Case No.14696

THE FAMILY HEALTH SERVICE APPEALS AUTHORITY

25 May 2010

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

Preliminary matters

1. By our decision dated 2 April 2009, we dismissed Dr Okonkwo's appeal against his removal from the PCT's Performers' List, and indicated that we would adjourn consideration of National Disqualification, so that the parties might consider their positions in the light of our findings. We invited written submissions from the parties on that issue, and any request for an oral hearing, by 3 July 2009. The PCT submitted written submissions from Counsel, dated 30 June 2009. By a letter dated 3 July 2009 from his solicitors, Dr Okonkwo sought an oral hearing.
2. However immediately prior to that date Dr Okonkwo had lodged an appeal to the High Court against our decision of 2 April 2009. We acceded to his request to defer consideration of National Disqualification until the disposal of his appeal, subject to the safeguards of Directions which we issued on 23 July 2009. Plainly, consideration of National Disqualification might not be necessary if the appeal were prosecuted diligently and was successful. In the event, however, Dr Okonkwo withdrew his appeal on 30 November 2009 and we have seen a consequential costs order made by a High Court Judge. The disposal of this final issue arising on the appeal has therefore been a protracted affair.
3. Although we received from Dr Okonkwo copies of his appeal documents, we have left them out of our consideration, as irrelevant for the purposes of this hearing.
4. The Tribunal considered National Disqualification on 25 May 2010 at the Lands Tribunal, Bedford Square, London, when Dr Okonkwo was represented by Mr Martin Forde QC, instructed by RadcliffeLeBrasseurs,

solicitors, and the PCT was represented by Mr Paul Ozin of Counsel, instructed by Mills & Reeve, solicitors.

DECISION

5. Our unanimous decision is that:
    a. National Disqualification shall be imposed on Dr Okonkwo, under Regulation 18A (2) of the Regulations, effective from the 25 May 2010; and
    b. the period after which Okonkwo may apply for a review shall be the period of two years specified in Section 159 (8) of the National Health Service Act 2006.
    c. A copy of this decision shall be sent to the Secretary of State for Health, the National Assembly of Wales, the Scottish Executive, the Northern Ireland Executive Committee and the Registrar of the General Medical Council.

REASONS

Documents before the Tribunal

6. In addition to the papers available to us on the hearing of the appeal we had:
    a. The written submissions of the PCT dated 20 June 2009.
    b. An un-numbered bundle sent under cover of Dr Okonkwo's solicitors dated 10 May 2010, comprising:
        i. His curriculum vitae;
        ii. Certificates relating to Continuing Professional Development;
        iii. Sentencing remarks of the Judge following his criminal trial (these were also available to us at the substantive appeal);
        iv. Recent correspondence with the Eastern Deanery.
    c. A further un-numbered bundle of testimonials from 26 individuals, under cover of Dr Okonkwo's solicitor's letter dated 18 May 2010.
    d. A further testimonial from Dr Okonkwo's brother, an Associate Specialist in Emergency Medicine, dated 15 May 2010 and sent under cover of a solicitor's letter dated 19 May 2010.
    e. A small bundle handed in at the commencement of this hearing, comprising a joint testimonial from David and Christine Morris, and a testimonial from his GP trainer Dr D A J Ker, dated 24 May 2010.

Legal Framework

7. Our consideration of National Disqualification arises from our powers and duties under Regulation 18A (2) of the NHS (Performers List) Regulations 2004 (as amended) ["the Regulations"][1] and Sections 106 and 159 of the National Health Service Act 2006.
8. There is no statutory guidance on the factors to be applied in considering National Disqualification. It is available whether the ground for removal is a mandatory or discretionary one, and if discretionary, whether it is on

[1] "If a performer appeals to the [First Tier Tribunal] under regulation 15 and the [First Tier Tribunal] decides – (a) to remove the appellant from a performers list; or…… the [First Tier Tribunal] may also impose a national disqualification on that performer".

grounds of suitability, fraud, or efficiency. In our view these wide powers are conferred on us so that we can deal with the multiplicity of different factual situations which arise without the necessity to pay undue regard to the label attached to the conduct or deficiency.

