**Record of Determinations – Medical Practitioners Tribunal**

PUBLIC RECORD

**Dates:** 06/09/2016 – 16/09/2016
Reconvened on 09/01/2017- 13/01/2017

**Medical Practitioner’s name:** Dr Obiako OKAFOR

**GMC reference number:** 5207579

**Primary medical qualification:** MB BS 1983 University of Benin

**Type of case**
New - Misconduct

**Outcome on impairment**
Impaired

**Summary of outcome**
Suspension, 6 months.

**Tribunal:**

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<th>Medical Tribunal Member (Chair)</th>
<th>Dr Wendy Kuriyan</th>
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<td>Lay Tribunal Member:</td>
<td>Mr Colin Davis, Mr Darren Shenton</td>
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<td>Legal Assessor:</td>
<td>Mr Oba Nsugbe QC</td>
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<td>Tribunal Clerk:</td>
<td>Ms Rosanna Sheerin</td>
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**Attendance and Representation:**

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<td>Medical Practitioner’s Representative:</td>
<td>Mr Craig Ferguson, Counsel, instructed by RadcliffesLeBrasseur</td>
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<td>GMC Representative:</td>
<td>Ms Rachel Smith, Counsel (06/09/2016- 16/09/2016) Ms Laura Barbour, Counsel, (09/01/2017- 13/01/2017)</td>
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Allegation and Findings of Fact

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

Willen Village Surgery

Patient A

1. In September 2012 you were working as a General Practitioner at the Willen Village Surgery ('the Surgery'). Admitted and found proved

2. On 7 September 2012 you were the on-call doctor at and for the Surgery at which time you failed to:

   a. make an adequate assessment of Patient A in that you did not contact the Kents Hill Care Home ('the Care Home') to obtain further history about Patient A’s condition and in particular whether or not Patient A was bleeding; Admitted and found proved

   b. provide adequate advice to the Care Home on:

      i. re-starting Patient A’s Warfarin; Admitted and found proved

      ii. re-testing Patient A’s INR; Admitted and found proved

   c. make an adequate assessment of Patient A following a home visit request that was subsequently faxed to the Surgery by the Care Home in respect of Patient A, in that you did not contact the Care Home for further information about Patient A’s condition in order to assess:

      i. the urgency of the request; Admitted and found proved

      ii. whether or not a home visit was required; Admitted and found proved
iii. whether it was necessary to call an ambulance for Patient A; 
   Admitted and found proved

d. contact the Care Home by telephone, upon realising you were unable to visit Patient A, to:

   i. assess the situation, including the urgency; Admitted and found proved
   ii. apologise for the delay; Admitted and found proved
   iii. make a clear plan in respect of Patient A; Admitted and found proved

e. arrange for Patient A to attend hospital; Admitted and found proved

f. visit Patient A. Admitted and found proved

3. On 10 September 2012 you:

   a. completed a Medical Certificate of Cause of Death ('MCCD') for Patient A contrary to section 22 of the Births and Deaths Registration Act 1953 in that you:

      i. had not attended to Patient A during her last illness; Admitted and found proved
      ii. did not have sufficient knowledge of Patient A’s condition upon which to base an opinion regarding Patient A’s cause of death; Admitted and found proved

   b. stated on Patient A’s MCCD that the cause of Patient A’s death was bronchopneumonia, when:

      i. you were not in a position to record any cause of death; Admitted and found proved
      ii. there were other potential causes of Patient A’s death; Admitted and found proved

   c. stated on Patient A’s MCCD and counterfoil that you had last seen Patient A alive on 3 September 2012, which:
i. was untrue; **Admitted and found proved**

ii. you knew to be untrue; **Admitted and found proved**

d. failed to report Patient A’s death to the Coroner.  
**Admitted and found proved**

4. Your actions were:

a. misleading in relation to paragraphs 3b and 3c; **Admitted and found proved**

b. dishonest in relation to paragraph 3c.  
**Found proved**

Patient B

5. On 13 September 2012 you failed to provide good clinical care to Patient B in that you:

a. did not follow the Consultant’s instructions in respect of Patient B’s prescription of Dosulepin; **Admitted and found proved**

b. issued a prescription of Dosulepin to Patient B, namely a prescription for:

i. an excessive dose (150 mg daily); **Withdrawn by GMC**

ii. an excessive quantity (56 tablets). **Admitted and found proved**

Stonedean Practice

6. Between 9 December 2013 and 2 April 2014 you were working as a General Practitioner at the Stonedean Practice (‘the Practice’). **Admitted and found proved**

7. On 6 January 2014 you started your surgery late without ensuring that adequate arrangements had been put in place for your work to be covered in your absence. **Found proved**

8. On the following dates you cancelled your surgery slots or left the Practice at short notice without ensuring that adequate arrangements had been put in place for your work to be covered in your absence:
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a. 10 January 2014; **Found proved**

b. 22 January 2014; **Found proved**

c. 20 March 2014. **Found not proved**

9. On the following dates you left the Practice when you were on-call, without ensuring that adequate arrangements had been put in place for your work to be covered in your absence:

a. 23 January 2014; **Found proved**

b. 13 February 2014. **Found not proved**

10. On the following dates you omitted to inform the Practice of the circumstances set out in Schedule 1:

a. 20 March 2014; **Found proved**

b. 23 24 March 2014. **Admitted and found proved as amended under Rule 17(6)**

11. Your omission at paragraph 10 above was misleading. **Found proved**

Patient C

12. On 3 January 2014 you failed to provide good clinical care to Patient C in that you did not:

a. conduct an adequate assessment of Patient C’s complaint of headache; **Admitted and found proved**

b. record your assessment of Patient C’s complaint of headache; **Admitted and found proved**

c. recommend that a pregnancy test be performed that same day to ascertain if Patient C was pregnant. **Admitted and found proved**

Patient D

13. On 6 January 2014 you failed to provide good clinical care to Patient D in that you did not:
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a. accurately calculate Patient D’s gestation;
   Admitted and found proved

b. make a referral for Patient D to be assessed by the Early Pregnancy Assessment Unit sufficiently promptly;
   Admitted and found proved

c. make an adequate record of your consultation with Patient D.
   Admitted and found proved

Patient E

14. On 9 January 2014 you failed to provide good clinical care to Patient E in that you:

   a. misunderstood the definition of dysphagia in that you stated that Patient E had ‘no dysphagia’ despite the fact that the patient had been experiencing a lump in her throat when swallowing; Admitted and found proved

   b. formed a management plan which was inappropriate in that you did not make a two week wait specialist referral for Patient E.
      Admitted and found proved

Patient F

15. On 13 January 2014 you failed to provide good clinical care to Patient F in that you did not make an adequate note of your consultation with Patient F.
   Withdrawn by the GMC

Patient G

16. On or around 30 January 2014 you failed to provide good clinical care to Patient G in that you did not:

   a. review Patient G’s swab results from 13 January 2014; Admitted and found proved

   b. put in place an adequate management plan for Patient G.
      Admitted and found proved
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Patient H

17. On or around 3 February 2014 you failed to provide good clinical care to Patient H in that you prescribed ibuprofen to Patient H without also prescribing gastroprotective medication to Patient H.

