Case No.14696

THE FAMILY HEALTH SERVICE APPEALS AUTHORITY

2 April 2009

Mr D Pratt – Chair
Dr H Freeman – Professional Member
Mrs M Harley - Member

BETWEEN:

DR JONATHAN OKECHUKWU OKONKWO
(GMC registration number 3611865)

Appellant

-and-

PETERBOROUGH PRIMARY CARE TRUST

Respondent

DECISION WITH REASONS

THE APPEAL

1. This is an appeal by Dr Jonathan Okechukwu Okonkwo ("Dr Okonkwo") against a decision of Peterborough Primary Care Trust ("the PCT") contained in its letter dated 30 July 2008, to remove him from its Performers List, pursuant to Regulation 10(3) of the National Health Service (Performers Lists) Regulations 2004, as amended ("the Regulations"). The PCT's decision to remove him from the List was expressed to be on the grounds set out at Regulations 10 (4) (b) and (c) and 10 (6)[1]. Those discretionary grounds for removal may be referred to in shorthand as "fraud" (Regulation 10 (4)(b)), "unsuitability" (Regulation 10 (4)(c)) and "non-performance of services for 12 months" (Regulation 10 (6)). The criteria for removal under the various provisions are set out at Regulation 11.
2. The appeal was heard on 2 April 2009 at the General Chiropractic Council in London. Dr Okonkwo was represented by Mr Hugh Lloyd of Counsel, instructed by Eastwoods, solicitors, and the PCT was represented by Mr Paul Ozin of Counsel, instructed by Mills and Reeve, solicitors. Dr Okonkwo was also present, although he chose not to give evidence before us.

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[1] Reg 10: (3) The Primary Care Trust may remove a performer from its performers list where any of the conditions set out in paragraph (4) is satisfied.

(4) The conditions mentioned in paragraph (3) are that – …..

(b) he is involved in a fraud case in relation to any health scheme; or

(c) he is unsuitable to be included in that performers list ("an unsuitability case").

(6) Where the performer cannot demonstrate that he has performed the services, which those included in the relevant performers list perform, within the area of the Primary Care Trust during the preceding twelve months, it may remove him from its performers list.

DECISION

3. Our unanimous decision is that this appeal is dismissed and we direct that Dr Okonkwo's name be removed from the Performers' List of the PCT.
4. We adjourn the decision whether to order that Dr Okonkwo be nationally disqualified so that the parties may consider their positions in the light of our findings. For that purpose we direct that (if so advised) the parties make any written submissions on that issue to us by no later than 3 July 2009. If either party wishes to request an oral hearing of the issue of National Disqualification then they shall do so by the same date.

REASONS

5. This appeal arises out of a number of incidents of fraudulent prescribing of drugs by Dr Okonkwo in 2005 and 2006, in which he obtained medications which he now explains were for the use of family members in Nigeria, by writing NHS prescriptions and making bogus entries in the medical records of real patients. These entries necessarily implied that the drugs were for the bona fide medical needs of those patients. He was subsequently convicted of three offences of obtaining property by deception, to a value of £283, with three similar offences taken into consideration, and sentenced to (among other things) a term of 24 weeks' imprisonment suspended for two years. The PCT's case also raised some other concerns (set out below) and in due course it decided to remove Dr Okonkwo from its Performers' List.
6. Dr Okonkwo's original appeal letter (dated 4 August 2008) was on the ground that the PCT was wrong to reject his application for an adjournment and to proceed in his absence with a hearing on 23 July 2008 which disposed of his case, because he was unwell and unable to attend personally. The subsequently served "Full Grounds of Appeal" dated 17 October 2008 expanded on the complaints about the PCT's refusal to adjourn the hearing and proceeding in his absence on 23 July 2008. It also complained that the substantive decision was wrong, and identified factors to which the PCT had allegedly had inadequate regard, and had wrongly concluded there was a risk to patient safety.
7. The PCT opposed and continues to oppose the appeal. Its Reply dated 22 August (and therefore lodged before receipt of the "Full Grounds of Appeal") focused on the complaints about procedural irregularity. It is now common ground that these complaints fall by the wayside since this appeal proceeds by way of redetermination of the issues and the burden is on the PCT to satisfy us that removal is appropriate for the reasons relied upon. Mr Lloyd told us that he did not seek to have the case remitted to the PCT, recognising no doubt that we had no power to do so.
8. The PCT further seeks an Order of National Disqualification against Dr Okonkwo (pursuant to Regulation 18A (3) (a) and in the event that we dismiss his appeal and direct his removal from the Performers List we have a free-standing power to order National Disqualification under Regulation 18A (2) (a).

