Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 05/12/2018 - 12/12/2018

Medical Practitioner's name: Dr Michael EIGBOGBA

GMC reference number: 7093969

Primary medical qualification: MB BS 1997 University of Lagos

Type of case	**Outcome on impairment**
New - Misconduct	Impaired
New - Conviction / Caution	Impaired

Summary of outcome

Suspension, 4 months.
Review hearing directed

Tribunal:

Legally Qualified Chair	Mr Andrew Lewis
Lay Tribunal Member:	Miss Susan Hurds
Medical Tribunal Member:	Dr Jeffrey Phillips

Tribunal Clerk:	Mr Michael Murphy

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Stephen McCaffrey, Counsel, from Kings View Chambers
GMC Representative:	Ms Catherine Cundy, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

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 - 10/12/2018

Background

1. Dr Eigbogba qualified as a doctor in Lagos, Nigeria, in 1997. He became a member of the Royal College of Psychiatrists in 2010. Subsequently, he worked in a number of roles as a psychiatrist in the UK and Ireland between January 2011 and February 2016. Between May 2015 and January 2016 he worked as a locum consultant in general adult psychiatry at Hairmyres Hospital, NHS Lanarkshire. In January 2016 he was appointed as locum consultant in older adult psychiatry at Witham Court, part of the Lincolnshire Partnership NHS Trust ('the Trust'). The Allegation arises from Dr Eigbogba's conduct during that employment.

2. At the time of his appointment as Locum Consultant at Witham Court, Dr Eigbogba was approved under Section 12 of the Mental Health Act 1983 ('MHA'), which meant that he was qualified to advise that patients should be detained under the MHA. However, as he had not obtained Approved Clinician ('AC') status, he could not take legal responsibility for detained patients. In particular, he could not decide when detained patients could be granted leave of absence, discharged from hospital, discharged subject to a Conditional Treatment Order or recalled to hospital if they breached conditions of that order.

3. When Dr Eigbogba was appointed as Locum Consultant it was known that he did not have AC status in England and Wales although he had achieved similar status in Scotland. Both Dr Eigbogba and the Trust expected that he would achieve AC status within a few months. In the meantime, it was agreed that his salary would be reduced by approximately two thousand pounds per annum to reflect the fact that his colleagues would have to carry out duties in respect of any detained patients which he was unable to undertake.

4. Witham Court was a Psychiatric Unit comprising two wards. The first was called Brant Ward and could hold up to 20 patients. The second ward, called Langworth Ward, held up to 17 patients. The patients in Langworth Ward were mainly treated for dementia and it was relatively unusual for a patient in that ward to be detained under the MHA.

5. Dr Eigbogba was one of three consultants responsible for the care of patients across both wards. The others were Dr A, the clinical director of adult psychiatric services, and Dr B. Patients were allocated to a consultant depending upon the catchment area in which they lived so that the consultant responsible for their care in hospital could continue to provide them with care in the community when they were discharged.

6. Dr Eigbogba was responsible for patients from his allocated catchment area. This would normally amount to approximately a third of the patients in the unit. It is accepted that only a small proportion of the patients in the unit were detained under the MHA so that Dr Eigbogba was responsible for only a small number of such patients at any one time throughout the period of his employment.

7. Dr Eigbogba was referred to the GMC in December 2016 by Lincolnshire Partnership NHS Foundation Trust following a Trust investigation which had revealed that between May and November 2016 Dr Eigbogba had signed 20 documents required under the MHA for the discharge, recall of and granting leave of absence to eight detained patients, not in his own name but that of Dr A.

The Outcome of Applications Made during the Facts Stage

8. The Tribunal granted an application, made by Ms Cundy on behalf of the GMC, to amend the Allegation, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules') that, the words *'one or more of"* should be removed from the stem of paragraph 1. Mr McCaffrey, Counsel, on behalf of Dr Eigbogba, had no objection to this. The Tribunal determined to allow this amendment as it was agreed between parties. The amended Allegation is set out in the body of the determination.

The Allegation and the Doctor's Response

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

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

1. Between May 2016 and November 2016 you signed ~~one or more of~~ the Mental Health Act ('MHA') documents set out in Schedule 1:
Amended under Rule 17(6)

   a. in the name of Dr A;
   Admitted and found proved

   b. when you knew that you did not hold responsible clinician status, as required under the MHA to sign such documents.
   Admitted and found proved

2. Your actions as described at paragraph 1 were dishonest.
To be determined

3. On 10 July 2017 you accepted a caution from Lincolnshire Police for signing paperwork in the name of another, which you were not permitted to do, contrary to Section 126(4)(a) and (5) of the MHA.
Admitted and found proved

And that by reason of the matters set out above your fitness to practise is impaired because of your:

a. misconduct in respect of paragraphs 1-2;

b. caution in respect of paragraph 3.

