PUBLIC RECORD

Dates: 10/08/2026 - 19/08/2026

Doctor:	Dr Stephen IGWE
GMC reference number:	8020277
Primary medical qualification:	MB BS 2021 Abia State University

Type of case	Outcome on facts	Outcome on impairment
New – Misconduct New – Deficient professional performance	Facts relevant to impairment found proved	Impaired

Summary of outcome

Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Miss Ruona Iguyovwe
Lay Tribunal Member:	Ms Jo Palmiero
Registrant Tribunal Member:	Dr Laura Florence

Tribunal Clerk:	Mr Joel Taylor-Garratt

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Mikhael Puar, Counsel, instructed by BMA Law
GMC Representative:	Mr Ian Brook, 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.

Protecting the Public

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

Determination on Facts and Impairment - 14/08/2026

1. Dr Igwe qualified in 2021 from Abia State University in Nigeria. Prior to the events which are the subject of the hearing, Dr Igwe had completed a Foundation rotation equivalent in Nigeria. At the time of the events, Dr Igwe was practising as a Junior Clinical Fellow in neonatology at Lewisham and Greenwich Trust ('LGT').

2. The allegations that have led to Dr Igwe's hearing relate to his conduct and clinical performance. It is alleged by the General Medical Council (GMC) that Dr Igwe dishonestly applied to various positions in which he had omitted or misrepresented information, including that he was subject to interim conditions, provided a false reference or that he had misrepresented his qualifications and/or his experience. It is further alleged that Dr Igwe underwent a performance assessment in which his performance was found to be a cause for concern in two areas and unacceptable in one area.

3. The Allegation includes that Dr Igwe completed a number of application forms after he was subject to an interim order of conditions due to his alleged dishonesty in previous applications. It is alleged that Dr Igwe dishonestly failed to include the full details of his conditions on these application forms.

4. The initial concerns were raised with the GMC in July 2024 by Dr A of Kings College Hospital after she interviewed Dr Igwe for a position. Dr A was unable to contact Dr Igwe's named reference, Dr B, and so reached out to a colleague who worked in the same team that Dr Igwe had claimed to work in. That colleague said he did not know Dr Igwe, which raised concerns with Dr A.

The Allegation and the Doctor's Response

5. The Allegation made against Dr Igwe is as follows:

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

King's College Hospital

1. On 1 July 2024 you submitted an application form to the King's College Hospital NHS Foundation Trust for the vacancy of Senior Clinical Fellow in Paediatric Emergency Medicine, in which you failed to provide accurate information in that you:

    a. claimed you were awarded MBBS with distinction in Medicine in 2019; **Admitted and found proved**

    b. stated you were employed by the Lewisham and Greenwich NHS Trust ('LGT') and your:

        i. job title was Clinical Fellow; **Admitted and found proved**

        ii. start date was July 2023; **Admitted and found proved**

        iii. grade was middle; **Admitted and found proved**

        iv. speciality was Paediatrics ED [Emergency Department]; **Admitted and found proved**

        v. referee Dr B's job title was senior and their relationship to you was employer/line manager; **Admitted and found proved**

    c. stated you had full registration with a license to practise; **Admitted and found proved**

    d. answered 'yes' to the declaration that 'The information in this application form is true and complete'. **Admitted and found proved**

2. On 17 July 2024 during a telephone call with Dr A, after she informed you that LGT had told her you did not work at LGT in Paediatrics ED and were not a Registrar, you replied 'Yes, I am' or words to that effect, which was untrue. **Admitted and found proved**

3. At the time of your actions as set out in paragraphs 1 and 2, you knew:

   a. (in relation to paragraph 1):

      i. you were awarded the degree of MBBS without distinction in October 2021; **Admitted and found proved**

      ii. your named referee Dr B was your junior clinical fellow colleague and not your line manager; **Admitted and found proved**

      iii. Dr B had not agreed to act as your employment referee; **Admitted and found proved**

      iv. your role at LGT was your first job as a NHS doctor in the UK, having gained full registration in an Approved Practice Setting on 15 February 2024; **Admitted and found proved**

   b. you were employed as a junior clinical fellow in the Neonatal Intensive Care Unit at LGT on a 6 month contract from 4 March 2024. **Admitted and found proved**

Croydon Health Services

4. On 5 November 2024, you submitted an application form to the Croydon Health Services NHS Trust ('CHST') for the vacancy of Junior Clinical Fellow in Emergency Department in which you:

   a. answered 'No' to the declaration question, 'Are you currently subject to a fitness to practise investigation and/or proceedings of any nature by a regulatory or licensing body which may have a bearing on your suitability for the position you are applying for?', which was untrue; **Admitted and found proved**

   b. failed to declare:

      i. the reasons for you being subject of an ongoing fitness to practise investigation by the GMC; **Admitted and found proved**

      ii. the details of the conditions that had been imposed on your GMC Registration pursuant to an interim order of conditions. **Admitted and found proved**

5. On 4 January 2025, you submitted an application form to the CHST for the vacancy of Trust Grade ST1/2 equivalent in Neonates in which you:

   a. answered 'No' to the declaration question, 'Are you currently subject to a fitness to practise investigation and/or proceedings of any nature by a regulatory or licensing body which may have a bearing on your suitability for the position you are applying for?', which was untrue; **Admitted and found proved**

b. failed to declare:

i. the reason for you being subject of an ongoing fitness to practise investigation by the GMC; Admitted and found proved

ii. the details of the conditions that had been imposed on your GMC Registration pursuant to an interim order of conditions; Admitted and found proved

c. signed a declaration on the Trac website stating 'The information in this application form is true and complete', which was untrue. Admitted and found proved

6. At the time of completing the forms set out in paragraphs 4 and 5 above, you knew the answers you gave were untrue as:

a. you were the subject of an ongoing fitness to practise investigation by the GMC from 3 September 2024; Admitted and found proved

b. your registration with the GMC was subject to an interim order of conditions from 10 October 2024 until 2 April 2025. Admitted and found proved

7. On 16 January 2025, you submitted the Model Declaration Form A to the CHST, in which you:

a. in response to the question 'Are you currently subject to any fitness to practise investigations and/or proceedings by a regulatory or licensing body in any country, which may have a bearing on your suitability for this position? If you have ticked YES, please provide the reasons given for the investigation and, if known, the details of any sanctions being considered on your professional registration including any warnings or interim orders':

i. ticked 'yes'; Admitted and found proved

ii. answered 'The investigation was based on a Teams meeting during an interview in July 2024. An interim order has been placed on my registration, requiring me to inform the GMC 24 hours before starting a new role. This interim order will be reviewed next month'; Admitted and found proved

iii. failed to disclose that you were subject to an interim order of conditions which included direct clinical supervision requirement, as set out in Schedule 1; Admitted and found proved

b. in response to the question 'Have you ever been subject to any sanctions being placed on your professional registration, by a regulatory or licensing body in any country? If you have ticked YES, please provide details of any sanctions':

i. ticked 'yes'; Admitted and found proved

ii. answered 'I need to inform the GMC 24 hours before I start. I have no suspensions, limitations, warnings, removal, or restrictions that has a bearing on the new role', which was untrue; Admitted and found proved

iii. failed to disclose that you were subject to an interim order of conditions which included direct clinical supervision requirement, as set out in Schedule 1; Admitted and found proved

c. you signed a declaration that 'The information I have provided is true to the best of my knowledge and belief', which was untrue. Admitted and found proved

8. At the time of submitting the Model Declaration Form A set out in paragraph 7 above, you knew:

a. the interim order of conditions placed upon your registration from 10 October 2024 until 4 April 2025 included conditions requiring direct clinical supervision, as set out in Schedule 1; Admitted and found proved

b. your answers gave a false impression as to the extent and/or detail and/or requirements of the interim order of conditions placed upon your registration. Admitted and found proved

Application Forms

9. Between ~~March~~ 19 January 2024 and November 2024 you submitted application forms for vacancies in the NHS ('the Forms') in which you failed to provide accurate information in each of the Forms as set out in in Schedule 2. Admitted and found proved. Amended under Rule 17(6)

10. You knew the answers you gave as set out in paragraph 9 and in Schedule 2 were untrue for the reasons set out in paragraphs 3.a.i, 3.a.iv, 3.b, and 8.a. Admitted and found proved

11. Your actions at paragraph(s):

a. 1 were dishonest by reason of paragraph 3; Admitted and found proved

b. 2 were dishonest by reason of paragraph 3.b; Admitted and found proved

c. 4 and 5 were dishonest by reason of paragraph 6; Admitted and found proved

d. 7 were dishonest by reason of paragraph 8; Admitted and found proved

e. 9 were dishonest by reason of paragraph 10. Admitted and found proved

Performance Assessment

12. Between 24 and 25 February 2025 you underwent a General Medical Council assessment of the standard of your professional performance. Admitted and found proved

13. Your professional performance was unacceptable in the following area:

    a. Clinical Management. Admitted and found proved

14. Your professional performance was a cause for concern in the following areas:

    a. Assessment of Patients' Condition; Admitted and found proved

    b. Relationships with Patients. Admitted and found proved

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

    a. misconduct in respect of paragraph(s) 1 to 11; To be determined

    b. deficient professional performance in respect of paragraph(s) 12 to 14. To be determined

The Admitted Facts

6. At the outset of these proceedings, through his Counsel, Mr Puar, Dr Igwe made admissions to the whole of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the 'the Rules'. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

7. In light of Dr Igwe's admissions, 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 Igwe's fitness to practise is impaired by reason of misconduct or deficient professional performance.

The outcome of applications made during the impairment stage

8. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the Rules, for the date in paragraph 9 of the Allegation to be amended. The application was not opposed by Mr Puar. The Tribunal was satisfied that this was an amendment to correct a factual error and could be done without prejudice to Dr Igwe. Dr Igwe in his witness statement has stated that he accepts the GMC allegations in their entirety and he has not opposed the application to amend.

Witness Evidence

9. 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, Consultant Paediatrician at Kings College Hospital, dated 14 January 2025;
- Dr C, Dr Igwe's Responsible Officer at LGT, dated 3 January 2025;
- Dr B, Clinical Fellow at LGT, dated 18 March 2025;
- Ms D, Head of Medical Workforce at CHST, dated 1 July 2025;
- Ms F, Proactive Counter Fraud Investigator at the NHS Counter Fraud Authority, dated 23 July 2025 and 18 June 2026.

10. Dr Igwe provided his own witness statement dated 29 July 2026 and a further reflective statement, which was undated.

Documentary Evidence

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

- Various correspondence relating to concerns about Dr Igwe's job applications, qualifications and employment history;
- Various job applications completed by Dr Igwe;
- Dr Igwe's comments in response to the initial allegations;
- Documents and correspondence in relation to a virtual assistant allegedly used by Dr Igwe to assist with job applications;
- Dr Igwe's Performance Assessment Report, dated 28 April 2025;
- Evidence of CPD courses and other qualifications and exams completed by Dr Igwe;
- Report of Dr E following Dr Igwe's clinical attachment in March 2026;
- Evidence of Dr Igwe's remedial work in Nigeria.