9. The "Advice for Primary Trusts on Lists Management" published by the Department of Health in 2004 ["the Guidance"] says at paragraph 40.4 that a PCT should "*recognise the benefits of a national disqualification both for protecting the interests of patients and for saving the NHS resources"*. It says further that *"this additional sanction is necessary in the most serious cases, only when a doctor has been ….removed by a PCT from its own list, and it is imposed by the FHSAA"* and *"unless the grounds for removal … were essentially local, it would be normal to give serious consideration to such an application"*.
10. The principles derived from published Guidance and from cases determined by the FHSAA and First-Tier Tribunal to date establish, in our view, that:
    a. Serious consideration should be given to national disqualification where the findings against the practitioner are themselves serious and are not by their nature essentially local to the area where the practitioner was working;
    b. Other relevant factors are:
        i. The range of the deficiencies or misconduct identified;
        ii. The explanations offered by the practitioner;
        iii. The likelihood of those deficiencies or conduct being remedied in the near to medium term;
        iv. Patient welfare and the efficient use of NHS resources;

    but balancing those against -

        v. The proper interests of the practitioner in preserving the opportunity to work within the NHS (which includes both pursuing his professional interests and earning money).
        vi. Whether national disqualification is proportional to the mischief of the Panel's findings as to the conduct or clinical failings of the practitioner, and to consider the common law requirement that national disqualification is reasonable and fair (see *Kataria v Essex SHA* [2004] 3 AER 572 QBD).

    We put these propositions to the parties in the course of argument and they were content to adopt them.
11. The standard of proof which we should apply (where fact-finding is involved) is the balance of probabilities, in accordance with the guidance of the House of Lords in *Re D* [2008] UKHL 33.

<u>Background of findings in the substantive appeal</u>

12. We refer to our findings and conclusions at paragraphs 64 to 81 of the appeal decision in this case. We concluded among other things that Dr Okonkwo was unsuitable to be included in the Performers' List of this PCT, because of a serious and protracted lack of probity and a breach of his position of trust towards his patients, which had imperilled patient

welfare for personal gain (albeit modest monetary values were involved) and poisoned the relationship of trust and confidence between him and the PCT.

13. The particular lack of probity involved (as we found) considered acts of dishonesty in falsifying the medical records of elderly and vulnerable patients so as to create bogus prescriptions allegedly for their genuine medical needs, when the drugs in question were being obtained by Dr Okonkwo himself. His explanation for this is that he was obtaining the drugs for use by his own family members in Nigeria, because they had difficulty in accessing reliable supplies of unadulterated drugs, and that this lapse of judgement in dishonestly obtaining the supplies from the NHS, rather than writing a private prescription himself, was because he was tired and under pressure. We rejected this explanation as to tiredness and pressure (see paragraph 67of our decision).

PCT's evidence and submissions

14. Dr Niall Bacon (Medical Director of the PCT) was called by Mr Ozin to state that the PCT would not wish to support retraining of Dr Okonkwo in light of his criminal activity and the immense cost which would be involved in retraining. This evidence was adduced to counter a suggestion in the correspondence that Dr Okonkwo believed the PCT would be supportive of retraining.
15. Mr Ozin submitted among other things that National Disqualification was the only course in light of our previous findings. He drew our attention to the further comments in the Guidance at paragraph 17.4: the GMC always takes a serious view of dishonesty. He submitted that the factors set out at paragraph 40.4 were all satisfied in the current case by our previous findings: guarding against risk to patients, the protection of NHS resources, namely guarding against fraud on the NHS, and on the other side of the coin, the disproportionate burden on public funds and resources to meet concerns about his conduct. The PCT's position was that it was not possible to formulate a framework of conditions to meet the concerns arising from our previous findings, and this must be so for any PCT wherever it was situated.
16. Mr Ozin pointed to the effects on others such as his former partner, the patients whom it was suggested had left the practice in consequence of these incidents, and the unfair suspicion which had fallen on the pharmacist who dispensed the drugs. This went to the seriousness of the matter, as did Dr Okonkwo's chosen method of targeting patients whose records were a convenient repository for the prescriptions he was issuing, were less likely to be questioned, and provided him with a plausible explanation for picking the drugs himself. In his submission elderly patients were more vulnerable because they would be less likely to gainsay the presumption that they had in fact received those drugs themselves.
17. Mr Ozin pointed to our findings at paragraphs 67 to 69 and relied particularly on the last sentence of paragraph 68:

> "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."

