Primary Health Lists

The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008

The National Health Service (Performers Lists)(England) Regulations 2013

Appeal heard at the Royal Courts of Justice, 17 and 18 July 2017

[2017] 2950.PHL

Dr Augustine Oraka-Onojeje

Applicant

v

NHS Commissioning Board (London – South)

Respondent

DECISION

Tribunal Panel – Judge D Shaw
Dr P García
Ms J Everitt

Parties Present
Mr Guy Micklewright of Counsel represented NHS England ("NHSE"). Dr Nicola Payne (Associate Medical Director, NHSE) and Mr Adam O'Donnell (CQC Inspector) appeared as witnesses for NHSE.

Dr Oraka attended without legal representation. Dr Clare Gerada (Psychiatrist, NHS Practitioner Health Programme ("PHP") appeared as his witness.

The Appeal

1. Dr Oraka appeals, pursuant to Regulation 17 of the National Health Service (Performers List) (England) Regulations 2013 ("the Regulations"), against a decision to remove him from the medical Performers List on the grounds of unsuitability and efficiency.
2. NHSE opposes the appeal on the basis that all of the factual allegations which formed the basis of the decision by the Performers List Decision Panel ("PLDP") on 23 January 2017 to remove the Applicant from the Performers List are properly made out on the evidence, and that the only proper exercise of the Tribunal's discretion is to uphold the decision to remove.

The Legislative Framework

3. On 27 January 2017 the PLDP formally notified Dr Oraka of its decision to remove him from the Performers List, exercising its powers under Regulation 14(3)(b) and (d) of the Regulations, which provide as follows:

    - Regulation 14(3)(b) gives the NHS Commissioning Board ("the Board") power to remove a practitioner from the Performers List on the grounds that their continued inclusion on the list would be prejudicial to the efficiency of services.

    - Regulation 14(3)(d) of the Regulations gives the Board power to remove a practitioner from the Performers List on the grounds that they are unsuitable to be included on the list.

4. Dr Oraka has a right of appeal to the First-Tier Tribunal ("the Tribunal") against the PLDP's decision by virtue of Regulation 17(1) and (2). This requires the Tribunal to make a fresh decision by way of redetermination in light of all the information before it, which includes any new information or evidence not available to the PLDP. Both parties have adduced further evidence in these proceedings.

5. Regulation 17(4) provides that on appeal, the Tribunal may make any decision which the Board could have made, i.e. it may act in accordance with Regulations 14(3)(b), 14(3)(d) or 10(1) and so has a discretion to remove a Practitioner from the Performers List on the grounds of unsuitability, or to remove or impose conditions to prevent any prejudice to the efficiency of services.

6. NHSE has submitted the Tribunal should apply a two stage-test to the question of dishonesty pursuant to R v Ghosh [1982] EWCA Crim 2:

    i. Was the conduct in question dishonest by the standards of reasonable and honest people?
    ii. Did Dr Oraka realise that his conduct was dishonest by those standards at the time?

The Allegations

7. The allegations which form the basis of NHSE's case before the Tribunal are as follows:

i. Dr Oraka currently holds inadequate indemnity cover, in particular in respect of retrospective indemnity cover.

ii. Dr Oraka practised without any, or any adequate, indemnity cover from between on or around 1 October 2009 until around November 2016.

iii. Dr Oraka dishonestly gave misleading information about his indemnity status at his appraisals in 2013, 2014, 2015 and 2016.

iv. Dr Oraka dishonestly failed to inform his appraisers that he was practising without indemnity at his appraisals in 2013, 2014, 2015 and 2016.

v. Dr Oraka dishonestly gave misleading information to Mr O'Donnell, a CQC Inspector, during an inspection of his practice on 20 October 2016.

vi. Dr Oraka dishonestly failed to inform Mr O'Donnell that he was practising without adequate indemnity cover.

vii. On or around 30 June 2016 Dr Oraka dishonestly gave misleading information to the Medical Protection Society ("MPS") when applying for indemnity cover, namely he indicated that he had not previously been refused professional indemnity cover or had been refused the renewal of professional indemnity cover.

The Issues

8. NHSE submits these allegations lead to the following issues requiring consideration by the Tribunal:

i. The adequacy of the retrospective indemnity cover.

ii. Whether there was an intention by Dr Oraka to mislead his appraisers as to his indemnity status, either by commission or omission.

iii. Whether there was an intention by Dr Oraka to mislead Mr O'Donnell as to his indemnity status, either by commission or omission.

iv. Whether Dr Oraka intended to mislead the MPS.

Background

9. Dr Oraka joined the Falmouth Road Practice ("the Practice") in 2005. Whilst there he became Prescribing Lead in 2005, had a managerial role from 2006, became a GP community medical student tutor in 2007, became a partner and QoF Lead in 2013, and became Child Safe Guard Lead in 2015.

10. Following CQC inspections on 29 April 2015 (when the Practice was placed in Special Measures) and 5 January 2016 (when it remained in Special Measures), during a further CQC inspection on 20 October 2016, Dr Oraka was unable to supply evidence of indemnity insurance.

11. Dr Oraka spoke to Mr O'Donnell, the CQC lead inspector, at the conclusion of the inspection and showed him an indemnity insurance application form. Mr O'Donnell asked if there was current cover for everyone, including Dr Oraka. As Dr Oraka was unable to supply evidence of current cover for himself on the day, Mr O'Donnell asked him to produce it within 48 hours.

12. On 24 October 2016 Dr Oraka telephoned Mr O'Donnell to confirm he did not currently have indemnity insurance. When the Practice Manager subsequently sent to CQC copies of two indemnity insurance application forms completed by Dr Oraka (one to MDDUS dated 20 October 2016 and one to MPS dated 30 September 2016 and 16 October 2016 in different places) it became apparent that he had not had indemnity insurance in place since September 2010.

13. CQC informed NHSE on 27 October 2016 and NHSE contacted Dr Oraka to inform him he must stop working immediately.

14. CQC wrote to the Practice on 16 November 2016 to notify it that it intended to cancel its registration as a provider. On 25 November 2015 the Practice responded that it would not be appealing cancellation of registration.

15. Following the PLDP hearing Dr Oraka arranged prospective insurance cover for £10,000,000 ("£10M") from Towergate Insurance at a cost of approximately £18,500 from January 2017. He also obtained a quote for retrospective insurance cover of £1M for the period during which he had practised without any indemnity cover.

Evidence and Submissions relating to Outstanding Issues

16. The fact that we have not specifically referred to all of the evidence does not mean that we did not consider it, but simply that we have restricted our summary of the evidence and the submissions herein to that which we consider most relevant to our conclusions.

Issue 1 - The adequacy of the retrospective indemnity cover

17. As Dr Oraka now has adequate prospective indemnity cover for £10M in place, NHSE restricted its case to the issue of retrospective cover. In its Skeleton Argument NHSE submitted that it is a contractual requirement under Regulation 4(3)(c) that performers maintain "appropriate indemnity" and that it is a requirement of the GMC's 'GMC Guidance of Good Medical Practice' ("GMP") that: "you must make sure you have adequate insurance or indemnity cover so that your patients will not be disadvantaged if they make a claim about the clinical care you have provided in the UK".