Admitted and found proved

Patient I

18. On or around 3 February 2014 you failed to provide good clinical care to Patient I in that you did not:

a. undertake an adequate assessment of Patient I in that you did not establish with Patient I the risk that she was pregnant;

Admitted and found proved

b. make an adequate record of your assessment of Patient I;

Admitted and found proved

c. recommend that Patient I undergo or take a pregnancy test;

Admitted and found proved

d. recommend that a vaginal examination, including an examination of Patient I’s cervix be undertaken;

Admitted and found proved

e. recommend that Patient I be screened for sexually transmitted infections.

Admitted and found proved

Patient J

19. On 13 February 2014 you failed to provide good clinical care to Patient J, a long term smoker, in that you:

a. did not give adequate advice to Patient J to enable the patient to maintain safe contraception prior to the removal of her intrauterine system (‘coil’); Admitted and found proved

b. recommended and prescribed the combined oral contraceptive pill, Microgynon, to Patient J when it was inappropriate to do so;

Admitted and found proved

c. did not:
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i. adequately warn Patient J of the risks of the combined oral contraceptive pill;
   Admitted and found proved

ii. record that such a warning had been given to Patient J.
   Admitted and found proved

Patient L

20. On 24 February 2014 you failed to provide good clinical care to Patient L in that you did not:

   a. take an adequate history from Patient L;  Found proved

   b. give adequate consideration to diagnoses other than pregnancy;
      Admitted and found proved

   c. examine Patient L;
      Admitted and found proved

   d. make an urgent referral for Patient L to be assessed that day by the Early Pregnancy Assessment Unit;
      Admitted and found proved

   e. give appropriate ‘safety net’ advice to Patient L.
      Found not proved

Patient M

21. On 6 March 2014 you failed to provide good clinical care to Patient M in that you:

   a. did not check what the drug Depakote was;
      Admitted and found proved

   b. gave Patient M inappropriate advice about Depakote.
      Admitted and found proved

Patient N

22. On 10 and 17 March 2014 you failed to provide good clinical care to Patient N in that you prescribed Nitrofurantoin to Patient N when it was inappropriate to do so as Patient N was breast feeding.
   Admitted and found proved
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And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.

Attendance of Press / Public
The tribunal agreed, in accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004, that the press and public be excluded from those parts of the hearing where matters under consideration were deemed confidential.

Determination on Facts - 16/09/2016

Dr Okafor:

1. At the outset of these proceedings the Tribunal determined that certain parts of this case be heard in private pursuant to Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 (“the Rules”). Therefore, the press and public will be excluded from those parts of the hearing relating to sensitive information XXX and this determination will be read in private. However, as this case does also concern your alleged misconduct, a redacted version will be published at the close of the hearing with those matters XXX having been removed.

2. Mr Ferguson, Counsel, made a number of admissions on your behalf and the Tribunal announced the following paragraphs as having been admitted and found proved. Paragraphs 1, 2 in its entirety, 3 in its entirety, 4a, 5 in its entirety, 6, 10b, 12 in its entirety, 13a, 14 in its entirety, 16a, 17, 18 in its entirety, 19 in its entirety, 20b, 20c, 21 in its entirety and 22.

3. Ms Smith, Counsel, on behalf of the GMC, withdrew Paragraph 5bi. She also made an application under Rule 17(6) to amend Paragraph 10b of the Allegation to read as follows:

"10. On the following dates you omitted to inform the Practice of the circumstances set out in Schedule 1:

... b. 24 March 2014."

4. Mr Ferguson did not oppose the application made.

5. The Tribunal acceded to the Rule 17(6) application.

6. During the course of the proceedings further admissions were made on your behalf and the Tribunal announced the following paragraphs as having been admitted and found proved: Paragraphs 13b, 13c, 16b and 20d.

7. The Tribunal has considered each sub-paragraph of the Allegation separately. In doing so it has considered all of the documentary and oral evidence
adduced in this case, it has taken account of the submissions made by Ms Smith on behalf of the GMC and the submissions made by Mr Ferguson on your behalf.

**Tribunal approach**

8. The Tribunal has borne in mind that the burden of proof rests upon the GMC throughout and that the standard is the civil standard of proof on the balance of probabilities. Accordingly, it has made the following findings on the facts.

**Assessment of witness evidence**

9. At the outset of its deliberations the Tribunal considered the evidence provided by all the witnesses. These were GP administrative staff, GP colleagues, an expert witness on your behalf, an expert witness on behalf of the GMC and your own evidence. Since there is dispute between you and a number of the individuals working at Stonedean Practice as to the exact events which occurred, the Tribunal has had to assess the reliability of all the evidence placed before it.

10. The Tribunal has determined that the oral evidence provided by Ms A, Practice Manager, Stonedean Practice and Dr A, GP Partner, Stonedean Practice was credible and consistent. The Tribunal was satisfied that their evidence was supported by the contemporaneous documentation and accurately reflected what occurred. When these witnesses not recollect certain facts they said so. The Tribunal was assisted by the expert evidence of Dr C, GMC Expert, and Dr B, Defence Expert, who were largely in agreement as to the nature and degree of your failings.

11. The Tribunal considered that you gave your evidence as best you could recall events. You made appropriate concessions during it. The Tribunal did not consider that you attempted to mislead with your version of events but that you were vague on certain aspects. The Tribunal has been made aware at this stage of your previous good character, and has been provided with testimonial evidence attesting to this.

**Background**

12. This case concerns your alleged misconduct relating to the care and treatment you provided to twelve patients arising from your work at two different practices, namely the Willen Village Surgery and the Stonedean Practice in 2012 and 2014.

**Patient A**

13. On 7 September 2012 you were the on-call doctor at Willen Village Surgery. A home visit request had been made by telephone and this was subsequently faxed to the Surgery by the Kents Hill Care Home ('the Care Home') in respect of Patient A. You did not contact the Care Home for further information about Patient A’s
condition in order to assess whether it was an urgent request, whether a home visit was required or whether an ambulance should be called for Patient A. You failed to obtain an adequate history, in particular whether or not Patient A was bleeding. You had given advice earlier in the day regarding Patient A’s considerably raised INR reading and the Warfarin dosage.

14. You said that your intention was to visit the Care Home at the end of your surgery but on your way you became sidetracked when you received a phone call from your son’s school. You went to the school to collect your son instead of attending the Care Home and failed to let them know that you would not be attending. Your evidence was that you assumed that the matter would have been passed onto the Out Of Hours Service.