The Admitted Facts

10. At the outset of these proceedings, through his representative Mr McCaffrey, Dr Eigbogba made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('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

11. In light of Dr Eigbogba's admissions to the Allegation, the Tribunal was required to determine only whether his admitted actions in paragraph 1 were dishonest

Witness Evidence

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

- Dr A Clinical Director within Older Adult Services at Lincolnshire Partnership NHS Trust, in person;
- Dr B, Consultant Psychiatrist at Witham Court, in person;
- Dr C, Consultant Forensic Psychiatrist and Medical Director at Lincolnshire Partnership NHS Trust, in person;
- Ms D, Community Psychiatric Nurse at Lincolnshire Partnership NHS Trust, by telephone link.

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

- Dr E, Dr Eigbogba's Responsible Officer at Independent Clinical Services;
- Dr F, Consultant Psychiatrist and expert witness.

14. Dr Eigbogba provided his own witness statement dated 8 October 2018 and supporting documentation. He also gave oral evidence at this hearing.

15. The Tribunal heard evidence from Dr A about the arrangements that were made to ensure that Dr Eigbogba could carry out his duties while obtaining AC status. He informed the Tribunal that Dr Eigbogba's detained patients were divided between himself and Dr B so that Dr Eigbogba would have day to day care of the patients while he and Dr B would be Responsible Clinicians and deal with the paper work which only they were entitled to sign. This question had become particularly acute within a day of Dr Eigbogba beginning clinical work because on his first day on the ward he had signed a discharge form for a detained patient when not entitled to do so. This incident generated a formal alert called a Datix. An email was sent to the ward staff on Brant Ward telling them that Dr Eigbogba could not authorise leave or discharge detained patients. This would be done by Dr A or Dr B. This email was never copied to Dr Eigbogba.

16. Dr A told the Tribunal that he had met with Dr Eigbogba in February 2016 following that incident. Dr Eigbogba had come to see him. Dr A accepted that his recollection of that meeting was not clear because of the passage of time and he had not made a note of the meeting. Nor had he confirmed the result of that meeting in writing. He recalled that the focus of the meeting was on ensuring that Dr Eigbogba obtained approved clinician status as soon as possible. He regarded what had happened on Dr Eigbogba's first day as a 'technical breach' which would be resolved by Dr Eigbogba obtaining AC status.

17. The Tribunal was satisfied that Dr A was an honest witness. However, he had little recollection of his meeting with Dr Eigbogba and his answers where often unclear and difficult to follow. He did recall telling Dr Eigbogba to '*put my name on the forms*'. However, he was clear in his evidence to the Tribunal that he had not intended Dr Eigbogba to understand that he should sign documents on his behalf, only that he should record him as being the Responsible Clinician.

18. Dr A accepted that in practice he had little contact with the patients in Dr Eigbogba's care for whom he was the Responsible Clinician. When questioned, he did not seem surprised that a patient for whom he was Responsible Clinician could be recalled to hospital without him knowing.

19. Dr Eigbogba gave evidence to the Tribunal about his employment at the Trust. He started work against the background of considerable personal difficulties which meant that he spent five hours of each day travelling to and from work. He was obliged to cover an additional clinic for Dr A, which involved him in a great deal of additional administration. Initially he did not have a junior doctor to assist him. When one was allocated to him it was somebody who had been out of medicine for

10 years and required an exceptionally high level of supervision. This left him with very little time to acquire his AC status.

20. This contrasted with the position of his previous job where he had been able to obtain the equivalent status in two months.

21. The incident when he signed a discharge form occurred on his first day on the ward. He admitted that a number of forms had been put in front of him and that he had signed a discharge form without reading it sufficiently carefully to see what it was. Dr Eigbogba understood that this was wrong and he accepted full responsibility. He described how he was upset by this incident and had approached Dr A to discuss what he should do. He did not recall every detail of the meeting but the Tribunal found his recollection to be better than Dr A's. He described the meeting as confused and confusing and recalled being offered what he described as '*option, option, option'*. Nevertheless, he told the Tribunal that because Dr A had told him to put his name on documentation, he came away from the meeting with a clear understanding that Dr A would be the Responsible Clinician for his detained patients while he would care for them and deal with any matters including documentation that were the responsibility of the Responsible Clinician.

22. Dr Eigbogba accepted that Dr A had not told him expressly that he should sign the MHA documents. Looking back now he was not sure why he had come to that conclusion. He said very pointedly to the Tribunal that if a friend of his had told him that he had come to that conclusion that he would just ask him *'why*?. Nevertheless, at the time, under XXX pressure and the pressure to make a success of a new job, that is the understanding that Dr Eigbogba formed. In the months that followed Dr Eigbogba acted upon that understanding by completing MHA forms in front of staff openly and nobody challenged him. The only forms he took to Dr A were those in complicated cases where he needed advice and on occasions, Dr A referred him to Dr B.

