PUBLIC RECORD

Dates: 07/11/2022 - 09/11/2022

Medical Practitioner's name:	Dr Oyindamola KOLEDOYE
GMC reference number:	6069729
Primary medical qualification:	MB BS 1996 University of Lagos

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

Summary of outcome
Warning

Tribunal:

Legally Qualified Chair	Miss Anya Lewis
Lay Tribunal Member:	Mr Colin Sturgeon
Medical Tribunal Member:	Mr Gulzar Mufti

Tribunal Clerk:	Ms Angela Carney

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Scott Ivill, Counsel, instructed by CMO
GMC Representative:	Mr Ryan O'Donoghue, Counsel

Attendance of Press / Public
In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly in private.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts and Impairment - 08/11/2022

1. This determination will be handed down in private. However, as this case concerns Dr Koledoye's misconduct, a redacted version will be published at the close of the hearing with confidential matters removed.

Background

2. Dr Koledoye gained her primary medical qualification, MBBS, in 1996, from the College of Medicine at the University of Lagos in Nigeria. Having undertaken House Officer jobs in Nigeria, Dr Koledoye came to the UK to work in 2009 and worked across a range of posts.

3. In 2011, Dr Koledoye commenced work as a Clinical Fellow at Barts and the London NHS Trust in Cardiothoracic Surgery, where she remained until 2015, at which point she commenced her Specialty Training in general practice undertaking posts in various specialities. Dr Koledoye commenced work as a GP Registrar at the Shipway Medical Centre in Maidstone from August 2017 until July 2018, where she then worked as a Locum GP until June 2019.

4. At the time of the events which are the subject of the hearing, in January 2021, Dr Koledoye was working as a GP partner at the City Way Medical Practice (the Practice) covering six sessions over three days a week, namely, Wednesdays, Thursdays and Fridays. She had started working at the Practice as a salaried GP in June 2019 and became a GP partner on 1 January 2020. She left the Practice on 30 April 2021.

5. In January 2021 Dr Koledoye also undertook sessional out-of-hours GP work for Integrated Care 24 (IC24) covering Kent, Surrey and Sussex. She had undertaken this work since July 2018. From October 2021 Dr Koledoye has undertaken Locum GP shifts at Matrix Medical Centre for three days per week.

6. In terms of the Allegation, following the emergence of the Covid-19 pandemic, the operation of the Practice had changed completely, and staff and doctors were provided with laptops in case they needed to work from home. On most days doctors would still come into the Practice, but they were able to work from home if, for example, they needed to self-isolate following a positive Covid test.

7. On Saturday 16 January 2021 at 06.29, Dr Koledoye sent a WhatsApp message to the Practice Manager informing her that she had tested positive for Covid-19 stating, "*I will be self-isolating for 10 days from today. That means no homeworking. Please organise cover for Wednesday duty. Thanks."* The Wednesday duty referred to was Wednesday 20 January 2021.

8. On Monday 18 January 2021, Dr B, another GP partner at the Practice, was also working for IC24 in Maidstone, when she noticed Dr Koledoye logged onto the internal instant messaging system. Dr B referred this information to the Practice Manager. Both considered it to be out of character for Dr Koledoye to be working for IC24 after she had informed the Practice that she was unfit to work from home. On 24 January 2021 Dr B contacted the GMC for advice and she also spoke briefly with one of the Local Medical Committee doctors.

9. On 1 April 2021 a partnership meeting was held at the Practice where Dr Koledoye was asked about the incident for the first time. During the meeting Dr B expressed concerns that Dr Koledoye had apparently worked for IC24 when the Practice had been rushing to organise cover for her shifts because she had told them she was self-isolating and unable to work from home.

10. Dr Koledoye's response at the meeting was that she had worked for IC24 from home. One of the other partners asked Dr Koledoye if she was aware that she could work from home for the Practice, to which Dr Koledoye said that she was, but that there were times when she worked from home and did not finish until midnight. Dr Koledoye said that it was a choice she made, and she needed to rest. In her statement, Dr B said that Dr Koledoye, "*did not appear to understand that the rules had been broken, but we also didn't know of the rules were broken either. She tried to explain to us why she thought it was ok*." Emails were sent by Dr Koledoye after the meeting confirming that she had not worked for IC24 on the days she was meant to be working at the Practice.

11. The meeting concluded with Dr Koledoye accepting that the Practice and partners should do whatever they needed to do. Following the meeting, Dr B sought further advice from the GMC. In her statement Dr B states, *"We had concerns, but we didn't know what to do and couldn't estimate the significance of what had happened, because it was out of character, and we were living in very different times."*

12. It was confirmed, in due course, by Dr A, Medical Director of IC24, that Dr Koledoye had worked the following shifts for IC24, during the period of her Covid-19 self-isolation:

- 16 January 2021; 1830 – 0000
- 17 January 2021; 1800 – 0000
- 18 January 2021; 1800 – 0000
- 23 January 2021; 0800 – 1500 and 1800 – 0000
- 24 January 2021; 0800 – 1500 and 1800 – 0000

- 25 January 2021; 1800 – 0000.

