Case No: CO/5139/2015

Neutral Citation Number: [2016] EWHC 524 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15 March 2016

Before :

MRS JUSTICE LANG DBE

- -

Between :

THE PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE	**Appellant**
- and -	
(1) THE GENERAL MEDICAL COUNCIL	
(2) OKWUOLISA DUKE IGWILO	**Respondents**

- -
- -

David Bradly (instructed by **Capsticks Solicitors LLP**) for the **Appellant**
The **First and Second Respondents** did not appear and were not represented

Hearing date: 9 March 2016

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Judgment

Mrs Justice Lang :

1. The Professional Standards Authority for Health and Social Care ("the PSA") has referred to the High Court, under section 29 of the National Health Service Reform and Health Professions Act 2002 ("the 2002 Act"), decisions of the General Medical Council Fitness to Practise Panel of the Medical Practitioners Tribunal Service ("the Panel"), set out in its Record of Determinations dated 16 September 2015, that Dr Igwilo's fitness to practise was not impaired by reason of his misconduct and that it was not appropriate to issue him with a warning.

2. The General Medical Council ("GMC") has conceded that the Panel was unduly lenient in finding that his fitness to practise was not impaired. Dr Igwilo did not respond to the notice of appeal at all.

Facts

3. Dr Igwilo qualified as a doctor at the University of Nigeria Teaching Hospital in 1997, and registered with the GMC in 2002. He obtained his membership of the Royal College of Psychiatrists in 2006, as well as an MSc. At the time at which the incidents of misconduct occurred, he was employed as a locum consultant psychiatrist in the private sector. He was also undertaking a placement at Broadmoor to gain further expertise in forensic psychiatry.

4. Dr Igwilo applied to the GMC for a Certificate of Eligibility for Specialist Registration (CESR) for entry in the Specialist Register of Forensic Psychiatrists, which would qualify him for appointment as a consultant. In support of the application, he was required to submit a portfolio of work demonstrating that he had the requisite knowledge, skill and experience. The evidence has to be validated.

5. Dr Igwilo's first application in July 2010 was unsuccessful. He was sent a detailed decision on 1 April 2011 which made seven recommendations. Dr Igwilo exercised his right to apply for a review of the GMC's decision on 29 June 2011, but this was also unsuccessful. The decision letter of 1 November 2011 made four recommendations.

6. Dr Igwilo re-applied on 15 November 2012, submitting *inter alia* further evidence to address the recommendations in the letter of 1 November 2012. The GMC noticed that one of the reports which was signed by him had also been submitted by another applicant as his own. Upon investigation, it transpired that Dr Igwilo had falsely altered the author's name to his own. In the course of the investigation, Dr Igwilo misled the GMC about the provenance of the report. He also claimed that all the other reports he had submitted were his own work. On 29 January 2013, he withdrew his application by email.

7. Following further investigation by the GMC, falsification of a large number of other documents was alleged against him. The allegations, and the Panel's findings, were as follows.

> "**Allegations and Findings of Fact**

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

1. From August 2011, you were employed as a Locum Consultant Psychiatrist at the Glen Care Group. **Admitted and found proved**

Review Application

2. On 27 June 2011, you signed and submitted an application ('the application') for review of the refusal of your initial application for entry onto the Specialist Register ('the Specialist Register') of the General Medical Council in which you falsely declared that 'The information I provide in my application is correct and true.' **Found not proved**

3. As part of the application, you submitted a report that you had prepared in relation to Patient A, dated 12 May 2011, despite being instructed by Consultant B that you must not do so. **Found not proved**

4. As part of the application, you submitted a report in relation to Patient C, dated 24 May 2011, falsely:

    a. naming yourself as the author; **Found not proved**

    b. naming Consultant B as your supervising Consultant. **Found not proved**

5. As part of the application, you supplied the documents listed at *Schedule 1*, knowing that:

    a. that had not been properly certified in line with the application requirements; **Found not proved**

    b. they had not been certified by Nurse D; **Found not proved**

    c. you caused a false signature to be applied to those documents; **Found not proved**

    d. you caused or permitted a certifying stamp to be applied to those documents, when you knew the signature was false. **Found not proved**

Reapplication for Review

6. On 21 November 2012, you submitted to the GMC a reapplication for review of your initial application for entry onto the Special Register ('the reapplication'). **Admitted and found proved**