Preliminary matters

9. Two previous dates fixed for the hearing of this appeal were adjourned. Firstly on 30 October 2008 the matter came before a Panel chaired by Mr Trevor Jones. It became apparent that Dr Okonkwo was due to appear before Peterborough Crown Court in early November to face criminal charges arising from these matters. The case was adjourned to 21 January 2009 and Directions were given to ensure that a transcript of any sentencing remarks was obtained and made available by Dr Okonkwo's solicitors, together with a summary of the prosecution case and copy of the Indictment and any other offences taken into consideration.
10. These documents show that Dr Okonkwo was indicted on 8 charges, in the form of four pairs of obtaining property (namely the medication) by deception and forgery (of the relevant prescription), and there were originally 6 other offences (again in 3 similar pairs of charges) to be taken into consideration. On 5 November 2008 Dr Okonkwo pleaded guilty, we are told, to 3 offences of dishonestly obtaining property by deception. For reasons which are not apparent to us, pleas of Not Guilty to the corresponding charges of forgery were accepted. He also accepted a further 3 offences of obtaining property by deception, to be taken into consideration. He was sentenced to 40 weeks imprisonment suspended for 2 years, and a 12 months supervision order was also imposed. A compensation order was made for £283, the value of the drugs involved, and Dr Okonkwo was ordered to pay costs of £2,500.
11. Further representations were made because a sentence of imprisonment of 6 months or more would result in a mandatory removal from the Performers List. The matter was relisted in the Crown Court, when HHJ Enright varied the suspended sentence of imprisonment to 24 weeks. His remarks indicate he had not intended to declare Dr Okonkwo unfit and unable to practise in the future.
12. Mr Jones was informed that he had sat as a Legal Assessor when the GMC Interim Orders Panel considered Dr Okonkwo's case and suspended him from practice for a period of 18 months. He therefore recused himself from further consideration of this case and Mr Duncan Pratt was appointed to the Panel in his place. On 19 January the newly constituted Panel further adjourned Dr Okonkwo's case (due to be heard on 21 January), on his paper application, to a date to be fixed and gave further Directions, because Dr Okonkwo had appealed his sentence to the Court of Appeal Criminal Division. However, by letter dated 29 January 2009 the FHSAA was informed that Dr Okonkwo had abandoned his appeal, and a new date was thereafter set for 2 April 2009.
13. At the outset of this hearing Mr Ozin raised a preliminary issue, namely whether a proper substantive ground of appeal had been identified in the Grounds of Appeal. He informed us that at the hearing on 30 October 2008 those representing Dr Okonkwo had given an undertaking to specify substantive grounds of appeal. Mr Lloyd relied on paragraph 16 onwards of the Full Grounds of Appeal, which addressed the substantive merits of the decision. Mr Ozin submitted that Dr Okonkwo required permission to amend his original notice of appeal. We considered and rejected this submission

(although it would be right to say that Mr Ozin raised the matter as a concern rather than by way of an application seeking a ruling). In our judgment the appeal was properly constituted and sufficiently set out the grounds of appeal. The PCT had served a fully argued response and a significant body of evidence, demonstrating awareness of the case it had to meet on the papers. We further ruled that in the event that we were wrong about that, we gave permission for the grounds of appeal to be amended in the form appearing as the document entitled Full Grounds of Appeal, pursuant to Rule 40(7) of the Rules.

Documents

14. In addition to the appeal documents, correspondence relating to adjournments and disclosure, and previous Orders and Directions, we have two bundles supplied by the Respondent which were given the following letters at the appeal hearing: R1 (223 pages) and R2 (41 pages). We have bundles A1 (13 pages) and A2 (38 testimonials) supplied by the Appellant. We also had a bundle provided by the Respondent for a previous hearing (134 pages) which duplicated much of what was in R1 and was not referred to at the appeal hearing. Bundles R2 and A1 were supplied on the day of the hearing and in the case of A1 during the hearing. We agreed to receive these but parties should be aware that Directions for timeous disclosure are to be complied with and Panels may not agree to receive late documents as a matter of course.

Witness evidence

15. We heard evidence on behalf of the PCT from Dr Neall Anthony Bacon, a GP and Medical Director of the PCT, who had taken over that post from his predecessor shortly before the PCT removal hearing, but after the investigations giving rise to this case.
16. We heard evidence on behalf of Dr Okonkwo from Dr Michael John Kennedy, a GP practitioner in Peterborough for 15 years, who was also a friend and fellow member of a local Church.

The issues and relevant law

17. The burden of satisfying us that Dr Okonkwo should be removed from the Performers List for any of the discretionary grounds set out at Regulation 10 of the Regulations on which the PCT based its own decision (unsuitability, fraud or failure to provide services for 12 months) lies on the PCT. So does the burden of satisfying us that Dr Okonkwo should be removed on any alternative ground of efficiency[2].
18. The standard of proof is the civil one of the balance of probabilities, as more fully explained by the House of Lords in *Re D* [2008] UKHL 33, where Lord Carswell, giving the leading opinion, also adopted the helpful guidance of Lord Hoffman in *Sec of State for the Home Department v Rehman* [2001] UKHL 47:

> *"The civil standard of proof always means more likely than not. The only higher degree of probability required by the law is the criminal standard. But, as Lord Nicholls of*

[2] Reg 10 (4) (a) "his continued inclusion in its performers list would be prejudicial to the efficiency of the services which those included in the relevant performers list perform ("an efficiency case")".

Birkenhead explained in In re H (Minors) (Sexual Abuse: Standard of Proof) [1996] AC 563, 586, some things are inherently more likely than others. It would need more cogent evidence to satisfy one that the creature seen walking in Regent's Park was more likely than not to have been a lioness than to be satisfied to the same standard of probability that it was an Alsatian. On this basis, cogent evidence is generally required to satisfy a civil tribunal that a person has been fraudulent or behaved in some other reprehensible manner. But the question is always whether the tribunal thinks it more probable than not".

In this case there is no issue but that Dr Okonkwo behaved fraudulently in obtaining drugs by making out false prescriptions.