15. Patient A was found pale and unresponsive on the morning of Saturday 8 September 2012. Paramedics were called but she had died. On 10 September 2012 you completed a Medical Certificate of Cause of Death (‘MCCD’) for Patient A. You stated on Patient A’s MCCD that the cause of death was bronchopneumonia and that you had last seen Patient A alive on 3 September 2012. This latter entry was untrue. You had assumed that the cause of death was bronchopneumonia without considering other possible causes. You failed to report Patient A’s death to the Coroner.

Patient B

16. On 13 September 2012 you failed to provide good clinical care as you did not follow the Consultant Psychiatrist’s instructions in respect of Patient B’s prescription of Dosulepin as you issued an excessive quantity (56 tablets) instead of the one week supply suggested by the Consultant. Patient B later took an overdose and died. There was no evidence that this was due to your prescription.

Patient C

17. On 3 January 2014 you failed to provide good clinical care as you did not conduct an adequate assessment of Patient C’s complaint of headache, record your assessment of her complaint of headache or recommend that a pregnancy test be performed that same day to ascertain if she was pregnant.

Patient D

18. On 6 January 2014 you failed to provide good clinical care as you did not accurately calculate Patient D’s gestation period, make a referral for Patient D to be assessed by the Early Pregnancy Assessment Unit sufficiently promptly, or make an adequate record of your consultation with her.
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Patient E

19. On 9 January 2014 in your consultation with Patient E you failed to provide good clinical care as you misunderstood the definition of dysphagia. You stated that Patient E had ‘no dysphagia’ despite the fact that she had complained of experiencing a lump in her throat when swallowing. You formed a management plan which was inappropriate in that you did not make a two week wait specialist referral for Patient E.

Patient G

20. On or around 30 January 2014 you failed to provide good clinical care to Patient G as you did not review the swab results from discharge coming from his ear, this swab was taken on 13 January 2014. You did not put in place an adequate management plan for this patient.

Patient H

21. On or around 3 February 2014 you failed to provide good clinical care to Patient H as you prescribed ibuprofen without also prescribing gastroprotective medication.

Patient I

22. On or around 3 February 2014 you failed to provide good clinical care to Patient I as you did not establish with her the risk that she was pregnant, make an adequate record of your assessment with her, recommend that she undergo or take a pregnancy test, recommend that she undergo a vaginal examination of her cervix, or recommend that she be screened for sexually transmitted infections.

Patient J

23. On 13 February 2014 you failed to provide good clinical care to Patient J who was a long term smoker. You did not give adequate advice to her to enable her to maintain safe contraception prior the removal of her intrauterine device. You recommended and prescribed the combined oral contraceptive pill, Microgynon, to her when it was inappropriate to do so. You also failed to adequately warn Patient J of the risks of the combined oral contraceptive pill or record that you had given such a warning to her.

Patient L
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24. On 24 February 2014 you failed to provide good clinical care to Patient L as you gave inadequate consideration to diagnoses other than pregnancy, examine Patient L, or make an urgent referral for her to be assessed that day by the Early Pregnancy Assessment Unit or any other form of clinical assessment available to you as a referring GP.

Patient M

25. On 6 March 2014 you failed to provide good clinical care to Patient M as you did not check what the drug Depakote was and gave Patient M inappropriate advice about Depakote.

Patient N

26. On 10 and 17 March 2014 you failed to provide good clinical care to Patient N as you prescribed Nitrofurantoin for her when it was inappropriate to do so as she was breast feeding at the time.

Facts

Patient A

Stem of Paragraph 4:
"Your actions were:

Paragraph 4b:
"dishonest in relation to paragraph 3c"

Found proved

27. In considering this paragraph the Tribunal noted the advice of the Legal Assessor. He stated that the Tribunal would have to first decide on the balance of probabilities that, what was done was dishonest according to the standards of reasonable and honest people. If so, whether you realised that what you were doing was dishonest according to those standards.

28. Your evidence to the Tribunal was that you wholeheartedly regretted the deficiencies in the care that you provided to Patient A and the actions that you took following her death.

29. The Tribunal is aware that you did not attend Patient A at the Care Home on 7 August 2012 despite being contacted twice. You were aware of the importance of the MCCD and the fact that the information in it was required by law. You went on to complete the document despite the fact that you did not attend to Patient A during her last illness, and did not have sufficient knowledge of her condition upon
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which to base an opinion regarding her cause of death. You recorded the cause of
death as bronchopneumonia when there were other possible reasons for her death.
Finally, you stated on the document that you had last seen Patient A alive on
3 September 2012 which was something you knew to be untrue. Indeed your
evidence was that you had never attended this patient.

30. Your stated that you felt you were completing the MCCD “on behalf of the
practice” and in order to assist the family who had requested the document.

31. The Tribunal has considered your evidence and in particular the
circumstances in which you came to put inaccurate information on the document. It
has concluded that in recording information on a legal document, which was untrue,
you were wholly misrepresenting the true extent of your interaction with Patient A.
In its view reasonable and honest people would have regarded this as dishonest and
the Tribunal concluded that you knew what you were doing was dishonest according
those standards.

32. Accordingly, the Tribunal has found this paragraph proved.

Stonedean Practice

Paragraph 7:
“On 6 January 2014 you started your surgery late without ensuring
that adequate arrangements had been put in place for your work to
be covered in your absence.”

Found proved

33. In your witness statement you stated that Monday 6 January 2014 was your
first working day after the Christmas holiday and that the working rota had not been
confirmed prior to the Christmas break. As a result you were not sure as to the days
that you would be required to work at the start of the year. However, you stated
that you attended the practice on 6 January 2014 to continue with your remediation.

34. The Tribunal has considered the notes made by Dr A on 6 January 2014
which states:

"Had started a surgery late.
"I didn’t know what time I was starting”
"I haven’t got any equipment”
"I can’t even get onto ICE”"

35. The Tribunal has also considered the email correspondence dated
8 September 2016 sent by Ms A to Ms B, GMC Legal, at the request of the Tribunal,
to confirm the dates that you had worked between 20 December 2013 and 6
January 2014. In this correspondence Ms A confirmed:
"Dr Okafor worked the following between those dates: Friday 20th December am and pm, Monday 23rd December am and pm, Tuesday 24th December am, Friday 27 December am and pm, Monday 30th December am and pm, Tuesday 31st December am, Thursday 2nd January am, Friday 3rd January pm, Monday 6th January am."

36. The Tribunal notes that Monday 6 January 2014 was not your first working day after the Christmas break as there was a note of a consultation you had with a patient on 3 January 2014. The Tribunal has determined that the notes from Dr A and Ms A confirmed their oral evidence. This is further supported by your note of 3 January 2014. It is therefore satisfied that you should have attended the surgery as scheduled on 6 January 2014 and that you arrived late without prior arrangements being made.