He also pointed to paragraph 73 in relation to Dr Okonkwo's apparent lack of insight into his conduct.

18. Lastly Mr Ozin submitted that while he accepted Dr Okonkwo was a competent GP, well regarded by professional colleagues and patients, the protection of the public was involved and in those circumstances "matters which sound in mitigation have rather less purchase in regulatory proceedings". In light of the range of deficiencies and lack of proper explanation for what had happened, and why, we could not have confidence that matters would be remedied in the near future.

Submissions on behalf of Dr Okonkwo

19. Mr Forde described this as a personal and professional tragedy for Dr Okonkwo, arising as it did from a period of 15 months during a lengthy career of 32 years. He reminded us that Dr Okonkwo's clinical competence was not in question, nor the good opinion of colleagues and patients (illustrated by the number of testimonials). However he realistically accepted that our findings of dishonesty raised issues of probity which were not geographically limited and therefore the PCT cleared the first hurdle for national disqualification in that the findings were not essentially local to the area where he had been working. He also accepted that the public have a right to expect their doctor to behave honestly and to manage NHS resources properly, and that the GMC take a serious view of dishonest conduct, but submitted (by reference to the Crown Court Judge's sentencing remarks and the compensation order) that this was not at the most serious end of the scale of dishonesty.
20. Mr Forde submitted that our concern would be whether the behaviour would be repeated. He argued that the dramatic nature of Dr Okonkwo's fall from grace and the humiliation involved in admitting these matters to his family, his peers and colleagues and his Church community, meant we could have confidence that the behaviour would not be repeated.
21. Mr Forde pointed out that Dr Okonkwo has not practised for 3 years since 23 April 2007, because of these matters, and has had to account to several different Courts or Tribunals for them. He acknowledged that we would have had justifiable concerns about the degree of Dr Okonkwo's insight at the time of his appearance in the Crown Court, and that it had taken him some time to come to terms with what he had done, because of the shame involved. But he boldly submitted that Dr Okonkwo had already been disproportionately punished, and had "up to this point expressed such remorse as he feels able".
22. Mr Forde submitted that it was his task to persuade us that Dr Okonkwo had moved on and had insight. He pointed out among other things that he had attended an ethics course at Imperial College, run by the Royal College; this in fact took place in May 2007 before the substantive appeal

hearing. He told us the Deanery had indicated it would cause huge difficulties in resuming his career if he were not on a Performers' List.

23. Mr Forde further submitted that the public was adequately protected by the decision this Tribunal had made thus far. Dr Okonkwo had (he argued) no prospect of being able to apply for remedial training or to go on another Performers' List, without revealing his criminal conviction or his removal from the Respondent PCT's List and his history before the FHSAA and the GMC, including his period of suspension. So on the issue of proportionality there was no need for further sanction. He posed the question "is it so serious you have to nationally disqualify?". He placed some reliance on the sentencing remarks of the Crown Court Judge. We observed in argument that we read those remarks as simply seeking not to pre-judge what the GMC or other appropriate body might do. Mr Forde agreed they might be read in this way.
24. Mr Forde's submissions on two points caused us to seek further information from him:
    a. Firstly Mr Forde drew our attention to the memo recording Dr Okonkwo's contact with Professor Hibble, the Director of Postgraduate GP Education at the East of England Deanery, in January 2010. We enquired what was the outcome of the recommendation made in that memo by Professor Hibble, namely that Dr Okonkwo:
    "*needs to write a reflective paper about the prescribing course and the ethics course [he had attended] and detail his report in the light of his false prescribing, the lessons learnt including the factors that affected his judgement, and the actions he has put in place to ensure that this will not occur again.*
    He needs to create an active personal Professional Development Plan that demonstrates his ability to reflect upon learning and how it might be put into practice."
    b. Secondly he submitted that alternative arrangements had been made for supplying family members in Nigeria with drugs of the type he had dishonestly obtained in 2005-6. We invited him to tell us what these arrangements were.
25. Mr Forde took instructions and called Dr Okonkwo to give evidence, explaining that evidence needed to come from him and not be provided through Counsel.