7. As part of your reapplication, you supplied the documents listed at *Schedule 2*, knowing that you:

a. had not prepared the original document; **Admitted and found proved**

b. had altered the name of the author to your own name; **Admitted and found proved**

c. had altered the date on the document. **Admitted and found proved**

8. As part of your reapplication, you supplied the documents listed at *Schedule 3*, knowing that you:

a. had not prepared the original document; **Admitted and found proved**

b. had altered the name of the author to your own name. **Admitted and found proved**

9. As part of your reapplication, you supplied to the GMC the documents listed at *Schedule 4*, knowing that:

a. they had not been properly certified in line with the application requirements; **Admitted and found proved**

b. they had not been certified by Consultant E; **Admitted and found proved**

c. you had caused a false signature to be applied to those documents; **Admitted and found proved**

d. you caused or permitted a certifying stamp to be applied to those documents, when you knew the signature was false. **Admitted and found proved**

10. As part of your reapplication, you supplied the documents listed at *Schedule 5*, knowing that:

a. they had not been properly certified in line with the application requirements; **Admitted and found proved**

b. they had not been certified by Colleague F; **Admitted and found proved**

c. you had caused or permitted to be caused a false signature to be applied to those documents. **Admitted and found proved**

11. On 17 January 2013, you sent an email to GMC Adviser G confirming, falsely, that you were the author of the medical report on Patient H (or words to that effect). **Admitted and found proved**

12. On 29 January 2013:

    a. you telephoned GMC Adviser G to confirm that the remainder of the documents submitted as part of your application were your own work (or words to that effect); **Admitted and found proved**

    b. you emailed GMC Adviser G and falsely stated that 'My medical report, which was queried by you, contained information which I copied and pasted from someone else's report'. **Admitted and found proved**

13. Your action at paragraph 3 was misleading. **No finding made as paragraph 3 of the allegation was found not proved**

14. Your actions at paragraphs 2, 4, 5, 7, 8, 9, 10, 11 and 12 were:

    a. misleading; **Admitted and found proved in relation to paragraphs 7, 8, 9, 10, 11 and 12**

    No findings made in relation to paragraphs 2, 4 and 5 as these paragraphs of the allegation were found not proved

    b. dishonest. **Admitted and found proved in relation to paragraphs 7, 8, 9, 10, 11 and 12**

    No findings made in relation to paragraphs 2, 4 and 5 as these paragraphs of the allegation were found not proved

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

8. The Panel concluded that, despite the findings of misconduct, Dr Igwilo's fitness to practise was not currently impaired, even though it had been when the misconduct occurred. This was an isolated period of dishonesty that occurred against a background of severe personal stress. He had since undergone extensive reflection and remediation, and there was no risk of repetition. Public confidence in the profession would not be undermined by a finding of no impairment.

9. The Panel held, in all the circumstances, it would be disproportionate to issue a warning.

The scope of the reference

10. Pursuant to section 29(4) of the 2002 Act, the Authority may refer a case to the High Court where it considers that:

> "(a) a relevant decision falling within subsection (1) has been unduly lenient, whether as to any finding of professional misconduct or fitness to practise on the part of the practitioner

> concerned (or lack of such a finding), or as to any penalty imposed, or both
>
> …
>
> and that it would be desirable for the protection of members of the public for the Council to take action under this section."

11. Where a case is referred to the High Court, it is to be treated as an appeal (s.29(7)).

12. In *Ruscillo v Council for Regulation of Healthcare Professionals* [2004] EWCA Civ 1356, the Court of Appeal held, applying CPR 52.11, that an appeal under section 29 should be allowed if the relevant decision was "wrong" or if there has been "a serious procedural or other irregularity". Lord Phillips MR gave the following guidance on the test of "undue leniency":