12. The Tribunal also received in support of Dr Igwe a number of testimonials from colleagues and friends, all of which it has read.

Submissions

Submissions on behalf of the GMC

13. Mr Brook, Counsel, submitted that Dr Igwe's fitness to practise was currently impaired. He stated that the concerns in this case represent serious misconduct and that the case falls at the higher end of the spectrum of seriousness. He submitted that dishonesty is a breach of a fundamental tenet of the medical profession.

14. He said that Dr Igwe's case was that his dishonesty arose because of being panicked at the prospect of his employment contract not being renewed meaning he may lose his visa and income and potentially have to return to Nigeria. Mr Brook submitted that Dr Igwe knew he was on a fixed term contract at LGT so it should have come as no shock that his employment was coming to an end. He also submitted that, whilst Dr Igwe claimed he was concerned about the instability in Nigeria and the prospect of returning, that concern could not have been serious as he ultimately did return to Nigeria without issue.

15. Mr Brook reminded the Tribunal that Dr Igwe had admitted to dishonesty and had acknowledged that many doctors face the same pressures he had been under without acting dishonestly. He had also accepted in his statement that his dishonesty was fundamentally incompatible with being a doctor.

16. Mr Brook submitted that Dr Igwe's claim to have acted dishonestly due to panic does not hold water when looking at the case as a whole. He submitted that Dr Igwe's dishonesty predated the events that are the subject of this hearing as he attained his role at LGT through dishonest means, without having the necessary qualifications. Mr Brook also submitted that Dr Igwe continued to act dishonestly after being made aware of the investigation into his probity concerns both in additional job applications and by falsely claiming to have used a virtual assistant, who was to blame for the 'mistakes' in his applications, mistakes to which Dr Igwe has now admitted. Mr Brook submitted that these events indicated that Dr Igwe was dishonest before and after the events in question and did not act in such a way merely out of panic.

17. Mr Brook submitted that Dr Igwe's dishonesty was made up of a variety of omissions, embellishments and fabrications including that he received a distinction for his MBBS qualification when it was just a pass, claiming to have been working as a clinical fellow when he was in fact a junior fellow and providing false answers in relation to the ongoing GMC investigation.

18. Mr Brook acknowledged that Dr Igwe had undertaken various CPD courses but submitted that a doctor should not need to undertake specific training to understand the need to be honest about their qualifications and experience. He also submitted that Dr Igwe completed a total of nine and a half hours' worth of training on the same day, which Mr Brook stated was not conducive to effective learning but was rather an exercise in collecting certificates.

19. Mr Brook submitted that Dr Igwe's dishonesty occurred in his professional role, was persistent and repeated, was premeditated and showed a reckless disregard for professional standards and patient safety. This was compounded by further dishonesty when the concerns came to light. He submitted that this amounted to serious misconduct and was at the higher end of the spectrum of seriousness.

20. Mr Brook submitted that Dr Igwe had put his own interests ahead of those of patients and, when confronted, had doubled down on his lie. Later, he created a false narrative that a virtual assistant had been to blame for mistakes on his application forms, a position that Dr Igwe subsequently resiled from and admitted to be false. Mr Brook submitted that Dr Igwe's dishonesty was ongoing and repeated and meant that a finding of impairment was necessary.

21. In relation to the performance aspects, Mr Brook submitted that the seriousness was at the lower end of the spectrum of seriousness as they were relatively limited in scope and Dr Igwe was a junior clinician. He said that the risk to public protection was low in relation to the performance issues.

Submissions on behalf of Dr Igwe

22. Mr Puar, Counsel, reminded the Tribunal to be cautious as to what weight to put on Mr Brook's submissions in relation to any matters that were not particularised within the Allegation. He submitted that these matters were being put to Dr Igwe without proper notice to allow the defence to respond. Notwithstanding this, Mr Puar submitted that Dr Igwe had used a virtual assistant. He said the virtual assistant was an associate in Nigeria and Dr Igwe accepts that he tried to use the virtual assistant to deflect the blame for his dishonesty, which he now accepts was dishonest.

23. Mr Puar submitted that Dr Igwe conceded his actions amounted to misconduct and that the seriousness was at the upper end of the spectrum, although not at the very top. He accepted that Dr Igwe had been dishonest about several different aspects over an extended period of time.

24. Mr Puar submitted that Dr Igwe's motivations for being dishonest were multifactorial, including financial concerns having to support his family, visa issues and worries about having to return to Nigeria. He said it was bold of Mr Brook to suggest that Dr Igwe's concerns about returning to Nigeria were false owing to the fact that he did return there in 2025. Mr Puar said that Nigeria is a large and diverse country and Dr Igwe's family had subsequently moved.

25. Mr Puar submitted that it was relevant that Dr Igwe was at the beginning of his career and had only recently begun working in the UK at the time of the events in question. He submitted that Dr Igwe had demonstrated insight into his dishonesty and that there was hope for change in the future. He said that Dr Igwe now held a long-term visa but acknowledged this would be of little weight.

26. Mr Puar submitted that Dr Igwe's initial response to the allegations was poor, having continued to be dishonest and to maintain his innocence. Mr Puar submitted that Dr Igwe had been on a journey and had developed his understanding over time. He said that by December 2025, following the completion of CPD and reflections, Dr Igwe had recognised that his actions were appalling and began to reach out to consultants for support and advice. Mr Puar submitted that Dr Igwe accepted his culpability from February 2026.

27. Mr Puar submitted that there was no actual harm caused to patients because of Dr Igwe's dishonesty but there was clear potential for him to have caused harm. He said that Dr Igwe had caused actual harm to the profession and public confidence because of his breach of trust. Mr Puar submitted that Dr Igwe has taken steps to remediate, has sought employment as a healthcare assistant and checked with the GMC that he would not be in breach of a suspension by undertaking a clinical attachment. Mr Puar submitted these demonstrated Dr Igwe's insight and desire to remediate.

28. Mr Puar said that Dr Igwe accepted the performance- based allegations and reiterated they were at the lower end of the spectrum of seriousness as submitted by Mr Brook on behalf of the GMC. He reminded the Tribunal of the steps taken by Dr Igwe to address the shortcomings in his performance identified in the Performance Assessment. He stated it was open to the Tribunal to make no finding of impairment on that ground.

The relevant legal principles

29. There is no burden or standard of proof at this stage of the proceedings and the decision of impairment is a matter for the Tribunal's judgment alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

30. 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, or deficient professional performance. It then must decide whether the finding of that misconduct, which was serious, or deficient professional performance poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

31. To assess whether Dr Igwe poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal will follow the steps set out it in the *MPTS Guidance for Tribunals (Section three: MPT Hearings > Part B > Stage 2: Impairment > Steps 2(a) to (e)* ('the Guidance'). It will consider:

- where on the spectrum of seriousness the allegation lies, based on the facts found proved the impact of any relevant context known about Dr Igwe and/or their working environment, and
- how Dr Igwe has responded to the Allegation.

32. Where appropriate, the Tribunal will also have regard to the *MPTS Guidance for Tribunals > General introduction > Protecting the public in specific case types* ('the Guidance Introduction'). The relevant case types in this case are: Case Type 2 Dishonesty and Case Type 5 Clinical concerns.

33. As the allegations fall under more than one ground for impairment, an assessment of current and ongoing risk to public protection must be made in respect of each of them.

34. The Tribunal had regard to the case of *Roylance v GMC (No.2) [2000] 1 AC 311:*

'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 will qualify. The professional misconduct must be serious.'

35. The Tribunal noted the case of *Nandi v General Medical Council [2004] EWHC 2317 (Admin) (04 October 2004):*

> *'31 [misconduct is observed] 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 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.'*

36. The Tribunal also had regard to *Cheatle v General Medical Council [2009] EWHC 645 (Admin) (27 March 2009):*

> *'22 In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both before the misconduct and to the present time, is such as to mean that his or her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct.'*

37. The Tribunal had regard to the test for impairment that was set out by Dame Janet Smith, as cited in the case of *CHRE v Grant and NMC, [2011] EWHC 927 (Admin):*

> *'a) Whether the registrant 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;*

b) Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;

c) Whether the registrant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession.

d) Whether the registrant has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

Also:

'74 In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

The Tribunal's determination on impairment

Deficient professional performance

Is there a legal basis for considering impairment?

38. The Tribunal noted that deficient professional performance is one of the legal grounds for impairment set out in the Guidance and that Dr Igwe had admitted to this. As such, the Tribunal was satisfied that there was a legal basis for considering impairment in relation to Dr Igwe's performance.

Where on the spectrum of seriousness does the allegation lie?

39. The Tribunal considered the evidence of the performance assessments undertaken by the GMC and the findings made and the conclusions reached by the assessors. It noted the parties' submissions that the performance issues were at the lower end of the spectrum of seriousness. It also had regard to paragraph 28 of the Guidance:

'28 Allegations that usually fall at the lower end of the spectrum of seriousness and due to their nature are more likely to be easily remediable include, but are not limited to:

- *clinical failings, including where a doctor has acted without regard for patients' rights or feelings provided this is not a wilful disregard of their wishes'*

40. The Tribunal had regard to the performance assessment conclusions, which included findings that Dr Igwe's professional performance was deemed to be unacceptable in the area of clinical management and was a cause for concern in the areas of assessment of patients' conditions and relationship with patients. The assessors had all concluded that Dr Igwe was fit to practise in a limited capacity.

41. The Tribunal considered the submissions made on behalf of the GMC and Dr Igwe. It decided that its starting point for assessing seriousness was that Dr Igwe's performance issues were at the lower end of the spectrum of seriousness and therefore this was the starting point for determining risk.

42. The Tribunal considered Paragraphs 151, 153, 154, 155, 156, 162, and 164 of the MPTS Guidance: Introduction Case Type 5: Clinical Concerns

'*151. Clinical concerns usually arise in a doctor's working life. A clinical concern describes behaviour or poor performance relating to a doctor's clinical practice or how they discharge a specific role for which they require or use their clinical knowledge, skills or experience. This includes a wide range of activities such as delivering patient care.*

…

153. *Whether the doctor's performance or behaviour amounts to a clinical concern will be judged by considering whether there has been a departure from the professional standards and if so, the extent of that departure.*

154. A clinical concern can incorporate a wide range of actions or omissions, and the doctor's poor performance or behaviour may be directed towards or impact patients, former patients, relatives of patients or colleagues.

The professional standards doctors are expected to meet

155. Good doctors make the care of patients their first concern, work effectively with colleagues, provide a good standard of practice and care and are open and honest when things go wrong. They work within their competence, keep their knowledge and skills up to date and demonstrate leadership within their role

156. Doctors must provide a good standard of practice and care.

…

162. Doctors must be competent in all aspects of their work, including, where applicable, formal leadership roles, management, research and teaching. They must recognise and work within the limits of their competence and keep up to date with guidelines and developments that affect their work.