37. Accordingly, the Tribunal has found this paragraph proved.

Stem of Paragraph 8:
“On the following dates you cancelled your surgery slots or left the Practice at short notice without ensuring that adequate arrangements had been put in place for your work to be covered in your absence:”

Paragraph 8a:
“10 January 2014”
Found proved

38. With the agreement of the practice and in order to relieve the pressures you were experiencing in working five days a week your work pattern was finally reduced to two days a week.

39. In relation to your surgery slots on 10 January 2014 you asserted that this was a Wednesday and that you had agreed with the Practice Manager that you would not be working on either Wednesdays or Fridays.

40. The Tribunal has considered the contemporaneous note made by Dr A relating to 10 January 2014 which states:

"Eddie did not show up- phoned XXX just before morning surgery to say he could not come in to work."

41. The Tribunal has considered the email correspondence dated 8 September 2016 sent by Ms A to Ms Kirsty B, GMC Legal, at the request of the Tribunal, to ascertain what date your surgeries were reduced from full time to two days a week. Ms A confirmed:
"Dr Okafor changed to two days a week w/c Monday 10th February 2014”

42. The Tribunal notes that you were in fact still working on Wednesdays in January 2014 and that the notes of Dr A and Ms A confirmed their oral evidence. The Tribunal preferred their evidence in regard to this matter. It is therefore satisfied that you left the Practice at short notice without ensuring that adequate arrangements had been put in place for your work to be covered in your absence on 10 January 2014.

43. Accordingly, the Tribunal has found this paragraph proved.

Paragraph 8b: “22 January 2014”
Found proved

44. In relation to your surgery slots on 22 January 2014 you asserted that this was a Wednesday and that you had agreed with the Practice Manager that you would not be working on either Wednesdays or Fridays.

45. The Tribunal has considered the note made by Dr A on 23 January 2014 (restropective) which states:

“However PM informed me that Dr Okafor had cancelled his Wednesday afternoon surgery at short notice. He had asked for his afternoon surgeries to be urgents only in case he had to cancel but one patient had been booked in”

46. The Tribunal notes that you were still working on Wednesdays in January 2014 and that the notes of Dr A and Ms A confirmed their oral evidence. The Tribunal preferred their evidence in regard to this matter. It is therefore satisfied that you left the Practice at short notice. You did not ensure that adequate arrangements had been put in place for your work to be covered in your absence on 22 January 2014.

47. Accordingly, the Tribunal has found this paragraph proved.

Paragraph 8c: “20 March 2014”
Found not proved

48. Your evidence to the Tribunal was that on Thursday 20 March 2014 you attended the surgery as normal. During the afternoon session there were blocked appointments to enable you to collect your son from school. On this day, you left as normal to collect your son at around 3.30pm. XXX came to see you accompanied by two police officers, who requested that you attend the police station with them. You
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stated that the officers did not explain why they wished you to attend the police station. You told them that you were already late for your afternoon surgery and you had patients who would be waiting. The police officers allowed you to return to the practice en route to the police station so that you could inform the practice that you would not be able to see any patients during the evening. You stated that the police officers waited in the car park whilst you went into the practice. You then informed Dr D, a fellow GP colleague, that there XXX and that the police had asked you to attend the police station. You stated that Dr D agreed to see your patients and you left the practice thereafter.

49. The Tribunal has not been provided with any evidence from Dr D in relation to this matter.

50. The Tribunal considers that if Dr D had been informed that you had to leave and you had asked him to cover your patient list then there would have been no need for you to inform other members of the practice that you were leaving as adequate arrangements had been put in place for your work to be covered in your absence.

51. Accordingly, the Tribunal has found this paragraph not proved.

Stem of Paragraph 9:
“On the following dates you left the Practice when you were on-call, without ensuring that adequate arrangements had been put in place for your work to be covered in your absence:”

Paragraph 9a:
“23 January 2014”
Found proved

52. You stated that at the end of your morning debrief with Dr A you informed her that you needed to go home for a period in the afternoon because you had an important appointment with BT. You stated that Dr A confirmed that she would cover your duty at the practice during this time. You stated that you did not say that you would be absent for just for one hour during the afternoon or that you had subsequently informed the reception staff that you would be absent for two hours.

53. The Tribunal has considered the notes made by Dr A on 23 January 2014 which states:

"At the end of the session Eddie mentioned that he wanted to get home as BT were coming. He was duty doctor and was having 40 minutes blocked from his afternoon surgery to collect his son from school. He said he would be gone for 1 hour and I agreed to cover his duty. However when he went out to
54. The Tribunal has determined that Dr A’s contemporaneous notes confirmed her oral evidence and has preferred her evidence in regard to this matter. It is therefore satisfied that you left the practice when you were on-call, without ensuring that adequate arrangements had been put in place for your work to be covered in your absence, on 23 January 2014.

55. Accordingly, the Tribunal has found this paragraph proved.

Paragraph 9b: 
“13 February 2014”
Found not proved

56. You stated that on 8 February 2014 you received confirmation that your son had a long awaited XXX appointment for the morning of 13 February 2014. On 10 February 2014 you attended the practice and it was a very busy day. You stated that as the evening approached you remembered that your son’s XXX appointment had been booked for 13 February 2014. You sought to speak to the practice manager (Ms A) to inform her of this, but she was not there. As a result you spoke to the assistant practice manager, C, and informed her that you would not be able to attend the practice on the morning of 13 February 2014.

57. The Tribunal has not been provided with any direct evidence from C, the assistant practice manager in relation to this matter. However, your conversation with C was confirmed by Ms A in her evidence.

58. The Tribunal considers that as you informed the assistant practice manager that you would not attend the surgery, this was sufficient to ensure that adequate arrangements had been put in place for your work to be covered in your absence.

59. Accordingly, the Tribunal has found this paragraph not proved.

Stem of Paragraph 10:
"On the following dates you omitted to inform the Practice of the circumstances set out in Schedule 1:"

Paragraph 10a:
“20 March 2014”
Found proved

60. You said that you were of the opinion that you did not have any obligation to inform anyone at the practice about this incident as it was private and
that you had not yet been charged. You were contacted some time later by the police to confirm that the matter would not be pursued.

61. The Tribunal has found this paragraph proved notwithstanding the evidence you gave. It considers that potential safeguarding issues were raised by the circumstances of your involvement with the police. This should have been reported to the practice.

**Paragraph 11:**
“Your omission at paragraph 10 above was misleading”
**Found proved**

62. The Tribunal has determined that any professional who is under investigation by the Police has an obligation to inform his employer. This was even more important in your case as you are a doctor in remediation. The Tribunal has determined that this was misleading.