Documentary Evidence

23. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included copies of the MHA documents signed by Dr Eigbogba, a copy of his contract of employment, relevant emails and documents generated by the Trust investigation. It also included Dr Eigbogba's appraisal, a copy of the police caution he had accepted, the factual basis of that caution, his approved clinician induction training certificate and a character reference.

Submissions

24. Ms Cundy reminded the Tribunal of the test laid down by the supreme Court in *Ivey v Genting Casinos (UK) Ltd 2017 UKSC 67* and submitted that the Tribunal should first ascertain (subjectively) ascertain the state of Dr Eigbogba's state of knowledge and belief when he signed the MHA documents.

25. She accepted that if Dr Eigbogba honestly believed he had been instructed or at least authorised to write Dr A's signature on the documents, his actions would not be dishonest. She submitted that the Tribunal should find that Dr Eigbogba's explanation was untrue because the explanation he advanced was so unreasonable that he could not have believed that he was entitled to act as he did. She also reminded the Tribunal of the inconsistencies in Dr Eigbogba's evidence which she had exposed in cross examination.

26. Mr McCaffrey submitted to the Tribunal that it should accept Dr Eigbogba's explanation. He reminded the Tribunal that Dr Eigbogba was regarded as an honest man by all of the GMC witnesses who had worked with him. His explanation had effectively been consistent. However unreasonable his belief was, there can be no other reason for him acting as he did when he had nothing to gain by so doing.

The Tribunal's Approach

27. In reaching its decision on facts, the Tribunal bore in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Eigbogba 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.

28. The Tribunal had regard to the direction of the High Court in *Collins J in Lawrence v General Medical Council [2015] EWHC (Admin)* which states:

> *'35. The legal assessor should in my view have directed the panel that they should only find dishonesty established if they were satisfied that there was cogent evidence of dishonesty. The civil standard applies, but where dishonesty or particularly a serious offence is alleged the decision makers must be aware of the need for such cogent evidence. A direction making clear that need is in my judgment required coupled with a requirement for them to consider the full circumstances.'*

29. The Tribunal also had regard to *Fish v General Medical Council [2012] EWHC 1269 (Admin) which states:*

> *"67. What, however, seems to be a proposition of common sense and common fairness is this: an allegation of dishonesty should not be found to be established against anyone, particularly someone who has not been shown to have acted dishonestly previously, except on solid grounds. Given the consequences of such a finding for an otherwise responsible and competent medical practitioner, any Panel will almost certainly (without express reminder) approach such an allegation in that way.*
>
> *68. An allegation of dishonesty against a professional person is one of the allegations that he or she fears most. It is often easily made, sometimes not*

> *easily defended and, if it sticks, can be career-threatening or even career-ending. Who would want to employ or otherwise deal with someone against whom a finding of dishonesty in a professional context has been made? I am, of course, dealing with the issue of dishonesty in a professional person simply because that is the issue before me. It is, however, a finding that no-one, whatever their walk of life, wishes to have recorded against their name.*
>
> *69. I do not think that I state anything novel or controversial by saying that it is an allegation that (a) should not be made without good reason, (b) when it is made it should be clearly particularised so that the person against whom it is made knows how the allegation is put and (c) that when a hearing takes place at which the allegation is tested, the person against whom it is made should have the allegation fairly and squarely put to him so that he can seek to answer it. It is often uncomfortable for an advocate to suggest that someone has been deliberately dishonesty, but it is not fair to shy away from it if the same advocate will be inviting the tribunal at the conclusion of the hearing to conclude that the person being cross examined was dishonest. (I should say that Counsel presenting the case to the FTP did put the case advanced against him fairly to the Appellant. The problem, as I see it, for the reasons I will give below, is that what she put to him and what the Panel in due course concluded were arguably different or, at all events, the conclusion for which she contended did not have the compelling logic behind it that made its acceptance by the Panel valid.)*

30. The Tribunal considered the test for dishonesty in *Ivey v Genting Casinos (UK) Ltd 2017 UKSC 67* which states:

> *74. 'When dishonesty is in question the fact-finding tribunal must first ascertain-(subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held.*
>
> *When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

The Tribunal's Analysis of the Evidence and Findings

31. The Tribunal had regard to the admissions made by Dr Eigbogba, all the evidence and the submissions of Counsel.

32. Dr Eigbogba admitted at the beginning of this hearing that between February and November 2016 he had signed Dr A's name on 20 MHA documents relating to the recall, discharge and grant of leave to eight detained patients in his care for whom Dr A was the responsible clinician. On 10 July 2017 Dr Eigbogba accepted a police caution for committing the offence of making a *'false entry or statement'.* The Tribunal noted that when accepting that caution Dr Eigbogba had submitted a written basis of fact in which he said that he had been acting *'in accordance with the instructions I have been provided'*.