19. Mr Ozin placed reliance on paragraph 8.6 of the PCT's Statement of Grounds dated 22 August 2008, namely that the case in favour of removing Dr Okonkwo from the List was overwhelming in the light of, in particular:
    a. His admissions of defrauding the NHS;
    b. His admissions as to entering false medical details on patient records of patients under his trust for the purpose of defrauding the NHS; and
    c. The evidence that he had not performed the relevant services for a period in excess of 12 months.
20. He also submitted that the same issues arose on the question of National Disqualification, which the PCT also invited us to direct in the event that we dismissed Dr Okonkwo's appeal.
21. It is appropriate to state at this point that after the PCT had closed its case Mr Lloyd informed us that his case today was effectively a mitigation on behalf of Dr Okonkwo: he was seeking disposal of the appeal by way of *contingent removal*. He submitted that conditions, such as retraining, supervision, an audit of his prescribing and practising as a salaried doctor in a multi-handed practice, would meet the mischief of the case.
22. The main issue between the parties was therefore whether there should be an outright removal or a contingent removal from the Performers' List.
23. The power to exercise our discretion to direct contingent removal under Regulation 12 applies only to an efficiency case or a fraud case, and so would not arise if this Panel were to find (as the PCT did) that Dr Okonkwo was unsuitable to remain on the Performers' List.
24. Regulation 11 of the Regulations sets out the criteria for removal in cases of unsuitability and efficiency, and we have had regard to those and to the Department of Health Guidance to which our attention was drawn. We have not limited our consideration solely to the factors set out in the DoH Guidance, but have considered all the factors urged on us in this appeal.
25. If we were to find that the case against Dr Okonkwo had been proved on grounds of efficiency and fraud, but not unsuitability, we would need to consider whether the case could be appropriately disposed by way of contingent removal. Regulation 12 (2) requires:

    "*If [the Panel] so decides, it must impose such conditions as it may decide on his inclusion in [the] performers list with a view to –*

    (a) removing any prejudice to the efficiency of the services in question (in an efficiency case); or

    (b) preventing further acts or omissions (in a fraud case)."

Neither party placed before us any proposed draft conditions. At the close of the case Mr Ozin made some oral submissions, at our invitation, as to the sort of

conditions which might be considered, while making it plain that his primary position was that Dr Okonkwo had been shown to be unsuitable, and that in any event the PCT did not submit that conditions were appropriate or could be made workable. Mr Lloyd did not further elaborate his submission that we should consider conditions, save to urge that they should be proportionate and not too draconian.

The Factual Background

26. There is no issue as to the main facts, save to the very limited extent appearing from paragraphs 36, 39 and 44 below. We find the following facts proved.
27. Dr Okonkwo was born on 23 March 1952 and obtained his primary medical qualifications from the University of Nigeria in 1978. He came to the UK in 1985 and practised for 13 years in Obstetrics and Gynaecology, latterly in Peterborough District Hospital. He commenced training as a GP in 1998 and completed his training in August 1999, thereafter joining the Orton Health Centre, Peterborough as a partner on 1 July 2001. On the same date he was admitted to the PCT's Performers' List.
28. On 6 September 2006 one of his patients, Mrs C (then aged 76), who lived in warden-staffed residential accommodation, suffered choking with a swollen tongue, which was suspected to be an allergic reaction. The warden contacted a Dr Alcock at the Orton Health Centre, who noted that Mrs C's records showed she had that day been prescribed Valsartan (a drug used to combat high blood pressure), which might mean the reaction was drug induced, and advised calling an ambulance: this can be seen from the contemporaneous note of a telephone contact with the GP surgery that day Bundle R1 page 58. However Mrs C had not in fact received any Valsartan, and her condition was in fact unconnected to that medication. Paramedics who attended her gave her chlorphenamine and advised she see her doctor. The Orton Practice noted that a local pharmacist had been enquiring about a prescription for the same patient. Dr Okonkwo was in fact in that pharmacy awaiting dispensing of 112 Valsartan tablets (a four month supply) which was on one prescription and two other medications, 200 Co-codamol tablets, a pain killer, and 500 Senna tablets, a laxative, which were on another prescription issued at the same time for the same patient: see R1 pages 79-80. Both prescriptions had been issued by him. He presented them at a pharmacist which Mrs C did not normally use (see R1 page 46). The medications were dispensed and handed to him.
29. On 7 September 2006 Mrs C went to see Dr Outar at the Orton Health Centre, as advised by the paramedics. He consulted the practice records and seeing the entry made by Dr Okonkwo on 6 September he told Mrs C that it was possible that she had suffered an adverse reaction to the newly prescribed Valsartan. She insisted she had never received this drug and indeed had not recently seen Dr Okonkwo and was unaware that he had issued prescriptions to her on 6 September. The other doctors in the practice sought advice from the Local Medical Committee, and its Chief Executive Dr

Guy Watkins visited the practice and spoke to them and to Dr Okonkwo on 21 September. It was established that the entries in her GP medical records were completely bogus. Dr Okonkwo was recorded by Dr Watkins (see A1 page 2) as admitting that:

> *"he had issued the prescription for these three items in the name of a patient with the intention of obtaining supplies of the three medicines for the use of his mother who lives in Nigeria.*
> ***He explained that medicine supply in Nigeria is unreliable and often subject to counterfeit supplies**. He also explained that **he knew he could issue a private prescription on his letterhead to obtain supplies for his mother lawfully**; he indicated he had done this before at the same (West Town) pharmacy.*
> *He indicated the reason he had issued an FP10 in a patient's name on this occasion was because he was in a hurry. He regretted his partners had felt the need to take their concerns outside the partnership.*
> *He regretted his course of action, and accepted it was wrong, in the sense that it could be seen as fraud. He did not deny that he had done this before when invited to do so"*. [Emphasis added]