…

164. Clinical concerns can include a wide range of matters relating to a doctor's behaviour and/or performance at work. A view will need to be reached about where on the spectrum of seriousness the concern or allegation lies with reference to the nature and extent of the departure from the professional standards and considering the presence of any features that increase seriousness. An expert opinion may be available to assist with this depending on the stage of the fitness to practise process the matter has reached. '

43. The Tribunal considered Dr Igwe's performance and whether it amounted to a clinical concern to be judged by whether there had been a departure from the professional standards and if so, the extent of that departure. The Tribunal noted that clinical concerns can incorporate a wide range of actions or omissions and the poor performance may be directed towards or impact patients or colleagues.

44. In terms of the professional standards that doctors are expected to meet, Dr Igwe was expected to make the care of patients his first concern and to work effectively with colleagues to provide a good standard of care. He had put his own interests above the interests of the patients. He was required to work within the level of his competence and to keep his knowledge and skills up to date. He had put himself forward for roles he did not have the qualifications and/or experience for. He was required to provide a good standard of practice and care and if a task was delegated to him that he was not confident that he had the necessary knowledge, skills and training to carry out safely, he was required to prioritise patient safety and seek help. Dr Igwe was required to be competent in all aspects of his work and was required to recognise and work within the limits of his competence. He failed to do this by putting himself up for roles that he did not have the qualification, training and/or experience to undertake and falsifying references to support his job applications.

45. The Tribunal noted that the MPTS Guidance indicates that clinical concerns can include a wide range of matters relating to a doctor's behaviour and/or performance at work and that a view would need to be reached about where on the spectrum of seriousness the concern or allegation lies with reference to the nature and the extent of the

departure from the professional standards and considering the presence of any features that may increase seriousness. An expert opinion may be available to assist the Tribunal with this depending on the stage of the proceedings.

46. The Tribunal considered the performance assessment report. A Performance Assessment was carried out of Dr Igwe by Mr G (Team Leader), Dr H (Medical Assessor) and Dr I (Medical Assessor), between 24-25 February 2025. The report set out the following:

'The Assessment Team's formal opinion, given under The General Medical Council (Fitness to Practise) Rules 2004 is that Dr Igwe's professional performance has been deficient. Dr. Igwe is fit to practise on a limited basis.

Dr Igwe's performance was assessed under the categories listed below and with reference to the professional standards in the GMC Publication Good Medical Practice. The Team's overall assessment for each category is shown below.

Category	*Overall Assessment*
Maintaining Professional Performance	*Acceptable*
Assessment of Patients' Condition	*Cause for concern*
Clinical Management	*Unacceptable*
Operative/Technical Skills	*Insufficient evidence*
Record-Keeping	*Insufficient evidence*
Relationship with Patients	*Cause for concern*
Working with Colleagues	*Acceptable*

Dr Igwe demonstrated that he had an acceptable level of knowledge in paediatric and adult medicine. He was aware of guidelines relevant to his specialty although lacked detailed knowledge of some guidance. He did demonstrate the ability to reflect on his performance. The Team did not identify a risk to patient safety. The overall judgment in the **Maintaining** *domain was* **acceptable**.

There were mixed findings in the **Assessment** *domain. He demonstrated that he could obtain a satisfactory history and safely examine patients. There was little information obtained about investigations in this area. His comments regarding need for radiological assessment in a suspected case of NAI* (Non-Accidental Injury) *may be related to lack of detailed knowledge of guidelines as highlighted in the Maintaining domain. He did not reach an acceptable standard of making a differential diagnosis,*

but the Team agreed that this was unlikely to be a risk to patient safety in actual practice. The overall judgment in this category was therefore ***cause for concern****.*

In the ***Management*** *domain, he did demonstrate acceptable performance in some areas for example with breast feeding advice and management of febrile convulsions. His prescribing skills did not reach an acceptable standard in the OSCE* (Objective Structured Clinical Examination)*. He gave unclear advice regarding management of an NAI, pyrexia and reoccurrence of a febrile convulsion. His advice regarding hypoglycaemia was incorrect which may be related to unclear knowledge of relevant guidelines as discussed in the Maintaining domain. His performance in the Basic Life Support* (BLS) *Station did not reach an acceptable standard. The Team judged that the findings around prescribing and BLS could pose a risk to patient safety. The overall conclusion in this domain was therefore* ***unacceptable****.*

There was insufficient data to make a judgment in the ***Skills and Records*** *domains.*

There were mixed findings in the ***Patients*** *domain. He did demonstrate kindness, courtesy and respect for parents and children. There were no issues with obtaining informed consent. He did use some jargon and his explanations to parents were unclear and inaccurate at times. The Team judged that there was no risk to patient safety in this domain but his performance did not reach an acceptable level on some occasions. The overall judgment was therefore* ***cause for concern****.*

Dr Igwe consistently demonstrated that he worked well in a team and communicated well with colleagues. There were mixed findings in a teaching station in the OSCE, but the Team agreed that his performance did reach an acceptable level. The overall judgment in the domain of Colleagues was ***acceptable****.*

The Team received four documents from Dr Igwe and his Solicitor following the assessment. The Team acknowledged that Dr Igwe did not agree with many of [Dr M's] statements in the TPI (Third Party Interviews)*. Her comments only contributed a small amount to the evidence considered in the report. The Team were not in a position to investigate allegations that her comments were inaccurate or biased.*

The Team note that Dr Igwe has completed his Neonatal life support training since the assessment. They also note his plans to complete the Advanced Paediatric Life Support Training and the final theory examination of the MRCPCH (Member of the Royal College of Paediatrics and Child Health)*.*

The Team's opinion was that Dr Igwe's performance has been deficient. His core knowledge was satisfactory; although he was aware of relevant guidelines, he was not familiar with some of the actual guidance. Although he could take a history and examine patients at an acceptable level, he was unable to diagnose a common neonatal disease and was unable to outline the relevant differential diagnoses in neonates with jaundice and vomiting. His advice about management of neonatal hypoglycaemia was incorrect. His performance with prescribing and basic life support did not reach an acceptable standard and could lead to patients being put at risk. His explanations to parents could be unclear.

The Team agreed that Dr Igwe was fit to practise on a limited basis.

Recommendations:

The Assessment Team's recommendations for future management of Dr Igwe's case are set out below.

After discussions at the RRD (Report Review Day)*, the Team agreed on the following recommendations:*

- *Dr Igwe should work at the level of an F2 doctor*
- *He should not undertake locum work*
- *He should be subject to close supervision of his work during normal working hours.*
- *He should be directly supervised in "out of hours" work.*
- *He should be directly supervised when attending deliveries of a newborn baby.*
- *The degree of supervision could be gradually relaxed if his supervisor is satisfied that Dr Igwe has made sufficient progress.'*

47. The Assessment Team's conclusions that Dr Igwe's performance was a 'Cause for concern' in categories of Assessment of Patients' Condition and Relationships with Patients, and 'Unacceptable' in the area of Clinical Management and overall conclusion that his professional performance was deficient and that he was fit to practise on a limited basis are reflected in allegations 12-14 which Dr Igwe has admitted.

48. The Tribunal noted that Dr Igwe had demonstrated acceptable performance in some areas. However, there were other areas that had given the assessors cause for concern. It considered whether there were any features of Dr Igwe's deficient performance that increased the seriousness. The Tribunal noted that he was at an early stage in his

career and the performance issues were over a relatively limited timeframe. No features increasing seriousness were identified by the Tribunal.

49. As such, the Tribunal determined that the performance issues remained at the lower end of seriousness and that, therefore, the starting point for assessing risk to public protection was that it was low.

What is the impact of any relevant context known about Dr Igwe and/or their working environment?

50. The Tribunal considered the impact of any relevant context known about Dr Igwe. First it identified if there was any relevant context – working environment, role and experience or other personal context. The Tribunal considered the submissions made by the GMC and on behalf of Dr Igwe and decided that there was relevant context. The Tribunal concluded that it was relevant context that Dr Igwe was a foreign doctor, at an early stage in his career, had only recently arrived in the UK and that this was his first job with in the NHS so he may not have been fully aware of the standards and procedures in the UK. The Tribunal also noted and considered it relevant that Dr Igwe had stated he had limited support and supervision at the time as he was working as a *'floating doctor'*.

51. Next, the Tribunal considered whether the relevant context identified directly or indirectly affected Dr Igwe's performance and if so, whether it was appropriate to take that context into account. The Tribunal determined that the relevant context identified may have affected Dr Igwe's performance and that it was appropriate to take that context into account but it acknowledged that Dr Igwe had put himself in that position by dishonestly applying for a role that he did not have the qualification and/or experience to undertake.

52. The Tribunal then considered what impact the relevant context had on the level of risk. It was submitted by Mr Brook on behalf of the GMC that there is no information to suggest that there were systems factors or interpersonal factors outside of Dr Igwe's control which had an impact on his actions, such that its seriousness could be mitigated. It was submitted on behalf of Dr Igwe that the relevant context identified above should mitigate the risk in his case.

53. Overall, the Tribunal considered that these factors did not impact the level of risk to public protection in Dr Igwe's case. In reaching this decision, the Tribunal took into account the fact that Dr Igwe's personal context was that he was in a role that he was

not qualified for, which inevitably impacted his performance. This was of his own making.

How has Dr Igwe responded to the allegations?

54. The Tribunal considered how Dr Igwe had responded to the allegation relating to his performance.

Insight

55. First, the Tribunal considered what evidence there was relating to insight, it assessed if the insight was genuine. The Tribunal considered the witness statement of Dr Igwe, his reflection statement, witness statements of the referees and submissions made by the GMC and by Mr Puar on Dr Igwe's behalf. The Tribunal concluded that Dr Igwe has shown some acknowledgment of some of the shortcomings in his performance. The assessors remarked on Dr Igwe showing the ability to reflect on his performance. However, the Tribunal concluded that Dr Igwe had shown only limited insight into his deficient professional performance.

56. In his witness statement, Dr Igwe stated:

'338. When I underwent the GMC Performance Assessment, I genuinely believed that I was a safe doctor. I recognised that I had experienced significant challenges when I first started working within the NHS, particularly adapting to different clinical systems, documentation standards and neonatal practice. However, I believed that many of the concerns arose because of my difficult induction, limited supervision during my initial weeks and unfamiliarity with NHS processes. Although I accepted that I had areas requiring improvement, I underestimated the extent to which gaps in my clinical reasoning, application of guidelines, prescribing, communication and emergency management affected my overall performance.

339. Looking back, I now recognise that I viewed clinical competence too narrowly. I believed that having good medical knowledge and good intentions was sufficient to practise safely. I failed to appreciate that safe medical practice requires the consistent application of knowledge under pressure, effective communication, awareness of one's own limitations and strict adherence to current evidence-based guidelines. The Performance Assessment demonstrated that competence is

measured not only by what a doctor knows, but by what the doctor consistently does in practice.

…

341. The Performance Assessment identified deficiencies in several important including patient assessment, clinical management, prescribing, communication with patients and Basic Life Support, while acknowledging that my core medical knowledge and teamwork were acceptable…

342. Reflecting honestly, I recognise that my biggest weakness was not a lack of commitment to patient care but an overestimation of my readiness to practise independently within the NHS. I had not fully appreciated the importance of mastering local clinical guidelines, structured clinical reasoning, recognising deteriorating patients, communicating complex information clearly to families and understanding that every prescribing decision carries significant responsibility.'