18. As at 2015, NHSE's position regarding what it considers to be adequate indemnity cover is set out in an internal letter dated 27 November 2015. In short, the minimum is £10M of cover for each claim, both prospectively and retrospectively. However, the quote provided by Dr Oraka from Towergate for retrospective cover is limited to cover to the value of only £1M and NHSE submits this is inadequate.

19. There is no dispute of fact that Dr Oraka did not have the benefit of indemnity cover from on or around 1 October 2009 until January 2017.

20. NHSE submits that any administrative difficulties which Dr Oraka asserts he had in maintaining and then securing indemnity cover, however sympathetic one may be to them, are entirely irrelevant to this allegation. The duty on a doctor once he is on notice that he does not have the benefit of indemnity cover is to cease practice immediately until the situation has been remedied. Dr Oraka failed to do so; indeed, he continued in practice for over 7 years.

21. Dr Oraka's argument that in the intervening period no claims have been made and therefore no harm has been caused against him entirely lacks merit; in fact, it exemplifies his lack of insight. The time limit for bringing clinical negligence claims in the UK is three years from the date at which damage became known, or should reasonably have been known, to the claimant. The time limit does not begin to run from the date of the negligent act. There may well be negligent acts committed during the time Dr Oraka was without cover which will give rise to a claim against him in the future of which he is currently unaware.
22. In NHSE's submission, the Tribunal should infer from Dr Oraka's lack of insight a risk that he may, should cashflow prove to be difficult in future, fail to maintain his indemnity cover.

23. In his amended witness statement dated 6 July 2017 Dr Oraka submitted that, as well as obtaining revised prospective indemnity insurance (above normal crown indemnity and with £10M cover for meningitis) for a year in advance,

effective from January 2017, since the PLDP hearing he has also secured a quote for retrospective indemnity cover at a cost of £27,500 pending availability of expected funds and due tribunal considerations.

24. Dr Oraka contended that the period of lapsed indemnity cover was investigated by NHSE with the assistance of the National Clinical Assessment Service (NCAS) before the PLDP oral hearing and the outcome was confirmed as no concerns. In addition, on LMC advice, he has refrained from attending to NHS patients since November 2016.

25. Dr Oraka confirmed that prior to the period of lapsed indemnity cover, he paid indemnity subscriptions by direct debit. He submitted that this arrangement fell apart and became unsustainable due to the lingering, extraordinary, dysfunctional and fractious partnership which appeared to have clouded his sense of judgement. He had struggled with attempts to explore options of alternative indemnity providers over this period, but his letter of good standing ("LOGS") from MDU (which is required to secure indemnity cover) was only released directly to him in November 2016 after many attempts to change indemnity provider to MDDUS.

26. In his Skeleton Argument Dr Oraka quoted the GMP requirement for adequate insurance or indemnity cover to protect patients and NHSE's position as at 2015 that adequate indemnity cover is a minimum is £10M for each claim, both prospectively and retrospectively. He reiterated the chronic, complex and profound challenges he had experienced, especially during the period in question, which he submitted had clouded his sense of judgement, as supported by the outcome of his medical assessment report from PHP. He further submitted that he is willing to do more to ensure the same problem does not occur again and it should be recognised that he has not always been like this. He is willing and amenable to make amends to ensure continued safe practice as he has done for over 28 years without any claim and the Tribunal should take his efforts to restore prompt indemnity cover, make appropriate disclosures in his March 2017 appraisal, reflect on the issues and engage with PHP as ample evidences of insight and desire to turn over a new leaf.

27. At the hearing Counsel for NHSE submitted that there being no known negligence or clinical complaint does not absolve Dr Oraka from the requirement to have retrospective indemnity cover in place and as a GP he could not take advantage of general NHS indemnity cover. He has a fundamental lack of insight and understanding of the need for such cover.

28. Dr Oraka gave evidence that it had only recently been brought to his attention that £1M retrospective cover would be inadequate and he had previously thought NHSE was satisfied with that. Since he was informed (in NHSE's

Skeleton Argument dated 7 July 2017) that he requires more retrospective cover, he has contacted Towergate; the underwriters are currently looking into this and he is willing to pay the additional premium.

29. On questioning Dr Oraka submitted that he got into financial difficulties in 2009, which resulted in his direct debits for indemnity cover not being paid. He could not recall if he had responded to MDU's letters in November 2009 and January 2010 informing him that his direct debit mandate had been cancelled and asking for outstanding premium of £3,720, or to its letter on 12 February 2010 telling him that his name had been taken off the MDU's list of registered members from 1 October 2009. Whilst he did respond to the 12 February letter in an e-mail dated 3 April 2010, he thought he might have telephoned them before then, but he could not be sure.

30. MDU had been his only indemnity provider since the time Dr Oraka was a hospital doctor, his income was severely reduced, he had cash flow problems and his direct debits failed a few times. He attempted to reinstate the direct debits but he was asked to pay the outstanding £3,720 premium balance. He could not afford this and tried to appeal. He also tried to explore other providers, not knowing that his LOGS would need to be released in order for him to obtain cover elsewhere.

31. MDDUS would not give retrospective cover and required the LOGS for prospective cover. MDU would not release the LOGS but said Dr Oraka was at liberty to reapply. He continued to contact MDDUS and also MPS to try and reinstate cover and although he discovered it would be more effective to obtain group cover, his partners would not co-operate.

32. It may have been ignorance on his part that Dr Oraka continued to practise without indemnity cover. He was also hoping to resolve the issue and he was not fully aware of the implications at the time. It was much more relaxed and loose in those days and his dysfunctional partnership, his marriage and his cash-flow problems had clouded his judgment. It was only when it was first brought to his attention in November 2016 that he realised he should not be practising without indemnity cover.

33. Although he did not know he should not be practising without indemnity cover until November 2016, he knew he should have cover as a safeguard against complaints and negligence.

34. It was not a deliberate attempt to evade responsibility. Dr Oraka made several reapplications for both group and individual indemnity cover, including on 28 July 2010 with MDU. To the best of his memory, he had been honest and transparent with them and explained the position to them over the phone in

response to their question in a letter dated 3 September 2010 asking if he had been working without indemnity since 1 October 2009. That letter was subsequent to their phone conversation and he had been trying to play down the level of risk.

35. Dr Oraka confirmed that indemnity cover is insurance in case of any eventuality, litigation or complaints, such as patient action against a doctor. He knew there was a requirement for him to obtain his own cover when he left hospital and went into general practice, but things started to slip after a few years. He conceded that by continuing to see patients without cover, he was putting them at risk. He had reflected on this over time, but not to the depth he has now done. The lapse of cover was not deliberate and he had no ulterior motive to mislead his appraiser. It does not reflect the type of person he is; his previous track record of cover is unblemished and there have never been any claims against him.