30. In due course the PCT was informed and referred the matter to the NHS Counter Fraud Service. Dr Okonkwo was interviewed by the PCT's then interim Medical Director, Dr Pugh, on 9 October 2006 and told him that he must have been looking at another patient's medical record on the computer when he printed out the script for Mrs C and that this was therefore a genuine mistake: see R1 page 51. By that stage a total of 5 instances where Dr Okonkwo appeared to have prescribed Valsartan inappropriately were being investigated: the PCT was seeking to obtain the original prescriptions. Mrs C complained to the GMC in consequence of which Dr Okonkwo appeared before its Interim Orders Panel on 23 April 2007 and was suspended for 18 months. We were told today that an application has been made to the High Court to extend that period of suspension.
31. Other questions are raised in the documents (and referred to in the PCT's Statement of Facts) concerning Dr Okonkwo's prescribing of 4 other drugs, which the PCT concluded it had insufficient time to investigate. Quite properly, this was not pursued further in front of us and we disregard it.
32. In the event, 3 additional cases were identified concerning Dr Okonkwo's prescribing of Valsartan:
    a. Mr G (1) then aged 84: Dr Okonkwo raised a script on 15 August 2005 [R1/67].
    b. Mr O then aged 85: Dr Okonkwo raised a script on 7 October 2005 [R1/63](and appeared to have collected the Valsartan)
    c. Mr G (2) then aged 71 years: Dr Okonkwo raised a script on 26 January 2006 [R1/66].
33. In each of these cases the elderly patient denied ever receiving it and there was no clinical reason for prescribing such medication. In fact, in each case Dr Okonkwo had raised the script and obtained the drug himself, in order (as he later suggested) to supply relatives in Nigeria. The cost of these drugs fell

on the NHS. He did not (as he might lawfully have done) raise a private prescription and pay for the drugs himself.

34. In two cases (Mrs C and Mr G2) other drugs had been prescribed on the same date but the Valsartan was put on a separately generated prescription.
35. In each case the prescribing of Valsartan was recorded and remained on the patient's computerised GP records, where the entries could be, and were, seen by other doctors who had occasion to review the patient. Any doctor doing so would rely on these entries being genuine, and so be misled, as Dr Bacon confirmed he would have been. It was suggested in argument that consultation records could be amended on screen (so avoiding the scope for casual misleading) but would leave an audit trail on the computer software. This appears a wholly theoretical point as they were not in fact removed on the screen, and we have seen the printouts of the consultation records.
36. We are told, and accept, that in due course Dr Okonkwo provided information to the PCT about issuing prescriptions for prostate medication which was needed by his uncle in Nigeria. This assisted the PCT which was making a trawl through the records from which 14 cases identified and forwarded to the GMC [see PCT letter of 6 November 2007 and attachment at R1/90]. However, those enquiries give rise to the facts set out at paragraph 2.10 of the PCT's statement of facts, namely that false information had been entered on the records of 14 patients without their knowledge, over a period between March 2005 and September 2006, relating to several different types of drugs, more particularly set out at R!/90-93. In light of a letter produced by Mr Lloyd [A1/13] Dr Bacon accepted that one prescription (out of these 14 cases) for a drug to treat a prostate problem [EMIS reference number 35154] was "above board". Subject to a caveat about prescribing a large amount at once, one other prescription for Metformin [EMIS reference number 36909] was accepted by Dr Bacon as "legitimate". Four other cases out of the 14 relate to the matters for which Dr Okonkwo was prosecuted at the Crown Court (see below). Following these answers it appeared that the remaining 8 cases detailed at R1/90-93 were acknowledged by or on behalf of Dr Okonkwo to be unchallenged allegations of recording drug prescriptions for which there was no indication or clinical reason. Nevertheless because we have been told by Counsel that at his Crown Court trial Dr Okonkwo admitted 3 charges on the Indictment of obtaining drugs by the deception of a false prescription, and a further 3 similar offences were taken into consideration, we make a cautious finding of fact, in favour of Dr Okonkwo, that there were a total of 6 such cases.
37. The police arrested Dr Okonkwo on 4 May 2007 at his home. Numerous drugs were seized at the property, in containers bearing the names of his patients at the Orton Practice. The explanation offered on behalf of Dr Okonkwo is that these were unused drugs returned by patients, and would have been destroyed if he had returned them to the NHS but which he intended might be used in Nigeria. He told police he had done it out of humanitarian concern for his relatives and fellow human beings. No separate allegation arises from that, and although there was some suggestion during

the hearing that this was inappropriate, it did not really feature in the PCT's case when the matter was originally heard and we make no adverse findings against Dr Okonkwo as a result of his having these drugs. Police also found at his house a partly used prescription pad belonging to Dr Kennedy (for whom Dr Okonkwo had done some locum work and who gave evidence to us). There is no means of tracing prescriptions from this pad and the PCT accepts that the pad was properly obtained in the course of his work.

38. At his first police interview Dr Okonkwo stated he needed the drugs for two relatives and had falsified prescriptions on [real] patients to obtain them and then either posted them or got friends to take them. He said he had done this on about 7 occasions. At his second police interview he was asked about letters of apology he had written to 4 patients (patients whom he had named in the previous interview) and he said these were the only ones whose names he could remember. He admitted being aware of prescriptions written for Mrs C and Mr O but not other persons about whom the police asked him. He said he could not assist further as to how many other patients he had affected, but offered to help further if he could be shown prescriptions. In fact police could not show him further prescriptions as they are destroyed after about 14 months. See R2/16-19.
39. At a third police interview Dr Okonkwo admitted fully all offences put to him [R2/19], and on this basis he was charged on 18 December and ultimately came before Peterborough Crown Court on 5 November 2008. The indictment (which we have seen) contained 8 counts, in four pairs alleging respectively obtaining property by deception and forgery in relation to the prescriptions of Valsartan for each of the 4 patients mentioned above. We were originally informed that Dr Okonkwo pleaded guilty to all counts but in the course of his submissions Mr Lloyd told us that Not Guilty pleas to the respective forgery counts were accepted. The Judge's sentencing remarks do not shed light on the pleas. We approach the matter on the basis outlined by Mr Lloyd, namely that the sting of the offences was sufficiently accepted by the pleas to 3 counts of obtaining property by deception.
40. On 7 November 2008 HHJ Enright passed a sentence of 40 weeks' imprisonment suspended for 2 years, and 12 months supervision during which Dr Okonkwo was required to live at his home address. He also made a compensation order of £283 in favour of the NHS and a costs order of £2,500: see R2/7]. The compensation order represented the value to the NHS of the drugs obtained. On 2 December 2008 the matter was relisted and HHJ Enright varied the suspended sentence to one of 24 weeks' imprisonment. He did so because [R2/26] he was told that "the effect of a sentence of 6 months or more is to result in the [mandatory] removal of the doctor from the [Performers' List]" and it was "not my intention to declare him unfit and unable to practise in the future".
41. Dr Okonkwo was formerly a man of good character.
42. The partnership in Peterborough in which Dr Okonkwo formerly practised has been dissolved at the instance of his partner. He is not currently practising as a GP. On 23 April 2008 the PCT noted that Dr Okonkwo had been subject to