13. Dr A confirmed that, during those hours, Dr Koledoye worked in a virtual triage role of the Clinical Assessment Unit. Dr Koledoye was not due to work for the Practice on any of the dates on which she worked for IC24. The only dates, during her period of self-isolation, which Dr Koledoye was due to work for the Practice were Wednesday 20 January 2021, Thursday 21 January 2021 and Friday 22 January 2021.

The Allegation and the Doctor's Response

14. The Allegation made against Dr Koledoye is as follows:

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

> 1. On 16 January 2021, you sent a WhatsApp message to Ms A indicating you had tested positive for Covid-19 and were required to self-isolate for 10 days (the 'Self-isolation'), and this included 'no homeworking', so you were unable to work for City Way Medical Practice ('the Practice').
> **Admitted and found proved**
>
> 2. On one or more of the dates set out in Schedule 1, you worked from home for Integrated Care 24 Out of Hours Service during the Self-isolation.
> **Admitted and found proved**
>
> 3. You:
>
> a. knew you were able to undertake at least some of your scheduled duties for the Practice from home during the Self-isolation;
> **Admitted and found proved**
>
> b. failed to notify the Practice at any point during the Self-isolation that you were able to undertake at least some of your scheduled duties for the Practice from home during the Self-isolation.
> **Admitted and found proved**
>
> 4. Your actions as set out in paragraph:
>
> a. 1 were dishonest by reason of paragraph 3.a;
> **Admitted and found proved**
>
> b. 3.b were dishonest by reason of paragraph 3.a.
> **Admitted and found proved**

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

The Admitted Facts

15. At the outset of these proceedings, Dr Koledoye made admissions to all of the paragraphs and sub-paragraphs of the Allegation in full, 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.

Witness Evidence

16. The Tribunal 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 A, Medical Director, Integrated Care 24
- Dr B, GP partner, at City Way Medical Practice

17. Dr Koledoye provided her own witness statement dated 27 September 2022; she did not give oral evidence at the facts or impairment stages of the hearing.

Documentary Evidence

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

- Text message from Dr Koledoye to the Practice dated 16 January 2021
- Email from Dr B to the GMC dated 24 January 2021
- Notes of City Way Medical Practice partnership meeting 1 April 2021, incorrectly dated 1 March 2021
- Emails from Dr Koledoye to the Practice containing Covid-19 test result, dated 1 April 2021
- Email from Dr B to the GMC expressing the Practice's concerns, dated 19 April 2021
- Email from IC24 to the GMC concerning shifts Dr Koledoye worked for IC24, dated 6 July 2021
- Letter from the GMC to Dr B, dated 14 January 2022
- Emails from Ms C, Practice Manager, The Practice, to the GMC, dated 5 July 2021 and 7 September 2021
- Certificate Maintaining Professional Ethics dated 12-14 July 2022
- Dr Koledoye's testimonials
- Statement from Dr D, Dr Koledoye's Responsible Officer, dated 31 August 2021
- Email from Dr B, dated 3 November 2022

DETERMINATION ON IMPAIRMENT

19. 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 above, Dr Koledoye's fitness to practise is impaired by reason of misconduct.

Submissions

20. On behalf of the GMC, Mr Donoghue referred the Tribunal to the relevant case law. He stated that in her fifth report to the Shipman Inquiry Dame Janet Smith DBE identified the test to be applied when considering whether a practitioner's fitness to practise is impaired. Dame Smith stated, inter alia:

> *"25.50 I think it will be helpful, in the resolution of the problems that I am about to outline, if I analyse the reasons why a decision-maker might conclude that a doctor is unfit to practise or that his/her fitness to practise is impaired. In the examples I discussed above, four reasons for unfitness recurred. They were*
> *(a) that the doctor presented a risk to patients,*
> *(b) that the doctor had brought the profession into disrepute,*
> *(c) that the doctor had breached one of the fundamental tenets of the profession and*
> *(d) that the doctor's integrity could not be relied upon.*
> *Lack of integrity might or might not involve a risk to patients. It might or might not bring the profession into disrepute. It might be regarded as a fundamental tenet of the profession. I think it right to include it as a separate reason why a doctor might be regarded as unfit to practise, because it is relevant even when it arises in a way that is quite unrelated to the doctor's work as a doctor.'*

Mr Donoghue submitted that reasons (b) and (c), identified by Dame Smith, were particularly engaged in this case and that a doctor's fitness can be found to be impaired notwithstanding that the Tribunal may consider the doctor's clinical skills to be without question.

21. Mr Donoghue invited the tribunal to adopt the two-step process outlined in *Cheatle v General Medical Council [2009] EWHC 645 (Admin).*

22. In relation to misconduct, Mr Donoghue reminded the Tribunal that the term 'misconduct' is not defined in legislation and has developed through a long line of authorities.

