PUBLIC RECORD

Dates: 16/05/2022 - 27/05/2022

Medical Practitioner's name: Dr Oluwaseun OLUWAJOBI

GMC reference number: 4177780

Primary medical qualification: MB BS 1986 University of Nigeria

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

Summary of outcome

No action (warning not considered)

Tribunal:

Legally Qualified Chair	Miss Samantha Gray
Lay Tribunal Member:	Mr Paul Curtis
Medical Tribunal Member:	Dr Candida Borsada

Tribunal Clerk:	Ms Rebecca Paterson

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Ghazan Mahmood, Counsel, instructed by Hempsons
GMC Representative:	Mr Christopher Rose, 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 - 26/05/2022

Background

1. Dr Oluwajobi qualified from University of Nigeria in 1986 and prior to the events which are the subject of the hearing Dr Oluwajobi completed his surgical training at leading centres of excellence in London. At the time of the events Dr Oluwajobi was practising as a Consultant General and Laparoscopic Colorectal Surgeon at Russell Hall Hospital ('the Hospital'), part of the Dudley Group NHS Foundation Trust.

2. Patient A had a history of Crohn's Disease and prior to the events which form the subject of these proceedings he had required very little medical intervention. However, in October 2017 he was admitted into hospital because he was suffering from an iron deficiency anaemia and on 22 March 2018, he was listed for an urgent colonoscopy and an MRI on the basis that he had relapsing anaemia due to his Crohn's. Patient A had an MRI on 17 May 2018 and his colonoscopy was fixed for 20 June 2018. On 20 June 2018, Patient A presented for his colonoscopy at Russell Hall Hospital, but he was in so much pain that it was not possible to undertake this procedure and he was admitted as an in-patient and referred for surgery. Dr Oluwajobi was the on-call emergency surgeon at the time Patient A was admitted.

3. The allegation that has led to Dr Oluwajobi's hearing can be summarised as follows. The GMC allege that between 20 and 25 June 2018, Dr Oluwajobi was responsible for the care and treatment of Patient A and made a number of failings including failing to explore Patient A's severe symptoms, arrange a CT scan or keep an adequate record of Patient A's care. It is further alleged Dr Oluwajobi inappropriately placed Patient A on the emergency operating list and his decision to discharge Patient A was inadequate in a number of ways. It is also alleged Dr Oluwajobi was rude when visiting Patient A on 25 June 2018 and that Dr Oluwajobi made inappropriate and inadequate comments in Patient A's medical records.

4. The initial concerns were raised with the GMC in November 2018 by Patient A's wife.

The Outcome of Applications Made during the Facts Stage

5. The Tribunal granted the GMC's application to adduce Patient A's witness statement as hearsay evidence in accordance with Rule 34 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'). The Tribunal's full decision on the application is included at Annex A.

The Allegation and the Doctor's Response

6. The Allegation made against Dr Oluwajobi is as follows:

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

1. On 20 June 2018 you were responsible for the care and treatment of Patient A and you failed to:

    a. explore Patient A's symptoms of:

        i. severe abdominal pain; To be determined

        ii. vomiting; To be determined

        iii. anaemia; To be determined

        iv. weight loss; To be determined

    b. adequately challenge Patient A's diagnosis of Crohn's disease; To be determined

    c. physically examine Patient A; To be determined

    d. investigate why Patient A was:

        i. in severe pain; To be determined

        ii. losing weight; To be determined

    e. consider possible complications, such as:

        i. obstruction; To be determined

        ii. penetration into other organs; To be determined

        iii. abscess formation; To be determined

    f. arrange a CT scan for Patient A; Admitted and found proved

    g. appropriately diagnose Patient A's condition; To be determined

    h. record having taken the actions referred to at paragraph 1a-g; To be determined

i. ensure your team kept an adequate record of Patient A's care. To be determined

2. Between 20 June 2018 and 13:00 on 22 June 2018 you:

a. inappropriately placed Patient A on the emergency operating list when you had not first obtained a CT scan; To be determined

b. failed to:

i. adequately investigate Patient A's symptoms of:

1. severe pain; To be determined

2. an inability to eat; To be determined

ii. make any record of your involvement in Patient A's care; To be determined

iii. ensure your team kept an adequate record of Patient A's care. To be determined

3. Your decision to discharge Patient A at around 10:00 on 22 June 2018 was inadequate insofar as you:

a. took no regard of Patient A's deterioration since being admitted to hospital on 20 June 2018; To be determined

b. failed to adequately investigate why Patient A was deteriorating; To be determined

c. based your decision upon the fact that you no longer had access to the emergency operating list; To be determined

d. failed to take any account of the opinions or comments of:

i. Patient A; To be determined

ii. Patient A's wife. To be determined

4. On the evening of 25 June 2018, you visited Patient A and you:

a. inappropriately communicated with him insofar as he was led to believe:

i. that you were angry and rude; To be determined

ii. your advice, that an urgent operation would be an open procedure and would likely result in a stoma, was a threat; To be determined

b. kept an inappropriate record in that you:

i. included the following comments on Patient A's record:

1. 'insisted on staying in hospital'; To be determined

2. 'failed to work with me'; To be determined

ii. recorded 'needs an elective operation' but failed to make reference to:

1. your previous treatment plan that an emergency operation was indicated; To be determined

2. why an emergency operation was no longer indicated; To be determined

3. Patient A's continued symptoms of abdominal pain, vomiting and anaemia. To be determined

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

7. At the outset of these proceedings, through his counsel, Mr Mahmood, Dr Oluwajobi made admissions to one sub-paragraph 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 this sub-paragraph of the Allegation as admitted and found proved.

Witness Evidence

8. The Tribunal received evidence on behalf of the GMC from the following witness:

- Mrs B, Patient A's wife, by video link.

9. The Tribunal also received evidence on behalf of the GMC in the form of a witness statement from the following witness who was not called to give oral evidence:

- Patient A, dated 16 September 2019.

10. Dr Oluwajobi provided his own witness statement, dated 12 May 2022, and also gave oral evidence at the hearing. In addition, the Tribunal received evidence from the following witnesses on Dr Oluwajobi's behalf:

- Mr C, former Senior Registrar at the Hospital, by video link;
- Mr D, former Surgical Registrar at the Hospital, by video link;
- Mr E, former Surgical SHO at the Hospital, by video link.

Expert Witness Evidence

11. The Tribunal also received evidence from two expert witnesses, Mr H (for the GMC) and Mr I (for Dr Oluwajobi), who were both Consultant Colorectal Surgeons ("the Experts"). The Tribunal had available to it a report and supplemental report of Mr H (dated 7 November 2019 and 19 February 2021 respectively). The Experts also prepared a Joint Experts Report, dated 12 May 2022, and they both gave evidence via video link during the hearing.

Documentary Evidence

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

- Patient A's medical records;
- Records of correspondence between Mrs B and the Hospital;
- Records of correspondence between Mrs B and the GMC;
- Documents relating to the Trust investigation into the complaints raised by Mrs B;
- Dr Oluwajobi's initial response to the complaints and Trust investigation prepared in or around December 2018;
- Dr Oluwajobi's surgical lists between 20 and 22 June 2018;
- 18 testimonials produced on behalf of Dr Oluwajobi from current and former colleagues.