36. Dr Oraka's attempts to obtain retrospective cover were previously declined. He was advised that it is easier to first obtain prospective cover. The only company which responded favourably was Towergate, and he has now asked them to revise their quote for retrospective cover up to £10M.

37. Dr Oraka submitted indemnity cover is a safeguard for both clinicians and patients, but more for clinicians if there is a negligence issue. However, he acknowledged that if patients knew there was no cover in place they would be disappointed, as it is a crucial requirement for doctors, without which patients' confidence and trust in a doctor could be undermined.

38. Given NHSE indicated in its response to the appeal on 5 April 2017 that £1M retrospective cover would be inadequate and Dr Oraka had quoted in his Skeleton Argument that NHSE's current position in relation to adequate indemnity cover is a minimum is £10M for each claim, both prospectively and retrospectively, Dr Oraka was asked why he now claimed he only found out that £1M retrospective cover would be inadequate when he received NHSE's Skeleton Argument on 7 July 2017. He replied that he did not recall seeing this in NHSE's response to the appeal and he had included the word "retrospectively" in his Skeleton Argument in error.
39. Dr Oraka submitted that he proposes obtaining retrospective cover as soon as possible, once he receives Towergate's revised quote. He had not as yet obtained such cover because of his financial position and on advice from the LMC and PHP. He will obtain funds when the Practice premises are disposed of and he can obtain financial support from relatives, colleagues and friends, from refinancing his house and from returning to work. He confirmed that he planned to obtain retrospective cover even if he loses this appeal and cannot return to NHS practice.

40. Dr Oraka submitted prospective, rather than retrospective, cover is most important at this point.

41. When asked whether the revised quote of £27,500 for retrospective cover from Towergate is additional to the £16,700 Dr Oraka has already paid (i.e. over £44,000), or whether he is only required to pay the differential (i.e. approximately £10,800), Dr Oraka thought it was only the differential. He also said he understood this to be a one-off premium for retrospective cover and was unclear about the fact this is an annual premium and he will need to continue to pay for tail-off retrospective indemnity cover for a number of years, even if he does not return to, or ceases, active practice. He also indicated he plans to change provider (e.g. MDU) to obtain a lower annual premium from January 2018, although he cannot know if any other provider will accept him.

42. Dr Gerada gave evidence that it is not unusual for a doctor's indemnity cover to lapse for various reasons, e.g. when there are mental health, practical or practice issues, the latter being the case for Dr Oraka. However, she acknowledged that she would have serious concerns relating to a lack of indemnity cover for over 6 years and that, ultimately, it is the partners', as opposed to the Practice Manager's responsibility. In her experience complaints tend to happen in the first few weeks or months and historic complaints are very unusual in general practice.

43. In closing, Counsel for NHSE submitted that, to date, Dr Oraka has not obtained any retrospective cover. As he is not currently in practice prospective cover is not key, but it is attractive to Dr Oraka as it is less expensive. Dr Oraka's submission that he needs prospective cover before he can obtain retrospective cover should be treated with caution. NHSE does not accept Dr Gerada's evidence that complaints tend to happen in the first few weeks or months and historic complaints are very unusual in general practice; she was not an expert witness, this was purely anecdotal evidence unsupported by data and the Tribunal could not rely on it in relation to the likelihood of future claims being made against Dr Oraka. NHSE submitted that Dr Oraka continues to pose a risk to the public as:

    - He still does not have any retrospective cover. Beyond obtaining a quote for an inadequate amount, which he has been aware of for some time, he has taken no steps to take up such cover, other than to seek a revised quote in the last few days.

    - He has no proper understanding of the significance of indemnity cover, having given evidence it is more important from the clinician's, as opposed to the patient's, perspective. He clearly does not understand the legislative and GMP requirement that patients need to be protected

against negligence and be able to obtain damages if something goes wrong.

- He has no understanding of tail-off cover, even after ceasing active practice.

- There remain ongoing financial risks in respect of his continued cover. He gave evidence he has difficulties affording the premiums, which will be high due to his previous lack of cover for so long, although given he has no employment prospects at the moment, the risk is mitigated if only retrospective cover is necessary. In addition, if the Tribunal decides to dismiss this appeal, the GMC will bring proceedings and his insurers will be required to fund his defence.

44. In closing, Dr Oraka submitted that he is appealing against the proportionality of the penalty and he does not contest the factual evidence. He has taken steps to address the indemnity issues with prospective cover, including revised cover for meningitis, and he has taken steps to get a quote for, and is working on, a revised quote for retrospective cover.

Issue 2 - Whether there was an intention by Dr Oraka to mislead his appraisers as to his indemnity status, either by commission or omission

45. In its Skeleton Argument NHSE submitted that Dr Oraka dishonestly gave misleading written information about his indemnity status for his appraisals in 2013, 2014, 2015 and 2016 and also dishonestly failed to verbally inform his appraisers that he was practising without indemnity at those appraisals. Whilst Dr Oraka has submitted this was due to, among other matters, clouded judgment due to difficulties in the Practice's partnership, other overwhelming distractions, financial problems and ignorance, it is NHSE's case that at all material times he knew full well that he did not have any indemnity cover, knew full well that he needed to and that he deliberately misled the appraisers as to his indemnity status and in doing so acted dishonestly.

46. In his amended witness statement Dr Oraka submitted that his incorrect indemnity disclosures during the period of lapsed indemnity were due to human error precipitated by complex protracted challenges, but this was a significant departure from his usual historic indemnity record. As a result of the protracted challenges he experienced over the years, he tended to do his appraisals last minute, with a propensity to rush his appraisal preparations with potential for error, as should be obvious from his appraisal history, especially over the period of lapsed indemnity. The GMC had found him not to be dishonest and he had an appraisal in March 2017 with appropriate honest

declarations, demonstrating insight consistent with disclosures in previous appraisals prior to the period of lapse of indemnity.

47. In his Skeleton Argument Dr Oraka submitted that although the facts were not in dispute, his appraisal disclosures were influenced by the prevailing factors at the time (as referred to in paragraph 45 above). His contact with MDU, MPS and MDDUS over the period in question were his honest, albeit frantic, attempts to secure an alternative indemnity provider, complicated by MDU's reluctance to release his LOGS, which was eventually released in November 2016 after the CQC inspection on 20 October 2016. It was only after this that Dr Oraka became aware (via LMC and PHP) of other alternative indemnity providers besides MDU, MPS and MDDUS.

48. At the hearing Counsel for NHSE submitted that appraisals must take place by the end of March each year. In his 2013 appraisal form Dr Oraka named MDU as his indemnity provider in the drop-down box in section 1, which gives the alternatives of MDU, MPS, MDDUS or "Other". At the PLDP hearing he had claimed there was no opportunity to explain his situation in the drop-down box, where he had had to make an entry. However, he was also required to sign declarations on this form, including a probity declaration, where there was space for free text to set out any issues, but Dr Oraka failed to do so. Nor is there any evidence that he mentioned anything during the appraisal itself; if he had done so the appraiser would have been expected to make a full note and to instruct Dr Oraka to immediately cease practice.

