Bayley confirmed Dr Ekpiken's current employment circumstances. Dr Ekpiken has been subject to interim conditions of practice since 13 August 2024, XXX. However, these conditions have not been actively engaged as Dr Ekpiken has not been working as a doctor during that time, nor has she made any job applications to seek to do so. Dr Ekpiken has undertaken some work shadowing with GP colleagues (3 days per week for 3 months during 2025), voluntary work with a hospital chaplaincy and paid work (that does not require GMC registration) in an administrative role. No supporting documentary evidence or references was provided in relation to these work/work experience roles.

The Tribunal's Determination on Sanction

100. In making its decision on sanction, the Tribunal has reviewed its decision on facts and impairment and has considered the level of current and ongoing risk the doctor poses to public protection. It has referred to the general guidance on outcomes available to the MPT at the sanction stage as set out in Part C of the Guidance for MPT hearings, and 'case type 5: clinical concerns' in the Guidance Introduction. It has also considered the impact of any specific sanction type, where applicable, and the testimonials provided by Dr Ekpiken.

101. The outcomes available to the Tribunal at the sanction stage are:

- Taking no action
- Imposing conditions for up to a maximum period of three years
- Suspension for up to a maximum period of twelve months
- Erasure from the medical register

102. The MPTS Introduction Guidance 'case type 5: clinical concerns' lists the recommended sanctions banding in cases that pose a medium level of risk to the public to be conditions up to 36 months to suspension up to 6 months. It also provides:

> '*175. Where the level of current and ongoing risk to public protection is low or medium, conditions will often be the proportionate response.*
> *176. Suspension or removal are only likely to be needed where the assessment of risk is high based on the case falling at the higher end of the spectrum of seriousness, there being relevant context known about the doctor and/or their working environment that increases risk and/or because the doctor has shown a lack of insight and/or is not willing or able to remediate*'.

103. The Tribunal reflected on its earlier findings at the facts and impairment stages, and the new information presented at the sanction stage. The Tribunal noted that there were striking similarities between the clinical concerns found proved against Dr Ekpiken in 2018 and those found proved in this case, namely failures in patient assessment and record-keeping. That repetition of similar clinical failings increased the level of risk, both to public protection (in terms of patient safety) and also the wider public interest. Although the Tribunal had accepted that Dr Ekpiken had shown genuine remorse and a willingness to take steps to develop insight and to remedy her failings, the fact that the clinical failings in question represented such similar clinical failings as had occurred in the past, called into question Dr Ekpiken's ability to effectively remediate. This concern was underlined when the Tribunal read Dr Ekpiken's reflective letter dated 2 June 2026. Although she rightly re-iterated her apology for her misconduct and expressed a sincere commitment to returning to safe practice, she was still unable, at this stage, to identify the underlying causes of her repeated clinical failures. She stated "*I cannot well explain the reason for this repeated occurrence*". The Tribunal also noted that, although the interim conditions had afforded Dr Ekpiken the opportunity to seek work as a GP and to start making and embedding improvements in her practice, she had not yet made any efforts to secure a role to undertake such action.

104. Taking into account this new information, the Tribunal determined that the repetition of similar concerns was an aggravating feature which increased the risk to public protection

and the wider public interest, such that the case falls within the top end of the mid-range sanction banding for clinical concerns.

105. The Tribunal considered the sanctions in ascending order starting with the least restrictive.

No action

106. The Tribunal first considered whether to conclude the case by taking no action. It considered paragraphs 13 – 16 of Part C of the Guidance which relate to consideration of 'Taking no action'. It noted paragraphs 13 and 16 in particular which state:

> *13. Where a doctor's fitness to practise is impaired, it will usually be necessary for the MPT to restrict the doctor's registration to achieve public protection. But there may be exceptional circumstances to justify an MPT taking no action. Exceptional circumstances are unusual, special, or uncommon, so such cases are likely to be very rare.*
> *16. Where an MPT decides to take no action, its determination must fully and clearly explain:*
> *a. what the exceptional circumstances are,*
> *b. why the circumstances are exceptional, and*
> *c. how the exceptional circumstances justify taking no action.*

107. The Tribunal determined that there were no exceptional circumstances to justify taking of no action in this case. In the context of the facts found proved and the Tribunal's determination on impairment, the Tribunal considered that taking no action would not be proportionate, nor would it be sufficient to protect the public.

Conditions

108. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Ekpiken's registration and it reminded itself of the relevant paragraphs of the guidance:

> *'17. Conditions are suitable for those cases where the doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is currently incompatible with unrestricted registration. This means the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting their registration for a period of time, with the aim they should be able to safely return to unrestricted practice in the future.*

…

20. Where conditions are put in place, they should be appropriate, workable, and measurable.

21. To be appropriate, conditions must address the specific findings about the current and ongoing risk to public protection posed by the doctor.