The Tribunal's Approach

13. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Oluwajobi 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. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied.

14. In this matter the Tribunal was required to consider the hearsay evidence admitted into proceedings, it having previously been determined that it was relevant and fair to admit the same. In considering this evidence in the round, the Tribunal was also required to

consider the weight to attach to it. The Tribunal had regard to Section 4 of the Civil Evidence Act 1995 which identifies the following circumstances from which inferences can reasonably be drawn as to the reliability or otherwise of the evidence. In considering the weight to apply to hearsay evidence, the Tribunal considered these points in conjunction with all other evidence available to it, and balanced this in order to determine the credibility and weight to be applied to the same:

a) whether it would have been reasonable and practicable for the party by whom the evidence was adduced to have produced the maker of the original statement as a witness;

b) whether the original statement was made contemporaneously with the occurrence or existence of the matters stated;

c) whether the evidence involves multiple hearsay;

d) whether any person involved had any motive to conceal or misrepresent matters;

e) whether the original statement was an edited account, or was made in collaboration with another or for a particular purpose;

f) whether the circumstances in which the evidence is adduced as hearsay are such as to suggest an attempt to prevent proper evaluation of its weight.

15. The Tribunal was mindful of the good character of Dr Oluwajobi who has co-operated throughout with the investigations of the complaints, the subsequent GMC investigation and this Tribunal. The Tribunal also noted that whilst being of good character is not a defence to the allegations denied, the evidence of good character counts in Dr Oluwajobi's favour in two ways. First, it supports his credibility and is therefore something the Tribunal has taken into account when deciding whether they believe his evidence (the 'credibility limb'); and secondly, Dr Oluwajobi's good character may mean that he is less likely to have committed the allegations cited (the 'propensity limb'). The Tribunal also took into account a number of character references provided on behalf of Dr Oluwajobi. A number of these statements commented on the character of Dr Oluwajobi and they were taken into consideration when deciding what weight should be accorded to his good character. However the Tribunal was also mindful that the good character evidence should not detract from the primary focus on the evidence directly relevant to the stated Allegation.

The Tribunal's Analysis of the Evidence and Findings

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

Paragraph 1

17. In considering this subparagraph of the Allegation, the Tribunal had to determine whether on 20 June 2018, Dr Oluwajobi was responsible for the care and treatment of Patient A and he failed to explore Patient A's symptoms including; severe abdominal pain; vomiting; anaemia; and weight loss.

18. The Tribunal first sought to determine the date on which Dr Oluwajobi's first consultation with Patient A was likely to have taken place. In his witness statement Patient A was unclear as to the dates and times of consultations and was unsure whether his first consultation with Dr Oluwajobi occurred on 20 or 21 June 2018, although he had described the consultation as lasting for five minutes. The Tribunal was also mindful that Patient A's witness statement amounted to hearsay evidence, that Patient A was unclear as to the exact dates, and that he was in pain and, at times during his admission, prescribed morphine and other pain killers.

19. The Tribunal noted from the clerking-in notes provided within the medical records that Patient A was admitted at 17:25 on 20 June 2018 and that Dr Oluwajobi was in surgery between 18:10 and 20:35. It was therefore apparent that the first opportunity during which Dr Oluwajobi could have possibly attended Patient A on that day would therefore have been some time after the surgery finished at 20:35. The Tribunal noted that Dr Oluwajobi described in his witness statements, the consultation with Patient A as occurring during his ward round. It had particular regard to Dr Oluwajobi's working timetable on 20 June 2018, as well as the supporting evidence that there had been a lengthy consultation in order for Patient A to impart the information he stated that he discussed with Dr Oluwajobi in his witness statement.

20. The Tribunal considered this in light of Mr C's evidence that he had been present and taking notes during this consultation. Although these notes had not been put before the Tribunal, the Tribunal noted that there was a significant absence of notes relating to 21 June 2018. In particular, it was recognized that apart from notes contained on proforma documents there were no other notes available in relation to Patient A's treatment on 21 June 2018, supporting the assertion that Mr C's notes for that day may have gone missing from Patient A's file. Mr C described his memory of sitting on the window with the sun shining on his back during the consultation. This appeared to corroborate the documents produced by Dr Oluwajobi that at the relevant time Mr C was the day shift Registrar undertaking an 08:00 to 20:00 shift. In his evidence Mr C confirmed that the consultation may have possibly occurred as part of the first ward round on 21 June 2018, rather than after his shift which had ended at 20:00 on 20 June 2018. The Tribunal was also mindful of Dr Oluwajobi's evidence that he had called his secretary during the relevant ward round. Had the initial consultation occurred on 20 June 2018, this phone call must therefore have taken place at some time after 20:35. The Tribunal considered that, though not inconceivable, it was unlikely that Dr Oluwajobi's secretary would still have been working so late into the evening.

21. Taking all of the circumstances into account, the Tribunal found that it was more likely that the consultation occurred during the day on 21 June 2018. It noted that the clerking-in

notes completed at 17.25 on 20 June by the SHO on duty had then been subject to a senior review of another doctor (not Dr Oluwajobi or Mr C) on 20 June 2018. The notes relating to that review stated that Patient A would have a right hemicolectomy. The Tribunal concluded that this was decided by a doctor other than Dr Oluwajobi and considered that this explained why the medical records show that an anaesthetist was able to see Patient A on the 21 June 2018 at 08:55 and knew which operation Patient A was scheduled for.

22. The Tribunal acknowledged that although Dr Oluwajobi had referred to the consultation as occurring on 20 June 2018, he had given a significant amount of evidence which demonstrated that this had been an exceptionally busy time for him. He stated that '*during the 60 hour period from the morning of Wednesday 20 June 2018, until the evening of Friday 22 June 2018 I was operating almost continuously and slept for a total of two and a half (2.5) hours*'. The Tribunal considered that this may have accounted for any confusion as to the relevant date.

23. Although the Tribunal was of the view that Dr Oluwajobi did not actually examine Patient A on 20 June 2018, it concluded that Dr Oluwajobi, as the consultant on duty, was nevertheless responsible for Patient A on that date.

24. The Tribunal noted Mr Mahmood's submission that an omission could only be described as failure where Dr Oluwajobi had a positive obligation. The Tribunal reminded itself that on 20 June 2018, Patient A had been clerked in by an SHO at 17:25 and was later seen by a senior reviewing doctor. In light of this, the Tribunal considered that it would be unreasonable to assume that on 20 June 2018, Dr Oluwajobi also had a positive obligation to examine Patient A.

25. Although it had found that there was no obligation on Dr Oluwajobi to have a consultation with Patient A on 20 June 2018, the Tribunal nevertheless considered Dr Oluwajobi's consultation with Patient A on 21 June 2018 alongside the allegations as set out at paragraph 1.

<u>Subparagraph 1.a.</u>

26. At this subparagraph of the Allegation, the Tribunal considered whether Dr Oluwajobi failed to explore Patient A's symptoms of severe abdominal pain, vomiting, anaemia, and weight loss.