49. The situation remained the same in his 2014 appraisal, i.e. Dr Oraka continued to maintain in his appraisal form that he was covered by MDU and there is no evidence that he mentioned anything during the appraisal itself.

50. Having indicated during the PLDP hearing that in or around 2014 he contacted MDDUS and enquired about membership, during which time he was given a reference number, Dr Oraka put that number in the drop-down box on his 2015 appraisal form and declared that he had membership of MDDUS. The appraiser has recorded on that form that Dr Oraka confirmed that he is a member of MDDUS.
51. Dr Oraka continued to maintain in his 2016 appraisal form that he was covered by MDDUS and there is no evidence that he mentioned anything during the appraisal itself.

52. Dr Payne gave evidence at the hearing that it is a practitioner's responsibility to ensure the information provided in their appraisal form is current and accurate and changing the details of the indemnity provider on the form would require active input by the practitioner. The form also contains a probity declaration, which has free text space for practitioners to add as many probity

issues as necessary. It is their professional responsibility to have indemnity cover; if they do not have it they should not be seeing patients.

53. Dr Oraka gave evidence that he had not had any intention to mislead. He had satisfactorily carried out appraisal work for many years before this. He was facing all the challenges of a very fractured partnership; two partners retired within 6 months of each other and he had to do almost everything within the Practice, often staying there until 12 or 1am. His two marriages had also failed.

54. The MDDUS number he provided in his 2015 appraisal form was genuine and given to him when he tried to change provider. Dr Oraka had not declared indemnity as a probity issue as he had disclosed other very major issues and it was a case of him having to come to the realisation that it was a probity issue. Nor had he been sure that it was a matter to discuss with his appraiser. Whilst his 2015 appraiser had recorded on the appraisal form that Dr Oraka had confirmed that he was a member of MDDUS, he was not too sure if he had said that or just that he had made the application [to join MDDUS].

55. Dr Oraka did not accept that he had acted dishonestly in relation to his appraisals. He referred to his errors of judgment, clouded judgment and human error as an objective assessment of his mental state at the time, which was not as good as it should have been as he was under enormous pressure. His appraisals were all rushed and pressurised and he had been blindfolded and distracted by the other probity issues he had raised.

56. When asked if he had done work with PHP around taking personal, professional responsibility for his own actions, Dr Oraka confirmed his engagement with the LMC and PHP was ongoing and he has come to realise how he could have handled matters differently. PHP had recommended alternative indemnity providers, the partnership has been deregistered so there is no longer a partnership crisis, he had taken steps to obtain both prospective and retrospective indemnity cover and he made contrite disclosures in his 2017 appraisal a probity issue. He now has the necessary insight to take steps and put measures in place to ensure this does not happen again. He understands the duty of candour is important and that patients need to have trust and confidence in doctors.

57. In closing Counsel for NHSE submitted that it is wholly incredible that Dr Oraka did not intend to mislead his appraisers because:

    - By 4 April 2010 at the very latest he knew he had no indemnity cover.

    - He knew that he should not be practising without indemnity cover. Why else would he keep applying for it and appealing those applications? It

is absurd and unacceptable that between 2010 and 2016 he thought it acceptable to continue to practise without it, given he had previously held it and said he was aware of the GMC's requirements for it.

- Whatever the position was with section 1 of the appraisal form and the dropdown boxes, Dr Oraka accepted in his evidence that by inserting a provider and membership number, he was representing to his appraiser that he had adequate indemnity cover in place. Over and above that, there is no doubt that when he amended the provider from MDU to MDDUS on his 2015 appraisal form, he knew he was making a representation relating to change of provider.

- Dr Oraka accepted in evidence that he could have raised the issue of his lack of indemnity cover either in his declarations on the appraisal form or in subsequent discussions with his appraiser.

- There is a note by Dr Oraka's appraiser on his 2015 appraisal form that he had confirmed membership of MDDUS (but nothing further). Had he disclosed his lack of cover and the fact he was still practising to any of his appraisers, it is highly unlikely they would not have noted it or taken any action.

Accordingly, the only conclusion the Tribunal could reach is that Dr Oraka deliberately misled his appraisers when he filled in his appraisal forms and deliberately omitted to correct the position in the declarations section or during the appraisals themselves.

58. In closing Dr Oraka submitted that he had previously had appraisals and made disclosures and if he was a dishonest person he would have a track record. He maintained that his intention was not to mislead, but it was the circumstances he found himself in and the pressures and complex challenges that he faced.

Issue 3 - Whether there was an intention by Dr Oraka to mislead Mr O'Donnell as to his indemnity status, either by commission or omission

59. In its Skeleton Argument NHSE submitted that Dr Oraka would have known during the CQC inspection that he had no valid indemnity cover as he had not even sent one of the application forms off and there was no way he could get a valid certificate to Mr O'Donnell within 48 hours. Moreover, he was still practising as a clinician despite knowing the correct indemnity position and he failed to inform Mr O'Donnell of that fact.

60. In his amended witness statement Dr Oraka submitted that the CQC inspection was disclosed with less than two weeks' notice in a high-level meeting of partners with NHSE, CQC, PHC and the LMC during which his fellow partner was encouraged to resign or retire.

61. He maintained that his disclosure to the CQC inspector was as honest as it could be at the time as he was hopeful, but subsequently disappointed, when his applications for indemnity were declined. He kept the CQC inspector abreast as promised, and as substantiated by the email trail.

62. Dr Oraka recalled that the CQC inspector responded to a polite invitation to his office for an explanation of his indemnity situation and was amenable for him to chase up matters urgently, which he subsequently did but unfortunately was let down by MDU, which had a knock-on effect on the other two major providers (MDDUS and MPS). He was not to know there were other, alternative, smaller company indemnity providers until much later, from his contact with PHP for stress management and from the LMC.

63. In his Skeleton Argument Dr Oraka reiterated that his disclosures to Mr O'Donnell should be seen in the context of the most complex and unusual challenging circumstances, which resulted in the clouding of his judgement as confirmed by his professional health assessment at PHP.

64. He submitted that his disclosures to Mr O'Donnell were as honest and candid as they could be at the time and consistent with the way he had dealt with the two previous CQC inspectors. His subsequent telephone contact with Mr O'Donnell was to keep him abreast of developments as promised. Although he did not recall his verbal exchange with Mr O'Donnell, his reaction at the time may have been influenced by the immense stress that he was under at the time from multi-factorial causes. He queried why, if 20 October 2016 was a Thursday, he would have promised to revert to Mr O'Donnell within 48 hours, which would have been the weekend when neither the indemnity provider, nor the GP practice, nor CQC would be open for business. Faced with the prospect of practice closure after the last CQC special measures inspection and the way the short notice of this CQC inspection was disclosed to the partners, the stress levels in the Practice at the time were visibly palpable and phenomenal. As multiple applications were attempted with different providers, considering the stress levels, improperly completed application forms were more likely to be due to human error than anything else.

65. As the Practice was faced with the grim prospect of closure after the previous CQC inspection, Dr Oraka tried to manage the situation as best as he could, with honest disclosures to Mr O'Donnell as he had done at the two previous CQC inspections.