…

23. Conditions are likely to be workable where:

a. *the doctor has shown insight*
b. *time is needed for the doctor to take steps to address the findings (remediate), for example through retraining, study, supervision and/or seeking medical treatment*
c. *the doctor is willing to remediate, and*
d. *the MPT is satisfied the doctor will comply with them'*

109. The Tribunal reminded itself that any conditions imposed must be appropriate, proportionate, workable and measurable. The Tribunal had regard to the Guidance and noted that, for conditions to be appropriate, they must address the specific findings about the current and ongoing risk to public protection posed by the doctor.

110. The Tribunal considered the submissions made by the parties. It determined that, given the circumstances of this case, particularly when considering the new evidence put before it at the sanction stage of these proceedings, conditions would not be an appropriate or proportionate response given the Tribunal's findings on the level of current and ongoing risk to public protection.

111. The Tribunal reminded itself of its earlier findings that Dr Ekpiken had breached fundamental tenets of the profession with her misconduct, she had put patients at risk of serious harm, similar clinical concerns had also been found in Dr Ekpiken's practice in the past, and despite almost two years having elapsed since the events in question in this case, Dr Ekpiken had developed only limited insight and steps towards remediation. Furthermore, as Dr Ekpiken had not worked as a doctor for approximately two years, it was likely that her knowledge and skills had deteriorated, and she had not been able to provide any evidence that learning from the clinical shadowing and CPD courses undertaken had been embedded

into her practice. The Tribunal therefore concluded that conditions would not be adequate to address the risks in this case and to uphold all three limbs of public protection.

Suspension

112. The Tribunal then went on to consider whether imposing a period of suspension on Dr Ekpiken's registration would be appropriate and proportionate. In doing so it had regard to the relevant paragraphs of Part C of the Guidance:

113. The Tribunal noted paragraphs 44 and 45 of the Sanctions Guidance, which provide:

> *'44 Restrictive action of suspension is intended to address the level of current and ongoing risk to public protection and is not intended to be punitive. However, as it prevents a doctor from working and earning a living within that profession, it can have this effect. Suspension can also have a deterrent effect and be used to send a signal to the individual doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor.*
>
> *45 Suspension may be proportionate in cases where some, or all, of the following factors are present:*
>
> *a conditions are not appropriate, measurable and/or workable*
>
> *b the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or*
>
> *c the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.'*

114. The Tribunal found that paragraphs 45a and 45b were engaged in this case. It had found that conditions would not be appropriate in this case because they would be insufficient to address the risks to patient health and safety, the need to promote and maintain public confidence and the need to promote proper professional standards and conduct. Given Dr Ekipiken's limited progress towards gaining insight into the causes of her repeated clinical failings, the Tribunal found that patient safety required a period of

suspension to prevent her from working as a doctor whilst she took steps to gain insight into the causes of her clinical deficiencies and to address them.

115. The Tribunal concluded that a period of suspension was necessary to uphold all three limbs of public protection.

Period of Suspension

116. In determining the length of suspension, the Tribunal had regard to the Guidance as set out below:

> *46 The MPT will need to decide the appropriate length of time that suspension should be put in place for, up to the maximum of 12 months. The following factors will be relevant:*
>
> *a. the assessment of the level of current and ongoing risk to public protection posed by the doctor*
> *b. the reasons for assessing suspension as being the proportionate response*
> *c. the amount of time the doctor is likely to need to remediate, complete treatment for and/or recover from a health condition that is having, or is likely to have, an impact on their ability to practise safely and effectively, and/or*
> *d. the amount of time the parties will reasonably need to prepare for any review of whether the doctor continues to pose a current and ongoing risk to public protection requiring restrictive action in response or is safe to return to unrestricted practice.'*
>
> *47. A short suspension may be appropriate in cases where: the doctor's behaviour fell at the higher end of the spectrum of seriousness; there was evidence of relevant context and/or evidence of insight and remediation that decreased the level of current and ongoing risk to public protection such that there are no outstanding patient safety considerations; and suspension is being imposed on public confidence grounds and/or to maintain professional standards. It might also be appropriate in relation to a very small number of clinical cases where a doctor's performance was such that although unlikely to recur, the nature of the allegation was so serious as to undermine the public's trust in the profession.*

117. The Tribunal reminded itself of the sanctions banding relevant to this case which indicated that a period of conditions up to 36 months or a suspension of up to 6 months

would be appropriate, depending on the specific circumstances of the case. It also considered its earlier finding that the case fell at the higher end of the mid-range on the spectrum of seriousness. With reference to paragraph 47 of the Guidance, the Tribunal noted that the evidence of insight and remediation was limited in this case, and that suspension was required for both public protection as well as to maintain public confidence and proper professional standards.

118. The Tribunal considered that there were no exceptional or special features in this case which would justify departing from the guidance.

119. The Tribunal noted that the period of suspension would need to allow sufficient time for Dr Ekpiken to take action to demonstrate development in her insight and steps towards remediation, and it reflected on its earlier finding that Dr Ekpiken has a considerable amount of work to do in that regard.

120. Having taken account of all of the above, and having carefully considered the question of the least restrictive sanction sufficient to uphold public protection and the wider public interest, the Tribunal concluded that a period of suspension of 6 months would be appropriate and proportionate in this case.