27. It was agreed that Dr Oluwajobi had been informed of Patient A's symptoms of pain, anaemia, and weight loss. Dr Oluwajobi's evidence that he had taken a detailed history and undertook a physical examination was supported by Mr C who was also present at the relevant time. The Tribunal noted that Patient A, Mrs B, Dr Oluwajobi and Mr C's evidence was also consistent in the type of information that was imparted during the course of this consultation, in particular in relation to Patient A's work and examination as to where body armour would sit which may be affected by the type of operation undertaken. The Tribunal considered that this type of conversation, together with Patient A discussing his family life

and his symptoms with Dr Oluwajobi was more than likely to have taken more than 5 minutes as suggested by Patient A and more likely to be 30 to 45 minutes as suggested by Dr Oluwajobi and corroborated by Mr C.

28. In addition, Dr Oluwajobi informed the Tribunal that he took these symptoms into account and concluded that they were attributable to an abdominal stricture, that had already been identified by the recent MRI scan undertaken. This was acknowledged by both Mr H and Mr I, the expert witnesses, as being a reasonable conclusion. With regard to the symptoms of vomiting, throughout oral evidence, it was agreed that Patient A did not have any symptoms of vomiting whilst under Dr Oluwajobi's care.

29. The Tribunal was of the view that planning diagnostic surgery demonstrated Dr Oluwajobi's intention to explore Patient A's symptoms further by this method.

30. In all the circumstances, the Tribunal found subparagraph 1.a (I-iv). of the Allegation not proved in its entirety.

Subparagraph 1.b.

31. At this subparagraph of the Allegation, the Tribunal considered whether Dr Oluwajobi failed to adequately challenge Patient A's diagnosis of Crohn's disease.

32. In his witness statement, Dr Oluwajobi stated that the symptoms with which Patient A presented were symptoms of Crohn's but accepted that they were also red flags for cancer. Dr Oluwajobi submitted that the laparoscopy for which Patient A was scheduled served to further diagnose the cause of Patient A's symptoms. The Tribunal was also mindful that four other doctors were, at that time, also of the opinion that a stricture was the cause of Patient A's symptoms.

33. The Tribunal referred itself to the Joint Expert Report in which it stated that there was no reason to challenge a diagnosis of a Crohn's stricture which had been found through an MRI scan in 2018.

34. Taking all of the evidence into account, and in particular that the diagnostic surgery planned would seek to investigate the cause of Patient A's pain, the Tribunal found subparagraph 1.b. of the Allegation not proved.

Subparagraph 1.c.

35. At this subparagraph of the Allegation, the Tribunal considered whether Dr Oluwajobi failed to physically examine Patient A.

36. The Tribunal reminded itself of the detailed information it had received about Patient A's discussion with Dr Oluwajobi about where his body armour would sit in his role as XXX. Dr Oluwajobi was also able to define Patient A's physique and this was confirmed by Mrs B in

her oral evidence. The Tribunal found that in order to accurately describe Patient A's physique, Dr Oluwajobi would have needed to see it. This is corroborated by Mr C's evidence of a clinical examination taking place.

37. The Tribunal referred itself to the testimonial evidence in relation to Dr Oluwajobi's practice as a doctor. It noted that he had some 35 years experience of practice and the Tribunal considered that it was improbable that a doctor of this standing would not physically examine a patient.

38. In all the circumstances, the Tribunal found subparagraph 1.c. of the Allegation not proved.

Subparagraph 1.d.

39. At this subparagraph of the Allegation, the Tribunal considered whether Dr Oluwajobi failed to investigate why Patient A was in severe pain and losing weight.

40. The Tribunal considered that to 'investigate' differed from to 'explore' because it referred to going beyond a verbal exploration of symptoms and additionally taking steps to determine a cause. On 20 June 2018, Patient A was put on the emergency list and on 21 June 2018 Dr Oluwajobi took a detailed clinical history and planned laparoscopic surgery. The Tribunal found that there was a clear intention that the laparoscopic surgery would be completed because Dr Oluwajobi had requested that the relevant kit be obtained and set out in the operating theatre in readiness for an opening on the emergency list. However, the surgery was unable to be completed as a result of a large number of emergency cases over the course of Dr Oluwajobi's time 'on call'. The Tribunal did not consider this to be a failure as the number of emergencies on the emergency list was not something within Dr Oluwajobi's control.

41. Accordingly, the Tribunal found subparagraph 1.d. of the Allegation not proved in its entirety.

Subparagraph 1.e.

42. At this subparagraph of the Allegation, the Tribunal considered whether Dr Oluwajobi failed to consider possible complications such as obstruction, penetration into other organs, and abscess formation.

43. The Tribunal noted that, on Dr Oluwajobi's evidence, it appeared that he and the other four doctors involved in Patient A's care had considered obstruction and abscess formation as possible complications as an x-ray and blood tests were carried out. Furthermore, in the Joint Expert Report, Mr H and Mr I agreed that the symptoms with which Patient A presented were attributable to the known Crohn's stricture. They were of the opinion that Dr Oluwajobi did not need to consider obstruction and/or abscess as they were so unlikely in view of his normal abdominal x-ray and white cell count.

44. With regard to the possible complication 'penetration into other organs', the Tribunal found that it was unclear what this was referring to and it noted that this was not clearly addressed within the Joint Expert Report. The Tribunal considered that there was no evidence to support whether Dr Oluwajobi did or did not consider this as a possible complication.

45. In all the circumstances, the Tribunal found subparagraph 1.e. of the Allegation not proved in its entirety.

Subparagraph 1.g.

46. At this subparagraph of the Allegation, the Tribunal considered whether Dr Oluwajobi failed to appropriately diagnose Patient A's condition.

47. The Tribunal was mindful that this subparagraph did not specify which condition Dr Oluwajobi failed to diagnose. Patient A had a condition known to the Hospital and Dr Oluwajobi and this was Crohn's, complicated with a stricture which was the likely cause of Patient A's symptoms. The initial diagnosis of Patient A's condition on the relevant dates was the stricture and he was due to undergo a diagnostic surgery to determine whether there was anything else at issue. It is a fact that Dr Oluwajobi did not diagnose Patient A's cancer on 20 June nor on 21 June 2018.

48. In considering whether the absence of this diagnosis could amount to a failure, the Tribunal considered the nature of the emergency list on which Patient A had been entered. It noted that operations were completed in the order of priority and that it was never certain that Patient A would have the laparoscopy done at all whilst on the list. It was also mindful that when Patient A later had the operation in August 2018, the operation did not diagnose his cancer and that it was only following the CT scan later on that the cancer was found. The Tribunal also noted that even had a CT scan been ordered on 20 or 21 June 2018, there was no guarantee nor suggestion that the scan could have been carried out on these dates, or indeed because of the nature of the requirement of CT scan for the priority operations, no guarantee that it would have happened within the next 4 or 5 days. It was also noted that the timing of the CT was in the control of the radiology department and not Dr Oluwajobi. The Tribunal were therefore of the opinion that it was more likely than not that it would not have been possible to diagnose Patient A's cancer on either 20 or 21 June 2018.

49. In the Joint Expert Report, Mr H and Mr I detailed their agreement that Patient A's symptoms were in keeping with a diagnosis of a Crohn's stricture.

50. In all the circumstances, the Tribunal found subparagraph 1.g. of the Allegation not proved.

Subparagraph 1.h. and 1.i.

51. At these subparagraphs, the Tribunal had to determine whether Dr Oluwajobi failed to record any of the above actions and ensure his team kept an adequate record of Patient A's care.