66. Dr Oraka stopped attending to NHS patients after the 20 October CQC inspection and with the aid of the LMC, the CQC and NHSE were promptly and formally notified.

67. At the hearing Counsel for NHSE submitted that, unlike at the previous two CQC inspections of the Practice, Mr O'Donnell had flagged up the issue of indemnity cover, which would have left Dr Oraka in no doubt that he would have to reveal that he had no indemnity cover and that he was practising without indemnity cover. However, Dr Oraka did not do this; instead, he had a conversation with Mr O'Donnell about group cover and showed him a document. He promised to provide his indemnity certificate within 48 hours, although he must have known he could not do this. All he could do was show an application to MPS dated 30 September/16 October 2016 and a second application to MDU dated 20 October 2016. NHSE contends this was an attempt to obfuscate and mislead Mr O'Donnell.

68. Mr O'Donnell gave evidence at the hearing that he had asked for copies of everyone's indemnity certificates when he inspected the Practice on 20 October 2016, but he was not provided with Dr Oraka's certificate. He had requested these prior to his inspection as it had been an issue at the previous CQC inspection in relation to a counsellor at the Practice.

69. He had followed up CQC's standard letter notifying the Practice of the inspection with a phone call to the Practice Manager, when he would have mentioned he would be checking up on concerns raised at the previous inspection. He would then have followed up with an email in which he would have specifically asked for indemnity certificates to be sent over, or to be available on the day.

70. During his visit to the Practice the Practice Manager confirmed she had requested copies of indemnity certificates from all staff, but Dr Oraka had not provided one or responded to her email.

71. Dr Oraka had taken Mr O'Donnell into his room and said he was in the process of putting together an application for group indemnity cover. Mr O'Donnell had replied that he still needed to have sight of Dr Oraka's indemnity certificate within 48 hours, as he needed to know he had adequate indemnity cover in place as at that date. Dr Oraka confirmed he would be able to do that. Mr O'Donnell expressly asked if Dr Oraka had indemnity cover in place and although it was hard to understand some of what he said, Mr O'Donnell recalled that Dr Oraka had replied "Yes" and Mr O'Donnell had also expressly told him that he needed to provide it within 48 hours. He could not recall what

Dr Oraka had said about the provider but he was certain that Dr Oraka had not disclosed that he had been practising without indemnity cover.

72. In response to questions Mr O'Donnell submitted that whilst it might be possible to argue a Practice Manager would have oversight, it is a clinician's own responsibility to ensure he has indemnity cover in place.

73. Mr O'Donnell had not understood a lot of what Dr Oraka was saying during their discussion but he recalled telling him that all he needed to know was that Dr Oraka had indemnity cover in place and he needed to see it within 48 hours and that Dr Oraka had said "Yes, he would be able to send it across".

74. Whatever the document that Dr Oraka had shown him, Mr O'Donnell had made it clear that this was a future plan and he needed to know what was currently in place.

75. When Dr Oraka had informed Mr O'Donnell on 24 October 2016 that he did not have indemnity cover in place, he did not disclose at that stage for how long he had been without cover.

76. Dr Oraka's evidence at the hearing was that he had been the sole GP concerned with preparing for the CQC inspection. Mr O'Donnell's inspection would be make or break for the Practice, which was one of only two practices in the country in special measures.

77. The Practice had been surprised by the second CQC report and morale was low. They had not been provided with the date of the next CQC inspection and, following a meeting with NHSE, they were only given 1½ weeks' notice. Everyone at the Practice was under stress as they had been told that if they failed in even one area the Practice would be deregistered.

78. Dr Oraka was the main lead in the Practice being asked all sorts of questions at the inspection and he only had time to speak to Mr O'Donnell towards the end of his visit. He had called Mr O'Donnell into his room and explained a few things to him. He had said he was in the process of getting cover from MDDUS and that he had been sent a quote with a cover start date of 20 October 2016, but MDDUS had requested a LOGS from MDU before cover could take effect. Mr O'Donnell had asked how long this would take and Dr Oraka had replied that he would be contacting MDU and MDDUS for a progress report. Mr O'Donnell had said this was beyond him and he would be going back to his superior to see how long Dr Oraka could be given. Dr Oraka had told Mr O'Donnell about his protracted difficulties with MDU and his LOGS and Mr O'Donnell said he would speak to his superior and revert to him. Dr Oraka categorically refuted that he had told Mr O'Donnell that he had indemnity

cover. He had shown him the MDDUS quote with a start date of 20 October 2016 and a premium of about £10,000.

79. At the time Dr Oraka was in contact with MDU and MDDUS and he also frantically contacted MPS to try to get a provider. He was also exploring group cover. He also tried to address the Practice Manager's concerns and he contacted the LMC to seek advice. When he eventually got his LOGS from MDU direct, he reapplied to MDU for indemnity cover but they declined him, as did MDDUS.

80. In response to questions Dr Oraka confirmed that the document he had showed Mr O'Donnell was his own application to MDDUS for individual cover, but he was also exploring other options at the time, including group cover. He was making frantic efforts to obtain cover by the time of the CQC inspection. He understood that not having indemnity cover could put the practice at risk.

81. Dr Oraka had proactively approached Mr O'Donnell during his visit and he had been open and honest with him. He had known Mr O'Donnell wanted confirmation of his current indemnity cover and that he would want to know if anyone without cover was continuing to offer medical services, but Dr Oraka did not say at that meeting that he did not have cover or that he was seeing patients.

82. In closing Counsel for NHSE submitted that Dr Oraka knew that the issue of indemnity cover would arise at the CQC inspection on 20 October 2016 because it had been an issue at the previous CQC inspection and also because of Mr O'Donnell highlighting it beforehand. It was clearly in Dr Oraka's mind and the reason for his "frantic attempts" to have indemnity cover in place for the inspection. Although Mr O'Donnell's evidence was not perfectly clear in relation to what was discussed or the document he was shown, it does not mean that he is an unreliable witness in relation to that discussion. Mr O'Donnell gave entirely credible evidence that he found it hard to understand exactly what Dr Oraka was saying, but he had made it clear that he needed to know within 48 hours that Dr Oraka had indemnity cover in place on the date of the inspection. Despite Dr Oraka accepting in his evidence that he knew a CQC visit was designed to ensure a practice was functioning in a way that did not put patients at risk and that Mr O'Donnell would wish to know if he did not have indemnity cover and/or that he was practising without it, he failed to provide any of that information. He knew that he was on the cusp of being found out, hence his endeavours to skirt round the issue and cause confusion and obfuscation. His explanation did not make sense to Mr O'Donnell and he intended to mislead him so that he did not understand the true position. He only informed Mr O'Donnell of the true position some days later when he

realised he no longer had a choice as all the providers he had approached had declined to offer him cover.

83. In closing Dr Oraka submitted that his disclosures during CQC inspections had been honest and straightforward. The Practice had learnt from previous CQC reports and improved service delivery. They wanted to improve quality of care and had invited in the RCGP to check everything and to help them to address CQC requirements.