63. Accordingly, the Tribunal has found this paragraph proved.

**Patient L**

**Stem of Paragraph 20:**
“On 24 February 2014 you failed to provide good clinical care to Patient L in that you did not:”

**Paragraph 20a:**
“take an adequate history from Patient L”
**Found proved**

64. Your evidence to the Tribunal was that when you saw Patient L on 24 February 2014 she was 7 weeks pregnant. You stated that you established Patient L’s medical history which was quite complicated. You acknowledged that you did not properly record Patient L’s medical history when she was complaining of right iliac fossa pain and was concerned about potentially losing her baby. You noted that Patient L was quite upset throughout most of the consultation.

65. The Tribunal has determined that there was a clear obligation on you to obtain a full medical history from Patient L, notwithstanding that she was clearly highly emotional at the consultation. The Tribunal has determined that given the nature of Patient L’s presenting symptoms, and in accordance with the joint expert report, you should have asked this patient about vaginal bleeding, to assist in exploring differential diagnoses which could have included an ectopic pregnancy.

66. Accordingly, the Tribunal has found this paragraph proved.
Paragraph 20e:
“give appropriate ‘safety net’ advice to Patient L”
Found not proved

67. Your evidence to the Tribunal was that you provided Patient L with appropriate safety net advice in that you reminded her of the need to call emergency services if her symptoms deteriorated. You also acknowledged that you should have noted the advice you provided to Patient L within her clinical record.

68. The Tribunal has considered Patient L’s notes and that the additions you made to the records were made later following your discussion with Dr A. Dr A told the Tribunal that she was aware that you did on occasion make additions to the patient notes, following discussions with her. In her note dated 9 January 2014 it states:

"31 year old with known hydrosalpinx awaiting laparoscopy and drainage who has fallen pregnant. Eddie had appropriately referred her to EPAU but made an appointment 4 weeks ahead. He had miscalculated her gestation as 3-4 weeks when it was in fact 5+ weeks and she needed an urgent appointment with EPAU, still demonstrating a lack of medico-legal awareness in recording notes (eg Failure to record that a patient at risk of ectopic pregnancy was advised to go to A+E if any bleeding/pain while awaiting EPAU appointment, or recording "no suicidal intent" when prescribing antidepressants). Eddie assures me that he did these things but again forgot to record them."

69. The Tribunal has determined that you did give appropriate ‘safety net’ advice to Patient L.

70. Accordingly, the Tribunal has found this paragraph not proved.

XXX

Determination on Impairment - 12/01/2017

Dr Okafor:

1. At the outset of these proceedings the Tribunal determined that certain parts of this case be heard in private pursuant to Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 ("the Rules"). Therefore, the press and public will be excluded from those parts of the hearing relating to sensitive information with regard to XXX and this determination will be read in private. However, as this case does also concern your alleged misconduct, a redacted version will be published at the close of the hearing with those matters, relating to XXX, having been removed.
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2. The Tribunal has considered under Rule 17(2)(j) of the General Medical Council (GMC) (Fitness to Practise) Rules Order of Council 2004 whether, on the basis of the facts found proved, your fitness to practise is impaired. It has taken account of all of the documentary evidence adduced. The Tribunal also heard evidence from Dr E, your clinical supervisor, during your period of remediation. It has also taken account of the submissions on your behalf and those on behalf of the GMC.

3. The Tribunal was provided with a bundle of documents which contained:

- Your reflective and remediation statement,
- List of Educational Activities in the period 28 January 2016 to 7 January 2017,
- CPD certificates for the period 11 March 2013 to 5 December 2016,
- Information in relation to the Bedford Trainers Course that you have undertaken,
- Reports from your Clinical Supervisor, Dr E, dated 5 August 2016 and 3 January 2017,
- Letter from the London Road Surgery, Practice Manager, Mrs D, dated 11 August 2016 and attachments,
- Testimonials – these included one from Dr F, who was your mentor and who worked closely with you during your remediation.

Submissions

4. The Tribunal does not intend to repeat in full the detailed submissions made by Ms Barbour, Counsel for the GMC, and Mr Ferguson, as they, and the Legal Assessor’s advice, are a matter of public record.

5. Ms Barbour submitted that your fitness to practise is impaired on the basis of the facts which were admitted on your behalf at the outset of the hearing and, the subsequent findings made by the Tribunal. She drew the Tribunal’s attention to the relevant paragraphs of Good Medical Practice (GMP) (2006)(edition relevant at the time) and in particular paragraphs 1, 2, 3, 48, 56 and 57. She also drew the Tribunal’s attention to the relevant case law. She stated that you have failed to follow GMP in a number of respects. She pointed out that in your case, the dishonesty occurred in the course of your work as a doctor and consequently the impact on public confidence is surely magnified. She stated that you had breached a number of the fundamental tenets of the profession. Her submission was that the Tribunal may feel a finding of impairment on the grounds of your dishonesty and your clinical failings is essential to uphold proper standards in the profession and to maintain public confidence.

6. Mr Ferguson reminded the Tribunal that you have been a medical practitioner of many years standing. He submitted that you accept that your dishonest behaviour
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constitutes serious misconduct and that you did not seek to dissuade the Tribunal from making a finding of impairment in that regard.

7. He submitted that throughout the proceedings you have accepted responsibility for your own actions and have been open and transparent with others about them. He referred the Tribunal to the remediation documentation provided on your behalf and to the oral evidence given by Dr E. He reminded the Tribunal of the steps you had taken, and continue to take, in order to fully remediate. He submitted that you have remediated your actions in relation to your clinical failings.

The Tribunal’s Approach

8. The Tribunal notes that the misconduct alleged against you falls broadly into two categories, namely:

   i) Issues of probity,
   ii) Clinical failings.

The GMC invited the Tribunal to find misconduct and impairment on both grounds.

9. In approaching the issues which it has to decide, the Tribunal has exercised its own judgement. Throughout its deliberations, the Tribunal has been mindful of the overarching objective of the GMC as set out in the Medical Act 1983 (the Act). That overarching objective is the protection of the public and involves the pursuit of the following objectives:

   a. to protect, promote and maintain the health, safety and wellbeing of the public
   b. to maintain public confidence in the profession
   c. to promote and maintain proper professional standards and conduct for members of that profession.

10. The Tribunal adopted a two stage process. Firstly, it asked whether the acts and omissions admitted by or proved against you were sufficiently serious to amount to misconduct. Secondly, if so, the Tribunal went onto consider whether your fitness to practise is impaired as a result.

The Tribunal’s Decision

Misconduct
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11. The Tribunal reminded itself that, although not defined by statute, misconduct has been said to constitute:

   “... 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”

   Roylance v GMC [2000] 1 AC 311

By way of further guidance misconduct has been described as:

"... conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession. R. (on the application of Remedy UK LTD) v GMC [2010] EWHC 1245 (Admin) at paragraph 37(1).”

**Probity Issues**

12. The Tribunal first considered whether the allegations proven against you involving issues of probity amounted to misconduct.