23. As to the meaning of professional misconduct, Mr Donoghue referred the Tribunal to the case of *Nandi v General Medical Council [2004] EWHC 2317 (Admin)* where Collins J. stated:

> *'31... What amounts to professional misconduct has been considered by the Privy Council in a number of cases. I suppose perhaps the most recent observation is that of Lord Clyde in Rylands v General Medical Council [1999] Lloyd's Rep Med 139 at 149,*

where he described it as "a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious". The adjective "serious" must be given its proper weight, and in Page 4 of 12 *other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners. It is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree.'*

24. Mr Donoghue referred the Tribunal to the case of *R (Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin),* in which Elias L.J. identified two key 'species' of misconduct and set out 10 principles, which included the following:

'37. I would derive the following principles from these cases:

(1) Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur out with the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession.
(2) Misconduct falling within the first limb need not arise in the context of a doctor exercising his clinical practice, but it must be in the exercise of the doctor's medical calling. There is no single or simple test for defining when that condition is satisfied.
(3) Conduct can properly be described as linked to the practice of medicine, even though it involves the exercise of administrative or managerial functions, where they are part of the day to day practice of a professional doctor
...
(6) Conduct falls into the second limb if it is dishonourable or disgraceful or attracts some kind of opprobrium; that fact may be sufficient to bring the profession of medicine into disrepute. It matters not whether such conduct is directly related to the exercise of professional skills...'

25. Mr Donoghue submitted that, in this case, Dr Koledoye's conduct almost straddles those two limbs. The dishonesty occurred as a direct consequence of Dr Koledoye's position as a doctor, however, it also involved conduct that would be considered dishonourable or disgraceful by the profession.

26. Mr Donoghue stated that in terms Good Medical Practice ('GMP') Dr Koledoye's fell short of the following requirements:

'65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

> *36 You must treat colleagues fairly and with respect.*
>
> *37 You must be aware of how your behaviour may influence others within and outside the team.'*

27. In relation to misconduct, Mr Donoghue submitted that all instances of dishonesty on the part of a medical practitioner are such that they are easily capable of amounting to serious misconduct. Mr Donoghue identified three additional factors which increase that seriousness in this case. Firstly, Dr Koledoye's dishonesty occurred in the context of professional practice. Secondly, this was not a single and isolated error or lapse of judgement. Dr Koledoye worked for IC24 on six occasions during her period of self-isolation, when she had expressly informed her Practice that she was unable to undertake homeworking. At none of those points did Dr Koledoye seemingly consider that she would have been able to undertake work from home for her GP Practice. Finally, there was likely to have been a financial benefit to Dr Koledoye from her dishonesty, in that she will have earned income from her time working for IC24. Whilst the GMC does not suggest this was the motivation behind Dr Koledoye's actions, the GMC submitted that it is a relevant factor to be considered.

28. Mr Donoghue stated that whilst the public health situation at the time, at the start of the Covid-19 pandemic, could fairly be described as exceptional, that cannot provide justification for what were repeated breaches of fundamental principles of GMP. He reminded the Tribunal that Dr Koledoye's first shift for IC24, during the relevant period, commenced only 12 hours after she had informed her Practice that she was unable to undertake home working. He submitted that it is inconceivable that the seriousness of Dr Koledoye's conduct could not have entered her mind when she decided to take on the work for IC24.

29. Mr Donoghue submitted that the facts found proved in this case involved Dr Koledoye acting in a way that falls far below the standards expected of medical practitioners, as set out in the relevant guidance documents. He submitted that, in accordance with *Nandi* and *Remedy*, Dr Koledoye's actions would be considered deplorable by fellow medical professionals and would rightly attract opprobrium, such that they meet the definition of serious misconduct.

30. In relation to impairment, Mr Donoghue referred the Tribunal to the following authorities subsequent to Dame Janet Smith's fifth report to the Shipman Inquiry, Meadow *v General Medical Council [2007] QB 462*, *Cohen v General Medical Council [2008] EWHC 581 (Admin*) and *Cheatle [2009]*. He submitted that the authorities established that whilst the assessment of impairment is a forward-looking one (i.e. on the date of the assessment), it must also take into account the nature and seriousness of the original conduct. For example, it was said in *Cohen:*

> *'62. Any approach to the issue of whether a doctor's fitness to practice should be regarded as "impaired" must take account of "the need to protect the individual*

patient, and the collective need to maintain confidence profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the". In my view, at stage 2 when fitness to practice 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 whether by reason of the doctor's misconduct, his or her fitness to practice has been impaired…

64. 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 the 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. Indeed section 35D (3) of the Act states that where the Panel finds that the practitioner's fitness to practice is not impaired, "they may nevertheless give him a warning regarding his future conduct or performance".