52. The GMC position was that there had never been in existence any records relating to the relevant consultation and care of Patient A. However, Dr Oluwajobi and Mr C contended that the records had been made and subsequently went missing.

53. The Tribunal, having found that the consultation more likely than not occurred on 21 June 2018, considered the medical notes relating to that date. It directed itself to the relatively comprehensive notes on 20 June 2018 and 22 June 2018 in relation to Patient A. However, it noted that there was a significant lack of records on 21 June 2018. Indeed, the Tribunal noted that the only notes made on 21 June 2018 were recorded on proforma documents and there was a lack of any other note from surgical and nursing staff made on 21 June 2018. The Tribunal noted that in addition to the anaesthetist's record timed at 08.55 on that date and the pre-surgical checklist undertaken there was also a note entered onto the clerking in notes at 10:00 on that date which suggested a pre-admittance review undertaken by Mr C. The next note related to the following day, 22 June 2018. The Tribunal recognised that the evidence that Patient A was being prepped for surgery on 21 June 2018 supported the assertion that there must have been circumstances and consultations to which the records did not attest, including notes from the relevant nursing team. In the absence of any written note for 21 June 2018 the Tribunal considered it more likely than not that the notes for this particular day had gone missing from Patient A's file.

54. The Tribunal also noted that, although Mr C initially gave evidence that the consultation occurred on 20 June 2018, in oral evidence he was willing to accept that he may have confused the dates and that it was more likely that it happened on the following day. Mr C, who attended Patient A's consultation with Dr Oluwajobi, informed the Tribunal that he had taken a comprehensive record of this interaction. This supported Dr Oluwajobi's evidence that there was a long consultation and that a doctor other than himself was taking notes.

55. Taking all of the evidence into account, the Tribunal was of the view that the GMC had not proven these subparagraphs of the Allegation on the balance of probabilities.

56. Accordingly, the Tribunal found subparagraph 1.h. and subparagraph 1.i. of the Allegation not proved.

Subparagraph 2.a.

57. In considering this subparagraph of the Allegation, the Tribunal had to determine whether between 20 June 2018 and 13:00 on 22 June 2018 Dr Oluwajobi inappropriately placed Patient A on the emergency operating list when he had not first obtained a CT scan.

58. The Tribunal noted that it appeared to be Patient A's understanding that after his consultation with a surgical doctor, Dr F placed Patient A on the list for emergency surgery. Mrs B supported this point of view in her evidence.

59. In his initial statement Mr H gave the opinion that the absence of a CT scan prior to scheduled surgery was seriously below the standard expected of a reasonably competent surgeon. However, within the Joint Expert Report it is stated:

> *'The experts agreed it was not inappropriate to put Patient A on the emergency operating list because he had the opportunity to do so … They would both, however, have performed a CT scan before putting Patient A on the list.'*

The Tribunal considered that this reflected a change in Mr H's opinion as it did not refer to the lack of CT scan as a failure nor being seriously below the standard expected.

60. In addition, the Tribunal noted that whilst obtaining a CT may have been desirable prior to undertaking surgery, the Experts both accepted that this was not necessary and that there may be situations where, in emergency surgery in particular, it was not always possible to obtain such a scan.

61. The Tribunal therefore found subparagraph 2.a. of the Allegation not proved.

Subparagraph 2.b.i.

62. In considering this subparagraph of the Allegation, the Tribunal had to determine whether between 20 June and 13:00 on 22 June 2018, Dr Oluwajobi failed to adequately investigate Patient A's symptoms of severe pain and an inability to eat.

63. The Tribunal reminded itself of its findings in relation to the consultation and Dr Oluwajobi's evidence that he had undertaken a detailed and lengthy conversation which had been recorded in the now missing notes. The Tribunal also accepted that Dr Oluwajobi had been particularly busy during the course of his 'on call' shift. The Tribunal also noted that Dr Oluwajobi had at this time a plan in place for Patient A and this was to undertake diagnostic surgery when an appropriate opening became available on the emergency list.

64. The Tribunal also noted that there is no evidence from either Patient A or Mrs B that Patient A's symptoms deteriorated between the relevant dates and indeed the medical records show that the pain Patient A was suffering had decreased.

65. With regard to Patient A's inability to eat, the Tribunal noted that Patient A had been kept 'nil by mouth' in preparation for surgery. However, when it became clear that there would not be an opportunity to operate on him, he was given fluids for nutrition. Although the Tribunal was aware that there were no records on 21 June 2022 to confirm this, Patient A, Mrs B and the IBD nurses all stated that Patient A was receiving fluids when he was not 'nil by mouth'. On 22 June 2018 Patient A was seen by a dietitian in relation to nutrition. The

Tribunal considered that there was no indication that Patient A had vomited after he was admitted.

66. Accordingly, the Tribunal noted that there was no indication that there were any emerging problems which required Patient A to have a further medical review and it was reasonable for Dr Oluwajobi to assume that the plan for diagnostic surgery was on track pending an opening in the emergency list.

67. In light of the circumstances, the Tribunal therefore concluded that this subparagraph of the Allegation was not proved in its entirety.

Subparagraph 2.b.ii.

68. In considering this subparagraph of the Allegation, the Tribunal had to determine whether between 20 June 2018 and 13:00 on 22 June 2018, Dr Oluwajobi failed to make any record of his involvement in Patient A's care.

69. In considering this subparagraph, the Tribunal reminded itself of its findings at subparagraphs 1.h. and 1.i., that it was more likely than not that records had been made and subsequently lost. The Tribunal accepted that at some point on the morning of 21 June 2018 Patient A was seen by Dr Oluwajobi and that this lasted for around 45 minutes. Mr C's evidence was that he made a record of this consultation. The Tribunal noted that it would be unusual for a consultant under significant time pressure to take his own notes during consultations and this was often delegated to junior members of the team.

70. The Tribunal considered that in the absence of any notes, it could not conclude one way or another whether an inadequate record was kept, but it was satisfied that it was more likely than not that a record was made and subsequently lost. It therefore found this subparagraph not proved.

Subparagraph 2.b.iii.

71. In considering this subparagraph of the Allegation, the Tribunal had to determine whether Dr Oluwajobi, during the same time period, failed to ensure his team kept an adequate record of Patient A's care.

72. The Tribunal took into account its finding that there had been a record of Patient A's care as there was a comprehensive note taken by Mr C that has subsequently gone missing.

73. The Tribunal considered the note '*send patient home*' on 22 June 2018 after 10:45 and signed by Mr C. It accepted Dr Oluwajobi's evidence that this note was likely to have been 'prepped' in advance of seeing Patient A owing to how busy the ward was at the time. The Tribunal was of the view that if the relevant consultation with Patient A happened, this note was inadequate as there were no reasons listed for the discharge. However, the Tribunal noted that it was more likely that not that this consultation did not take place due to

the fact that Dr Oluwajobi commenced surgery at 11:45 that morning. The note prior to the prepped note is timed 10.45, accordingly, it is likely that Dr Oluwajobi's evidence is correct that this ward round was truncated on the basis that he was called into emergency surgery. The Tribunal considered that if this was indeed the case that note should have been amended to reflect that the consultation did not happen rather than simply leave it untimed and in this event the note made by Dr Oluwajobi's team was inadequate.