57. The Tribunal considered that Dr Igwe had acknowledged there were some deficiencies in his professional performance but appeared to still consider that he was a good doctor, his deficiencies only occurring in relation to processes and guidelines etc. His reflection statement does not show that he has a full understanding of the risk of harm posed to the public by him putting himself forward for roles that he did not have the qualification and/or experience to undertake.

58. The Tribunal determined that Dr Igwe's insight was incomplete. He had not shown adequate reflections on the fact his role was obtained through dishonest means, nor had he shown any understanding of the potential risk posed to the public by obtaining his role in this way. The Tribunal considered that Dr Igwe's insight, such as it was, was limited and had only been developed because he had no option other than to address the clinical concerns.

Remediation:

59. The Tribunal considered what evidence there was relating to Remediation, it assessed if the allegation was remediable, whether it had been remedied by Dr Igwe and if it was likely to be repeated.

60. The Tribunal considered evidence of remediation steps taken by Dr Igwe. He had completed Neonatal Life Support training, the Advanced Paediatric Life Support training and the final theory examination of the MRCPCH, following their assessment. He has

also completed a clinical attachment with Dr E and Dr E has provided a report. However, the Tribunal noted no oral evidence had been given by Dr Igwe, Dr E or any other witnesses in Stages 1 and 2 relating to Dr Igwe's clinical practice.

61. The GMC submitted that it has had no opportunity to test or challenge the evidence provided by and on behalf of Dr Igwe relating to insight and/or remediation. However, it was accepted by Mr Brook on behalf of the GMC that some of the training undertaken by Dr Igwe and examination passed will have reduced some of the ongoing risk in Dr Igwe's case.

62. The Tribunal concluded that some of the remediation steps undertaken by Dr Igwe such as completing Neonatal life Support training, advanced paediatric life support training and passing the final theory examination of the MRCPCH following their assessment will have the effect of reducing some of the current and ongoing risk in his case. However, in relation to the clinical attachment, no oral evidence was provided in these proceedings by Dr Igwe or by Dr E about the clinical attachment undertaken by Dr Igwe. There was an assessment by Dr E as an educational supervisor and case- based discussions are stated to have taken place on three dates in March 2026. The assessment commenced in March 2026. The Tribunal concluded that it was unable from the limited information available to it to properly assess the full nature and extent of the clinical attachment, its scope and duration and the extent to which it had fully addressed any deficiencies identified in Dr Igwe's professional performance. Consequently, the Tribunal decided that it could only place limited weight on the witness statement of Dr Igwe and report of Dr E relating to the work undertaken in the clinical attachment.

Risk of Repetition

63. The Tribunal considered whether the issues relating to performance were likely to be repeated. The Tribunal concluded from the available evidence that Dr Igwe had undertaken some remediation in relation to his clinical failings. He had undertaken a clinical attachment, completed a BLS certificate, had undertaken Neonatal and Advanced Paediatrics life support training and had passed his final theory exam for the MRCPCH. The Tribunal considered that this would mean there was less likely to be a risk of repetition but, given the limited insight into the issues shown by Dr Igwe, the Tribunal concluded that there remains a low risk of repetition. This would be the case until Dr Igwe develops a full understanding of all underlying issues and those issues are effectively addressed.

Has the doctor kept his knowledge and skills up to date

64. The Tribunal acknowledged the considerable steps taken by Dr Igwe to keep his knowledge up to date through training undertaken and passing the MRCPCH examination. However, it noted that in terms of clinical skills, Dr Igwe has been on suspension since 2 April 2025 and prior to that he was working under an Interim Order of Conditions. It is therefore difficult in the circumstances to conclude that he has kept his clinical skills up to date.

What impact do these factors (Insight, Remediation, Risk of Repetition, Knowledge & Skills) have on the level of risk

65. The Tribunal has acknowledged steps taken by Dr Igwe to bring his clinical performance up to the required standard but given its conclusion that there is limited insight, and also limited qualitative evidence of how some of the clinical deficiencies have been addressed in a clinical setting, these factors do not have any impact on the level of risk.

Tribunal's decision as to whether Dr Igwe poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

66. The Tribunal considered whether Dr Igwe poses any current and ongoing risk to public protection which may require restrictive action in response. The Tribunal considered which parts of public protection were engaged, the reasons why those parts of public protection were said to apply in Dr Igwe's case.

67. In considering the impact on public protection, the Tribunal referred to the MPTS Guidance Introduction Case Type 5: Clinical Concerns.

68. Impact on public protection

Part of public protection	How it might be engaged
Protecting, promoting and maintaining the health, safety and well-being of the public (patient safety)	Where a clinical failing has, or could have, impacted on patient care, there is a clear risk to patient or public safety.
Promoting and maintaining public confidence in the profession (public confidence)	Patients must be able to trust doctors with their lives and health. They must be confident that they will be treated by a doctor working within their area

	of competence and to an appropriate clinical standard. In a very small number of cases, even if the specific clinical failing is unlikely to recur, the behaviour or performance giving rise to the concern might be such that it undermines the public's trust in the professions. Public confidence in the profession is more important than the interests of an individual doctor.
Promoting and maintaining professional standards and conduct (upholding professional standards)	Good medical practice sets the standards of conduct that doctors are expected to meet when carrying out their clinical duties within their professional practice. Doctors are also expected to follow other clinical guidance or guidelines relevant and applicable to their area of work as published by other regulatory or professional bodies.

69. The Tribunal concluded that all three limbs of public protection were engaged in Dr Igwe's case.

Patient Safety

70. Dr Igwe's actions in applying for roles he did not have the experience or qualifications for could have, impacted on patient care, posing a clear risk to patient or public safety.

Public confidence

71. Public confidence in the medical profession is more important than the interests of an individual doctor. Patients must be able to trust doctors with their lives and health.

They must be confident that they will be treated by a doctor working within their area of competence and to an appropriate clinical standard. Dr Igwe was carrying out a role he did not have the qualifications and/or experience to undertake. He gained the employment by submitting false applications and references. He was not working within the area of his competence. He put his interests above that of patients. He will have undermined public confidence that the public will have that they will be treated by a doctor working within their area of competence to an appropriate clinical standard.

Upholding Professional Standards

72. Good medical practice sets the standards of conduct that doctors are expected to meet when carrying out their clinical duties within their professional practice. Doctors are also expected to follow other clinical guidance or guidelines relevant and applicable to their area of work as published by other regulatory or professional bodies. The Performance Assessment Reports shows that the Assessors found his clinical practice to be deficient and did not meet the professional standards expected. The Team's opinion was that Dr Igwe's performance has been deficient. His core knowledge was satisfactory; although he was aware of relevant guidelines, he was not familiar with some of the actual guidance. Example given although he could take a history and examine patients at an acceptable level, he was unable to diagnose a common neonatal disease and was unable to outline the relevant differential diagnoses in neonates with jaundice and vomiting. His advice about management of neonatal hypoglycaemia was incorrect. His performance with prescribing and basic life support did not reach an acceptable standard and could lead to patients being put at risk. His explanations to parents could be unclear. This limb of public protection was therefore engaged.

73. The Tribunal considered Paragraphs 168, 169 and 171 of the MPTS Guidance

'Decision on impairment

168. Allegations relating to clinical concerns can fall at the lower, mid-range or higher end of the spectrum of seriousness depending on the circumstances of the case. This means the starting point for assessing current and ongoing risk to public protection could be low, medium or high.

169. Where the starting point for assessing risk is low, evidence of relevant context known about the doctor and/or their working environment and evidence of insight and remediation that decrease risk, will usually have more impact. This is because

the risk to public protection, including the impact on public confidence, arising from clinical concerns falling at the lower end or mid-range of the spectrum of seriousness are generally easier to address.

…

171. Where an allegation about a clinical concern leads to a finding of impairment, it may engage one or more of the three parts of public protection. Whilst the MPT must consider the individual circumstances of the case, it will be unusual for a proven allegation about a clinical concern not to impact on patient safety.'

74. The Tribunal determined that on the basis of the conclusions reached above that Dr Igwe posed a current and ongoing risk to public protection that requires restrictive action in response. The Tribunal concluded as set out above that all three limbs of public protection were engaged. The level of risk is low due to some of the steps taken by Dr Igwe towards remediation of his deficient performance. However considering the assessment report, the findings and conclusions reached by the Assessment Team and their recommendations as set out above, the Tribunal decided that there is a current and ongoing risk that still remains in Dr Igwe's case. The Tribunal was not yet convinced on the basis of the available evidence of Dr Igwe's current clinical skills and competence.

75. The lack of evidence of Dr Igwe's current clinical skills, coupled with his limited insight, meant that in relation to performance, the Tribunal considered there remained a risk to public protection, albeit low, and that a finding of impairment was necessary due to the current and ongoing risk to public protection.

76. The Tribunal has therefore determined that Dr Igwe's fitness to practise is impaired by reason of deficient professional performance.

Misconduct

77. The Tribunal then went on to consider Dr Igwe's dishonesty.

Is there a legal basis for considering impairment?

78. The Tribunal considered whether there was a legal basis for considering impairment under this ground. The Tribunal considered the definition of Misconduct and whether the proven facts engaged this ground. The Tribunal reminded itself that misconduct is about behaviour. It could consist of acts and/or omissions arising in or outside of a doctor's working life and includes failing to act appropriately or demonstrating

behaviour that falls short of what can reasonably be expected. To amount to misconduct, the behaviour will be a serious departure from the professional standards, as set out in Good Medical Practice.

79. In approaching its decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amount to misconduct and that the misconduct is serious and then whether the finding of that misconduct which is serious, poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

80. The Tribunal reminded itself that Dr Igwe had admitted to dishonestly completing a range of application forms, including after he was under investigation by the GMC and subject to conditions, and to dishonestly defending his position and qualifications to Dr A. The MPTS Guidance: Introduction Case Type 2 Dishonesty indicates that doctors are expected to be honest and act with integrity, dishonest behaviour will usually amount to a significant breach of the professional standards.

81. The Tribunal had regard to the case of *Roylance v GMC (No 2) [2000] 1 AC 311* set out above. Dr Igwe's actions involved acts or omission which fell short of what would be regarded as proper in the circumstances.

82. The Tribunal considered whether it was "serious misconduct" and had regard to the case of *Nandi v General Medical Council [2004] EWHC 2317 (Admin) (04 October 2004)*. It concluded that Dr Igwe's misconduct was serious misconduct. He had by his actions fallen short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short was serious. He had provided false information about his qualifications and/or experience on his application forms and had misled future employers and when challenged had resorted to further untruths.

83. The Tribunal had regard to both the 2013 and 2024 editions of GMP, both of which indicate that honesty and integrity is a fundamental tenet of the profession. From the 2024 edition of GMP:

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

82 You must always be honest about your experience, qualifications, and current role. You should introduce yourself to patients and explain your role in their care.