Issue 4 - Whether Dr Oraka intended to mislead the MPS

84. In its Skeleton Argument NHSE submitted that in Dr Oraka's signed application to MPS for indemnity dated 30 September/16 October 2016, the "No" box has been ticked next to the question:

*"Have you ever been refused professional indemnity/insurance, i**ncluding refusal to renew** or been offered limited or conditional terms or a higher/enhanced subscription/premium (**if in doubt please indicate YES**). If you have answered YES please provide a summary in your own words providing dates and reasons, including copies of any correspondence." [emphasis added].*

85. He did this despite it being clear from the MDU correspondence and application forms that Dr Oraka had previously been refused an application to renew cover by MDU and, indeed, had tried to appeal against MDU's decision.

86. Dr Oraka signed a declaration on this application form that the information provided was correct to the best of his knowledge and belief, despite knowing at the time of signing that declaration that the information he had provided was false and would mislead the MPS. Accordingly, NHSE submits that it can properly be concluded that his actions were dishonest.

87. Dr Oraka did not separately address this issue in his amended Witness Statement, but in his Skeleton Argument he submitted that he was required to respond to about sixty boxes in the MPS Application. NHSE's conclusion of dishonesty is based on incorrect completion of one amongst sixty other correctly ticked boxes and need not be the only way to view the matter, which ought to be seen as human error rather than anything else or dishonesty. Dr Oraka completed the majority of the MPS form with honesty and candour. Furthermore, it is not known if MPS considers the disclosure referred to as dishonest.

88. At the hearing Counsel for NHSE submitted that Dr Oraka deliberately and knowingly misrepresented the position when he filled in the MPS application

form for indemnity cover dated 30 September/16 October 2016. Whilst Dr Oraka did answer “Yes” to the question whether there had been any gaps in his professional indemnity during the last 10 years and stated it was due to a misunderstanding with the MDU and that he was amenable to making a back payment, he failed to explain that he had been refused renewal of cover by the MDU or that he had practised without cover.

89. Dr Oraka also answered “No” to the question (set out fully in paragraph 84 above) whether he had ever been refused professional indemnity indemnity/insurance, before signing the declaration on the form that the information he had provided was correct and true to the best of his knowledge and belief.

90. NHSE submits the Tribunal can infer that Dr Oraka knowingly, deliberately and dishonestly gave untruthful and inaccurate information in relation to previous refusals of cover to improve his chances of gaining indemnity cover.

91. At the hearing Dr Oraka submitted that there were about 60 boxes to tick and answer. He had been making multiple applications and it was a very stressful time; it was only one box and MPS has not said he has been dishonest. The particular question had three parts to it and he had been focussing his attention on the parts asking if he had ever been offered limited or conditional terms or a higher/enhanced subscription/premium. It had not been his intention to mislead.

92. In response to questions Dr Oraka confirmed that completion of this form formed part of his frantic attempts to obtain indemnity cover. He understood it had to be filled in accurately. He had not said anything on the form about his attempts to get MDU to give him back indemnity cover but he had been in email correspondence with MPS. Given the amount of pressure he was under, he felt he had given a full explanation to the question whether there had been any gaps in his professional indemnity during the last 10 years.

93. When told there could have been no doubt in his mind when he filled in this form that he had at least once been refused indemnity cover in 2011, Dr Oraka replied that he “may not have remembered”.
94. He submitted that he had answered all of the other 59 questions correctly. He had been in a hurry and he had had subsequent phone conversations. However, in hindsight, the answer should have been “Yes”.

95. In closing Counsel for NHSE submitted that the MPS form was not ambiguous. Dr Oraka should understand, and did understand, the need to fill in administrative documents accurately; he was a partner within a medical practice with those sorts of burdens. He has accepted that he read and signed

the declaration that he had provided accurate information, despite knowingly giving the wrong answer to a question and wholly failing to properly explain the position regarding his lack of indemnity cover in another question, i.e. he deliberately sought to gloss over the true position. He claims he dealt with this issue in a telephone conversation with MPS but NHSE contends that his lack of candour on the application form was a deliberate attempt to improve his chances of obtaining swift indemnity cover. The LOGS is a red herring; it would not in any way have put MPS on notice that Dr Oraka had previously been refused indemnity cover by MDU.

96. In closing Dr Oraka submitted that he had made honest disclosures for group cover and he had signed the MPS form in relation to all of the questions and not just one answer.

Testimonials and Evidence of Dr Gerada

97. Dr Oraka disputed the allegations of dishonesty and intention to mislead underpinning NHSE's Allegations iii to vii and Issues 2,3 and 4 in its Skeleton Argument (set out in paragraphs 7 and 8 above). In this regard he asked the Tribunal to take into account his extenuating circumstances (as referred to in his evidence above), his supportive testimonials and the evidence of Dr Gerada.

98. In his amended witness statement Dr Oraka submitted that the GMC had not found him dishonest despite the outcome of the PLDP hearing. In addition to the GMC's stance, he asked for the supportive testimonials of colleagues, staff, patients and the LMC as well as multisource feedback from colleagues and patients in his 2017 appraisal report to be considered.

99. Many of these testimonials are general character references and do not specifically address the issues the subject of this appeal. However, we note Dr Olufemi (GP colleague for whom Dr Oraka did locum work in the past) refers to extreme pressure of work and at home in the last few years leading to Dr Oraka forgetting to pay his indemnity premium, which he deeply regrets. He indicates (incorrectly) that Dr Oraka has now purchased both retrospective and prospective cover.
100. Dr Sangowawa (GP colleague for whom Dr Oraka did locum work in the past) refers to Dr Oraka being gentle, hardworking and conscientious and, in the last few years, being under extreme pressure from the day to day running of his practice and his increased workload and how he has made big mistakes around his MDU membership, is incredibly remorseful, has reflected on his errors and is prepared to do whatever it takes to be given a second chance. He also refers to Dr Oraka having been unethical, with his judgment clouded by stress, but having learnt a lot from his mistakes.

101. Vicky Ferlia (Director, GP Support at the LMC) also gives a highly supportive character reference, setting out the dysfunctional nature of the Practice and the pressures Dr Oraka faced and noting his acceptance that his failure to maintain indemnity cover was a serious judgment of error. She refers to Dr Oraka being deeply committed to general practice, having suffered greatly from losing his practice after all the hard work and effort he put into it and submits that he has learnt a lot from this experience, recognised the implications of his actions and taken remedial action to address the issues.

102. In her witness statement Dr Gerada confirms that she has seen Dr Oraka at PHP over the course of several months and he has engaged well, having been a patient at PHP since November 2016. They have explored the issues which led up the CQC inspection and his problems with allowing his indemnity to lapse. Dr Gerada understands there were a series of unfortunate events which spiralled out of control and led to increasing workload, coupled with decreasing capacity to deliver care at the Practice. She submits that Dr Oraka is well aware of the seriousness of not having indemnity and has now redressed this and that he is also understandably contrite about the CQC inspection and the part he might have played in this. She has known Dr Oraka in a professional capacity for a number of years and has never heard or had any concerns herself about his fitness to practise or ability to work as a good GP. Accordingly, she asks the Tribunal to look favourably on him continuing to work, Dr Oraka having assured her that he will reduce his workload and will continue to consult with her on a regular basis. Dr Gerada also gave oral evidence at the hearing as set out in paragraph 42 above.