33. The Tribunal considered with great care Dr Eigbogba's account of his meeting with Dr A and the view he formed of what he was meant to do. It had regard to the personal and professional circumstances in which he found himself and the stress these inevitably caused him. The Tribunal also noted Dr Eigbogba's clear admission that, with the benefit of hindsight, the view he formed of what he was meant to do was not a reasonable one.

34. The Tribunal was satisfied that his view was not reasonable and it approached with caution and indeed scepticism the submission that it should accept Dr Eigbogba had honestly formed an unreasonable but honest belief.

35. Nevertheless the Tribunal came to the view that Dr Eigbogba had done so because of the matters set out below:

a. Dr Eigbogba is a man of good character. All GMC witnesses went out of their way to emphasise his honesty in his dealings with them. In oral evidence DrA described Dr Eigbogba as being *'clinically sound. A very honest doctor'*. Dr C, the medical director, told the Tribunal that she did not dismiss Dr Eigbogba immediately because she and his colleagues held him in such high regard;

b. despite extensive enquiries by the Trust, the GMC could not identify any potential benefit to Dr Eigbogba. The Trust was satisfied that he was not covering up any clinical failings. Nor was there any opportunity for him to benefit financially;

c. his admitted conduct in signing the MHA forms involved him in extra work for which Dr A and Dr B were being paid out of a deduction from his salary;

d. There is no evidence that he tried to conceal his actions either by imitating Dr A's signature or hiding what he was doing from his colleagues. Indeed, his misconduct came to light on 21 November 2016 because he openly signed Dr A's name on a document in front of Nurse D;

e. Dr Eigbogba's description of his meeting with Dr A in 2016 (a meeting which Dr Eigbogba had instigated) was that it was confused and he received

conflicting instructions. This is consistent with the impression the Tribunal formed of Dr A when he gave his oral evidence at this hearing;

f. the Tribunal accepted Dr Eigbogba's evidence of the stressful and distracting circumstances in which he began his employment. The Tribunal finds that these offer some explanation for him interpreting matters in a way that he might not otherwise have done;

g. The Tribunal found that the system of effectively shared care instigated to cover Dr Eigbogba's detained patients, was insufficiently clear and a recipe for confusion;

h. In this context the Tribunal found that Dr A had abdicated responsibility for the patients for whom he was Responsible Clinician in a way that had the potential to mislead Dr Eigbogba to believing he was intended to care for those patients entirely on his own;

i. the Tribunal noted that his explanation was consistent with the one he advanced to police when accepting a caution;

j. it considered carefully the matters very properly raised by Ms Cundy in cross examination. It does not agree that Dr Eigbogba's explanation to Dr C is inconsistent with what he told the Tribunal. It was merely incomplete in circumstances where Dr C told the Tribunal she had stopped Dr Eigbogba discussing the matters raised in the Allegation. Nor does the Tribunal find that his explanation was inconsistent with not signing forms between February and May 2016 because there is no evidence he had the care of detained patients in that period;

k. the Tribunal gave particular weight to the impression they formed of Dr Eigbogba as a witness during this hearing where they observed him giving evidence for two hours. The Tribunal assessed him as a truthful witness who was open about what he had done and how foolish he had been. It accepted that his account was truthful.

36. For all these reasons taken together, the Tribunal concluded that Dr Eigbogba's reason for signing Dr A's name was because he honestly believed that that was what he was instructed and expected to do.

37. Having established Dr Eigbogba's subjective understanding of the position when he signed the MHA forms, the Tribunal asked itself whether ordinary and decent people would regard his actions as dishonest in those circumstances.

38. The Tribunal determined that ordinary and decent people would not think Dr Eigbogba to be acting dishonestly if he believed he was only signing forms in the way he had been told to do Clinical Director in a new job.

39. The GMC did not seek a finding of dishonesty in those circumstances and the Tribunal is satisfied that the GMC are right not to do so.

40. The Tribunal therefore found Paragraph 2 of the Allegation not proved in relation to paragraph 1.

The Tribunal's Overall Determination on the Facts

41. The Tribunal has determined the facts as follows:

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

1. Between May 2016 and November 2016 you signed ~~one or more of~~ the Mental Health Act ('MHA') documents set out in Schedule 1:
Amended under Rule 17(6)

    a. in the name of Dr A;
    Admitted and found proved

    b. when you knew that you did not hold responsible clinician status, as required under the MHA to sign such documents.
    Admitted and found proved

2. Your actions as described at paragraph 1 were dishonest.
Not proved

3. On 10 July 2017 you accepted a caution from Lincolnshire Police for signing paperwork in the name of another, which you were not permitted to do, contrary to Section 126(4)(a) and (5) of the MHA.
Admitted and found proved

And that by reason of the matters set out above your fitness to practise is impaired because of your:

a. misconduct in respect of paragraphs 1-2;

b. caution in respect of paragraph 3

Determination on Impairment - 11/12/2018

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved, Dr Eigbogba's fitness to practise is impaired by reason of misconduct and a caution for a criminal offence.