…

98 To maintain patient safety, you must cooperate with formal inquiries, patient safety investigations, and complaints procedures. You must provide all relevant information and be open and honest.

…

100 If you are suspended by an organisation from a healthcare role or post requiring professional registration, or have restrictions placed on your practice, you must, without delay, inform any organisations for which you carry out medical work, and any patients you see independently of these organisations.'

84. The Tribunal considered that Dr Igwe's dishonesty breached these paragraphs of GMP, noting that it occurred within his professional role, and that it amounted to serious professional misconduct.

85. As such, the Tribunal was satisfied that there was a legal basis to consider impairment based on misconduct.

Where on the spectrum of seriousness does the allegation lie?

86. The Tribunal considered where on the spectrum of seriousness the allegation lies. It had regard to paragraph 87 of the Guidance Introduction:

'87 Whilst a range of behaviour can be seen, the nature of the departure from the standards expected may mean that a concern or allegation relating to dishonesty falls at the high end of the spectrum of seriousness. Even a single incident of dishonesty can have a significant harmful impact and pose a risk to public protection.'

87. The Tribunal also had regard to paragraph 31 of the Guidance:

'31 Allegations that are likely to fall at the higher end of the spectrum of seriousness include, but are not limited to:

…

- *dishonesty, other than where it occurred outside of the doctor's professional role and was not persistent or repeated, and the value or other benefit derived was not significant.'*

88. The Tribunal identified the starting point for assessing seriousness. The Tribunal considered that Dr Igwe's case fell into these paragraphs of the Guidance and that it fell at the upper end of the spectrum of seriousness.

89. The Tribunal then considered if there were any features that increased the seriousness of the allegation. The MPT's decision on where on the spectrum of seriousness the allegation lies must reflect (a) the starting point for assessing seriousness based on the nature of the allegation and (b) the impact of specific features about the allegation which may increase seriousness.

90. Paragraphs 34, and 35 of the MPTS Guidance Section 3: Hearings Stage 2: Impairment provide as follows:

> '*Features which may increase the seriousness of an allegation*
>
> *34. In all cases, there may be specific features about the allegation and departure from the professional standards which may increase its seriousness. These features may be seen in any type of case and where present may increase where on the spectrum of seriousness the allegation lies.*
>
> *35. The MPT should identify any relevant features and consider the extent to which they are present to decide how much weight to attach to them. This will help the MPT explain what, if any, impact each relevant feature has and decide where on the spectrum of seriousness the allegation falls.'*

91. Paragraph 36 of the Guidance outlines features of the allegation that may increase seriousness. They include the following which are relevant in Dr Igwe's case:

> *'a) The behaviour or poor performance was persistent or repeated over a long time. Behaviour or poor performance will be persistent or repeated where the same, or similar, act(s) or omission(s) occur(s) multiple times and/or where an act or omission continues over a prolonged period.'*

92. Dr Igwe's dishonesty was premeditated, persistent and repeated, which increased the seriousness. He had dishonestly completed a multitude of application forms. The misconduct also took place over a prolonged period of time.

> *b) Premeditated behaviour. This is characterised by the doctor having acted intentionally and with planning.'*

93. Dr Igwe's actions were premeditated and there was a degree of planning involved.

c) A reckless disregard of patient safety or professional standards. A reckless disregard for patient safety is where a doctor knew, or ought to have known, that their behaviour, was causing harm, or risked causing harm, to patients and should have taken steps to prevent this, or where they deliberately closed their mind to the existence of such a risk. A reckless disregard for professional standards is where a doctor knew, or ought to have known, they should have followed professional guidance and chose not to do so without having first considered any associated risks and taking reasonable steps to mitigate them. This may include failing to take reasonable steps to check that information provided to others, or written in documents, is correct and that relevant information has not been left out.'

94. The Tribunal considered that Dr Igwe had shown a reckless disregard for patient safety and/or professional standards by trying to obtain positions for which he was not qualified. This risked causing harm to patients and showed a reckless disregard for the professional standards expected from medical professionals.

d) Putting their own interests before those of patients. This occurs when a doctor puts their personal interests above those of a patient in a way that could compromise their judgment, decisions or actions.'

95. Dr Igwe acted in a way that put his own interests in securing a job before the interests of patients who would be expecting a suitably trained and qualified doctor to be in charge of their health and care.

e) An attempt to hide and/or avoid taking responsibility for behaviour. A doctor must be open and honest if things go wrong. Where, at the time of the circumstances giving rise to the allegation, they attempt to hide unacceptable behaviour or responsibility for behaviour or poor performance poor performance or avoid taking responsibility for their behaviour or poor performance by blaming others for their own acts or omissions, this can have a negative impact on patient safety and/or workplace culture. This type of behaviour can only arise in a doctor's working life.'

96. When Dr Igwe was challenged by Dr A, he denied wrongdoing. He sought to avoid taking responsibility by trying to shift blame to a virtual assistant.

97. Having identified the individual circumstances of Dr Igwe's case and the presence of features increasing the seriousness of the allegation, the Tribunal concluded that Dr

Igwe's misconduct was at the high end of the spectrum of seriousness and that its starting point for assessing the risk to public protection was therefore high.

What is the impact of any relevant context known about Dr Igwe and/or their working environment?

98. The Tribunal considered the impact of any relevant context known about Dr Igwe and/or his working environment.

99. First it identified if there was any relevant context arising from the working environment, his role and experience or his personal context. The Tribunal bore in mind the context put forward by Mr Puar, including the fact that Dr Igwe was a foreign doctor in the UK with immigration status dependent upon his employment, at an early stage in his career, the fact that he had panicked because of his potential loss of his visa at the end of his employment, his fear of returning to Nigeria, security issues in Nigeria, his personal pride and his financial concerns. The Tribunal also noted Dr Igwe's assertions of the limited support and supervision he received in his position as a "*floating doctor*".

100. The Tribunal then went on to consider whether the relevant context identified directly or indirectly affected Dr Igwe's behaviour. If so, whether it was appropriate to take it into account.

101. It was submitted by Mr Brook on behalf of the GMC that there is no information to suggest that there were systems factors or interpersonal factors outside of Dr Igwe's control which had an impact on his actions, such that its seriousness could be mitigated. It was submitted on behalf of Dr Igwe that the relevant context identified above should mitigate the risk in his case.

102. Considering the submissions made on behalf of Dr Igwe about relevant context, the Tribunal noted it had heard no oral evidence from Dr Igwe about his personal circumstances, his family circumstances and what the nature of his financial commitments were and why he was concerned about returning to Nigeria. Even if it was established that they were in financial difficulty, that would not justify a medical doctor acting dishonestly and putting patients at risk of harm by taking on roles they were not qualified to undertake. The Tribunal also noted the GMC submission that Dr Igwe had since returned to Nigeria and had taken on work there with no issues arising. The Tribunal concluded from all the available evidence that Dr Igwe's dishonesty was purely for financial gain, seeking employment that he knew he was not qualified for.

103. The Tribunal accepted that Dr Igwe had trained in Nigeria and had only recently come to work in the UK, where policies and procedures may be different. However, the Tribunal considered that it was incumbent on doctors to apprise themselves of relevant policies, procedures and standards. It also reminded itself that Dr Igwe was not qualified for his role at LGT in the first place.

104. The Tribunal did not accept Dr Igwe's explanation that he was panicked about the end of his employment as he was on a fixed term contract and so would have known that his contract would come to an end when it did.

105. The Tribunal considered the submissions made about the stage of Dr Igwe's career and the relevance of that to the allegation. It concluded that being a junior doctor or having trained abroad had no impact on the need for, and expectation of, honesty and integrity on the part of all doctors.

106. The Tribunal considered what impact any relevant context identified on the level of risk in Dr Igwe's case. In doing so the Tribunal reminded itself of Paragraph 50 of the Guidance which states that evidence of relevant context that may decrease the level of risk will usually carry less weight in cases that fall at the higher end of the spectrum of seriousness.

107. The Tribunal concluded that any relevant context identified in Dr Igwe's case had no impact on the level of risk to public protection.

How has Dr Igwe responded to the allegations?

108. The Tribunal considered how Dr Igwe had responded to the allegation of misconduct.

Insight

109. The Tribunal considered what evidence there was relating to insight and assessed whether the insight was genuine. It considered Dr Igwe's witness statement and reflective piece, evidence relating to CPD courses undertaken and the witness statements provided by the character referees. The Tribunal noted that the GMC had not been able to verify the character references due to late submission, and it was accepted on behalf of Dr Igwe that the GMC allegations had not been provided to those providing the references.

110. The Tribunal considered the contents of these documents and the submissions made by the parties. The Tribunal noted what Dr Igwe had set out in his witness statement and reflection statement about the impact of the CPD courses on his insight. The Tribunal found those comments to be unconvincing. Honesty is a fundamental tenet of the medical profession. GMP states that good doctors are honest and will act with integrity and in accordance with the law. The public would not expect a doctor to misrepresent his qualifications and/or experience. It should not require attendance of a CPD training course to recognise that.

111. In assessing whether the insight was genuine or not, the Tribunal considered the chronology of the case and Dr Igwe's actions throughout and the stage when he first accepted wrongdoing. The Tribunal noted that when Dr Igwe was first challenged by Dr A, his initial response was to maintain the lies and he entrenched his position. He did not take responsibility. Instead, he tried to avoid responsibility by blaming someone else.

112. The Tribunal also noted that when Dr Igwe was facing proceedings by the GMC, his Regulator he still continued to act dishonestly. Even after interim order of conditions were imposed by the Interim Order Tribunal, Dr Igwe continued to lie and to submit false applications. This ultimately led to the interim order of suspension.

113. Dr Igwe first became aware that he was under investigation by the GMC on the 3rd of September 2024. It was not until July 2026 when he finally admitted wrongdoing taking responsibility for his actions and it was during these proceedings that he accepted that he had used the virtual assistant to deflect blame from himself and that he had acted dishonestly.

114. Dr Igwe had stated that it was his attendance on the CPD courses that led him to understand the need to be honest as a doctor. The Tribunal noted that the CPD courses were only undertaken a few months ago in March 2026.

115. It was submitted on Dr Igwe's behalf that he had been on a journey in terms of his insight.

116. The Tribunal concluded that the chronology of the events and Dr Igwe's response throughout shows that Dr Igwe does not have genuine insight. The Tribunal did not find Dr Igwe's reflections from his attendance of CPD courses to be convincing. The insight has also been developed very late in these proceedings., which have been going on for some time. The Tribunal was concerned that Dr Igwe only allegedly developed an

understanding of the need for honesty after completing online CPD courses. Not misrepresenting qualifications is basic honesty that should be apparent to any doctor without the need for specific training.

117. The Tribunal reminded itself that Dr Igwe's initial response was to deny wrongdoing, then to blame a virtual assistant. Dr Igwe denied his wrongdoing to Dr A and entrenched himself in his lie.