Interim Suspension by the GMC since 23 April 2007 and therefore added as a ground of removal the allegation that he had not performed any services in the PCT's area for 12 months [see PCT statement at R1/31, para 2.9].

43. The PCT further alleges a failure by Dr Okonkwo to complete or co-operate with the appraisal process which is a requirement for a NHS General Practitioner, under Regulation 4 (3) (e) of the 2004 Regulations. It relies on the evidence at R1/ 76, a letter from the appraiser (a Dr SD Richards) to Dr Okonkwo in which Dr Richards stated:

    "*I am unable to construct a Form 4 Post Appraisal report on which we would be able to agree.*

    There were a number of issues that prompted my concerns, including:

    - *The difficulty in arranging the appraisal.*
    - *The late arrival of your pre-appraisal documentation which left me very little time to prepare.*
    - *Your negative attitude towards the appraisal process.*
    - *Your failure to achieve your development targets agreed in the last appraisal round, couple with the statement that you "exceeded your development goals".*
    - *A paucity of supporting documentation.*
    - *The impression I gained that your numerous activities outside of the practice make it impossible for you to provide an appropriate training environment for medical students."*

    Dr Richards concluded by suggesting Dr Okonkwo might wish to ask for another appraiser from a different person.

44. When the matter came before the PCT, Dr Bacon had said that it was almost unheard of for any GP to fail to complete an appraisal. It was put to him in evidence before us that in fact another appraiser (Dr Wishart) had been appointed and had completed the appraisal, and Mr Lloyd showed him the documents at A1/3-8, which include a completed Form 4. This is a summary of the appraisal discussion agreed between Dr Okonkwo and his appraiser. The underlying detailed appraisal documents remain confidential. Form 4 is typed, and was dated and signed on 3 May 2007 but sent to the PCT on 6 May 2007. Dr Bacon had not known of the existence of this document, or that Dr Okonkwo had made a complaint to the PCT about Dr Richards, until this appeal hearing. He expressed frustration that the "disparate elements" of the PCT were not always brought together. He said that the appraisal from Dr Wishart was difficult to reconcile with the letter of Dr Richards. We share that assessment. The appraisal document agreed with Dr Wishart gives rise to some matters of concern. Under the heading "Probity" is the comment "the GMC is investigating Dr Okonkwo at present over a prescribing irregularity". This was signed off 10 days *after* he had been suspended from practice by the GMC, and the day before his arrest by the police, but there is no mention of the former or hint of the latter (he may not have known it was imminent) or of the true seriousness of the situation. Moreover there is no hint in appraisal Summary or the Personal Development Plan attached to it, of the effect of his suspension from practice on his development goals and how he would

achieve them. However, in our view it cannot be said that Dr Okonkwo failed to participate in the appraisal system, without evaluating the clash between him and Dr Richards, and reaching a conclusion that Dr Okonkwo was wilfully or unreasonably failing to co-operate with him. We are not in a position to do that and we therefore find that Dr Okonkwo did participate in and complete the appraisal he was required to undergo.

Further matters arising from the Evidence adduced by PCT

45. Dr Bacon told us that he used the EMIS computer software system in his own practice which is the same as the one used by Dr Okonkwo to create the bogus prescriptions. We looked at R1/65 with him (Case 3, Mr G). He explained the various abbreviations on that page, which is an actual consultation, and the drugs listed there were apparently prescribed as part of that consultation. We then looked at R1/66 which is a prescription for one of the drugs (Valsartan) which is listed as prescribed in the consultation note. The other drugs had apparently been put onto a separately generated prescription. He said they should all be on the same prescription. On-screen cancellations will not delete a text entry (i.e. the consultation record) and thus drugs listed in the consultation record would still appear, even if you deleted the drugs from the prescribing record.
46. Dr Bacon further told us that if you want to issue a prescription on a private basis using this computer software, you press a single key, and the privately prescribed drug then appears on the right hand side of the prescription which is for non-NHS prescribing. There was no difference between the time taken to issue a private prescription in the proper way, and the way Dr Okonkwo did it, so it was difficult to explain he action on the ground of being pressed for time. In fact Dr Okonkwo must have interrupted the print process to produce the separate prescription.
47. It was the letter from Dr Watkins which had triggered the investigation of Dr Okonkwo, although he also agreed with Mr Lloyd that it was Dr Okonkwo who provided the information about the 14 cases referred to in their letter.
48. As to how a GP might view the information recorded on the computerised history created by Dr Okonkwo for the purpose of his deception, Dr Bacon said he would assume, looking at the record in (for example) R1/62 (patient O), that Valsartan was properly prescribed. He would assume that without checking the patient's earlier history. If he did, he would have noticed in the case of this patient that there was an earlier episode of stroke in the clinical records, which would reassure him. Similar consideration applied to the other patient records.
49. The documents provided to the Panel in consequence of previous directions include a Case Summary provided by prosecuting authorities for the purpose of the Crown Court appearance. In addition to some information summarised above, it says at R2/11 that Dr Outar, the former partner of Dr Okonkwo, believes that over one hundred patients left the practice since the problem arose, and he has had to cover manpower shortages, using locums which are not cost effective. The documents also indicate that the pharmacist who issued the drugs against these prescriptions was placed under suspicion.