<u>Dr Okonkwo's evidence</u>

26. Dr Okonkwo had not previously given evidence to us. He is an articulate, even loquacious man, who appeared to have some difficulty sticking to the point and answering questions without digressing at length on his previous impeccable character, the extra mile he habitually went to help his patients, family and others in a less fortunate position than himself, and his strong Christian family background and active involvement in the Church. But he could not demonstrate real focus on the practical concerns raised by our findings, or insight into the effect of his actions on patients

(or the concerns about risk to his patients in the future) as opposed to the effect on his own career. In relation to the query we raised at paragraph 24 (a) above, it appeared that Dr Okonkwo had done neither of the things suggested by Professor Hibble (write a reflective paper or a Professional Development Plan). For reasons he did not make clear he said he had been waiting to be contacted about this. In the result, he was unable to put before us two documents which might have been of assistance in demonstrating the development of insight, or to show he had put his own best foot forward.

27. Dr Okonkwo assured us that he would never again do the things which had given rise to these and other proceedings. He said his various Nigerian relations had made arrangements to get their supplies of medication privately although sourcing them in Nigeria. He said this was now possible as a result of the successes achieved in the fight against counterfeit drugs in Nigeria. He said there was a reliable source located about 6-8 miles away from his family. He had spoken to his mother and she had no problem getting her [anti-hypertensive] medication.
28. Dr Okonkwo said he understood the seriousness with which he action were viewed, but they were out of character. The first time he had written one of these prescriptions was for a cousin who was about to undergo an open prostatectomy, a highly risky operation which was no longer practised in the west, and Dr Okonkwo strongly advised him not to undergo the operation but to take medication instead. He said there was a friend going back to Nigeria and he had just finished a night shift so issued the prescription "which in hindsight was the wrong way to issue it". Dr Okonkwo said he had previous ordered medication in advance from a pharmacy and paid privately. He said "I saved this man [his cousin] from an unnecessary and dangerous operation". He was now healthy and at home. Dr Okonkwo said:

    "*I therefore feel quite sad that having made this mistake I have had to go through all these difficulties. It was not to save money in any way. As a doctor I worked hard and supported people. I did this as second nature; I have never taken anything from anybody*".

29. When asked about it, he accepted his actions had cost the NHS money. He assured us he understood the importance of managing taxpayers' money. He then described at length the financial benefits his organisational skills had brought to the GP practice he had joined in Peterborough prior to 2005.
30. As for maintaining and updating his skills, Dr Okonkwo told us he had met with a local GP colleague but that colleague had had to cancel appointments with him on a further two occasions. He again mentioned the ethics course at Imperial College which had taught him a lot of things. He mentioned weekly meetings of local GPs all of whom were aware of his difficulties and to whom he had apologised and was ashamed of his actions. Somewhat to our surprise he went on to say:

> "What I have done has been misrepresented in some ways as well because when I was training I was told GPs used to get prescriptions using other patients' names. My Medical Director said they know it happens but it is still illegal. I am still being punished for it."

We understood from this that Dr Okonkwo believed he was being punished for actions which were broadly similar to commonplace actions among GPs known to him since his days as a trainee [in 1998-99]