118. The Tribunal considered that Dr Igwe's statements appeared to be insincere, particularly in light of the fact that he continued to be dishonest even after knowing that he was under investigation for dishonesty, continuing to submit dishonest application until at least 4 January 2025. Since this point, Dr Igwe had given various different accounts and explanations, not making admissions until July 2026. The Tribunal did not accept that this was a journey, rather it considered that Dr Igwe had realised he had no other option but to make admissions. Any insight that Dr Igwe may have was only developed very recently.

Remediation:

119. The Tribunal then went on to consider what evidence there was relating to remediation. It assessed whether the allegation was remediable, and if it had been remedied by Dr Igwe and if it was likely to be repeated.

120. The Tribunal considered the evidence relating to steps taken by Dr Igwe to remediate his misconduct. It reminded itself that dishonesty is difficult to remediate as it may indicate an attitudinal issue on the part of the doctor.

121. The Tribunal had regard to Dr Igwe's witness statement and reflection statement, his letter of apology to Dr A and his evidence of CPD courses being completed. The Tribunal noted that it had not heard any oral evidence from Dr Igwe about how his behaviour had changed or how he would act differently in the future so it was difficult to gauge the effect of any remediation steps.

122. The GMC submitted that the Tribunal should give only limited weight to the witness statement of Dr Igwe, his reflection statement and other evidence of remediation steps put forward on Dr Igwe's behalf because it had not had the opportunity to challenge the evidence as Dr Igwe elected not to give oral evidence during Stage 2 of these proceedings. Mr Puar submitted that the GMC had not indicated that it opposed the defence evidence being admitted. The Tribunal considered it could only give limited

weight to Dr Igwe's written statements about the steps taken to remediate because no oral evidence was provided by Dr Igwe or any other witnesses and there was no opportunity for the evidence provided to be challenged in cross-examination. Submissions were made by both parties which the Tribunal took into account in reaching its overall conclusions.

123. The Tribunal accepted that Dr Igwe had completed the CPD courses that had been provided but was concerned and unconvinced about Dr Igwe's reflections following attendance of the training courses that the need for honesty was such a revelation to him, seemingly only revealed following these courses.

124. The Tribunal concluded that Dr Igwe had neither remediated nor developed full insight into his misconduct.

Risk of Repetition:

125. The Tribunal considered whether the misconduct was likely to be repeated.

126. Mr Brook submitted on behalf of the GMC that overall, despite Dr Igwe's recent admissions, the dishonesty in applying to LGT, the ongoing repeated dishonesty and further dishonesty by Dr Igwe when responding to the allegation, introducing a virtual assistant "Mr J" all mean that there is no basis for concluding that the ongoing risk to public protection arising from the allegations has decreased.

127. He submitted that Dr Igwe had stated in his witness statement that the dishonesty arose when his contract came to an end and he was concerned about the end of his employment and having to return to Nigeria. He submitted that Dr Igwe's first job at LGT was obtained dishonestly and further that it was a fixed term contract so Dr Igwe should have known that it would come to an end at the end of the contract term.

128. Mr Puar submitted that there was no risk of repetition due to the fact that Dr Igwe now has a visa so no more fear of returning to Nigeria. He had also undertaken successful remediation.

129. In the light of its conclusions that Dr Igwe had no full insight and had not remediated his misconduct, the Tribunal concluded that the risk of Dr Igwe repeating his misconduct was significant.

130. In reaching this conclusion, the Tribunal reminded itself that dishonesty can be difficult to remediate. The chronology of the case showed that Dr Igwe was consistently dishonest, including when challenged. His actions included the initial dishonest application to LGT, the ongoing repeated dishonesty in further job applications as set out in the allegation. The actions also included Dr Igwe maintaining his dishonesty when he was initially challenged by Dr A. He continued to maintain the dishonesty even when facing proceedings from his Regulator, the GMC. The Tribunal noted the fact that Dr Igwe had introduced the role of a virtual assistant and noted the lengths he went to in order to deflect blame for his dishonest actions to another person. Finally, the Tribunal noted with concern his behaviour when he was subject to an interim order of conditions which led to the interim order of suspension being imposed. The Tribunal concluded that overall Dr Igwe's actions all indicated a strong likelihood of him continuing to act dishonestly in the future.

Consider if the doctor has kept his knowledge and skills up to date

131. In relation to Dr Igwe's efforts to keep his clinical knowledge and skills up to date, the Tribunal referred back to its observations in relation to his performance. It acknowledged the steps taken by Dr Igwe in relation to keeping his knowledge and skills up to date.

Conclusion on impact of these factors (insight, remediation etc) on the level of risk:

132. The Tribunal considered what impact these factors had on the level of risk posed by Dr Igwe. The Tribunal reminded itself of Paragraph 80 of the MPTS Guidance which states that evidence of insight and remediation will usually carry less weight where the allegation falls at the higher end of the spectrum of seriousness. It also noted Paragraph 91 of the MPTS Guidance: Introduction Case Type 2 Dishonesty which states that in dishonesty cases, evidence of relevant context known about the doctor … and evidence of insight and remediation that decrease risk may have less impact because dishonesty allegations falling at the higher end of the spectrum of seriousness can be more difficult to remediate.

> *91. In these cases, evidence of relevant context known about the doctor and/or their working environment and evidence of insight and remediation that decrease risk may have less impact because dishonesty allegations falling at the higher end of the spectrum of seriousness can be more difficult to remediate.*

133. The Tribunal having concluded that there was no genuine insight, and no remediation in relation to the misconduct, determined that Dr Igwe's response to the allegations did not reduce the risk to public protection, which remained high.

Tribunal's decision as to whether Dr Igwe poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

134. On the basis of the conclusions reached above, the Tribunal then went on to decide if Dr Igwe poses any current and ongoing risk to public protection. The Tribunal considered which parts of public protection were engaged and the reasons why they were engaged.

135. The Tribunal referred to relevant Paragraphs of the MPTS Guidance: Introduction Case Type 2 Dishonesty: Paragraph 87 and relevant extracts from the table on impact on public protection, 91, 92, 93 and 94

> '87. *Whilst a range of behaviour can be seen, the nature of the departure from the standards expected may mean that a concern or allegation relating to dishonesty falls at the high end of the spectrum of seriousness. Even a single incident of dishonesty can have a significant harmful impact and pose a risk to public protection.'*

136. Impact on public protection: (some extracts from table)

Part of public protection	How it might be engaged
Protecting, promoting and maintaining the health, safety and wellbeing of the public (patient safety)	Where dishonest behaviour has impacted, or could impact on patient care, there is a clear risk to patient or public safety. Examples include: ➢ providing false or misleading references or information on a CV resulting in the doctor being appointed for a role they do not have the skills to perform safely. Where a doctor is dishonest in their interactions with colleagues, this can cause breakdowns in communication

	and/ or in the collaborative working needed to deliver safe patient care.
Promoting and maintaining public confidence in the profession (public confidence)	Patients and members of the public must have confidence in doctors to behave professionally and act with honesty and integrity. Dishonesty arising inside, or related to, a doctor's professional practice may result in a breakdown of trust and undermine public confidence. Dishonesty related to matters outside the doctor's clinical responsibility, such as providing false statements …, can undermine public confidence. The public should be able to trust the integrity of medical professionals, and where a doctor undermines that trust it may risk public confidence in the profession. Dishonesty arising outside a doctor's professional practice can also undermine public confidence. … The public having confidence in the profession is more important than the interests of an individual doctor.
Promoting and maintaining proper professional standards and conduct (upholding professional standards)	Good medical practice requires that doctors are honest, trustworthy, act with integrity and uphold the law. As doctors are expected to be honest and act with integrity, dishonest behaviour will usually amount to a significant breach of the professional standards.

'91. *In these cases, evidence of relevant context known about the doctor and/or their working environment and evidence of insight and remediation that decrease risk may have less impact because dishonesty allegations falling at the higher end of the spectrum of seriousness can be more difficult to remediate.*

92. *In such cases the MPT's decision on risk should reflect this and a conclusion the doctor poses a current and ongoing risk to public protection may be needed even in cases where the doctor has shown insight and taken steps to try and remediate. Where the MPT concludes that the doctor poses a current and ongoing risk, this will result in them finding that the doctor's fitness to practise is impaired.*

93. *The level of risk associated with a dishonesty allegation will often be medium or high. However, where there is a single incident of dishonest behaviour which falls at the lower end of the spectrum of seriousness, the level of risk may be lower.*

94. Where a dishonesty allegation leads to a finding of impairment, it may engage one or more of the three parts of public protection. Whilst the MPT must consider the individual circumstances of the case, it will be unusual for a proven allegation of dishonesty not to undermine public confidence in the profession.'

137. The Tribunal considered the MPTS Guidance and impact on public protection of the dishonesty allegation.

138. The Tribunal also considered the case of *Yeong v General Medical Council [2009] EWHC 1923 (Admin)* –where it was stated:

> *"There will be occasions where Impairment of Fitness to Practise must be found as a matter of* ***public policy****, to uphold public confidence in the profession, where to make no such finding would have an adverse impact on public confidence in the profession and the GMC/MPTS".*

139. The Tribunal concluded that there was a high level of current and ongoing risk to public protection in Dr Igwe's case. It decided that all three parts of public protection were engaged.

Patient Safety

140. The Tribunal accepted that no actual harm had been caused to patients by Dr Igwe but it concluded that Dr Igwe's actions in providing false or misleading references or false information in his job applications could have had an adverse impact on patient care. He had risked causing harm to patients due to him falsifying his qualifications, references and experience and obtaining a role that he did not have the skills to perform safely or qualifications and/or experience for. Where dishonest behaviour has impacted, or could impact on patient care, there is a clear risk to patient or public safety.

141. Also, the Tribunal noted that Dr Igwe had misled potential employers involved in recruitment. Where a doctor is dishonest in their interactions with colleagues, this can cause breakdowns in communication and/ or in the collaborative working needed to deliver safe patient care.

Public Confidence

142. Dr Igwe's dishonest actions would have led to patients and members of the public losing confidence in doctors to behave professionally and to act with honesty and integrity. Dishonesty arising inside, or related to, a doctor's professional practice may result in a breakdown of trust and undermine public confidence. Him providing false information about his qualifications and/or experience would have undermined public confidence in the medical profession. The public should be able to trust the integrity of medical professionals and Dr Igwe's dishonest actions would have undermined the public's trust and would have risked public confidence in the medical profession.

Upholding Professional Standards

143. Good medical practice requires that doctors are honest, trustworthy, act with integrity and uphold the law. As doctors are expected to be honest and to act with integrity, Dr Igwe's dishonest behaviour in this case amounts to a significant breach of the professional standards. The fact that his initial response was to maintain that dishonesty even when faced with proceedings by the GMC compounds his position further.

144. Consequently, the Tribunal determined that there was a current and ongoing risk to public protection that requires restrictive action in Dr Igwe's case. All three limbs of public protection are engaged for the reasons set out above. The level of risk is high.