Appellant's Evidence

50. Dr Okonkwo did not give evidence to the Panel, nor put medical evidence before us. Although we are told he was remorseful, that his mental health had suffered (because he has suffered depression), and that he was working under pressure and so yielded to pressure to obtain these drugs by deception, rather than paying for them on a private prescription as he could have done, it is therefore difficult for us to evaluate these assertions for ourselves.
51. Dr Michael John Kennedy was called to give testimonial evidence and to tell us that he believed that Dr Okonkwo should be allowed to return to local GP practice, for which purpose Dr Kennedy would be willing to offer Dr Okonkwo a post as a salaried doctor in Dr Kennedy's practice.
52. Dr Kennedy has practised in Peterborough for the last 15 years or so, having qualified in 1992 as a GP. He now has his own practice with one partner and 5 salaried "partners" and 6 nurses. His patient list is now 10800. He described his practice area as deprived, with a large influx of asylum seekers and itinerant Eastern European workers. He said that Dr Okonkwo had worked as a locum in his practice about 5 years ago, for about a month, during a period of 4 months when he was ill. He had had no complaints from his patients, whom he described as vociferous in expressing their opinions. However he had not (since he was absent through ill health) worked with Dr Okonkwo during the period of his locum. He said he had only worked with him as a colleague when they both did shifts at the "out of hours" centre. He described him as "fine, hardworking, committed, no problems, good fun, you could rely on him to do his fair share of work (unlike some)". It transpired that they had continued their relationship through attending the same Church.
53. He felt that Dr Okonkwo was committed to his work as a doctor. He regarded the offences as out of character "because he has been placed under pressure by his family at home. The culture is completely different". At first he said "That is my understanding from Jonathan of what has occurred". In cross examination he also said Dr Okonkwo had given him as a reason for his behaviour, "tiredness, strain and bafflement". He went on to say "I guess if you had a relative on the phone from Nigeria you might just do it. I myself would just have purchased them and sent them." He conceded that the reasons given made no sense and he was struggling to find an explanation. In further answer to the Panel Dr Kennedy said he was not saying the relatives asked Dr Okonkwo to obtain the drugs from the NHS fraudulently. He did not even know these phone calls even occurred. He was simply speculating "trying to make sense of it". Dr Kennedy made the point himself that defrauding the NHS by putting the drugs on the prescribing record of an actual patient is not easier than writing a private prescription yourself. At most "it saves you a few seconds". He told us that Dr Okonkwo himself does not understand why he did it and that "we have discussed this many times". He was asked whether he could say there was no risk of repetition, as he suggested, when the behaviour made no sense, and he replied that it was because the consequences were now so clear to Dr Okonkwo.

54. Dr Kennedy was a man of forthright views who did not stop at expressing support for Dr Okonkwo. He told us that although he did not condone the conduct, removing him from the Performers List was “a sledgehammer to crack a nut” and he should be allowed back to work. He said “I am looking at it as a hand in the till type of offence”. But he said he was in no difficulty about expressing his views about proportionality, which were that Dr Okonkwo had suffered a “punishment out of proportion to the offence”. He expressed it also as “a £1/4 million fine for a £250 offence”. We understood this figure to be a rough calculation of lost earnings or benefits.
55. Until he was asked about it in cross-examination he did not address the patient safety issues which are a feature of Dr Okonkwo’s conduct. When it was put to him he said these were “very obvious”. However he insisted that no clinical harm resulted.
56. The Panel questioned Dr Kennedy further about the arrangements he had in mind for Dr Okonkwo to work as a salaried GP in his practice. In his evidence in chief he told us that the subject of “retraining” had been mentioned to him, and he was prepared to offer him a salaried post. There was no exploration of his potential role pursuant to any conditions of the kind we were being asked to consider.
57. Dr Kennedy told us he was now medically retired and had recently taken on a junior partner. When that partner was on holiday he covered for him part time. Dr Kennedy was not a GP trainer. Nor had he ever acted as a workplace supervising doctor, but had mentored junior doctors. He had only discussed with his junior partner having Dr Okonkwo “sitting in” with him, Dr Kennedy. It had been indicated to Dr Kennedy that the problem was not a clinical one but a probity one.
58. He was asked about his capacity to check every consultation in view of the nature of the prescription fraud (involving adding drugs to a consultation record). He said he would have that capacity and may even have to employ somebody to assist him. If a named doctor only were made responsible, he would be able to cover it with his partner’s help. This might involve checking 28 consultations but in the first instance he suggested Dr Okonkwo would not be signing repeat prescriptions.
59. Asked how he would monitor Dr Okonkwo’s prescribing he said every GP had their own login which would enable him to trace what a doctor was doing. If they deleted the entry or script after issuing it that would be more difficult, but he could do so with the assistance of the software provider, because there was a “mirror disk” which stored all entries made, even if they were deleted on screen.
60. He said that he assumed that the GMC would remove the suspension currently in force, at which point he assumed that Dr Okonkwo would cease to be contingently removed from the Performers List and the conditions would lapse. He did not appear to have contemplated that the conditions attached to a contingent removal might continue for years, with their consequential burden on him and his practice.