74. Although this note was not timed, the evidence suggested that it had been written sometime between 10:45 and 11:00 on 22 June 2018. Despite Patient A stating that Dr Oluwajobi had been present at the consultation when the decision to discharge Patient A was made, Dr Oluwajobi was commencing surgery at 11:45. The Tribunal was mindful that there would have been time prior to that during which Dr Oluwajobi would have been preparing for that surgery. On that basis, the Tribunal considered it more likely than not that the ward round was truncated and unlikely that Dr Oluwajobi saw Patient A that morning.

75. In light of the evidence that Dr Oluwajobi was in surgery at the time of the consultation, the Tribunal did not consider that he could be held responsible for the inadequate record. Accordingly, the Tribunal found subparagraph 2.b.iii. not proved.

Paragraph 3

76. Paragraph 3 of the Allegation refers to Dr Oluwajobi's decision to discharge Patient A on 22 June 2018. Dr Oluwajobi's position was that he did not make this decision. Dr Oluwajobi informed the Tribunal that at that time he was in surgery when he was called regarding Patient A.

77. The Tribunal noted that Dr Oluwajobi's style had previously been collaborative and patient centred. Dr Oluwajobi had informed the Tribunal that by 22 June 2018 he was of the view that, as he had been unable to operate, the best option for Patient A was to be discharged and come back for elective surgery on 20 July 2018 as arranged. The Tribunal considered it likely that Dr Oluwajobi, while explaining the options, had informed the registrar who discharged Patient A of the same. Dr Oluwajobi as the Consultant in charge was ultimately the person in charge and the Tribunal therefore concluded that the discharge was therefore his responsibility.

78. The Tribunal considered that all of the evidence before it supported this position. In particular, the note of Nurse G timed at 13:30 on 22 June 2018 confirmed that she had been in contact with Dr Oluwajobi and he had explained to her the current situation.

79. The Tribunal also took account of Dr Oluwajobi's evidence that on 25 June 2018 he was unaware that he had a patient (Patient A) who he was being asked to see in the vascular ward. The Tribunal inferred that Dr Oluwajobi believed that Patient A had been discharged on 22 June 2018.

80. The Tribunal also had regard to the Trust report in which it was written three times that it was Dr Oluwajobi's decision to discharge Patient A:

> *'The decision was then made by Mr Oluwajobi to send your husband home and recall for elective surgery …*
>
> *Mr Oluwajobi had asked for your husband to be discharged on Friday 22 June 2018 …*
>
> *'Mr Oluwajobi was surprised to know that your husband was still in hospital as he had thought he had been discharged on 22 June 2018 as planned.'*

81. In light of the evidence before it, the Tribunal found that Dr Oluwajobi was responsible for the decision to discharge Patient A at around 10:00 on 22 June 2018.

Subparagraph 3.a. and 3.b.

82. In considering this subparagraph of the Allegation, the Tribunal had to determine whether Dr O's decision to discharge was inadequate in so far as he took no regard of Patient A's deterioration since his admission to hospital on 20 June 2018.

83. The Tribunal had regard to the Joint Expert Report and Patient A's medical records that there was no deterioration. Mrs B also accepted that Patient A had not deteriorated, just that his situation was being managed. Additionally, there was no evidence that the IBD nurses involved in Patient A's care believed that he was deteriorating, only that he required a plan in relation to nutrition.

84. With no evidence to support the assertion that Patient A had deteriorated between his admission and 22 June 2018, the Tribunal found subparagraphs 3.a. and 3.b. of the Allegation not proved.

Subparagraph 3.c.

85. In considering this subparagraph of the Allegation, the Tribunal had to determine whether the decision to discharge was inadequate in so far as Dr Oluwajobi based his decision upon the fact that he no longer had access to the emergency operating list.

86. The Tribunal considered the unchallenged evidence that when Dr Oluwajobi ceased to be the 'on call' doctor, he was followed by a general surgeon who would then have been responsible for the emergency list. Dr Oluwajobi had informed the Tribunal that having the operation carried out by someone who could not do key hole surgery increased Patient A's risk of having a stoma as a result. Given that the operation was urgent but not an emergency and bearing in mind Patient A and Mrs B's evidence, the Tribunal considered that Dr Oluwajobi aimed to prevent Patient A from having a stoma. Accordingly, the fact he no longer had access to the emergency list to do the surgery by key hole was a reasonable

matter to take into account when considering the options available to Patient A, particularly when Patient A's main concern communicated to Dr Oluwajobi was the risk of a stoma.

87. The Tribunal took into account the documentary evidence in which Nurse G detailed her concerns about discharging Patient A without having a nutritional plan in place. Mrs B confirmed this position in her oral evidence in which she informed the Tribunal that her main concern was the lack of support in place on discharge rather than the operation not being done on the emergency list.

88. In the Joint Expert Report, Mr H and Mr I were of the opinion that the circumstances of the discharge were seriously below the standards of a reasonably competent consultant surgeon but only if there was '*no plan or safety netting*'. However, this was not the case in relation to this specific subparagraph of the Allegation. Taking into account what Dr Oluwajobi wanted to achieve for Patient A, the Tribunal did not consider that the decision to discharge him when Dr Oluwajobi no longer had access to the emergency operating list was an inadequate decision.

89. Accordingly, the Tribunal found subparagraph 3.c. of the Allegation not proved.

Subparagraph 3.d.

90. In considering this subparagraph of the Allegation, the Tribunal had to determine whether Dr Oluwajobi failed to take any account of the opinions or comments of Patient A and Patient A's wife, Mrs B.

91. The Tribunal had regard to Patient A's witness statement in which he stated,

> *'I remember thinking he hadn't examined me and had never sent me for any scan- I was in shock that I was being discharged. I didn't vocalise any of this to Dr Oluwajobi at all.'*

92. Having heard Mrs B's evidence, it appeared that Patient A did vocalise his concerns to Mrs B, however it was agreed that Dr Oluwajobi and Mrs B had not ever spoken to nor seen each other. The Tribunal noted that Mrs B began making contact with the Hospital on or around 13:30 on 22 June 2018, which was after the time at which Dr Oluwajobi became off duty and at that point he had already made the decision to discharge Patient A.

93. The Tribunal considered the GMC submission that Dr Oluwajobi had made no efforts to hear Patient A or Mrs B's opinions in the first place. It found that this went beyond the realm of the wording of subparagraph 3.d. of the Allegation.

94. The Tribunal therefore found subparagraph 3.d. not proved in its entirety.

Subparagraph 4.a.i.

95. In considering this subparagraph of the Allegation, the Tribunal had to determine whether on 25 June 2018, Dr Oluwajobi inappropriately communicated with Patient A insofar as Patient A was led to believe that Dr Oluwajobi was angry and rude.

96. Dr Oluwajobi wrote in Patient A's record that he visited Patient A on this date with two other doctors, Mr D and Mr E. Mr D and Mr E informed the Tribunal that they did not remember Dr Oluwajobi acting in a rude or angry manner towards Patient A, and that if he had they believed they would have remembered and likely recorded the same.