13. These concern the facts relating to paragraphs 3b, 3c and 10 where your behaviour was found to be dishonest and/or misleading. In summary, at a time when you did not attend to Patient A during her last illness, or possess sufficient knowledge of her condition upon which to base an opinion regarding cause of death, you stated the cause of death on the Medical Certificate of Cause of Death (“MCCD”), dated 10 September 2012, to be bronchopneumonia. You also claimed that you had last seen her alive on 3 September 2012.

14. In fact, you had never seen or examined this patient before. As a consequence, your assertion that the cause of death was bronchopneumonia was misleading, as there were other potential causes of death which you were in no position to assess. Furthermore, given the fact that you had never seen Patient A before, your statement that you had last seen her on 3 September 2012 was both misleading and dishonest. Your actions and failure to inform the Coroner of the circumstances of the death prevented Coroner’s inquiries into the cause of that death. It also deprived the family of important information about the accurate cause of Patient A’s death.

15. They also concern paragraph 10 of the allegations, where you failed to inform your colleagues of the fact that XXX. This investigation raised safeguarding issues, and the fact that you did not alert your professional colleagues about it, when you had an opportunity to do so, was again misleading.
16. The Tribunal paid careful regard to the 2006 edition of Good Medical Practice (GMP) which related to this issue. The Tribunal considered that the following paragraphs were particularly relevant:

‘1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues*, are honest and trustworthy, and act with integrity. *(Those a doctor works with, whether or not they are also doctors.)

56 Probity means being honest and trustworthy, and acting with integrity: this is at the heart of medical professionalism.

57 You must make sure that your conduct at all times justifies your patients’ trust in you and the public’s trust in the profession.

65 You must do your best to make sure that any documents you write or sign are not false or misleading. This means that you must take reasonable steps to verify the information in the documents, and that you must not deliberately leave out relevant information.’

17. It is clear that you have breached a number of the principles dealing with probity in GMP, as referred to above, by your dishonest and misleading actions. Such conduct falls far short of the standards to be expected of a registered medical practitioner. Doctors occupy a position of privilege and trust in society and are expected to uphold proper standards of conduct. Members of the public are entitled to place complete reliance upon doctors being honest and trustworthy. The relationship between the profession and the public is based on the expectation that medical practitioners will act at all times with absolute integrity. The Tribunal has found that you have not done so.

18. Having considered all the evidence placed before it, the Tribunal concludes that your dishonest and misleading acts fell seriously below the standards of conduct which the public and patients are entitled to expect from all registered medical practitioners. These acts would be viewed as deplorable by fellow practitioners. The Tribunal determined that your actions in this regard amounted to misconduct which was serious.

Clinical Failings

19. The clinical failings which you admitted or were found proved against you were both wide-ranging and extensive in nature. The Tribunal refers to the Notice of Allegation and its Determination on Facts for the full detail of what these amounted to, however, in outline, they were marked by failures to provide good clinical care to patients through your acts or omissions.
20. A number of these deficiencies in your clinical care or actions as a doctor also contravened GMP. In this regard, the Tribunal notes that paragraphs 2 and 48 of GMP provides as follows:

‘2 Good clinical care must include:

(a) adequately assessing the patient’s condition, taking account of the history, (including the symptoms, and psychological and social factors), the patient’s views, and where necessary examining the patient

(b) providing or arranging advice, investigations of treatment where necessary

(c) referring a patient to another practitioner, when this is in the patient’s best interests.

48 You must be satisfied that, when you are off duty, suitable arrangements have been made for your patients’ medical care. These arrangements should include effective hand-over procedures, involving clear communication with healthcare colleagues. If you are concerned that the arrangements are not suitable, you should take steps to safeguard patient care and you must follow the guidance in paragraph 6. (this relates to raising concerns about patient safety).’

21. It was said on your behalf that financial and family stresses in your personal life were primarily responsible for the clinical and other difficulties which were manifesting themselves at work. Whilst the Tribunal accepts that a somewhat chaotic and stressful period in your personal life may have contributed to failings occurring in the work place by you, it has not heard that these were present when you committed the serious breaches concerning Patients A and B whilst at the Willen Village Surgery. Furthermore this cannot excuse the duty beholden on a doctor to be honest at all times and not place patients at risk on any count. The fact that these occurred before you went to the Stonedean Surgery and continued whilst you were there is suggestive of a pattern of behaviour in which you failed to acknowledge your deficiencies and take responsibility for them.

22. As noted, your clinical failings were extensive and varied in nature. They occurred over a considerable period of time and at two different practices. They placed the health and well-being of patients at risk and fell far below the standards to be expected of a competent medical practitioner. It concerned the Tribunal that there were occasions when you placed matters of a personal nature before the care of your patients, as set out in the circumstances of paragraphs 2, 8 and 9. The care of your patients ought to have been your priority. The Tribunal is in no doubt that, in nature and degree these failings were serious, and cumulatively amounted to misconduct.
Impairment

23. Having determined that both the probity issues and clinical failings proved against you amounted to misconduct, the Tribunal went on to consider whether your fitness to practice is impaired as a result.

24. The issue of impairment was one for the Tribunal to determine exercising its own judgment. The Tribunal took into account the public interest which included the need to protect patients and the public, to maintain public confidence in the profession, and to declare and uphold proper standards of conduct and behaviour. It has taken account of the documentation provided at this stage of the proceedings including the reports and oral evidence provided by Dr E.

25. In considering the circumstances in which impairment might be established, the Tribunal noted the case of Cohen v GMC [2008] EWHC 581 (Admin) in which Silber J stated, at paragraph 65:

"...It must be highly relevant in determining if a doctor’s fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."

26. It also considered features identified by Dame Janet Smith as being relevant for the consideration of impairment set out in her fifth Shipman report and cited in CHRE v NMC and Grant [2011] EWHC 927 (Admin):

"Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

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

d. has in the past acted dishonestly and/or is liable to act dishonestly in the future."

Probitly Issues
27. The Tribunal has already dealt with the circumstances of your dishonesty in its Determination of the Facts. It notes that the MCCD was an important legal document. It is clearly crucial that the information recorded on such documents is accurate, not least because a deceased’s family is entitled to know, insofar as is possible, how their relation has died. Furthermore, as well as misleading the Coroner, inaccurate information of this kind has the tendency of distorting records which are kept for the benefit of the public.

28. In the Tribunal’s view, your dishonest actions in this regard breached fundamental tenets of the profession. Although it accepts that you have reflected upon the circumstances and ramifications of what you did and are remorseful about it, the Tribunal is satisfied that the seriousness of these actions does undermine the reputation of doctors and the public’s confidence in the profession. This means that a finding of impairment on this ground is entirely appropriate.