The Evidence

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

Submissions

3. On behalf of the GMC, Ms Cundy submitted that Dr Eigbogba's fitness to practise is impaired by reason of a caution for a criminal offence and by the misconduct which underpins that caution.

4. Ms Cundy set out the legal principles governing a decision relating to fitness to practise. Mr McCaffrey agreed with her and the Tribunal has adopted her approach in its determination. She accepted that no one suffered harm as a result of Dr Eigbogba's misconduct. Nevertheless by signing MHA forms which he should have taken to a Responsible Clinician Dr Eigbogba created *'a legal vacuum'* which was not in the best interests of the patients or the safety of the public. She reminded the Tribunal that Dr Eigbogba's actions led him to accept a criminal caution, which was also liable to bring the medical profession into disrepute.

5. Ms Cundy submitted that a finding of impairment was necessary in the interests of patient safety and in order to maintain public confidence in the medical profession and to uphold proper standards of conduct for the profession.

6. On behalf of Dr Eigbogba, Mr McCaffrey accepted that the misconduct which gave rise to the criminal caution amounted to serious misconduct. Nevertheless he reminded the Tribunal that they did not find Dr Eigbogba to have been dishonest. He submitted that since 21 November 2016 Dr Eigbogba had demonstrated openness and honesty to the Trust, to the police, by accepting a criminal caution and to the Tribunal by making admissions and in his evidence.

7. Mr McCaffrey submitted that it is open to the Tribunal to mark Dr Eigbogba's misconduct without finding that his fitness to practise is impaired. He reminded the Tribunal that it must decide Dr Eigbogba's current fitness to practise which, he submitted, was not impaired because he had developed sufficient insight to reassure the Tribunal that he would not repeat his misconduct. He submitted that a finding of impairment was not necessary in the wider public interest.

The Tribunal's Approach

8. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision on impairment is a matter for the Tribunal's judgement alone.

9. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amount to misconduct which is

serious and secondly whether Dr Eigbogba's fitness to practise is currently impaired, taking into account his conduct at the time of the events and any relevant factors since then including whether the matters are remediable, have been remedied and any likelihood of repetition.

10. This is the approach directed by the High Court in *Cohen v GMC [2008] EWHC 581 (Admin), [2008] LS Law Med 246* in Silber J states:

> *'In my view, at stage 2 when fitness to practise is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering where by reason of the doctor's misconduct, his or her fitness to practise* [is] *impaired…'*

Misconduct

11. In deciding whether the facts admitted amounted to serious misconduct the Tribunal had regard to the direction given to Tribunals by the High Court in *Roylance v General Medical Council (No.2) [2000] 1 AC 311,* which states that:

> *'Misconduct' is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.'*

12. It also considered *Aranachalam v GMC 2018 EWHC 758* which states that if misconduct:

> *'was serious and which could be regarded as deplorable by your fellow practitioners", such that "a reasonably well-informed member of the public could also find your behaviour deplorable'*

13. Throughout its deliberations, the tribunal had regard to all three aspects of its overarching objective.

14. It also had regard to Good Medical Practice (2013) ('GMP'), the evidence, oral and written, given at the facts stage and also its previous determination.

15. The Tribunal had regard to the following paragraphs of GMP:

> *'12. You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.*
>
> *14. You must recognise and work within the limits of your competence.*

> *65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
>
> *71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.'*

16. The Tribunal was satisfied that other members of the medical profession and informed members of the public would find it deplorable that Dr Eigbogba had signed another doctor's name on MHA forms, which have legal implications for both patients and the public. The Tribunal found that his conduct was aggravated by the fact that he was not qualified to sign such forms. The Tribunal also accepted the evidence of Dr F that Dr Eigbogba's conduct fell far below the standard expected of a reasonably competent doctor. The Tribunal found that Dr Eigbogba was not dishonest when he signed the MHA forms. Nevertheless it is satisfied that the forms he produced were both false and misleading.