97. However, in his witness statement Patient A described feeling shocked and scared as a result of his interaction with Dr Oluwajobi. Mrs B informed the Tribunal that Patient A immediately informed her that Dr Oluwajobi had

> *'literally waltzed into his room with 2 other doctors and basically said to him "Why are you still her, you were told to go home?"'*

On the following day, 26 June 2018, a complaint from Patient A was documented.

98. When Dr Oluwajobi was questioned in oral evidence about this interaction, he informed the Tribunal that at the time he was '*flat out and dehydrated*'. He stated that he realised that there was a lot of anger and frustration and that Patient A was '*accusing*' him. Dr Oluwajobi stated that he therefore tried to explain the options to Patient A. The Tribunal found that it was accepted that this was the stage at which the relationship between Dr Oluwajobi and Patient A began to break down.

99. The Tribunal was of the view that Dr Oluwajobi may have made all of the comments and statements that Patient A has described in his witness statement. However, it took the circumstances into account, namely that Patient A was in pain, on medication, had hardly slept over the previous weekend, and was frustrated. With regard to Mrs B's evidence in her witness statement that Dr Oluwajobi was '*getting in* [Patient A]*'s face and pointing fingers at him*', the Tribunal reminded itself that, as she had not been present at the time of the conversation, this amounted to further hearsay evidence. The Tribunal also noted that Mrs B's statement was made in March 2021. When balanced against the evidence of Dr Oluwajobi, Mr D and Mr E, and the testimonial evidence which spoke to Dr Oluwajobi's good character, the Tribunal found that it could not accept that Dr Oluwajobi acted in the way described. However, the Tribunal also understood that whilst Patient A was frustrated with the situation it was more likely that not that he had misunderstood the context in which Dr Oluwajobi was setting out his options to him at this time.

100. Despite Patient A's impression of the situation, the Tribunal did not consider that this necessarily amounted to inappropriate communication. The Tribunal therefore found subparagraph 4.a.i. not proved on the balance of probabilities.

Subparagraph 4.a.ii.

101. In considering this subparagraph of the Allegation, the Tribunal had to determine whether Dr Oluwajobi inappropriately communicated with Patient A insofar as he was led to believe that Dr Oluwajobi's advice, that an urgent operation would be an open procedure and would likely result in a stoma, was a threat.

102. The Tribunal considered that, in the circumstances, it was likely that Dr Oluwajobi explained Patient A's options to him again and that this would have included a discussion about what he thought the general surgeon on duty would be able to do. Dr Oluwajobi had been consistent in his evidence that his advice was always that a stoma was a risk of an operation under the general surgeon.

103. In his witness statement, Patient A described Dr Oluwajobi as saying '*I will give you a stoma'*. The Tribunal took account of the evidence that Dr Oluwajobi would no longer have been in a position to operate on Patient A on the emergency list. It concluded that it was highly unlikely that Dr Oluwajobi would have described himself as giving Patient A a stoma because this would have been inaccurate in any event.

104. In her response to the Trust, Mrs B stated that:

> *'He told him that if he did not go home immediately and Mr Oluwajobi had to perform emergency surgery, he would be given a permanent stoma … The surgeon had, essentially told him, he would be giving him a substandard operation, if he was forced to perform this on an emergency basis, at his inconvenience and it would end with a stoma, whereas elective surgery several weeks away, at his convenience, would not.'*

105. The Tribunal was of the view that this was unlikely to have been the case as it was no inconvenience to Dr Oluwajobi if Patient A remained on the emergency list to be operated on by another surgeon. It considered that it was in fact more inconvenient for Dr Oluwajobi to reschedule Patient A's surgery for a day on which he was not previously due to work.

106. The Tribunal took into account the evidence of Mr D and Mr E who informed the Tribunal that they did not have any memory of Dr Oluwajobi leading Patient A to believe that he was being threatened with a stoma. Both Mr D and Mr E stated that they believed they would have remembered any such interaction. Further, Mr D described Dr Oluwajobi as being '*calm*, *empathetic, and thoroughly professional*' throughout the interaction with Patient A.

107. Taking into account the nature of Patient A and Mrs B's evidence as hearsay, and the inaccuracies as outlined above, the Tribunal did not consider that this subparagraph had been proved on the balance of probabilities.

<u>Subparagraph 4.b.i.1.</u>

108. In considering this subparagraph of the Allegation, the Tribunal had to determine whether on 25 June 2018, Dr Oluwajobi kept an inappropriate record in that he included the following comment: *'insisted on staying in hospital'*.

109. The Tribunal accepted that Dr Oluwajobi did write this comment as it had seen it within the records. However, it considered that it was likely to be accepted among parties that this was a factual note. The Tribunal did not consider that this entry reached the level of being inappropriate.

110. The Tribunal therefore found subparagraph 4.b.i.1. of the Allegation not proved.

Subparagraph 4.b.i.2.

111. In considering this subparagraph of the Allegation, the Tribunal had to determine whether Dr Oluwajobi kept an inappropriate record in that he included the following comment: '*failed to work with me'*.

112. The Tribunal had sight of the comment within Patient A's record and it was accepted that this had been recorded by Dr Oluwajobi. It also considered that the comment was not inaccurate in reflecting the interaction as described by Dr Oluwajobi to the Tribunal.

113. However, the Tribunal considered that the language used reflected the finding that the relationship had broken down. It considered that the comment portrayed the absence of Patient A's complete agreement negatively. The Tribunal referred itself to Dr Oluwajobi's oral evidence in which he described Patient A's '*utter lack of regard*' for the information he was being given. Although it was apparent that Dr Oluwajobi was providing Patient A with information and advice, the Tribunal did not consider that it was Dr Oluwajobi's role to tell Patient A which choice to make.

114. The Tribunal considered that, objectively, the comment appeared to convey personal emotions as regarded the interaction which were inappropriate on the patient record.

115. The Tribunal therefore found subparagraph 4.b.i.2. of the Allegation proved.

Subparagraph 4.b.ii.1. and 4.b.ii.2.

116. In considering this subparagraph of the Allegation, the Tribunal had to determine whether Dr Oluwajobi kept an inappropriate record in that he recorded 'needs an elective operation' but failed to make reference to his previous treatment plan that an emergency operation was indicated, and why an emergency operation was no longer indicated.

117. The Tribunal considered that it never formed part of Dr Oluwajobi's case that Patient A required an emergency operation and this was agreed by the Joint Experts who were of the opinion that an operation was necessary but not an emergency. The surgery continued to be treated as urgent as the surgery was listed to be within four weeks. This was not challenged

by Nurse G when Dr Oluwajobi explained Patient A's options to her on 22 June 2018 and she recorded that Patient A '*understood the decision but wasn't necessarily happy with it*'. This position was further supported by Mrs B who in her evidence described the surgery as being elective despite being on the emergency list.

118. The Tribunal was of the view that where an emergency operation was never indicated, there was no need to refer to the comments set out at these subparagraphs of the Allegation. The Tribunal therefore found subparagraph 4.b.ii.1. and 4.b.ii.2. not proved.

Subparagraph 4.b.ii.3.

119. In considering this subparagraph of the Allegation, the Tribunal had to determine whether Dr Oluwajobi kept an inappropriate record in that he failed to make reference to Patient A's continued symptoms of abdominal pain, vomiting and anaemia.