Erasure

121. The Tribunal considered whether erasure might be an appropriate sanction. It reminded itself of paragraph 57 of the guidance:

> *Erasure may be the proportionate response where:*
>
> a. *conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public*
> b. *the doctor's behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place*
> c. *the doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and/or*
> d. *the seriousness of the facts found proven and/or impact of any relevant context that increased the current and ongoing risk to public protection mean*

the effect of the doctor continuing to hold registration is such that it will undermine public confidence in the profession.

122. The Tribunal was satisfied that none of these factors were present in this case. Although conditions were not appropriate, the Tribunal was satisfied that a period of suspension was sufficient to protect the public. The doctor's misconduct in this case had not caused actual serious harm. The doctor had shown some insight into the seriousness of the misconduct by making early admissions and fully cooperating with the regulator. Given that the clinical failings are remediable, that Dr Ekpiken has engaged with the regulator and has begun a journey to develop insight and remediate, and that a suspension is sufficient to protect the public, the Tribunal was satisfied that public confidence would not be undermined if the doctor were permitted to remain on the register. Dr Ekpiken's misconduct was not fundamentally incompatible with continued registration. In those circumstances, the Tribunal concluded that erasure would be disproportionate and unduly punitive.

Review

123. The Tribunal determined to direct a review. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wished to remind Dr Ekpiken that, at her review hearing, the onus will be on her to demonstrate that she has developed further insight, remediated and that she is safe to return to unrestricted practice. It therefore may assist the reviewing Tribunal if Dr Ekpiken provides:

- Evidence of developing further insight. For example, a further reflective statement addressing matters including:
    - Identifying the potential causes/triggers of the repeated clinical failings;
    - Identifying what action Dr Ekpiken will take to prevent future recurrence;
- Evidence of any work or work experience, whether paid or voluntary, with related references;
- Evidence of Dr Ekpiken working towards the 'return to practice' programme;
- Evidence of relevant and targeted CPD training courses and meaningful reflection upon any learning;
- Evidence that Dr Ekpiken has kept her clinical skills and knowledge up to date;
- Any other information or evidence that Dr Ekpiken believes will assist the reviewing Tribunal.

Determination on Immediate Order - 04/06/2026

124. Having determined that Dr Ekpiken's registration should be suspended for six months the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Ekpiken's registration should be subject to an immediate order.

Submissions

On behalf of the GMC

125. On behalf of the GMC, Mr Rankin submitted that an immediate order was necessary in this case. He referred the Tribunal to paragraph 79 of the relevant guidance, which sets out the circumstances in which an immediate order may be required and identifies three relevant criteria.

126. He submitted that two of those criteria were engaged in this case, namely the protection of members of the public and the wider public interest. He submitted that, as identified in the Tribunal's determination, Dr Ekpiken had become de-skilled as a result of not having been in clinical practice for a considerable period of time. He submitted that it would not be in the interests of patients, the public, or Dr Ekpiken herself for her to return to unrestricted practice.

127. Mr Rankin further submitted that there was no basis for concluding that Dr Ekpiken required a period of time before the substantive sanction took effect in order to put her affairs in order. He referred the Tribunal to paragraph 84 of the guidance, which sets out circumstances in which an immediate order would not usually be appropriate, and submitted that those circumstances did not apply in this case.

128. Accordingly, Mr Rankin submitted that an immediate order was necessary, proportionate and appropriate.

129. On behalf of Dr Ekpiken, Ms Bayley confirmed that she did not oppose the making of an immediate order.

The Tribunal's Determination

130. The Tribunal accepted that it may impose an immediate order if it considers it necessary for the protection of members of the public, is otherwise in the public interest, or is in the best interest of the doctor.

131. The Tribunal had regard to the paragraphs 79, 83 and 84 of the Guidance, which sets out.

> *'79 The MPT may impose an immediate order where it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. Where the MPT has imposed a sanction of conditions, it may impose an immediate order of conditions. Where the MPT has imposed a sanction of suspension or erasure, it may impose an immediate order of suspension.*
>
> *83. The decision whether to impose an immediate order is at the discretion of the MPT based on the facts of the case. When deciding if an immediate order is needed the MPT should consider the seriousness of the proved allegation and the level of current and ongoing risk to public protection posed by the doctor.*
>
> *84 It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:*
>
> *a. the doctor poses a risk to patient safety*
> *b. the risk to one or more parts of public protection is high, and/or*
> *c. immediate action is needed to maintain public confidence in the medical profession.'*

132. The Tribunal considered its findings at the previous stage. It had found that Dr Ekpiken's misconduct was serious and that there was insufficient insight and incomplete remediation of her repeated clinical failings. Given that the Tribunal had found an ongoing risk to public protection and the wider public interest, it would be inconsistant not to impose an immediate order at this stage.

133. In light of these factors, the Tribunal determined that an immediate order was necessary in this case to address the risks to patient health and safety, uphold and maintain proper professional standards within the medical profession, and maintain public confidence in the profession.

134. This means that Dr Ekpiken's registration will be suspended from the date on which notification of this decision is deemed to have been served upon her. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

135. The interim order is hereby revoked.

136. That concludes this case.