31. When Dr Okonkwo was questioned during cross-examination about his reasons for writing these false prescriptions on NHS forms, why he did not pay for them himself, and details of the circumstances in which he had done so, such as the names of the friends who had fortuitously been about to return to Nigeria (he could not remember them), he became aroused and angry, shaking his finger at Mr Ozin. Counsel asked him on several occasions *why* he did not pay for the drugs himself, but Dr Okonkwo did not provide an answer to the question, choosing instead to explain that he had done it on the first occasion described above, and then unfortunately a few more times. He digressed onto the need to obtain reliable [i.e. non-counterfeit] medication. He described his action as "a wrong judgement", but denied he had done it to save himself money. However he was obliged to concede that the effect of what he did was just that. He accepted that he had repeated the fraud over a long period of time. He said "my sin is that I made the wrong judgement and issued the prescriptions in my patients' name for relatives".
32. Dr Okonkwo agreed that the false information about the prescribing of the drugs to these patients might stay on the practice computer, but maintained he was "quite illiterate about computers, although I use them regularly in my practice". He agreed he did carry on doing it, but denied that he had taken time and care to select the patients he was going to use. Indeed he became very animated when telling us that these patients were ones he had looked after for a long time and "are dear to me". He said there was no pre-selection of patients for issuing these prescriptions. As for the pressure of time for issuing a prescription, this had been an issue the first time but not after that: he would just get a phone call saying Mama's medicine is finishing" and somebody or other was coming home.
33. Dr Okonkwo said he had not put full thought into his actions. He was asked if he did not recognise what he was doing was dishonest, and told us that he realised when Mrs C's prescription was "in the open". He then put his hands up immediately. But it had not bothered him at the time because he did not think about it and was just concerned about his relatives. It bothered him now, so he had stood down from reading the lesson at Peterborough Cathedral.
34. We asked Dr Okonkwo what he could tell us that would provide reassurance that in future patient welfare would not be jeopardised by falsifying their records in order to create a bogus prescription. Dr Okonkwo said he would be willing to wear a badge to say what he had done. He

also said he had told his relatives he could not help them with medicines. He claimed he had done everything he could and his senior brother in Portsmouth knew everything, but repeated his claim that he would not have thought of doing this if the idea of using a prescription for someone other than the patient had not been given to him during training. He said that helping people was second nature to him.

Further submissions

35. Mr Forde further submitted that Dr Okonkwo's behaviour was driven by misplaced altruism, and that he had reflected on these matters. The real public interest was in retaining the services of a competent practitioner who had been out of practice for 3 years and may be lost to the public. He drew our attention to further testimonials in the bundle, and to certificates of attendance at a local training facility.
36. He submitted that dishonesty could be seen as a fundamental character flaw justifying national disqualification but this was a rare case where contrition and remorse were genuine and there was no risk to the public purse. Dr Okonkwo would be able to pay for his own retraining through the generosity of his family.
37. Mr Ozin submitted in response that police national computer checks pick up national warnings including national disqualification, but a local PCT removal is not a national warning and hence would not be picked up by a police national computer check. The could be no reassurance that the relevant history would be brought to the attention of any PCT to which Dr Okonkwo applied, in the absence of national disqualification. However he conceded that the gap in Dr Okonkwo's curriculum vitae should prompt enquiries.

Consideration

38. We considered the evidence and submissions against the criteria set out at paragraphs 7 to 11 above.
39. It is conceded that this wrongdoing is not peculiar to the locality and that it is serious (even if Mr Forde suggests it is nearer the bottom end of the scale of dishonesty). It also persisted between August 2005 and September 2006, when a false prescription written by Dr Okonkwo for his patient Mrs C came to light as described in our decision on the substantive appeal. Dr Okonkwo was challenged, arrested and the conduct stopped only at that point.
40. The incidents reflect adversely on Dr Okonkwo's probity and trustworthiness in relation to his dealings with his then patients, NHS resources, the PCT and local pharmacists. Patient welfare was compromised, as we have found, in order to further the fraudulent concealment of his actions. The particular patients were in fact all elderly and vulnerable ones and we consider this was not chance, but calculated to reduce the risk to Dr Okonkwo of discovery.
41. These serious and unavoidable conclusions are powerful factors in favour of national disqualification and give rise to a heavy burden of demonstrating convincing explanations, and a real likelihood that the

conduct has been remedied and will not be repeated in the future. We are not satisfied that Dr Okonkwo has gone anywhere near achieving that.