31. Mr Donoghue submitted that, insight and remediation aside, when deciding on the issue of impairment, the Tribunal must keep in mind the promotion and protection of the three limbs of the overarching objective. He referred the Tribunal to *Council for Healthcare Regulatory Excellence v Nursing & Midwifery Council and Grant [2011] EWHC 927* and *Yeong v General Medical Council [2010] 1 WLR 548*, where Sales J. drew a distinction between the relevance of remediation and insight in cases involving clinical errors or incompetence, and its relevance in cases involving other types of misconduct. Sales J. stated:

'48. Against this, Miss Grey submitted that each of Cohen's case, Meadow's case and Azzam's case was concerned with misconduct by a doctor in the form of clinical errors and incompetence. In relation to such types of misconduct, the question of remedial action taken by the doctor to address his areas of weakness may be highly relevant to the question whether his fitness to practise is currently (ie at the time of consideration by a FTPP) impaired; but Miss Grey submitted that the position in relation to the principal misconduct by Dr Yeong in the present case (ie improperly crossing the patient/doctor boundary by entering into a sexual relationship with a patient) is very different. Where a FTPP considers that the case is one where the misconduct consists of violating such a fundamental rule of the professional relationship between medical practitioner and patient and thereby undermining public confidence in the medical profession, a finding of impairment of fitness to practise may be justified on the grounds that it is necessary to reaffirm clear standards of professional conduct so as to maintain public confidence in the practitioner and in the profession. In such a case, the efforts made by the medical practitioner in question to address his behaviour for the future may carry very much less weight than in a case where the misconduct consists of clinical errors or incompetence.'

32. Mr Donoghue submitted that such considerations are engaged in Dr Koledoye's case, when considering the seriousness of the conduct that has brought her before the Tribunal.

33. Mr Donoghue stated that the GMC accepts that Dr Koledoye's witness statement demonstrates that she has reflected on her conduct and recognises why it was wrong. However, he pointed out that such an approach was not apparent in the immediate aftermath of the incident. Mr Donoghue stated that the GMC accepts that Dr Koledoye can now be considered to have developed insight into her misconduct. However, he submitted that, in accordance with the cases of *Grant and Yeong*, such insight can only take Dr Koledoye's case so far, at this stage, given the seriousness of her original conduct. Mr Donoghue submitted that the breaches of GMC guidance, whilst remediable, are not easily so, given the fundamental nature of the principles breached.

34. Mr Donoghue referred the Tribunal to the overarching objective, as set out in s.1 of the Medical Act 1983, which is to protect the public. He submitted that, notwithstanding the surrounding circumstances, Dr Koledoye's actions were such that they were likely to bring the medical profession into disrepute and undermine public confidence in the profession. He stated that the relationship between doctors is dependent upon trust. He submitted that Dr Koledoye's actions were very likely to have undermined that trust, such that they should also be considered to have undermined the professional standards that doctors are held to. Mr Donoghue submitted that it is on the above bases that a finding of impairment is required to promote and protect both the second and third limbs of the overarching objective.

35. On behalf of Dr Koledoye, Mr Ivill informed the Tribunal that Dr Koledoye fully accepts that her behaviour fell far short of the standards expected of her and was serious. She admitted the allegation, not only in these proceedings, but also at the Rule 7 stage. He focussed his submission on Dr Koledoye's current impairment and, in particular, whether her conduct was remediable, whether it had been remedied, the likelihood of repetition and insight.

36. Mr Ivill referred the Tribunal to paragraph 46 and paragraph 52, of the Sanctions Guidance, (the SG) which states:

> *'46 A doctor is likely to have insight if they:*
>
> > *a. accept they should have behaved differently (showing empathy and understanding)*
> > *b. take timely steps to remediate (see paragraphs 31–33) and apologise at an early stage before the hearing*
> > *c. demonstrate the timely development of insight during the investigation and hearing.'*
>
> *52. A doctor is likely to lack insight if they:*
>
> > *a. refuse to apologise or accept their mistakes*
> > *b. promise to remediate, but fail to take appropriate steps, or only do so when prompted immediately before or during the hearing*

c. do not demonstrate the timely development of insight
d. fail to tell the truth during the hearing'

37. Mr Ivill submitted that the fact that Dr Koledoye fully understands the seriousness of her behaviour and is remorseful, is supported by her witness statement and in particular the following paragraphs:

'18. At the meeting I was not fully focused as I had other matters pressing on my mind. I was completely distracted. I had so much going on at the time that I regret that I did not properly engage in the process and behaved completely out of character. I am so ashamed of behaving in such a way that I have never done before and will never do again. I made a poor judgement call not to have apologised there and then, for which I am so ashamed. Now I have clarity and have reflected and I obviously appreciate that it is not the fact that I was undertaking the out of hours shifts, rather that I had indicated that I was not available to work for City Way when, in fact, I could have undertaken at least some of my scheduled duties and should have notified the Practice of such. This is why I admit the allegations and I have apologised to the Practice.

19. I recognise that I am in a privileged position and this behaviour reflects badly on the profession and is not in keeping with the standards expected of a doctor. I wish to take this opportunity to apologise wholeheartedly to the Practice; the Tribunal; and my professional colleagues.