17. For these reasons the Tribunal was satisfied that Dr Eigbogba's conduct amounted to serious misconduct.

Impairment by reason of misconduct

18. The Tribunal then went on to consider whether Dr Eigbogba's fitness to practise is impaired by reason of misconduct.

19. The Tribunal had regard to the tests laid down by Dame Janet Smith in the fifth report to the Shipman inquiry relating to findings of impairment and adopted by the High Court in a number of cases including *Cheatle v GMC [2009] EWHC 645 (Admin)* and *CHRE v NMC and P Grant [2011] EWHC 927 (Admin)* which recognises that as part of the process of determining whether a doctor is fit to practise today it must take account of past actions or failures to act. In particular, whether he:

> *'a. Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. Has in the past or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. Has in the past breached or is liable to breach in the future one of the fundamental tenets of the medical profession; and/or*
>
> *d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

20. It also reminded itself that impairment does not follow automatically from a finding of serious misconduct and had regard to the following two paragraphs from

the decision of the High Court in *Cohen v GMC [2008] EWHC 581 (Admin), [2008] LS Law Med 246* in which Silber J states:

> *'I must stress that the fact that the stage 2 is separate from stage 1 shows that it was not intended that every case of misconduct found at stage 1 must automatically mean that the practitioner's fitness to practise is impaired.*
>
> *There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practice has not been impaired. Indeed the Rules have been drafted on the basis that once the Panel has found misconduct, it has to consider as a separate and discreet exercise whether the practitioner's fitness to practice has been impaired.'*

21. It also had regard to the overarching objective which is 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.

22. The Tribunal found that by discharging, recalling and granting leave to detained patients when he was not qualified to do so, Dr Eigbogba put patients at unwarranted risk of harm. The Tribunal also found that when he did this by signing forms with the signature of another doctor he acted in a way liable to bring the medical profession into disrepute. It also found that by acting as he did, and in particular signing the name of another doctor on the MHA forms, Dr Eigbogba abused the public's trust in the profession and so breached a fundamental tenet of the medical profession.

23. The Tribunal considered carefully if there was sufficient evidence of insight and remediation for it to be satisfied that Dr Eigbogba's fitness to practise is no longer impaired. It had regard to his previous good character and honesty in accepting responsibility for his actions, accepting a police caution, making admissions at the outset of this hearing, and giving evidence which the Tribunal found to be truthful. It also had regard to the character reference dated 17 October 2018 completed by Dr E, Consultant Psychiatrist and Clinical Lead for North Powys within the Powys Teaching Health Board. She stated that she had worked with Dr Eigbogba from around July 2017 until August 2018. She described having undertaken mentoring sessions with Dr Eigbogba and concluded that he had shown *'a high level of regret and insight into the factors that lead him to take the actions he did'.* She added that *'he has undertaken arduous and often extremely stressful self-examination and showed little propensity to deny or minimise his actions. On*

this basis I think he has learned from his experience and I would judge that there is a low probability that he is likely to repeat his behaviour'

24. The Tribunal found that Dr Eigbogba has developed understanding that what he did was wrong. Nevertheless, the Tribunal found that there is insufficient evidence that he has developed sufficient insight to ensure there will be no repetition of misconduct if he is under pressure in the future. Dr E is unable to give any examples of Dr Eigbogba's *'self-examination'* or insight. Above all, neither she nor Dr Eigbogba himself have understood why he acted as he did and so take the necessary steps to ensure there is a low risk of repetition.

25. The Tribunal is satisfied that there is a clear pattern to Dr Eigbogba's misconduct from his first day on the ward when he signed a discharge form he was not qualified to sign to the last day when he signed Dr A's signature on a document. In each case he was doing what he thought he was being told to do without exercising any independent judgement about whether it was the right thing to do.

26. In the Tribunals' view, it is fundamental to the practice of medicine that a doctor, in particular one at the level of Locum Consultant, forms an independent judgement of what he should do and doesn't just follow what he thinks his instructions are. Until Dr Eigbogba faces up to the nature of his failing, reflects upon it and demonstrates that he can exercise independent and autonomous judgement, the risk of repletion will remain. The Tribunal has been presented with little, if any, evidence on this issue. For those reasons the Tribunal is satisfied that Dr Eigbogba's fitness to practise is impaired.

27. The Tribunal then considered whether it was necessary to make a finding of impairment in the wider public interest. The Tribunal is satisfied that it would be failing in its duty to maintain public confidence in the profession if it did not make a finding of impairment in this case. The public is entitled to expect that patients are discharged from and recalled to hospital only by those qualified to do so. Above all, the public are entitled to trust that a form signed in the name of a particular doctor has in fact been signed by that doctor. In these circumstances, it is also necessary to make a finding of impairment to uphold proper standards of conduct for the medical profession and send a clear message that this conduct must not be repeated by others.

Impairment by reason of a criminal caution

28. On 10 July 2017 Dr Eigbogba accepted a criminal caution for the misconduct set out in paragraph 1(a) of the Allegation and the Tribunal find his fitness to practise impaired for the same reasons as set out above.

29. The Tribunal has therefore determined that Dr Eigbogba's fitness to practice is impaired by reason of misconduct and a caution for a criminal offence.