42. We found Dr Okonkwo's evidence failed to satisfy us that he had developed real insight as contended by Mr Forde, not did it provide any convincing explanation of his actions. We drew attention in the course of our determination of 8 June 2009, to the difficulty of evaluating the explanations put forward on his behalf. Dr Okonkwo took the opportunity to give evidence today. We refer to our impressions set out in the course noting the main points of his evidence above. He is still unable or unwilling to explain why he issued bogus NHS prescriptions rather than purchase drug supplies privately for his relatives. Even if we accept that the constraints of time on the first occasion caused him to write an NHS prescription (contrary to our previous findings), he does not put "time pressure" forward as a reason on the subsequent occasions. However even the "short cut" explanation of acting under pressure is not one we find convincing for the reasons set out in our previous determination.
43. We find it surprising that Dr Okonkwo can remember none of the names of friends, relatives or acquaintances to whom he handed over the drugs to be taken back to Nigeria, particularly as he has reflected at length on these events.
44. In the event Dr Okonkwo's explanations both of the circumstances surrounding his sending medicines to Nigeria originally, and the reason why his relatives are able to obtain reliable supplies now, are not supported by any independent evidence. We find the explanation as to why things were now different, and (as he suggests) remove the concerns about adequate supplies of drugs to Nigeria, and the consequential temptation, to be unconvincing.
45. We did not find that Dr Okonkwo's evidence, either in substance or demeanour, satisfied us that he had developed the degree of insight claimed for him by Mr Ford, into his wrongdoing, nor that he had reflected on practical steps to avoid any repetition. Some of that evidence is set out above. He had not taken the simple and practical steps sensibly suggested by Professor Hibble, which might be considered an essential step to reflective learning. Dr Okonkwo's contrition and remorse was freely expressed but as soon as he gave more detailed evidence, it became apparent that his concern continued to be focused on the effects on himself and his family. He continues to believe he has been disproportionately punished for a lapse of judgement which was motivated by his desire to help others. His assertion on two separate occasions that he would not have considered issuing a prescription for a patient which would actually be used for the benefit of someone else, but for the fact that he had told about this practice during his training, is highly suggestive of an inability to accept proper responsibility. It certainly does not demonstrate insight in the way contended for on his behalf.
46. We warned ourselves against attaching too much weight to our view of Dr Okonkwo's demeanour, having regard to his cultural background, and

asked ourselves whether this might prevent him from displaying the insight we hoped and expected. However these were simple questions to answer, but instead he was evasive, over-elaborate or contradictory. Moreover Dr Okonkwo has worked in the United Kingdom for many decades as a professional in public service, he is or should be very familiar with issues of professional probity, and the need to account for actions straightforwardly. On occasion he could be clear and forthright in his evidence, and had an excellent and nuanced command of both professional and vernacular English. We are satisfied that our impressions remain reliable after making all appropriate allowances for cultural factors.

47. We noted the references made both by Dr Okonkwo and Mr Forde to his punishment, and it is necessary to observe that this Tribunal is not concerned with punishment but with the application of regulatory safeguards in the public interest. We accept that the consequences may be serious to Dr Okonkwo and we should and do take into account that an order for National Disqualification will adversely affect his career and ability to resume the practice of medicine, but the issues for us are not ones of punishment.
48. It is also submitted that disclosure to other PCT's by Dr Okonkwo or via police national computer checks or PCT enquires will be an adequate safeguard for the public. In our judgement national disqualification is necessary to provide that degree of protection to which the public is entitled. Disclosure may or may not be achieved by one or other of the suggested routes. However Parliament has provided a system of national disqualification which eliminates the risk that an individual PCT fails to carry out proper enquiries or exercised an unjustified or ill-informed discretion in favour of Dr Okonkwo. We cannot avoid the responsibility placed on us to decide whether to impose a national disqualification having regard to the factors set out above.
49. We have given careful consideration to the impact on Dr Okonkwo of a national disqualification, and weighed that in considering issues of proportionality. This includes the steps described to us, which Dr Okonkwo wishes to take to maintain and update his clinical knowledge and skills. We are also aware of the potential impact of his pending appearance before the GMC and his current removal from this PCT's Performers List, which have been or are to be decided independently of our instant decision.
50. In all the circumstances we are satisfied that we should impose a national disqualification on Dr Okonkwo. We do not consider it is necessary or desirable to extend the period of 2 years before he can apply for a review.

Duncan Pratt
Tribunal Judge

15 June 2010