Clinical Failings

29. The Tribunal next turned to consider whether your fitness to practice is impaired on account of your clinical failings. Given the wide ranging and extensive nature of your clinical failings, there is no doubt that as at November 2014, when you began working at the Health Centre in London Road, Bedford, as part of a NHS England remediation plan, your fitness to practice was impaired.

30. An action plan was devised for you under the supervision of Dr E. This targeted the areas in which your clinical skills and knowledge were deficient. He was assisted in the supervision and mentoring of you by Dr F, who worked in the same practice.

31. Dr E is an experienced GP trainer and has also had considerable experience of supervising doctors in remediation. Both he and Dr F were the professionals most closely involved with you, supervising your remediation over a significant period of time. The Tribunal was impressed by his evidence which it found to be objective and persuasive.

32. The Tribunal has considered the reports of Dr E dated 5 August 2016 and 3 January 2017, and the oral evidence which he gave to it. To begin with you were not fully exposed to the pressures of modern day general practice; in particular, its regular high workloads and administrative burdens. This was very gradually increased in what was undoubtedly a supportive and well run practice. The action plan was successfully completed by the Summer of 2015.

33. The successful completion of the action plan led to you being recruited to paid work at the Practice at least two days per week, with less close supervision. By this time you were now effectively undertaking the same workload as other salaried doctors in the practice. This included undertaking administrative work, prescriptions,
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reports and carrying out home visits. Some of your colleagues were understandably
cautious about being completely confident of your clinical abilities as a doctor who
had been in remediation. In evidence, Dr E expressed a similar caution. All partners
and the practice manager at the surgery were advised to feed back any concerns in
relation to this to Dr F.

34. Dr E’s clear evidence was that you had positively and actively engaged in your
remediation programme and shown commitment to improve. In his view, you had
some way to go to reclaim the trust and support of your colleagues but performed
your responsibilities well. He informed the Tribunal that in fact you have been
working unsupervised part time as a salaried GP at his practice since July 2016. He
was familiar with the current views of his colleagues and concluded that there were
no concerns about your clinical skills, professionalism, work ethic and reliability. He
felt that you had reflected on your serious errors and were unlikely to repeat them in
the future. In his view you are fit to practice without restriction, although he
qualified this by saying that you should continue working in large supportive
practices for the foreseeable future where there was help and support readily to
hand.

35. The Tribunal finds that you have developed insight into your clinical failings.
It has noted your reflective and remediation statement, List of Educational Activities
in the period 28 January 2016 to 7 January 2017 and CPD certificates for the period
11 March 2013 to 5 December 2016. The Tribunal noted that your remediation work
reflects the matters contained within the Allegation.

36. As the Tribunal is satisfied that all aspects of your misconduct, in relation to
your clinical practice and knowledge, have now been addressed it has determined
that your fitness to practise in this respect is not impaired.

Conclusion

37. In conclusion the Tribunal finds your fitness to practice impaired by reason of
your dishonesty and misleading behaviour but not impaired by reason of your clinical
failings.

Determination on Sanction - 13/01/2017

Dr Okafor:

1. At the outset of these proceedings the Tribunal determined that certain parts
of this case be heard in private pursuant to Rule 41 of the General Medical Council
(Fitness to Practise) Rules 2004 (“the Rules”). Therefore, the press and public will be
excluded from those parts of the hearing relating to XXX and this determination will
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be read in private. However, as this case does also concern your alleged misconduct, a redacted version will be published at the close of the hearing with those matters, relating to XXX, having been removed.

2. Having determined that your fitness to practise is impaired by reason of your misconduct, the Tribunal has now considered what action, if any, it should take with regard to your registration.

3. In so doing, the Tribunal has given careful consideration to all the oral and written evidence adduced, including the remediation documentation provided at the impairment stage, Ms Barbour’s submissions on behalf of the GMC and Mr Ferguson’s submissions on your behalf.

4. The Tribunal does not intend to repeat in full the detailed submissions made by Ms Barbour, Counsel for the GMC, and Mr Ferguson, as they, and the Legal Assessor’s advice, are a matter of public record.

5. Ms Barbour submitted that the appropriate sanction in your case is one of suspension. She drew the Tribunal’s attention to the relevant paragraphs of the GMC’s Sanctions Guidance (SG) (July 2016) which included specific reference to paragraphs 14, 22, 85, 86, 87 and 91. She made submissions in relation to your previous interim order of suspension and drew the Tribunal’s attention to the cases of Khan v GMC [2015] EWHC 301 (Admin), Abdul-Razzak v GMC [2016] EWHC 1204 (Admin) and Kamberova v NMC [2016] EWHC 2955 (Admin).

6. She submitted that you had breached a number of the fundamental tenets of the profession, your dishonest actions occurred in the course of your work as a doctor and consequently the impact on public confidence is magnified.

7. Mr Ferguson submitted that suspension is the appropriate sanction given the circumstances of your case. He accepted that integrity, probity and honesty are important principles for those who practice medicine. He conceded that dishonesty is something which is taken very seriously. He drew the Tribunal’s attention to your personal financial circumstances and the impact which these matters have had upon you, both personally and professionally. His submission was that Dr E and Dr F as well as NHS England have been prepared to invest considerable time and resources in your remediation. He reminded the Tribunal that you had already served a period in excess of three years either out of practice completely or carrying out unpaid work due to Interim Orders. He added that a lengthy period of suspension could have the potential effect of undoing the considerable remediation work you have completed.

Tribunal’s Approach
8. The decision as to the appropriate sanction to impose, if any, was a matter for this Tribunal exercising its own independent judgement.

9. In reaching its decision, the Tribunal took account of the SG. It bore in mind that the purpose of the sanctions was not to be punitive, but to protect patients and the wider public interest, although they may have a punitive effect.

10. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing your interests with the public interest. The public interest includes the protection of patients, the maintenance of public confidence in the profession, and the declaring and upholding of proper standards of conduct and behaviour.

11. The Tribunal has already given a detailed determination on impairment. It took those matters into account during its deliberations on sanction.

12. The Tribunal considered the aggravating and mitigating factors in your case. The principal aggravating factors identified by the Tribunal are that in September 2012, at a time when you did not attend to Patient A during her last illness, or possess sufficient knowledge of her condition upon which to base a sound opinion regarding cause of death, you stated the cause of death on the Medical Certificate of Cause of Death ("MCCD"), dated 10 September 2012, to be bronchopneumonia. You also claimed that you had last seen her alive on 3 September 2012, when in fact you had not seen her at all. Your actions and failure to inform the Coroner of the circumstances of the death prevented Coroner's inquiries into the cause of that death. It also deprived the family of important information about the accurate cause of Patient A's death.

13. The fact that your dishonesty occurred in the performance of your duties and involved a legal document for the public benefit, aggravates your breach. As does the fact that it occurred after you failed in your clinical duties towards Patient A. Entering false information on the MCCD had the effect of concealing your failures, which the Tribunal considers to be an aggravating feature. The Tribunal also takes account of the fact that although an isolated dishonest act, it has found other aspects of your misconduct to be misleading.