Determination on Sanction - 12/12/2018

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

The Evidence

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

Submissions

3. On behalf of the GMC, Ms Cundy submitted that the appropriate sanction is one of suspension for a period which the Tribunal deem to be appropriate and proportionate. She reminded the Tribunal of its conclusion that it had received insufficient evidence of Dr Eigbogba's insight.

4. Ms Cundy submitted that it would be inappropriate and insufficient for the Tribunal to take no action and that a sanction of conditions would not address the deficiencies in Dr Eigbogba's insight or mark the seriousness of his misconduct. She submitted that a sanction of suspension is proportionate and referred the Tribunal to the relevant paragraphs of the Sanctions Guidance (2018) ('SG').

5. Mr McCaffrey submitted that the Tribunal could consider taking no action as it did not find his actions to be dishonest but that if this was deemed to be insufficient then there are appropriate conditions that could be formulated. He submitted that if the Tribunal determined to place a sanction on Dr Eigbogba's registration then this would be the second sanction placed on him overall as he has already accepted a criminal caution.

6. Mr McCaffrey reminded the Tribunal that Dr Eigbogba has always accepted full responsibility for his actions, that there is no evidence of repetition, that he made admissions at the commencement of this hearing and has demonstrated a degree of insight. He submitted that a sanction of conditions would be far more appropriate then one of suspension as suspending Dr Eigbogba would only be punitive.

The Tribunal's Determination on Sanction

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

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

9. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Eigbogba's interests with the public interest. It has taken account of the overarching objective, which includes the protection of the public, the maintenance of public confidence in the profession, and the promoting and maintaining of proper professional standards and conduct for members of the profession.

10. The Tribunal has already given a detailed determination on impairment and has taken those matters into account during its deliberations on sanction.

11. The Tribunal considered the mitigating factors of this case. It noted that Dr Eigbogba is a man of good character, as evidenced by the GMC witnesses. He made admissions to paragraphs 1 and 3 of the Allegation at the outset of this hearing. The Tribunal also noted that Dr Eigbogba accepted full responsibility for his actions and did not try to blame anyone else. It was aware that there has been no repetition of his misconduct, in the two years since it occurred and that he has taken steps to remediate by meeting with a mentor. The Tribunal also had regard to the lapse of two years since the index events.

12. The Tribunal next considered the aggravating factors of this case. It noted that Dr Eigbogba's misconduct wholly related to his clinical practice, involved eight patients and was repeated 20 times from May 2016 to November 2016. The Tribunal was of the view that Dr Eigbogba must have been aware that his actions were unlawful, or at least contrary to GMP.

No action

13. In reaching its decision as to the appropriate sanction, if any, to impose in Dr Eigbogba's case, the Tribunal first considered whether to conclude the case by taking no action. It was of the view that taking no action would not manage the identified risk to patients or mark the seriousness of his misconduct and acceptance of a criminal caution.

14. The Tribunal determined that there were not any exceptional circumstances to justify taking no action.

Conditions

15. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Eigbogba's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measureable.

16. It had regard to paragraph 81 of GMP which states:

'81. Conditions might be most appropriate in cases:

a. involving the doctor's health

b. involving issues around the doctor's performance

c. where there is evidence of shortcomings in a specific area or areas of the doctor's practice

d. where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision.'

17. The Tribunal noted that none of the above applies in this case and next had regard to paragraph 82 of the SG which states:

'82. Conditions are likely to be workable where:

a. the doctor has insight'

18. The Tribunal was satisfied that Dr Eigbogba has demonstrated a degree of insight and would comply with conditions, if they were imposed on his registration. However it was of the view that no conditions could be formulated which would address the identified risk to patients or maintain public confidence in the profession.

19. The Tribunal also had regard to paragraph 84 of GMP which states:

'Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:

…b. identifiable areas of their practice are in need of assessment or retraining'

20. It noted that no evidence has been presented, at this hearing, to indicate any clinical shortfalls or identifiable areas of Dr Eigbogba's practice that require further training. However, the Tribunal was satisfied that Dr Eigbogba's misconduct amounted to a significant breach of the values set out in GMP and for those reasons the imposition of conditions upon Dr Eigbogba's registration would neither not mark the seriousness of Dr Eigbogba's misconduct nor comply with the overarching objective.

21. The Tribunal therefore concluded that conditions are neither appropriate nor proportionate to ensure protection of patients, meet the public interest and to maintain proper professional standards of conduct for the members of the profession.

Suspension

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

23. The Tribunal had regard to paragraphs 91 and 92 of the SG which states:

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

24. Having regard to these paragraphs of the SG the Tribunal concluded that a period of suspension was necessary for two reasons. First, it was necessary to ensure that Dr Eigbogba had a period of time to reflect upon his past and future practice in a way that he had been unable to do during the last two years in practice.