120. The Tribunal did not consider that there was any evidence to support this subparagraph in relation to continued symptoms of vomiting because it was accepted by parties that at this point, Patient A was not vomiting. In relation to the abdominal pain, the Tribunal noted that Patient A's pain score had decreased. It was accepted that there was no evidence to suggest that there was any change in Patient A's symptoms of anaemia.

121. However, the Tribunal did not consider the symptoms Patient A had at that time would have influenced the decision for an elective operation. Having already recorded symptoms in relation to pain and anaemia, the Tribunal did not find that Dr Oluwajobi was required to record the position again on the evening of 25 June 2018 as alleged.

122. The Tribunal therefore found subparagraph 4.b.ii.3. not proved.

The Tribunal's Overall Determination on the Facts

123. The Tribunal has determined the facts as follows:

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

1. On 20 June 2018 you were responsible for the care and treatment of Patient A and you failed to:

    a. explore Patient A's symptoms of:

        i. severe abdominal pain; **Not proved**

        ii. vomiting; **Not proved**

        iii. anaemia; **Not proved**

iv. weight loss; **Not proved**

b. adequately challenge Patient A's diagnosis of Crohn's disease; **Not proved**

c. physically examine Patient A; **Not proved**

d. investigate why Patient A was:

i. in severe pain; **Not proved**

ii. losing weight; **Not proved**

e. consider possible complications, such as:

i. obstruction; **Not proved**

ii. penetration into other organs; **Not proved**

iii. abscess formation; **Not proved**

f. arrange a CT scan for Patient A; **Admitted and found proved**

g. appropriately diagnose Patient A's condition; **Not proved**

h. record having taken the actions referred to at paragraph 1a-g; **Not proved**

i. ensure your team kept an adequate record of Patient A's care. **Not proved**

2. Between 20 June 2018 and 13:00 on 22 June 2018 you:

a. inappropriately placed Patient A on the emergency operating list when you had not first obtained a CT scan; **Not proved**

b. failed to:

i. adequately investigate Patient A's symptoms of:

1. severe pain; **Not proved**

2. an inability to eat; **Not proved**

ii. make any record of your involvement in Patient A's care; **Not proved**

iii. ensure your team kept an adequate record of Patient A's care. **Not proved**

3. Your decision to discharge Patient A at around 10:00 on 22 June 2018 was inadequate insofar as you:

   a. took no regard of Patient A's deterioration since being admitted to hospital on 20 June 2018; Not proved

   b. failed to adequately investigate why Patient A was deteriorating; Not proved

   c. based your decision upon the fact that you no longer had access to the emergency operating list; Not proved

   d. failed to take any account of the opinions or comments of:

      i. Patient A; Not proved

      ii. Patient A's wife. Not proved

4. On the evening of 25 June 2018, you visited Patient A and you:

   a. inappropriately communicated with him insofar as he was led to believe:

      i. that you were angry and rude; Not proved

      ii. your advice, that an urgent operation would be an open procedure and would likely result in a stoma, was a threat; Not proved

   b. kept an inappropriate record in that you:

      i. included the following comments on Patient A's record:

         1. 'insisted on staying in hospital'; Not proved

         2. 'failed to work with me'; Determined and found proved

      ii. recorded 'needs an elective operation' but failed to make reference to:

         1. your previous treatment plan that an emergency operation was indicated; Not proved

         2. why an emergency operation was no longer indicated; Not proved

         3. Patient A's continued symptoms of abdominal pain, vomiting and anaemia. Not proved

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

Determination on Impairment - 27/05/2022

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

The Evidence

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

- Dr Oluwajobi provided a further, reflective, statement.

3. The Tribunal also received in support of Dr Oluwajobi four testimonials from colleagues, all of which it has read.

4. The Tribunal also received documentary evidence including but not limited to:

- Appraisals dated 2020, 2021 and 2022;
- Patient feedback;
- Continuing professional development extracts in relation to decision making, patient safety and communication;
- Continuing professional development in relation to record keeping and data protection;
- Surgical and Professional Development Materials.

Submissions

GMC Submissions

5. On behalf of the GMC, Mr Rose submitted that the GMC's position was one of neutrality and that he had no submissions in relation to misconduct and impairment. The Tribunal noted the written submissions of the GMC in relation to the relevant case law in relation to the test for impairment.

Dr Oluwajobi Submissions

6. On behalf of Dr Oluwajobi, Mr Mahmood submitted that the facts found proved did not amount to misconduct and that Dr Oluwajobi's fitness to practise was not therefore impaired.

7. Mr Mahmood reminded the Tribunal of the relevant case law in relation to misconduct and impairment and referred it to the documentary evidence and Dr Oluwajobi's witness statement adduced at this stage. Mr Mahmood submitted that a mere departure from GMP or 'any' misconduct would not be sufficient to satisfy the first stage of the test for misconduct as it must be conduct which is deplorable. In relation to impairment, he submitted that a finding must reflect current impairment as a result of the charges as found proven.

8. Dealing with misconduct, Mr Mahmood submitted that the threshold had not been crossed. Referring to the failure to order a CT scan, he submitted that Dr Oluwajobi had always admitted and accepted this failure. Although he did not consider it to be immediately required, he nevertheless found it to 'weigh on his mind'. Mr Mahmood reminded the Tribunal of its findings that there was no guarantee nor suggestion that a CT scan could have been carried out as quickly as implied by the GMC, it was not necessary but desirable, that Dr Oluwajobi was extremely busy on the day, he had planned to undertake diagnostic surgery, and that his style was always collaborative and patient focused. Mr Mahmood submitted that, taking all of the evidence and the Tribunal's findings into account, whilst his conduct could be criticised with hindsight, it could not be suggested on the evidence that his conduct crossed the threshold for serious misconduct. Mr Mahmood submitted that this was reflected in Mr I's expert opinion.

9. In relation to the inappropriate entry on Patient A's medical records, Mr Mahmood submitted that Dr Oluwajobi's statement accepted the Tribunal's finding and apologised unreservedly. Mr Mahmood directed the Tribunal to Dr Oluwajobi's first witness statement and submitted that Dr Oluwajobi always recognised that it would have been better not to have recorded *'failed to work with me'* in the notes. He submitted that Dr Oluwajobi was 'deeply sorry' and that it was never his intention to cast aspersions. Mr Mahmood reminded the Tribunal of the very difficult time in which Dr Oluwajobi was operating, and submitted that, in the circumstances, Dr Oluwajobi's conduct in recording this in the medical records did not even begin to cross the threshold of serious misconduct.

10. Mr Mahmood referred to the context in which the findings were made. He submitted that this was a '*truly unique case'*, that Dr Oluwajobi was of impeccable character, and that there had been no suggestion of Dr Oluwajobi acting in the same way prior to Patient A, nor ever since. Mr Mahmood addressed Dr Oluwajobi's remediation and submitted that it went considerably beyond remediation in respect of the two findings.