145. The Tribunal has therefore determined that Dr Igwe's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 19/08/2026

The Outcome of Applications Made during the Sanction Stage

146. The Tribunal granted the GMC's application, made pursuant to the slip rule, that, a minor correction be made in the Tribunal's facts and impairment determination. Mr Brook submitted that there was a factual inaccuracy that indicated he had made submissions in relation to Dr Igwe not having given evidence at Stage 1, which should be removed. This application was not opposed by Mr Puar. The Tribunal considered that it amounted to a simple mistake, which did not substantively alter the determination, and that it could be made without issue.

147. During the sanction stage, additional evidence was adduced, as set out below. The Tribunal invited submissions from the parties as to whether the Tribunal should update its assessment of the risk posed to public protection in light of this evidence. The parties made submissions and were in agreement that the new evidence can be considered at this stage but does not require the re-opening of the impairment stage. The Tribunal determined that, as this case had not been split listed or adjourned, there was no need to conduct an updated assessment of risk. In deciding on the most appropriate sanction, it would consider the evidence given at Stage 3 and determine what weight should be given to it.

The Evidence

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

149. The Tribunal received further evidence on behalf of Dr Igwe including:

- Testimonials in support of Dr Igwe from colleagues and friends.

150. The Tribunal heard evidence from the following witnesses:

- Dr K, via video link;

- Dr L, via video link.

151. Dr Igwe also gave oral evidence. His evidence included that he had realised he needed to own up to his actions by November 2025 and that he spoke with a consultant colleague for guidance. He said that he realised he needed help and sought that out from his colleagues as well as faith groups. Dr Igwe described how he now accepted he had acted dishonestly and wanted to teach others about the importance of probity, using himself as an example.

Submissions

152. On behalf of the GMC, Mr Brook submitted that erasure was the appropriate sanction in this case. He said that the evidence received at this stage did not address the issue of sanction and was focussed on insight and remediation, which are relevant to the impairment stage. He said that the testimonial evidence was also all focussed on Dr Igwe's insight and were not relevant to this stage of proceedings. He also submitted to the Tribunal that the GMC had not verified any of the testimonial witnesses and stated there was no confirmation that any of the witnesses, other than those who gave oral evidence, had seen the allegations against Dr Igwe.

153. Mr Brook reminded the Tribunal of its findings at the impairment stage, including that Dr Igwe's dishonesty was premeditated, persistent and repeated, showing a reckless disregard for patient safety and professional standards. He said Dr Igwe had acted in a way that put his own interests first, having engaged in his pattern of dishonesty for personal, financial gain. Mr Brook reminded the Tribunal that Dr Igwe had continued to act dishonestly even after knowing he was under investigation for dishonesty and had been dishonest in his attempts to shift blame onto a virtual assistant. He also reminded the Tribunal that it had found the risk to public protection was high.

154. Mr Brook submitted that there were no exceptional circumstances to justify taking no action against Dr Igwe and that an order of conditions was not appropriate or proportionate. He said that the Tribunal had found Dr Igwe had shown a persistent lack of insight and submitted that his conduct was fundamentally incompatible with continued registration, meaning that erasure was the only appropriate and proportionate sanction in this case. He also submitted that Dr Igwe had appeared to accept this in his statement.

155. On behalf of Dr Igwe, Mr Puar submitted that the Tribunal should have regard to the sanction bandings and take note that it indicates a range of sanction in cases such as

this from 9 months suspension to erasure. He submitted that Dr Igwe was on a journey to remediate his misconduct and that a period of suspension, with a review, could form part of that journey whilst safeguarding the public.

156. Mr Puar submitted that Dr Igwe had changed his practise and was a different person, no longer denying his dishonesty and without the same personal factors that led to his dishonesty in the first place. Mr Puar submitted that Dr Igwe should be given a further opportunity to demonstrate his remediation and to fully develop his insight. He said that more time is needed for Dr Igwe to develop this understanding but that the case fell short of erasure.

157. Mr Puar submitted that the Tribunal should take into account all the evidence before it, including that of the testimonial witnesses, whose evidence was not challenged by the GMC, save that Mr Brook sought to establish that the witnesses were merely offering their opinions.

The Tribunal's Determination on Sanction

158. The Tribunal bore in mind that the reason for imposing sanctions is to protect the public. Sanctions are not imposed to punish doctors, although they may have a punitive effect. The issue of sanction is a matter for the Tribunal's own judgement.

159. The Tribunal took a proportionate approach, balancing the interests of Dr Igwe with the public interest. It bore in mind that the reputation of the profession as a whole is more important than the interests of any individual doctor.

160. In making its decision on sanction, the Tribunal has reviewed its decision on facts and impairment and has considered the level of current and ongoing risk the doctor poses to public protection. The Tribunal took into account the evidence received at Stage 3. The Tribunal considered the submissions made by the parties in respect of admissibility of that evidence. The Tribunal concluded that some of that evidence was relevant and admissible in respect of its decision on sanction. Having reviewed the additional evidence received at Stage 3, the Tribunal concluded that it did not undermine its previous findings on impairment.

161. The Tribunal referred to the sanctions banding for dishonesty as set out in *Guidance for MPT hearings, Part C* (the Sanctions Guidance). It has also considered the impact of any specific sanction type, where applicable, and any references or testimonials provided.

162. The Tribunal reminded itself that the sanction must be proportionate to the gravity of the misconduct and impairment found. It was referred to the case of *Sawati v GMC [2022] EWHC 283 (Admin).* In that case it was stated that erasure for dishonesty is not automatic, so these cases are not exempt from the general requirement to assess the seriousness of misconduct in every case before a sanction is imposed. Tribunals should also objectively and appropriately evaluate the offending behaviour by reference to the relevant aggravating and mitigating factors. The nature and the extent of dishonesty may be variable and must be evaluated on a case by case basis.

No action

163. The Tribunal noted that to take no action, exceptional circumstances must be present to justify such a course. The Tribunal considered that no such exceptional circumstances were present in this case. It considered that taking no action would not be sufficient, proportionate, or in the public interest and would undermine public confidence in the MPTS proceedings.

Conditions

164. The Tribunal next considered whether to impose conditions on Dr Igwe's registration. It noted paragraphs 19 and 20 of the relevant section of the Sanctions Guidance and bore in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

165. The Tribunal considered that an order of conditions may be appropriate to address the performance aspect of this case. However, given the nature of Dr Igwe's misconduct, an order of conditions would not be proportionate to address the seriousness of the case, nor could any appropriate, workable and measurable conditions be formulated to reduce the risk posed to public protection by Dr Igwe's dishonesty.

166. In all the circumstances, the Tribunal concluded that a period of conditional registration would not be an appropriate sanction in this case. This was due to the seriousness of the case.

Suspension

167. The Tribunal went on to consider suspension. It referred to paragraph 45 of the Sanctions Guidance:

'45 Suspension may be proportionate in cases where some, or all, of the following factors are present:

a. conditions are not appropriate, measurable and/or workable
b. the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions, and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or
c. the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.'

168. The Tribunal considered whether this paragraph indicated suspension may be appropriate in this case. It noted Mr Puar's submission that a period of suspension, with a review, could enable Dr Igwe to complete his remediation and develop full insight.

169. The Tribunal also considered paragraph 62 of the Sanctions Guidance, which sets out the sanctions banding for dishonesty cases at the higher end of seriousness as ranging between 9 months' suspension to erasure. The Tribunal reviewed its earlier findings made at the impairment stage. The Tribunal reminded itself that the misconduct in Dr Igwe's case involved multiple instances of dishonesty over a prolonged period, which included him making dishonest job applications, putting his own interests above those of patients and potentially putting patients at serious risk of harm by applying for jobs that he did not have the qualifications and/or experience for. It also included him lying about his experience to potential employers involved in the recruitment process and putting forward false references in support of his application. Once the GMC proceedings commenced, Dr Igwe persisted in his dishonesty. He failed to declare interim conditions imposed upon his registration when completing job applications after an interim orders Tribunal imposed those conditions.

170. The Tribunal concluded that these were serious aggravating features of the case, which increased the seriousness.

171. The Tribunal was referred to the case of *PSA v NMC and another [2025] EWHC 3132 (Admin).* In that case it was stated that *'dishonesty – particularly where linked to professional practise or regulatory obligations – strikes to the heart of the nursing and midwifery professions. As such, the panel's decision to impose only a suspension did not properly meet the statutory objectives of public protection, maintaining standards and*

preserving confidence in the regulatory system.' The Tribunal also reminded itself that each case must be considered on its own basis.

172. Having considered the seriousness of Dr Igwe's case, the Tribunal concluded that a period of suspension was not an appropriate sanction in Dr Igwe's case. This was due to the seriousness of the case, as outlined above and in the Tribunal's impairment determination, and the risk to public protection. The Tribunal also noted that, in Dr Igwe's case, it had found that Dr Igwe had shown limited insight and there had been no remediation of the misconduct. The Tribunal reminded itself of paragraph 91 of the Guidance Introduction, which states:

> *'…evidence of insight and remediation that decrease risk may have less impact because dishonesty allegations falling at the higher end of the spectrum of seriousness can be more difficult to remediate.'*

173. The Tribunal also acknowledged that in cases like this, where there may be deep seated attitudinal issues of dishonesty, they can be more difficult to remediate.

174. The Tribunal decided that suspension, even a lengthy one with a review requirement, would not be appropriate or proportionate to address the risk to public protection in Dr Igwe's case. It therefore went on to consider erasure.

Erasure

175. The Tribunal had regard to paragraph 57 of the Sanctions Guidance:

> *'57 Erasure may be the proportionate response where:*
>
> *a. conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public*
> *b. the doctor's behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place*
> c. *the doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and/or*
> d. *the seriousness of the facts found proven and/or impact of any relevant context that increased the current and ongoing risk to public protection*

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

176. The Tribunal considered that erasure was the proportionate response in Dr Igwe's case. It concluded that conditions were not appropriate, proportionate, workable or measurable and that suspension was not proportionate in the circumstances of the case and would undermine public confidence.

177. The Tribunal had concluded that Dr Igwe's behaviour had put patients at serious risk of harm and that this could not be sufficiently mitigated by conditions or suspension.

178. Dr Igwe had shown limited insight into the seriousness of the Allegation and the potential for actual consequences to patients. Dr Igwe's persistent and repeated dishonesty put patients at risk of harm by virtue of him seeking work that he did not have the relevant qualifications and/or experience for through dishonest means.

179. The Tribunal considered its earlier findings made at Stages 1 and 2 in relation to Dr Igwe's response to the Allegation. It also considered the evidence given by and on behalf of Dr Igwe at Stage 3. The Tribunal reminded itself of its findings made at the impairment stage relating to the seriousness of the case, significant risk of repetition of the behaviour and the risk to public protection. All three limbs were found to be engaged.

180. Dishonesty is a fundamental tenet of the medical profession. The Tribunal considered that the public would not accept a doctor being allowed to hold registration after engaging in such a protracted campaign of dishonesty, as outlined above and in the Tribunal's impairment findings. The Tribunal considered that a member of the public would consider Dr Igwe's persistent dishonesty to be fundamentally incompatible with continued registration.