61. When we explored with Dr Kennedy what remorse Dr Okonkwo had expressed, he said he had repeatedly told him that he regrets it. When asked why he regretted it, it appeared (if Dr Kennedy was accurately recalling conversations) that Dr Okonkwo primarily regretted the impact on his own life and that of his family. He said he should be allowed rehabilitation and the best form of rehabilitation was to be back on the Performers List.
62. The PCT's position was that it did not regard conditions as appropriate. Mr Ozin's submissions on conditions (which we invited him to make) focused on the need for supervised prescribing and audit to guard against the risk of repetition. He submitted this would require all prescriptions to be countersigned. The audit structure would need to be capable of verification with supporting printouts. But any cost or resources arising from supervision or retraining would not be provided by the PCT and should be met by Dr Okonkwo. The PCT would not be willing to employ Dr Okonkwo directly; he would have to be a salaried GP. Any supervision would have to be of a nature which would inevitably be intrusive and extensive, requiring patient contact only when supervised and the patient would need to be informed of the position and give consent.
63. A testimonial bundle prepared originally for the purpose of his Crown Court appearance, contains 38 supportive testimonials. One is from a hospital cardiologist to whom Dr Okonkwo referred his patients when necessary, three are from doctors who knew Dr Okonkwo in the days when he was working in the hospital setting, before becoming a GP, one is from Dr Kennedy who gave evidence to us, one from a local pharmacist, and the others from patients who had known him for all or part of his period as a GP starting in 2001. Of those patients, one was also a member of staff at his practice. All wrote praising his personal qualities and in the case of his patients his interpersonal skills, for example as a listener and someone willing to discuss his diagnosis. Those patients clearly valued him as a GP. It was not clear to us how much detail they knew about the matters with which we are concerned. Dr Rowlands (the cardiologist) wrote: "I understand that there has been an aberration of his judgement with prescription for family members".

<u>Consideration</u>

64. The hearing was adjourned at the end of the first day so that the Panel could meet at a later date to consider its decision.
65. We found Dr Bacon to be a quiet, measured, and reasonable witness, who made appropriate concessions when shown new material. We accept his evidence.
66. We are satisfied that the instances of falsifying patient records in order to obtain drugs without paying for them was deliberate, and showed some pre-meditation. In each case the patient was elderly and vulnerable. Not only did that make it less likely that the mis-prescribing would be picked up, but it also made it possible for Dr Okonkwo plausibly to act the role of picking up the prescribed drugs from the pharmacist for an elderly patient. In each case the additional drugs were introduced into a record of an apparently genuine consultation. There is evidence that in at least some of these cases there was

a history which gave some credibility to the “false” prescription, if anybody bothered to look. On at least one occasion Dr Okonkwo printed out two different prescriptions of the drugs listed in a single consultation record, so that the Valsartan he wanted for himself appeared on a separate prescription.

67. The explanation offered for defrauding the NHS rather than issuing a private prescription and paying for the drugs himself is that he was in a hurry (see paragraph 29 above) or was under pressure, and tired. Dr Kennedy modified this explanation to suggest that he was under pressure from members of his family in Nigeria. When subjected to analysis, it is difficult to see how any of these factors could explain or be the trigger for his dishonesty. We are satisfied that the conduct in fraudulently obtaining the drugs would not save either time or effort. Arguably, more thought and effort had to go in to the dishonest method of obtaining these drugs. There is no evidence of where these drugs went other than the explanation given to police by Dr Okonkwo and to us today, that they went to family members in Nigeria who had a genuine medical need, and we approach the matter on that basis. But there is no evidence that Dr Okonkwo was under pressure from family members to provide drugs without paying for them. Dr Kennedy was reduced to speculation about how family pressure might have been exerted, despite having discussed these offences many times with Dr Okonkwo, who did not come forward to explain matters to us himself. We do not accept the explanations (being in a hurry, under pressure or tired) offered on his behalf. It is as easy, or easier, to issue a private prescription, as it is to do it dishonestly, as he did. The system was manipulated with pre-meditation, in the ways outlined in the previous paragraph.
68. In our view these are considered acts of dishonesty, which took place over a period of more than a year. The method adopted involved falsifying patient records. In our judgement this is the most serious aspect of his conduct. Not only were the prescriptions issued but bogus entries were made in the record of clinical consultations. These could not be erased. Indeed although there was some discussion about what could and could not be erased, there is no evidence that Dr Okonkwo ever attempted to erase or rectify bogus entries that he had made. Any doctor subsequently reviewing that patient’s records would believe, and in the case of Mrs C, did in fact believe, that the medication had been prescribed to and taken by that patient. In Mrs C’s case, her breathing difficulties were wrongly believed to be a drug reaction to the medication recently prescribed by Dr Okonkwo. The response to, and treatment for her problem was conditioned by bogus information entered on her records by Dr Okonkwo. Happily, Mrs C was able to convince her doctors that it was not so, but her case illustrates how dangerous Dr Okonkwo’s conduct was. In our judgement this is a case in which patient welfare was put in peril for personal gain, however modest the sums of money involved in the charges were.
69. It follows that in our judgement Dr Okonkwo’s conduct represents a serious and protracted lack of probity, and a breach of his position of trust towards his patients. Inevitably, and understandably, it also poisons the relationship of

trust and confidence between him and the PCT, which remains unwilling to employ him or to have him on its Performers List.