103. Counsel for NHSE addressed the issue of dishonesty in closing submissions. He referred to the two-stage test (set out in paragraph 6 above), submitting that cogent evidence is required to displace the presumption that a professional would act in a dishonest manner. In this regard he contended that the testimonials provided by Dr Oraka go primarily to his clinical ability and his remorse, with only a few going to his integrity. Counsel also urged the Tribunal to consider dishonesty in the round, as opposed to each allegation of dishonesty in isolation. He submitted Dr Oraka's continuing pattern of misrepresentation to the CQC, different indemnifiers, in correspondence, to appraisers and to the Tribunal demonstrates that he is someone who regularly and knowingly misrepresents issues when it is not in his interests to be upfront. In other words, he knows he has acted dishonestly at the material times.

104. Given all of the above, Counsel submitted that if the Tribunal finds dishonesty made out in relation to any of the four issues, then Dr Oraka is not suitable to remain on the Performers List. Honesty and integrity lie at the heart of any

professional's conduct and the probity issues in this case are such that the Tribunal should find Dr Oraka unsuitable to undertake NHS work. In addition, the unsatisfactory position of Dr Oraka's current indemnity cover and the ongoing risk to the public, coupled with his lack of insight and the fact there is no indication that matters will be resolved appropriately in the near future, makes him unsuitable to remain on the Performers List.

105. Alternatively, and for the same reasons, although with slightly more emphasis on the indemnity issues, Dr Oraka's continued inclusion on the Performers List. Would be prejudicial to the efficiency of services and his appeal should be dismissed.

106. In his skeleton argument Dr Oraka submits that his appeal is based on the proportionality of the penalty and the possible alternative of initially attaching conditions for an interim period.

107. He contends that there were significant extenuating circumstances, supported by the robust, fresh evidence he has submitted, including his 2017 appraisal multisource feedback, his testimonials and other evidence in support of his long-standing good character based on long-standing, professional, working relationships. He also refers to his ongoing remedial efforts to restore indemnity cover and his robust efforts to address most, if not all, of the areas of concern raised by NHSE to ensure continuity of safe clinical practice as indeed he has done for much longer than the period of lapsed indemnity in question.

108. He also points out that although NHSE escalated the case to the GMC during the PLDP, the GMC responded by providing appropriate advice to Dr Oraka to ensure provision of indemnity cover to enable continuation of safe practice. He has since responded by reinstating adequate prospective indemnity cover in January 2017 and continues to make efforts to address the issue of retrospective indemnity.

109. Dr Oraka contends that as he has made strenuous remedial efforts, reflected, gained further insight from engaging with PHP to modify his workload and responsibilities and is willing to restore continued safe practice, it is unlikely that anything like this should happen again, particularly in view of the fact he is approaching pensionable age (60) in October 2017.

110. Dr Oraka reiterated many of these points in his closing submissions. He maintained that it was never his intention to mislead; it was the circumstances he found himself in and the pressure of the complex challenges which led him to react as he did. He has had time to reflect and learn from all that has happened and he is amazed that he allowed it to drag on for so long. If he was

a deceitful person he would have a track record; he has tried to give an objective background of the type of person he is and to provide testimonials and character references in support.

111. He now appreciates the implications of the risk to patients and has not seen any patients since November 2016. He urged the Tribunal to consider all of the extenuating circumstances and consider his actions in context. He submitted a negligence claim would be more likely at specialist, as opposed to, GP level. He deeply regrets what has happened, he is very contrite and willing to make amends and remedy his errors. He was as honest as could be and made full disclosure at his 2017 appraisal. He is no longer a partner and would like to work as a locum.

Consideration of the Evidence with our Conclusions

112. We have carefully considered all of the evidence. We reiterate that simply because we have not specifically referred to all of the evidence does not mean that we have not considered it, but that we have restricted our summary of the evidence and the submissions herein to that which we consider most relevant to our conclusions.

113. Turning first to the adequacy of the retrospective indemnity cover, we note that there is conflicting evidence in relation to when Dr Oraka became aware that the quote he obtained from Towergate for £1M retrospective cover is inadequate and that he needs £10M of retrospective cover, which is the minimum level set by NHSE for any claim, either prospective or retrospective. Dr Oraka gave evidence that it was only when he received NHSE's Skeleton Argument dated 7 July 2017 that it came to his attention that £1M retrospective cover would be inadequate, having previously thought NHSE was satisfied with that level of cover. NHSE contended that it had indicated in its response to the appeal on 5 April 2017 that £1M retrospective cover would be inadequate and Dr Oraka had quoted in his Skeleton Argument that NHSE's current position in relation to adequate indemnity cover is a minimum is £10M for each claim, both prospectively and retrospectively. We note that when Dr Oraka was asked why he was claiming he had only found out that £1M retrospective cover would be inadequate a few days ago, he replied that he did not recall seeing this in NHSE's response to the appeal and that he had included the word "retrospectively" in his Skeleton Argument in error. We find Dr Oraka's explanation to be unconvincing and far-fetched and prefer NHSE's evidence that Dr Oraka was put on notice that he requires £10M retrospective cover in early April 2017.

114. Having resolved the one area of factual dispute on this issue, we note that Dr Oraka has, to date, failed even to obtain £1M of retrospective cover. Moreover,

we are concerned that he appears to believe that the Towergate quote is for a one-off payment for retrospective cover and he was unclear about the fact this is an annual premium and he will need to continue to pay for tail off retrospective indemnity cover for a number of years, even if he does not return to, or ceases, active practice. We are also concerned that he believes he will be able to change provider to obtain a lower annual premium from January 2018, when he cannot know if any other provider will accept him.

115. In addition, we have grave concerns about Dr Oraka's lack of insight in relation to indemnity cover; he told us that prospective, rather than retrospective, cover is most important at this point despite him not currently being in practice and he also said that whilst indemnity cover is a safeguard for both clinicians and patients, it is more important for clinicians if there is a negligence issue. This leads us to conclude that he does not fully understand the legislative and GMP requirement for patients to be protected against negligence and to be able to obtain damages if something goes wrong. NHSE did not accept Dr Gerada's evidence that complaints tend to happen in the first few weeks or months and historic complaints are very unusual in general practice, and neither do we; we accept this is unsupported anecdotal evidence which cannot be relied upon in relation to the likelihood of future claims being made against Dr Oraka.

116. We also consider there remain ongoing financial risks in respect of Dr Oraka's continued cover. He gave evidence he has difficulties affording the premiums, which will be high due to his previous lack of cover for so long and told us about his financial difficulties and cashflow problems.