26. Until this investigation I have had an unblemished career and have never been the subject of a GMC investigation. I am utterly ashamed by my actions and I want to assure the Panel that I fully understand the seriousness of the issues involved. I acknowledge that my actions were serious and a departure from Good Medical Practice. I have read up and reflected on the GMC guidance on probity and honesty. I acknowledge that doctors must be honest and trustworthy and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession. I fully understand that if a doctor does not act in an honest way, it can undermine the trust the public place in the medical profession and that, where the trust is undermined, there is a risk to public confidence in the profession.

27. I profoundly regret my actions and I would, as stated, like to take this opportunity to apologise to the Practice, the Panel and my colleagues. I clearly see how incidents such as this could undermine the public's confidence in the medical profession and compromise the privileged position of trust I hold with colleagues and patients, as a GP. I have reflected at great length and acknowledge that my actions were dishonest and not the way a doctor should behave. I have also considered the effect of my actions on everyone involved, including my colleagues at City Way Medical Centre. My actions would have increased my colleagues' workloads and potentially impacted on patients and their expectations being met. For this I am truly sorry.

38. Mr Ivill further referred the Tribunal to the fact Dr Koledoye had attended a 3 day Maintaining Professional Ethics course in July 2022 and the reflective essay she had written after the course.

39. Mr Ivill referred the Tribunal to Dr Koledoye's explanation about her personal circumstances at the time of the events not as a means of justification, but by means of explanation as to why she had acted so out of character. Dr Koledoye explained that:-

> *'7. The Covid 19 pandemic was a hugely stressful period for me for a number of reasons. Working conditions were extremely difficult. There were a significant number of sicknesses amongst colleagues and some also left the Practice during that time. I ended up covering absences which led to extra-long working hours and an unending administrative workload, often resulting in my working until midnight.*
> *…*
> *9 XXX By September 2020 XXX we decided that the best thing was to move house. This was in the middle of the pandemic and without any help from my husband who was still stuck in Nigeria. Unfortunately, the house move meant that I ended up having to travel much further to get to work.*
> *…*
> *12. By January 2021 I was completely burnt out. I had not had any time off since October 2020 and was exhausted, feeling the intense pressures of having to cover extra duties at City Way due to staff absences and the additional pressures brought by the pandemic whilst also dealing with all the stresses at home. IC24 were very understanding and I found the out of hours work easier and less stressful in comparison with my workload at City Way. The IC24 work was less demanding as consultation times were longer thereby offering more time with patients and thorough management plans; I had little or no administrative duties; follow-up duties would be referred to patients' registered GPs; and I was not required to attend partnership meetings or undertake any training/clinical Supervision:'*

40. Mr Ivill referred the Tribunal to the comments made by others who knew Dr Koledoye well as to how out of character her behaviour was on that occasion, including comments made by Dr B who made a number of such comments, including:

> *'6. I remember I was very shocked and I thought it was out of character for Dr Koledoye…I shared the information that I had seen her name on the system with the practice manager…The practice manager was shocked and thought it was very out of character of Dr Koledoye…*
>
> *13. I emailed the GMC again on 19 April 2021 seeking further advice, as the other partners and I wanted clarification and help. I produce a copy of this email as Exhibit GA/6…We had concerns, but we didn't know what to do, and couldn't estimate the significance of what had happened, because it was out of character for Dr Koledoye, and we were living in very different times. This was her first partner position. She has*

been a very helpful colleague, and during the pandemic, people may have reacted differently…'

41. Mr Ivill also referred the Tribunal to paragraphs 20 and 28 of Dr Koledoye's statement and said that Dr Koledoye's insight has developed over time. Paragraphs 20 and 28 state:

'20. I feel the practice meeting was like a wake-up call for me and I have been on a process of reflection ever since. After the meeting I reflected on my actions and it was then that I recognised that XXX I decided to reduce my workload in order to be able to provide more support to XXX, hence the difficult decision to leave City Way on 30th April 2021. This enabled me to reduce my workload and give more attention to XXX. I was sad to leave City Way as I had been optimistic about my future there but XXX and I recognised that I also needed XXX. After leaving the practice I took some time out to focus on my family and XXX and this has had a positive effect upon all of us.

…

28. Since my referral, I have been open and honest with the GMC. I have co-operated fully with the GMC investigation and I believe I have shown genuine insight. Again, I am truly sorry for my actions and I want to assure the Panel that I will never repeat such behaviour. This is something I have never done before and I never intend to do again.'

42. Mr Ivill stated that there has been no report of dishonesty prior to or in the period of over eighteen months subsequent to events. He submitted that the lack of repetition is relevant to insight and to the fact that the misconduct is remediable. In so far as the impact the GMC investigation has had on Dr Koledoye, he referred the Tribunal to paragraph 29 of her statement:

'29. My life has been thrown into complete disarray by this investigation. When I told my family about the GMC investigation, this led to enormous anxiety for all of us.'

43. Mr Ivill submitted that the impact of the GMC's investigation on Dr Koledoye demonstrates that it is highly unlikely that she will repeat her actions. Mr Ivill referred the Tribunal to various testimonials from Dr Koledoye's colleagues and submitted that they attest to her honesty.