The Relevant Legal Principles

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

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

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

14. In relation to misconduct, the Tribunal bore in mind the case of *Roylance v General Medical Council (No.2)* [2000] 1 A.C. 311, which provides:

> *'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. The misconduct is qualified in two respects. First, it is qualified by the word professional which links the misconduct to the profession* [of medicine]. *Secondly, the misconduct is qualified by the word serious. It is not any professional misconduct which would qualify. The professional misconduct must be serious.'*

15. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in *CHRE v NMC and Paula Grant* [2011] EWHC 297 Admin. The Tribunal noted that any of the following features are likely to be present when a doctor's fitness to practise is found to be impaired:

> *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 and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. Has in the past breached and/or is liable to breach in the future one of the fundamental tenets of the medical profession; and/or*
>
> *d. Has in the past and/or is liable in the future to demonstrate that his integrity cannot be relied upon.'*

The Tribunal's Determination on Impairment

Misconduct

16. The Tribunal first considered the facts found proved in relation to subparagraph 1.f. of the Allegation, namely that Dr Oluwajobi failed to order a CT scan for Patient A. The Tribunal noted that Dr Oluwajobi had admitted that not ordering a CT scan at the relevant time did amount to a failure. However, in the Joint Expert Report, Mr H and Mr I did not refer to it in the same way, nor did they conclude that Dr Oluwajobi's actions fell seriously below the standard expected of a reasonably competent consultant colorectal surgeon. The Tribunal did not identify any paragraphs of Good Medical Practice ('GMP') from which Dr Oluwajobi had significantly departed in relation to this subparagraph of the Allegation. The Tribunal did not therefore consider that failing to order a CT scan, where it was desirable but not essential, amounted to misconduct.

17. In relation to its findings at subparagraph 4.b.i.2. of the Allegation, namely that Dr Oluwajobi inappropriately wrote 'failed to work with me' in Patient A's medical records, the Tribunal was mindful of the circumstances of Dr Oluwajobi's exceptionally busy work at that time. It noted that Dr Oluwajobi had described himself as *'exhausted and dehydrated'* and that the relationship had begun to break down. Dr Oluwajobi had acknowledged that the entry was inappropriate and had demonstrated insight insofar as he had stated that he wished he had phrased it in a better way. The Tribunal was of the view that the entry did not amount to offensive nor abusive remarks aimed at Patient A but, rather, unwise phraseology which when read outside of context could possibly be construed differently to the manner intended. Accordingly, the Tribunal concluded that this could not be described as misconduct.

18. The Tribunal has concluded that Dr Oluwajobi's conduct did not fall so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct. The Tribunal has therefore determined that Dr Oluwajobi's fitness to practise is not impaired.

19. Given the submissions made by the parties and the Tribunal's findings in relation to misconduct and impairment, the Tribunal determined that consideration of a warning was not necessary.

20. That concludes this case.

ANNEX A – 17/05/2022

Application to Admit Hearsay Evidence under Rule 34(1)

1. On day one of the hearing, Mr Christopher Rose, on behalf of the GMC, made an application to admit the witness statement of Patient A as hearsay evidence under Rule 34 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules').

Submissions

On behalf of the GMC

2. On behalf of the GMC, Mr Rose submitted that Patient A's witness statement was relevant and that it could fairly be admitted into evidence.

3. Addressing relevance, Mr Rose submitted that Patient A's witness statement was relevant to each paragraph in the Allegation as it provided Patient A's recollection of his interactions with Dr Oluwajobi.

4. With regard to fairness, Mr Rose submitted that there would be opportunities for Dr Oluwajobi to challenge the evidence because Mrs B would be called as a witness. Mr Rose submitted that Mrs B received contemporaneous comments and complaints from Patient A as matters progressed and that she could therefore be questioned about Patient A's manner, state of mind, and mood. Mr Rose also submitted that Dr Oluwajobi could call evidence from other doctors who were in the room at the time of the alleged events and that there were documentary records of a number of the consultations referred to. Mr Rose submitted that the Tribunal could demonstrate fairness to Dr Oluwajobi in how it apportioned weight to the hearsay evidence.

On behalf of Dr Oluwajobi

5. On behalf of Dr Oluwajobi, Mr Ghazan Mahmood submitted that although Patient A's witness statement was relevant to the Allegation, there were considerable concerns in relation to the issue of fairness.

6. Mr Mahmood submitted that the safeguards referred to by the GMC were '*more artificial than real*'. He submitted that there were very serious factual allegations in this case and that some relied solely on the account given by Patient A. Mr Mahmood submitted that although Mrs B could be challenged on the account she had been given by her husband, she was not present in the room at the time of the relevant conversations and that her evidence was therefore hearsay in its own right. It was also submitted that all other witnesses had limited knowledge of the various interactions and would be insufficient to test the veracity of the hearsay evidence.

The Tribunal Approach

7. The Tribunal acknowledged that the admission of evidence is a matter for the Tribunal to decide having regard to the questions of fairness and relevance. It had regard to Rule 34(1) of the Rules, which states:

> *'The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'*

8. The Tribunal had regard to the case of *Thorneycroft* in which, at paragraph 56, Thomas J considered that there were seven matters to be taken into account when determining whether to admit hearsay evidence:

> *'56… The decision to admit the witness statements despite their absence required the Panel to perform a careful balancing exercise. In my judgment, it was essential in the context of the present case for the Panel to take the following matters into account:*
>
> *(i) whether the statements were the sole or decisive evidence in support of the charges;*
>
> *(ii) the nature and extent of the challenge to the contents of the statements;*
>
> *(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
>
> *(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*
>
> *(v) whether there was a good reason for the non-attendance of the witnesses;*
>
> *(vi) whether the Respondent had taken reasonable steps to secure their attendance; and*
>
> *(vi) the fact that the Appellant did not have prior notice that the witness statements were to be read.'*

9. The Tribunal bore in mind the relevant principles as laid out at paragraph 45 of Thorneycroft:

> *'For the purposes of this appeal, the relevant principles which emerge from the authorities are these:*

1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.

1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.

1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.

1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.'

10. In making its decision on admissibility, the Tribunal noted that it was agreed by both parties that Patient A's evidence was relevant, however the Tribunal was required to consider whether to admit the evidence would be fair, considering the case as a whole. Further, the Tribunal bore in mind that admissibility of evidence is a separate issue to its weight, which would be assessed in due course if admitted. If it would be unfair to admit the evidence then what weight could be attached to it could not in itself remedy that unfairness, but the fact that the absence of the witness can be reflected in the weight is a factor to be taken into account in the Tribunal's assessment of fairness.

The Tribunal Decision

11. The Tribunal found that Patient A's witness statement was determinative of a large number of issues within the Allegation. However, taking into account the documentary records and the witness statements of other practitioners who may have been present at the time of the alleged events, the Tribunal did not consider that the witness statement was the sole and decisive evidence on all of the issues to be determined.

12. The Tribunal considered whether there was a means of testing the statement's reliability. It was of the view that the statement could be tested against the evidence of Mrs B as well as the medical records and accounts of other practitioners who may have been present at the relevant time. The Tribunal considered that when looking at the evidence as a whole, it would then be able to consider the correct weight that could be attached to Patient A's witness statement.

13. The Tribunal acknowledged that the Allegations in this case were serious. However, it considered that the impact of any adverse findings of Dr Oluwajobi's career was outweighed by the public interest in the serious issues being heard, particularly in circumstances where there was a good and cogent reason for Patient A's absence, in that Patient A is now deceased.

14. Accordingly, the Tribunal determined to approve the GMC's application to admit Patient A's witness statement as hearsay evidence.