70. We have considered the additional allegations of failure to participate in the assessment process. In our view the fact that the first appraiser found he was unable to secure agreement to a form of words for the purpose of the Summary (Form 4) is neutral, in view of the fact that a second appraiser was able to complete the process. It seems to us that Dr Richards' criticisms of Dr Okonkwo's engagement and attitude goes beyond a mere clash of personalities, but the assessment from Dr Wishart was satisfactory, and the PCT has not satisfied us to the required standard that Dr Okonkwo failed to participate in his assessment. Our main concerns arising from this issue relate to the document shown to us at A1/3-7 (and summarised at paragraph 44 above), which appears to show some lack of candour by Dr Okonkwo towards his appraiser, or at least a continuing disinclination to accept that he was suspended and facing difficulties. This is a small point to weigh in the balance but has some bearing on our view of the degree of insight demonstrated by Dr Okonkwo.
71. We have also considered the Dr Okonkwo's failure to supply services within the PCT's area for 12 months. This is a separate ground for removal. It is plain that the allegation is factually correct. However, it arises solely because Dr Okonkwo was suspended from practice by the GMC in April 2006, and remains suspended to date. His suspension in turn arose from the substantive allegations of misconduct which we have considered in this appeal. In considering whether to exercise our discretion whether to remove Dr Okonkwo from the List on this ground, our judgement is that it adds nothing to the sting or mischief of the substantive allegations. We are not prepared to say that a removal should always or never be considered where services have not been performed on account of a GMC suspension, but on the facts of this case we do not think it adds anything and are not prepared to remove Dr Okonkwo for that reason.
72. We have carefully considered the matters urged on us by Mr Lloyd. These include his admissions and pleas of guilty, for which credit is due, and the impact upon him of his Crown Court sentence and his suspension at the hands of the GMC. We are not wholly convinced that Dr Okonkwo volunteered all he might have done as soon as he might have done: for example it was Dr Watkins who wrote to the PCT and not Dr Okonkwo when the matter came to light within the practice, and the police summary indicates there were three interviews before it was considered that full admissions had been secured on which he could be charged. However he undoubtedly provided further information on some 14 cases to the PCT for which credit is due.
73. It is also urged on us that he has shown genuine remorse, that his health has suffered, and his family has suffered. We find ourselves unable to assess the character of his remorse, since we have not heard from Dr Okonkwo. We accept he has expressed it through Counsel and elsewhere. We also accept that he wrote to three of the patients concerned. Dr Kennedy regarded him as

genuinely remorseful. As we have noted, that remorse has tended to focus first and foremost on the effect upon himself and his family.

74. We are told that Dr Okonkwo' health has suffered and he has experienced a reactive depression. Dr Kennedy thought he might have been receiving some treatment for this. We have seen no medical evidence other than a short-form medical certificate that he was unfit for a limited period a year ago. We accept that the events which occurred have had a serious adverse effect on Dr Okonkwo and that part of that effect is likely to be some degree of reactive depression, but we have no evidence on which we can properly assess the nature and degree of that reactive depression, or the duration of any health problem.
75. Dr Okonkwo comes from a good family, many of whom, like himself, have obtained professional qualifications and worked hard to better themselves. He was previously a man of good character who had an unblemished medical career, and enjoyed the high opinion of a number of former colleagues and patients, some of whom have provided testimonials. We accept that there must have been an effect on his own family when he was prosecuted for criminal offences and suspended from practice.
76. Nevertheless in light of our conclusions above we find that he is unsuitable to remain on the Performers' List of this PCT.
77. In deference to the extensive evidence given and submissions made on the subject of conditional removal, we have considered whether, if our conclusion had been different on unsuitability, this would be a case for contingent removal. We note that contingent removal is formally available in cases of fraud. We can see that where the nature of the fraud involves false claims or taking money, it might be possible to frame conditions which keep the doctor away from those activities and limit him (for example) to clinical activities. We find it impossible to see how workable conditions could be framed in circumstances such as these where the probity of the doctor in the course of his dealings with patients, making a truthful clinical record and issuing prescriptions has been found wanting. In order to frame conditions which tried to meet the criteria in Regulation 12 (preventing further acts or omissions of fraud) it would be necessary to have each and every consultation monitored, to have each and every prescription checked for genuine medical need of the patient, and put in place a framework of the kind which was canvassed with Dr Kennedy and summarised above. In our judgement that is unworkable, and an unreasonable use of resources.
78. Sadly we felt that Dr Kennedy's otherwise admirable instinct to assist his friend Dr Okonkwo had blinded him to an objective or realistic view of what might be involved in taking him on as a salaried GP. He seemed not to have considered the impact on his own practice. We were frankly astonished that despite being medically retired he thought he could provide a sufficient level of monitoring, not only of his consultations but also of the paperwork. Nor did he appear to understand that if conditions were put in place, they would not necessarily come to an end when and if Dr Okonkwo's suspension was lifted by the GMC. We were not satisfied that Dr Kennedy's partner, on whom he

seemed to think some responsibility would fall, was sufficiently aware of what would be involved.

79. Moreover Dr Kennedy himself seemed to lack a degree of insight into the mischief of Dr Okonkwo's conduct. He appeared as an advocate rather than as a professional colleague seeking to provide help in remedying deficiencies. On a number of occasions he made plain that he thought a sledgehammer was being used to crack a nut. We felt that he was such a close friend, who told us he was willing to do anything he could to enable Dr Okonkwo to resume practice, that he might not prove able to bring the necessary degree of objectivity to bear as a supervisor, a role which in any event he had never performed before.
80. We therefore conclude that in the event we had felt able to consider this case as one restricted to fraud or efficiency, contingent removal would not be appropriate, and we would have directed removal.
81. In our judgement the conduct of Dr Okonkwo in this case, impacting as it does on patient welfare, crosses the line which marks out unsuitability, and we dismiss the appeal and direct that Dr Okonkwo be removed from this PCT's Performers' List.
82. We adjourn our decision on National Disqualification so that the parties may consider their positions in the light of our findings. For that purpose we direct that (if so advised) the parties make any written submissions on that issue to us by no later than 3 July 2009. If either party wishes to request an oral hearing of the issue of National Disqualification then they shall do so by the same date.
83. In accordance with Rule 42 (5) of the Rules we hereby notify the parties that this decision may be appealed under Section 11 of the Tribunals and Inquiries Act 1992 by lodging a notice of appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days from the receipt of this decision.

Duncan Pratt
Chair of the Panel appointed to hear this appeal

8 June 2009