44. Mr Ivill submitted that Dr Koledoye has demonstrated insight and stated that the GMC agree with that contention. He said that Dr Koledoye has shown an understanding of her behaviour and its impact that she has taken immediate actions and expressed genuine remorse and apology. He said that she has full insight, remediated her behaviour and the risk of repetition is low. He submitted that this is not a case where Dr Koledoye represents a current risk to the public. He submitted that the conduct on the dishonesty scale is towards the lower end of seriousness. He highlighted that Dr Koledoye did not work for IC24 on her

usual working days at the Practice and that the incident can be fairly described as an isolated episode of dishonesty. He reminded the Tribunal of Dr B's statement that:

> *'12. I thought she would be apologetic and we would've left it there,…'*

45. Mr Ivill submitted that a finding of dishonesty does not necessarily lead to a finding of impairment. He referred the Tribunal to paragraph 57 in the case of *Chaudhury v GMC 2017 EWHC 2561 Admin*, which states:

> *'57. First of all, I respectfully agree with the MPT that dishonesty is not necessarily a monolithic concept. That has two consequences. First of all, questions of degree obviously arise that much must be self-evident but secondly, that dishonesty in an individual does not have to be an all pervading or immutable trait. A person can be dishonest just on one occasion. Secondly, I agree with the MPT that at least it was open for the MPT to consider the context of the respondent's dishonesty...'*

46. Mr Ivill stated that whether there is impairment or not it is matter for the Tribunal alone exercising its independent judgement. He submitted that the Tribunal may find that a finding of impairment is not necessary, given the circumstances of this case.

47. The Tribunal received in evidence at a late stage an email from Dr B dated 4 November 2022 which contained a written apology from Dr Koledoye that she had submitted to her colleagues at the Practice in June 2022. This was subsequent to a verbal apology in late April 2021 and an earlier written apology in May 2021. In that email Dr B stated on behalf of herself and other partners at the Practice:

> *'From her email and knowing her previously I sincerely believe that she truly regret her actions at the time. Upon my personal reflection, I wish I had had a chance then to rebuild the bridge with our working relationship so I could have helped Oyin to realise what she had done.'*

The Relevant Legal Principles

48. 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.

49. 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.

50. The Tribunal must determine whether Dr Koledoye's fitness to practise is impaired today, taking into account her conduct at the time of the events and any relevant factors

since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

The Tribunal's Determination on Impairment

Misconduct

51. The Tribunal considered, first of all, whether Dr Koledoye's admitted and found proved dishonesty amounted to misconduct that was serious. The Tribunal concluded that by her actions in failing to notify the Practice that she could undertake at least some of her scheduled duties at home during her self-isolation period, Dr Koledoye breached a number of requirements of GMP. Her behaviour in placing her colleagues under pressure to cover her work when, in fact, she could have undertaken some of it herself, since she was able to work for IC24, undermined the principle that her conduct must justify her patient's trust in her and the public's trust in the profession. It further undermined the principle that she must treat colleagues fairly and with respect and be aware of how her behaviour influenced others within and outside her team. The Tribunal noted that Dr Koledoye worked for IC24 only 12 hours after sending the text to the Practice indicating that she could not work from home the following Wednesday.

52. The Tribunal noted that the dishonesty occurred in the context of Dr Koledoye's professional practice, albeit not within her clinical practice. The Tribunal were of the view that the Allegation could properly be described as an isolated episode with the consequences of the poor decision made by Dr Koledoye on 16 January 2021 extending to the period of 20 to 22 January 2021. The Tribunal were of the view there was a financial benefit to Dr Koledoye from her dishonesty, albeit the offence was not motivated by financial gain but instead by very poor decision making by her at that time. The Tribunal noted that Dr Koledoye found the work she undertook for IC24 considerably less onerous than the work which she undertook for the Practice.

53. In the circumstances the Tribunal concluded that Dr Koledoye's behaviour amounted to serious misconduct.

Impairment

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

Insight

55. The Tribunal noted that Dr Koledoye did not demonstrate immediate insight in this case, and in fact, it was her failure to understand that her behaviour was wrong at the partner's meeting on 1 April 2021 which had led to the case being referred to the GMC.

56. Despite Dr Koledoye's initial response, the Tribunal was satisfied that Dr Koledoye has subsequently developed insight into her misconduct, as was accepted by the GMC. This was evidenced by Dr Koledoye's acceptance of the Allegation at the Rule 7 stage, her admissions to the Allegation in its entirety at the outset of this hearing, her witness statement, the statement of her Responsible Officer, Dr D and her reflective essay.

Remediation

57. The Tribunal noted that dishonesty can be difficult to remediate. However, the Tribunal were satisfied that, in the circumstances of this case, Dr Koledoye's behaviour was both capable of being remediated and that it had been remediated.