25. Secondly, the Tribunal concluded that a period of suspension was necessary to maintain public confidence in the medical profession because of the nature of Dr Eigbogba's misconduct and the fact that he had committed a criminal offence. The Tribunal was of the view that this sanction would act as a deterrent to this type of misconduct in the future and send this message into the wider medical profession.

26. The Tribunal considered Mr McCaffrey's submission that the only effect of suspension would be punitive. It does not agree. The Tribunal is satisfied that a period of suspension is necessary for the reasons set out above and that it is a legitimate use of a sanction to *'send out a signal'* even if the effect is punitive.

27. The Tribunal therefore determined that a period of suspension would be an appropriate and proportionate sanction which would protect public confidence in the profession and promote and maintain proper standards of conduct and behaviour.

28. The Tribunal also had regard to paragraph 97 of the SG which states:

> *'Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*

> *a. A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.'*

29. It was of the view that Dr Eigbogba's misconduct is not fundamentally incompatible with continued registration for the following reasons:

- The Tribunal did not find Dr Eigbogba to have been dishonest;
- There are no previously adverse findings of any sort recorded against him;
- A number of his senior colleagues spoke well of his skills as a doctor and his personal integrity before this misconduct;
- There has been no repetition of his misconduct in two years;
- He has accepted full responsibility for his actions;
- He made early admissions to the Trust and to this Tribunal;
- He showed a willingness to remediate with his mentor, Dr E;
- He received a criminal caution as opposed to a conviction.

30. For all these reasons the Tribunal concluded that erasure was not necessary.

31. In considering the appropriate period of suspension, the Tribunal was aware that the maximum period of suspension is 12 months. The Tribunal determined that four months would be sufficient to give him adequate time to remediate and would mark the seriousness of his misconduct and the criminal caution.

32. Shortly before the end of the period of period of suspension, Dr Eigbogba's case will be reviewed by a Medical Practitioners Tribunal. A letter will be sent to him about the arrangements for the review hearing. At the next hearing, the review Tribunal is likely to be assisted by the following:

- A reflective piece demonstrating his understanding of the importance of making autonomous decisions and taking responsibility for his practice;
- Evidence of any training he considers appropriate to address the areas of concern identified by this Tribunal;
- Any other relevant evidence he wishes to present to assist the Tribunal, for example, testimonials and evidence of his continuing professional development.

33. The effect of the foregoing direction is that, unless Dr Eigbogba exercises his right of appeal, his registration will be suspended 28 days from the date on which written notice of this decision is deemed to have been served upon him. A note explaining his right of appeal will be sent to him.

Determination on Immediate Order - 12/12/2018

104. Having determined to suspend Dr Eigbogba's registration for a period of four months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

105. On behalf of the GMC, Ms Cundy submitted she has not been instructed to give submissions on an immediate order.

106. On behalf of Dr Eigbogba, Mr McCaffrey submitted that he has no objection to this.

The Tribunal's Determination

107. The Tribunal agreed with the GMC's submission and determined not to impose an immediate order of suspension on Dr Eigbogba's registration.

108. This means that Dr Eigbogba's registration will be suspended from the Medical Register 28 days from when notice of this decision is deemed to have been served upon him, unless he lodges an appeal. If Dr Eigbogba does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

109. There is no interim order to revoke.

110. That concludes the case.

Confirmed
Date 12 December 2018 Mr Andrew Lewis, Chair

SCHEDULE 1

Date	MHA document	Patient
04/05/2016	Discharge Form (D1)	XXX
26/07/2016	Discharge Form (D1)	XXX
19/08/2016	Community Treatment Order Revoke (CTO5)	XXX
31/08/2016	s.17 Leave Form (L1)	XXX
06/09/2016	s.17 Leave Form (L1)	XXX
20/09/2016	s.17 Leave Form (L1)	XXX
23/09/2016	s.17 Leave Form (L1)	XXX
27/09/2016	s.17 Leave Form (L1)	XXX
30/09/2016	Consent to Treatment Form (T2)	XXX
11/10/2016	s.17 Leave Form (L1)	XXX
11/10/2016	s.17 Leave Form (L1)	XXX
11/10/2016	s.17 Leave Form (L1)	XXX
18/10/2016	s.17 Leave Form (L1)	XXX
18/10/2016	s.17 Leave Form (L1)	XXX
20/10/2016	Discharge Form (D1)	XXX
20/10/2016	Discharge Form (D1)	XXX
08/11/2016	s.17 Leave Form (L1)	XXX
08/11/2016	s.17 Leave Form (L1)	XXX

16/11/2016	s.17 Leave Form (L1)	XXX
16/11/2016	Discharge Form (D1)	XXX
17/11/2016	Discharge Form (D1)	XXX
21/11/2016	Discharge Form (D1)	XXX