117. We conclude that Dr Oraka currently does not have any, let alone inadequate, retrospective insurance cover.

118. Turning to the issue of whether there was an intention by Dr Oraka to mislead his appraisers as to his indemnity status, either by commission or omission, we note that Dr Oraka does not dispute that he gave misleading written information about his indemnity status for his appraisals in 2013, 2014, 2015 and 2016 and also failed to verbally inform his appraisers that he was practising without indemnity at those appraisals. Furthermore, he accepted in evidence that he could have raised the issue of his lack of indemnity cover either in his declarations on the appraisal form or in subsequent discussions with his appraiser, but he omitted to do so.

119. We further note Dr Payne's evidence that it is a practitioner's responsibility to ensure the information provided in their appraisal form is current and accurate and changing the details of the indemnity provider on the form would require active input by the practitioner.

120. Dr Oraka gave evidence that he had not had any intention to mislead and he had satisfactorily carried out appraisal work for many years before this; if he was a dishonest person he would have a track record. He pleaded extenuating circumstances, including clouded judgment due to difficulties in the Practice partnership, other overwhelming distractions, financial problems and ignorance. He also submitted that, as a result of the protracted challenges he experienced over the years, he tended to do his appraisals last minute, with a propensity to rush his appraisal preparations with potential for error.

121. It is NHSE's case that at all material times Dr Oraka knew full well that he did not have any indemnity cover, knew full well that he needed to and that he deliberately misled the appraisers as to his indemnity status and in doing so acted dishonestly.

122. We prefer NHSE's submissions on this issue. Dr Oraka acknowledged at the hearing that he could have raised the issue of his lack of indemnity cover either in his declarations on the appraisal form or in subsequent discussions with his appraiser, but he omitted to do so. Whilst we have some sympathy for the circumstances in which he found himself, we do not consider they can be used to justify his actions or lack of action. We note, for example, that in 2015 Dr Oraka actively changed the details of his indemnity provider on his appraisal form and confirmed membership of MDDUS to his appraiser that year. Accordingly, we conclude that between 2013 and 2016 Dr Oraka deliberately misled his appraisers as to his indemnity status when he filled in his appraisal forms and deliberately omitted to correct the position in the declarations section or during the appraisals themselves and, in doing so, acted dishonestly.

123. Turning to consider the issue of whether there was an intention by Dr Oraka to mislead Mr O'Donnell as to his indemnity status either by commission or omission, we note that there is conflicting evidence in relation to the contents of the discussion between Mr O'Donnell and Dr Oraka at the CQC inspection on 20 October 2016. We consider Mr O'Donnell was an honest and credible witness; he tried to assist the Tribunal from recollection as he did not have contemporaneous notes and told us when he could not be sure of what was said. However, he was clear that he had expressly asked if Dr Oraka had indemnity cover in place and that he would need to provide it within 48 hours and although he told us it had been hard to understand some of what Dr Oraka said, he was also clear that Dr Oraka had replied "Yes, he would be able to send it across". He was also clear that Dr Oraka had not disclosed that he had been practising without indemnity cover. By contrast, Dr Oraka gave us a convoluted and far-fetched account of this discussion; whilst he categorically refuted he had told Mr O'Donnell that he had indemnity cover, he told us that

he had shown him the MDDUS quote for future cover and talked about the possibility of future group cover and discussed the protracted problems he had experienced with obtaining his LOGS from MDU before cover could take effect, whereupon Mr O'Donnell had said this was beyond him and he would be going back to his superior to see how long Dr Oraka could be given. We prefer Mr O'Donnell's evidence on this point; we see no reason why he should be untruthful. By contrast, we accept NHSE's submission that Dr Oraka knew that he was on the cusp of being found out, hence his endeavours to skirt round the issue and cause confusion and obfuscation.

124. Having resolved this area of factual dispute on this issue, we note that Dr Oraka was only able to show Mr O'Donnell an application form for indemnity cover rather than an indemnity certificate as has been requested. Although Dr Oraka submitted that his disclosures during CQC inspections had been honest and straightforward, given our finding that Dr Oraka attempted to cause confusion and obfuscation rather than come clean to Mr O'Donnell about his lack of indemnity cover, we conclude that Dr Oraka dishonestly attempted to mislead Mr O'Donnell as to his indemnity status.

125. Turning to the issue of whether Dr Oraka intended to mislead the MPS, we are not persuaded by Dr Oraka's submission that he was required to respond to about sixty boxes in the MPS Application and that NHSE's conclusion of dishonesty is based on incorrect completion of only one box amongst sixty other correctly ticked boxes, where the particular question had three parts to it and he had been focussing his attention on the parts asking if he had ever been offered limited or conditional terms or a higher/enhanced subscription/premium, rather than the first part which asked whether he had ever been refused professional indemnity/insurance, including refusal to renew. We are, quite frankly, astonished by his claim that it had not been his intention to mislead and this need not be the only way to view the matter, which ought to be seen as human error rather than anything else or dishonesty.

126. Although Dr Oraka has submitted that he completed the majority of the MPS form with honesty and candour, we simply cannot comprehend how he can argue that he did not intend to mislead. We note and accept NHSE's submissions that the MPS form was not ambiguous and that Dr Oraka should understand, and did understand, the need to fill in administrative documents accurately, given he was a partner within a medical practice with those sorts of burdens. We conclude that he deliberately intended to mislead MPS by glossing over the true position.

127. We turn now to the overarching issue of whether Dr Osaka was dishonest and intended to mislead, and his request for the Tribunal to take into account his

extenuating circumstances, his supportive testimonials and the evidence of Dr Gerada. Whilst we have already referred to our sympathy for the difficulties and challenges which he faced in both his professional and personal life, we do not consider these can in any way excuse his having knowingly practised for approximately 7 years without indemnity cover and the implications and risks of him having done so. Nor do we consider they can be used to explain away his dishonesty in relation to his appraisals, the CQC inspection and his attempts to obtain indemnity cover. Whilst we note there have, to date, been no complaints or clinical concerns and that Dr Oraka has been provided with some supportive testimonials and personal support from Dr Gerada, we do not consider these can compensate for his very serious, dishonest, misconduct. We consider that Dr Oraka's continuing pattern of misrepresentation to the CQC, to different indemnifiers, to appraisers, to the Tribunal and in correspondence indicates that he regularly and knowingly misrepresented issues when it was in his interests to do so and that he acted dishonestly at the material times.

Decision

128. Given all of the above and the ongoing risk to the public, Dr Oraka's lack of insight and the fact there is no clear indication that matters will be resolved appropriately in the near future, we conclude that Dr Oraka is not suitable to remain on the Performers List.

129. In addition, and for the same reasons, particularly the issues around indemnity cover, we conclude that Dr Oraka's continued inclusion on the Performers List would be prejudicial to the efficiency of services. We further conclude that the gravity and prolonged period of his misconduct are such that it would be inappropriate to consider the imposition of conditions as opposed to removal.

Appeal dismissed

Judge D Shaw
Tribunal Judge, Care Standards
First-tier Tribunal (Health Education and Social Care)

Date Issued: 26 July 2017