58. The Tribunal noted, in this regard, that the behaviour was an isolated episode at the lower end of the scale of dishonest behaviour. The behaviour was described as out of character by those who it impacted at the time and by those who subsequently provided testimonials. There had been no previous dishonest behaviour and no repetition. Dr Koledoye had completed a Maintaining Professional Ethics course in July 2022 and provided a reflective essay subsequent to the course. Her Responsible Officer had provided a statement and the Tribunal took into account the evidence of remediation set out in Dr Koledoye's witness statement.

59. In light of the Tribunal's findings in relation to insight and remediation, the Tribunal concluded that the risk of repetition in this case is low. The central consideration for the Tribunal was whether Dr Koledoye's fitness to practise is currently impaired because of the nature of her misconduct, in light of the overarching objective, in particular, the promotion and maintenance of public confidence in the medical profession and proper professional standards.

60. The Tribunal considered that Dr Koledoye's misconduct was as a result of a serious error of judgement which occurred at a time when she was unwell with Covid-19 and under considerable personal pressure. However, the Tribunal put limited weight on Dr Koledoye's difficult personal circumstances.

61. The Tribunal concluded that Dr Koledoye's dishonesty was at the lower end of the scale of dishonest behaviour and was not so egregious that Dr Koledoye was not fit to practice without restrictions (or at all). It considered the factors set out in its conclusions on misconduct at paragraph 52, alongside the fact that Dr Koledoye had not worked for IC24 on the days she was due to work at the Practice. The Tribunal placed weight on the reaction of Dr B and others at the Practice at the time. It was clear that neither Dr B, the Practice Manager or the other partners at the Practice were entirely sure, initially, as to the gravity of Dr Koledoye's actions. Dr B states that at the time of the partners' meeting on 1 April 2021, Dr Koledoye's did not appear to understand that the rules were broken and we, '*also did not know if the rule were broken either*'. It was further clear that had Dr Koledoye apologised at the meeting on 1 April 2021, the partners at the Practice would have concluded that that was the end of the matter.

62. In all the circumstances the Tribunal was of the view that a finding of impairment is not required in this case to promote and maintain public confidence in the profession and proper professional standards in light of the nature of the dishonesty involved, Dr Koledoye's previous good character, her insight and her remediation.

63. The Tribunal has therefore determined that Dr Koledoye's fitness to practise is not impaired by reason of misconduct.

Determination on Warning - 09/11/2022

64. As the Tribunal determined that Dr Koledoye's fitness to practise was not impaired it considered whether, in accordance with s35D(3) of the 1983 Act, a warning was required.

Submissions

65. On behalf of the GMC, Mr Donoghue referred the Tribunal to the GMC's Guidance on Warnings (March 2021) (the Guidance):

> *16. A warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstances:*
>
> - *there has been a significant departure from Good medical practice…*
>
> *17. There is no definition of 'significant' in the Medical Act or in the Fitness to Practise Rules. The paragraphs below are therefore intended to help decision makers, at both the investigation and hearing stages, consider whether a warning is appropriate.*
>
> *20. The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning.*
>
> > *a. There has been a clear and specific breach of Good medical practice or our supplementary guidance.*
> >
> > *b. The particular conduct, behaviour or performance approaches, but falls short of, the threshold for the realistic prospect test or in a case before a tribunal, that the doctor's fitness to practise has not been found to be impaired.*
> > *c. A warning will be appropriate when the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Warnings may be an appropriate response to any type of allegation (subject to the comments in paragraph 7 regarding cases solely*

relating to a doctor's health); the decision makers will need to consider the degree to which the conduct, behaviour or performance could affect patient care, public confidence in the profession or the reputation of the profession. If the decision makers consider that a warning is appropriate, the warning should make clear the potential impact of the conduct, behaviour or performance in question, accordingly.

d. There is a need to record formally the particular concerns (because additional action may be required in the event of any repetition).'

66. Mr Donoghue submitted that the Tribunal found that there has been a clear and specific breach of GMP in this case, in particular in relation paragraph 65 and also in relation to paragraphs 36 and 37. He drew attention to the Tribunal's finding that the dishonesty was in the context of Dr Koledoye's professional practice and that there had been a financial benefit. He invited the Tribunal to conclude that the clear and specific breach was significant. In relation to paragraph 20 of the Guidance, Mr Donoghue submitted that paragraphs (a) to (d) are all applicable and that paragraph (c) is particularly significant. He stated that if Dr Koledoye's misconduct were to be repeated it would likely result in a finding of impaired fitness to practise. He said that misconduct of this nature is particularly serious and requires a formal warning. He submitted that dishonesty of any kind has the potential to undermine public confidence in the profession.

67. Mr Donoghue referred the Tribunal to paragraphs 24 and 25 of the Guidance which are specific to cases of dishonesty:

'24. There is a presumption of impaired fitness to practise where the allegations concern dishonesty or violence. This presumption can be rebutted however where the doctor's behaviour is not a risk to public protection which includes maintaining public confidence in the medical profession.

25. There will be some cases involving dishonesty or violence that are not related to the doctor's professional practice and/or which are sufficiently low level in nature that taking action on the doctor's registration would be disproportionate. A warning is likely to be appropriate in these cases. Examples might include, in the absence of any other concerns, police cautions for theft or common assault.'