181. The Tribunal bore in mind the fresh evidence received during the sanction stage but did not consider that it served to reduce the seriousness of Dr Igwe's case which the Tribunal determined to be at the higher end of the spectrum of seriousness. Dr Igwe had breached a fundamental tenet of the profession. There were a number of features increasing the seriousness of his case as outlined in the Impairment determination. Despite having shown some, limited insight, Dr Igwe's actions in dishonestly completing application forms, denying dishonesty to Dr A, dishonestly attempting to shift blame and in continuing to be dishonest even whilst under interim conditions were fundamentally incompatible with continued registration.

182. The Tribunal considered that Dr Igwe had put patients at serious risk of harm and public confidence in the profession would be undermined if he were permitted to remain on the register.

183. In light of this, the Tribunal determined that erasure was therefore the appropriate and proportionate sanction in this case in order to protect patients, maintain public confidence in the profession and uphold proper professional standards.

Determination on Immediate Order - 19/08/2026

184. Having determined that Dr Igwe's name should be erased from the register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

185. On behalf of the GMC, Mr Brook submitted that an immediate order was necessary in this case and referred the Tribunal to the relevant paragraphs of the Sanctions Guidance.

186. On behalf of Dr Igwe, Mr Puar submitted that he did not oppose an immediate order.

The Tribunal's Determination

187. The Tribunal referred to the relevant section of the Guidance, including:

> *'79 The MPT may impose an immediate order where it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. Where the MPT has imposed a sanction of conditions, it may impose an immediate order of conditions. Where the MPT has imposed a sanction of suspension or erasure, it may impose an immediate order of suspension.*
>
> *80 In the context of an immediate order, the best interests of the doctor includes avoiding putting them in a position where they may come under pressure from patients and/or may repeat the behaviour or poor performance giving rise to the allegation, particularly where this may also put the doctor at risk of committing a*

criminal offence. It may also include where the doctor's ability to practise safely and effectively may be impacted by an ongoing health condition.

81 When deciding if an immediate order is needed, the MPT should balance these considerations against the other interests of the doctor, which may be to return to work pending the outcome of any appeal, and against the wider public interest which may require an immediate order is put in place.

…

83 The decision whether to impose an immediate order is at the discretion of the MPT based on the facts of the case. When deciding if an immediate order is needed the MPT should consider the seriousness of the proved allegation and the level of current and ongoing risk to public protection posed by the doctor.

84 It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:

a. the doctor poses a risk to patient safety
b. the risk to one or more parts of public protection is high, and/or
c. immediate action is needed to maintain public confidence in the medical profession.'

188. The Tribunal had regard to the paragraphs set out above. In particular, the Tribunal considered that paragraph 84 was relevant in this case. The Tribunal had found that all three parts of public protection were engaged and the risk to patients was high. The Tribunal reminded itself it had found that there was a risk to patients.

189. The Tribunal considered that public confidence would be undermined if Dr Igwe were permitted to practise unrestricted during the appeal period. The Tribunal had determined at the sanction stage that Dr Igwe's persistent dishonesty was fundamentally incompatible with continued registration.

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

191. The interim order currently in place on Dr Igwe's registration is hereby revoked.

SCHEDULE 1

5. He must only work at the level of SHO/Junior Clinical Fellow/Core Trainee or below.

6. a. He must be directly supervised in all of his posts by a clinical supervisor, as defined in the *Glossary for undertakings and conditions*. His clinical supervisor must be appointed by his responsible officer (or their nominated deputy).

   b. He must not work until:

      i. his responsible officer (or their nominated deputy) has appointed his clinical supervisor and approved his supervision arrangements

      ii. he has personally ensured that the GMC has been notified of these arrangements.

   c. He must provide a report from his clinical supervisor in advance of or at his next IOT review hearing.

7. …

8. He must personally ensure that the following persons are notified of the conditions listed at 1 to 7:

   a. …

   b. …

   c. …

   d. his immediate line manager and senior clinician (where there is one) at his place of work, at least 24 hours before starting work (for current and new posts, including locum posts).

SCHEDULE 2

No	NHS Trust	Role	Registration Status	FTP Declaration	Qualification	Current Job Role	Previous Job Role
1	Lewisham and Greenwich	Junior Clinical Fellow MT03	Failed to disclose APS restriction				Junior Clinical fellow (Grade ST1) in Paediatrics at LUT from Jan 2022 – Jan 2023 House Officer (FY2 Equivalent) at LUT from Jan 2021 – Dec 2021
2	St George's University Hospitals	Junior Clinical Fellow in Cardiology	Fail to disclose APS restriction		MBBS in Medicine in 2024	Senior Clinical Fellow at LGT from May 2022 – June 2024	ED Consultant (grade SHO) at LUT from Jan – Jun 2022 Foundation Year 1 - 2 at LUT from Jan 2021- Jan 2022
3	Chelsea and Westminster Hospital	Senior Clinical Fellow- Acute Medicine			MBBS in Medicine in 2024	Senior Clinical Fellow in Acute Medicine at LGT from May 2022 – Jun 2024	ED Consultant (grade SHO) at LUT from Jan – Jun 2022 Foundation Year 1 - 2 at LUT from

							Jan 2021-Jan 2022
4	Chelsea and Westminster	Junior Clinical Fellow in Neonatology	Failed to disclose APS restriction		MBBS in Medicine in 2024	Junior Clinical Fellow (grade SHO) at LGT from Nov 2023 – Jun 2024	Consultant Paediatrician (grade SHO) at LUT from Jan 2022 – Nov 2023 Foundation Year 1 - 2 at LUT from Jan 2021-Jan 2022
5	Chelsea and Westminster	Junior Clinical Fellow in Paediatrics and Neonatology	Failed to disclose APS restriction		MBBS in Medicine in 2024	Junior Clinical Fellow (grade SHO) at LGT from Jan 2024 - Jun 2024	Consultant Paediatrician (grade SHO) at LUT from Jan 2022 – Dec 2023 Foundation Year 1 - 2 at LUT from Jan 2021-Jan 2022
6	Chelsea and Westminster	Senior Clinical Fellow - Paediatrics and Neonatology	Failed to disclose APS restriction		MBBS in Medicine in 2024	Junior Clinical Fellow (grade SHO) at LGT from Jan 2024 - Jun 2024	Consultant Paediatrician (grade SHO) at LUT from Jan 2022 – Dec 2023 Foundation Year 1 - 2 at LUT from Jan 2021-Jan 2022
7	Croydon Health	Junior Clinical Fellow in	Failed to disclose		MBBS in Medicine with	Senior Clinical Fellow	

	Services NHS Trust	Paediatric Emergency Department	APS restriction		distinction in 2019	(grade SHO) at LGT from Jul 2023 – Jul 2024	
8	Croydon Health Services NHS Trust	Senior Clinical Fellow in Paediatric Emergency Department	Failed to disclose APS restriction		MBBS in Medicine with distinction in 2019	Clinical Fellow (grade SHO) at LGT from Jul 2023 – Jul 2024	

9	St Geroge's University Hospitals	Clinical Fellow in Emergency Medicine	Failed to disclose APS restriction		MBBS with distinction in Medicine in 2019	Clinical Fellow at LGT from Jul 2023 – Aug 2024; Grade 'Middle'; Speciality 'Paediatrics ED'
10	St George's University Hospitals	Junior Clinical Fellow in Paediatrics (ST1-3)	Failed to disclose APS restriction	Failed to disclose GMC investigation and IOT conditions	MBBS in Medicine in 2024	Junior Clinical Fellow (grade SHO) at LGT from Oct 2023 – Jul 2024
11	St George's University Hospitals	Junior Clinical Fellow in Paediatrics (ST1-3)	Failed to disclose APS restriction		MBBS with distinction in Medicine in 2019	Clinical Fellow in Paediatrics and Neonate in Paediatric ED at LGT from Feb 2024 - Aug 2024; Grade 'SHO'; Speciality 'Paediatrics ED'
12	Surrey and Sussex Healthcare	Junior Clinical Fellow in Paediatrics (ST1/2 level)			MBBS in Medicine with distinction in 2019	Clinical Fellow in Paediatrics and Neonate at LGT from Feb 2024 - Aug 2024; Grade 'SHO'; Speciality 'Paediatric ED'

13	St George's University Hospitals	Facilities Assistant General Manager			Bachelors in Medicine, Bachelors in Surgery MBBS with merit in 2017	
14	Chelsea and Westminster	General Manager - Emergency and Acute Medicine			Bachelors in Medicine, Bachelors in Surgery MBBS with merit in 2017	
15	University Hospitals Sussex	General Manager / Emergency Care			Bachelors in Medicine, Bachelors in Surgery MBBS with merit in 2017	
16	St George's University Hospitals	Deputy General Manager			Bachelors in Medicine, Bachelors in Surgery MBBS with merit in 2017	
17	Chelsea and Westminster Hospital	Qualitative Insights & Engagement Manager			Bachelors in Medicine, Bachelors in Surgery MBBS with merit in 2017	Qualitative Insights and Engagement Manager at University Hospital from Jan 2023-Sep 2024

18	Chelsea and Westminster	Chief People Officer			Bachelors in Medicine, Bachelors in Surgery MBBS with merit in 2017	HR Director at University Hospital from Jan 2023 – Sep 2024
19	Chelsea and Westminster Hospital	Junior Service Manager - Dermatology			Bachelors in Medicine, Bachelors in Surgery MBBS with merit in 2017	Junior Service Manager – Dermatology at UH from Aug 2023 - Sep 2024
20	Chelsea and Westminster Hospital	General Manager - Women's Services & Neonates			Bachelors in Medicine, Bachelors in Surgery MBBS with merit in 2017	General Manager - Women and Neonates at UH from Aug 2023 – Sep 2024
21	Bedfordshire Hospitals	Senior Service Manager - General Surgery & Gastroenterology			Bachelors in Medicine, Bachelors in Surgery MBBS with merit in 2017	General Manager – Surgery at UH from Aug 2023 – Sep 2024
22	East Sussex Healthcare	General Manager – Specialist Medicine			Bachelors in Medicine, Bachelors in Surgery MBBS with	

					merit in 2017	
23	University Hospitals of North Midlands	Specialty Doctor in Neonatal	Failed to disclose APS restriction	Failed to disclose GMC investigation and IOT conditions	MBBS in Medicine with distinction in 2019	Clinical Fellow (grade ST4) at LGT from Jul 2023 – Jul 2024
24	Chelsea and Westminster Hospital	EPU Clinical Fellow: Early Pregnancy and Acute Gynaecology		Failed to disclose GMC investigation and IOT conditions	Bachelors in Medicine, Bachelors in Surgery MBBS with merit in 2021	
25	Royal National Orthopaedic Hospital	Junior Clinical Fellow in Paediatrics		Failed to disclose GMC investigation and IOT conditions	MBBS in Medicine in 2020	Senior Clinical Fellow in Paediatrics at LGT from May 2022 – Jun 2024
26	Epsom and St Helier University Hospitals	Junior Clinical Fellow in Emergency Medicine		Failed to disclose GMC investigation and IOT conditions	MBBS with distinction in 2020	