14. The Tribunal accepted that there were a number of mitigating factors in your case. You admitted a number of paragraphs of the Allegation at the outset of the proceedings and appeared genuinely remorseful about your failings. The Tribunal noted that you are of good character and there is no evidence of any previous failings on your part. The Tribunal accepted the testimonials which were presented to it that attested to your being a good and competent doctor. The Tribunal is satisfied that you have demonstrated insight and Dr E's clear evidence was that you had positively and actively engaged in your remediation programme. He also said that you had been transparent when detailing the matters which brought you before
this Tribunal. He stated that you have shown genuine commitment to improve. The Tribunal has been informed that Willen Village Surgery was in chaos at the time you were working there and the surgery has subsequently closed.

**Tribunal’s Decision**

15. In its considerations at this sanction stage, the Tribunal recognised that your dishonesty was in relation to one patient only.

16. In coming to its decision as to the appropriate sanction, if any, to impose in your case, the Tribunal first considered whether to conclude the case by taking no action.

17. The Tribunal determined that in view of the serious nature of its findings in relation to your dishonesty at the impairment stage, it would not be sufficient, proportionate nor in the public interest, to conclude this case by taking no action.

18. The Tribunal next considered whether it would be sufficient to impose conditions on your registration. It bore in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

19. The Tribunal did not consider that suitable conditions could be devised to remediate your dishonesty. It determined further that, an order of conditions would not be sufficient to uphold public confidence in the medical profession. Therefore, the Tribunal determined that it was not sufficient to direct the imposition of conditions on your registration.

20. The Tribunal then considered whether to suspend your registration would be appropriate and proportionate. The SG at paragraph 85 states:

   "Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practiseing (and therefore from earning a living as a doctor) during the suspension, although this is not its intention."

21. The Tribunal also noted paragraph 91 which states:

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

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

b. In cases involving deficient performance where there is a risk to patient safety if the doctor’s registration is not suspended and where the doctor demonstrates potential for remediation or retraining.

... 

... 

e. No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor’s unwillingness to engage.

f. No evidence of repetition of similar behaviour since incident.

g. The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.”

22. In relation to dishonesty, the Tribunal took account of paragraph 114 of SG which states:

“Good medical practice states that registered doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients’ trust in them and the public’s trust in the profession.”

23. The Tribunal is of the view that your actions amounted to serious departures from the principles of Good Medical Practice. These involve breaches of the trust placed in doctors. Although each case must be dealt with on its own facts, findings of dishonesty are at the top end of the spectrum of gravity in cases of misconduct. As part of its duty to protect the public interest, the Tribunal must declare and uphold proper standards of conduct and behaviour. The Tribunal is aware that the SG makes it clear that misconduct involving dishonesty may lead to erasure.

24. Having recognised the importance of probity in doctors, the Tribunal considered with care the facts of your case. Given the particular findings made by the Tribunal in your case it concluded that, although serious, they are not so serious, as to be fundamentally incompatible with you continuing to be a registered medical practitioner.

25. Whilst there is a clear public interest in the promoting and maintaining of proper professional standards and conduct for members of the profession, there is also a public interest in not depriving the public of services of an otherwise
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competent practitioner. The Tribunal heard evidence that your practice has been supervised for a significant period of time by Dr E and Dr F. They provided evidence of their high level of satisfaction with your progress. Taken in the round therefore, the Tribunal considered that the sanction of erasure would be disproportionate given your record of remediation and the fact that your misconduct in 2012 has not been repeated.

26. The Tribunal carefully considered whether suspension would be a sufficient sanction in your case. It noted that suspension has a deterrent effect and sends out a signal to you, the profession, and the public about behaviour which is unbefitting a medical practitioner. It also has a punitive effect in that it prevents you from practising and thereby earning a living, although this is not the intention. In this case the Tribunal concluded that suspension would be sufficient to achieve this.

27. In all the circumstances, the Tribunal determined that it would be both sufficient and proportionate to suspend your name from the Medical Register for a period of six months. In deciding the length of suspension, the Tribunal took account of the nature of your dishonesty, and the need to demonstrate clearly to you, the profession and the public that such misconduct is unacceptable. It balanced this against the public interest in retaining an "otherwise competent and useful doctor" who, after a period of supervision and changes to his practice, no longer presents a risk to the public. The Tribunal has also taken into consideration the potential detriment to your practice that a long period of suspension could have and on the significant remediation work you have undertaken with London Road Practice, Bedford, and NHS England. It has determined that a period of six months will not hamper or halt that progress.

28. The Tribunal considered whether to direct a review in this case. It has had regard to your CPD documentation and the positive report from your Clinical Supervisor, Dr E. It has noted that during your period of remediation you have engaged fully, have followed procedures and there has been no repeat of your previous dishonest behaviour. The Tribunal is confident that you would maintain your medical knowledge and skills during the period of suspension. It considered that a review would serve no useful purpose.

29. The effect of this direction is that, unless you exercise your right of appeal, your name will be suspended from the Medical Register for a period of six months, with effect from 28 days from when written notice of this determination has been served upon you. A note explaining your right of appeal will be sent to you.

**Determination on Immediate Order - 13/01/2017**

Dr Okafor:
Record of Determinations –
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1. Having determined to impose a period of suspension on your registration, the Tribunal has now considered in accordance with Section 38 of the Medical Act 1983, as amended, whether to impose an immediate order of suspension on your registration.

2. Ms Barbour submitted that given the seriousness of the Tribunal’s findings, it is necessary, in the public interest to impose an immediate order of suspension. She submitted that based on the serious findings made by Tribunal in relation to your probity the message would be diluted if an immediate order was not imposed. She drew the Tribunal’s attention to the relevant sections of the SG in particular paragraphs 168-170.

3. Mr Ferguson submitted that the imposition of an immediate order was not necessary in this case. He also drew the Tribunal’s attention to paragraph 166 of SG. He submitted that the Tribunal has been provided with documentary evidence which denotes the lack of risk to patient safety. He submitted that it is recognised that the matters in your case are serious but that the public interest has been served by the substantive order of suspension made by the Tribunal.

4. The Tribunal determined that, in the light of its earlier finding that you do not present a risk to patients, it is not necessary for the protection of patients to impose an immediate order of suspension on your registration. The Tribunal determined its duty to protect the public interest, which includes the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour will be achieved by the imposition of the period of six months suspension.

5. The effect of the foregoing direction is that, unless you exercise your right of appeal, your registration will be suspended 28 days from the date on which written notice of this decision is deemed to have been served upon you.

6. The interim order of conditions imposed on your registration is revoked.

7. That concludes your case.

Confirmed
Date 13 January 2017

Dr Wendy Kuriyan, Chair