68. Mr Donoghue submitted that the issuing of a warning would be entirely in keeping with the Guidance.

69. On behalf of Dr Koledoye, Mr Ivill referred the Tribunal to paragraph 13 of the guidance:

'13. Although warnings do not restrict a doctor's practice, they should nonetheless be viewed as a serious response, appropriate for those concerns that fall just below the threshold for a finding of impaired fitness to practise.

70. Mr Ivill submitted that although the Tribunal found that Dr Koledoye has breached the principles in GMP that should be balanced against the factors set out in paragraph 32 of the Guidance which states:

> *'32. If the decision makers are satisfied that the doctor's fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of factors to determine whether a warning is appropriate. These might include:*
>
> *a. the level of insight into the failings*
> *b. a genuine expression of regret/apology*
> *c. previous good history*
> *d. whether the incident was isolated or whether there has been any repetition*
> *e. any indicators as to the likelihood of the concerns being repeated*
> *f. any rehabilitative/corrective steps taken*
> *g. relevant and appropriate references and testimonials.'*

71. Mr Ivill submitted that Dr Koledoye has full insight and there has been both an expression of genuine regret and an apology in this case. He reminded the Tribunal that Dr Koledoye has no previous fitness to practise history and that it concluded that the misconduct was an isolated episode, the risk of repetition is low and that her conduct has been remediated. He also reminded the Tribunal that Dr Koledoye has provided relevant and appropriate references and testimonials.

72. Mr Ivill submitted that the Tribunal's determinations on facts and impairment will properly inform the public that Dr Koledoye's conduct was unacceptable. He submitted that a warning would be unlikely to have a deterrent effect when the Tribunal is already satisfied that the risk of repetition is low. He submitted that the finding of misconduct is sufficient to protect the public interest. He stated that this was a 'one-off' incident which Dr Koledoye has already remediated. He submitted that in the circumstances it would not be proportionate to issue a warning in this case.

The Tribunal's Determination on Warning

73. The Tribunal has borne in mind the overarching objective and, in particular, limbs b) and c), b) to promote and maintain public confidence in the medical profession and c) to promote and maintain proper professional standards and conduct for the members of the profession.

74. The Tribunal determined that Dr Koledoye's misconduct fell below the standard expected to a degree warranting a formal response by the Tribunal and represented a significant departure from GMP. Dr Koledoye's misconduct resulted from an episode of dishonesty which, although isolated, occurred in the context of her professional practice. Her behaviour placed her colleagues under pressure to cover her work. She undermined the

principle that her conduct must justify her patients' trust in her and the public's trust in the profession. It further undermined the principle that she must treat colleagues fairly and with respect and be aware of how her behaviour influenced others within and outside her team. The Tribunal found that Dr Koledoye's dishonest conduct was serious and if there were a repetition, would likely result in a finding of impaired fitness to practise.

75. The Tribunal took account of paragraphs 24 and 25 of the Guidance (as above). The Tribunal found the nature of Dr Koledoye's dishonesty was at a sufficiently low level in nature that taking action on her registration would have been disproportionate but noted the guidance that a warning is likely to be appropriate in such cases.

76. The Tribunal balanced the public interest in maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour against Dr Koledoye's interests. In carrying out this balancing act the Tribunal considered the full range of factors set out in paragraph 32 of the Guidance including the insight and remediation shown by Dr Koledoye, her previous good character, the positive references and testimonials and its previous finding that the risk of repetition was low.

77. The Tribunal concluded that there is a need to issue a warning in this case in order to maintain public confidence in the profession and to declare and uphold proper standards of conduct and behaviour. Accordingly, the Tribunal has issued the following warning:

> 'Dr Koledoye
>
> On 16 January 2021, you sent a WhatsApp message to the Practice where you were a partner (the Practice), indicating you were unable to work for 10 days and stating *'…That means no home working…'.* You were due to work at the Practice on 20, 21 and 22 January 2021 and did not do so. On six occasions between 16 and 25 January 2021, other than the dates you were due to work at the Practice, you worked from home for a separate out-of-hours service. You knew you were able to undertake at least some of your scheduled duties for the Practice from home during the 10-day period from 16 January 2021 and you failed to notify the Practice of this. Your actions were dishonest.
>
> This conduct does not meet with the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in Good Medical Practice. In this case, paragraphs 65 and 36 and 37 of Good Medical Practice are particularly relevant. Paragraphs 65 and 36 and 37 state:
>
> > *'65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession*
> >
> > *36 You must treat colleagues fairly and with respect.*

> *37 You must be aware of how your behaviour may influence others within and outside the team.'*

> Whilst this failing in itself is not so serious as to require any restriction on your registration, it is necessary in response to issue this formal warning.'

78. This warning will be published on the medical register in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy

79. That concludes this case.

SCHEDULE 1

16 January 2021
17 January 2021
18 January 2021
23 January 2021
24 January 2021
25 January 2021