> "73. What are the criteria to be applied by the Court when deciding whether a relevant decision was "wrong"? The task of the disciplinary tribunal is to consider whether the relevant facts demonstrate that the practitioner has been guilty of the defined professional misconduct that gives rise to the right or duty to impose a penalty and, where they do, to impose the penalty that is appropriate, having regard to the safety of the public and the reputation of the profession. The role of the Court when a case is referred is to consider whether the disciplinary tribunal has properly performed its task so as to reach a correct decision as to the imposition of penalty. Is that different from the role of the Council in considering whether a relevant decision has been 'unduly lenient'? We do not consider that it is. The test of undue leniency in this context must, we think, involve considering whether, having regard to the material facts, the decision reached had due regard for the safety of the public and the reputation of the profession.
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> …..
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> 75. The reference to having regard to double jeopardy when considering whether a sentence is unduly lenient is not, as we have already indicated, really apposite where the primary concern is the for the protection of the public. More apposite is this passage in …. *Attorney General's Reference (No. 4 of 1989)* (1990) 90 Cr App. R. 266:
>
> > "The first thing to be observed is that it is implicit in the section that this Court may only increase sentences which it concludes were unduly lenient. It cannot, we are confident, have been the intention of Parliament to subject defendants to the risk of having their sentences increased – with all the anxiety that this naturally gives rise to – merely because in the

> opinion of this Court the sentence was less than this Court would have imposed. A sentence is unduly lenient, we would hold, where it falls outside the range of sentences which the judge, applying his mind to all the relevant factors, could reasonably consider appropriate. In that connection regard must of course be had to reported cases, and in particular to the guidance given by this court from time to time in so-called guideline cases. However it must always be remembered that sentencing is an art rather than a science; that the trial judge is particularly well-placed to assess the weight to be given to various competing considerations; and that leniency is not in itself a vice. That mercy should season justice is a proposition as soundly based in law as it is in literature."
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> 76. … We consider that the test of whether a penalty is unduly lenient in the context of section 29 is whether it is one which a disciplinary tribunal, having regard to the relevant facts and to the object of disciplinary proceedings, could reasonably have imposed…
>
> 77. … In any particular case under section 29 the issue is likely to be whether the disciplinary tribunal has reached a decision as to penalty that is manifestly inappropriate having regard to the practitioner's conduct and the interests of the public.
>
> 78. … Where all material evidence has been placed before the disciplinary tribunal and it has given due regard to the relevant factors, the Council and the Court should place weight on the expertise brought to bear in evaluating how best the needs of the public and the profession should be protected. Where, however, there has been a failure of process, or evidence is taken into account on appeal that was not placed before the disciplinary tribunal, the decision reached by that tribunal will inevitably need to be reassessed."

Grounds of appeal

13. The Appellant's first ground of appeal was that the Panel failed to make adequate findings of misconduct in that it failed to have sufficient regard to the serious nature and extent of Dr Igwilo's dishonesty and the public interest in the standards of the Specialist Medical Lists being regulated effectively by the GMC.

14. The second ground of appeal was that the Panel was wrong to find that Dr Igwilo's fitness to practise was not impaired. The Panel failed to have sufficient regard to the factors identified in the first ground of appeal, and gave undue weight to the mitigating factors. The Panel also failed to give adequate regard to the public interest in maintaining public confidence in the profession.

15. The third ground of appeal, put forward in the alternative, was that the Panel was wrong not to issue a warning to Dr Igwilo, in the light of the guidance in the Indicative Sanctions Guidance and the Guidance on Warnings.

The statutory scheme

16. By section 35C(2) Medical Act 1983:

> "A person's fitness to practise shall be regarded as "impaired" for the purposes of this Act by reason only of –
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> (a) misconduct;
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> ....."

17. By section 35D(2), a Fitness to Practise Panel, upon finding that a person's fitness to practise is impaired, may erase or suspend his registration or make it conditional upon compliance with specified requirements.

18. Section 35D(3) provides:

> "Where the Panel find that the person's fitness to practise is not impaired they may nevertheless give him a warning regarding his future conduct or performance."

19. The principles to be applied when considering the question of impairment were helpfully summarised by Cox J. in *CHRE v NMC & Grant* [2011] EWHC 927 (Admin):

> "64. This Scheme is set out in the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 [2004 SI No. 1761] and in particular Rule 24, which provides for staged hearings addressing the factual findings, impairment of fitness to practise and finally, as appropriate, sanctions.
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> 65. The term "impairment to fitness to practise" has not been defined in these rules, and this is also the position in relation to those schemes which apply to other, medical practitioners. Thus, as Dame Janet Smith pointed out in her Fifth Report from The Shipman Enquiry (9 December 2004), the concept has the advantage of flexibility, being capable of embracing a multiplicity of problems, but also the disadvantages that flow from a lack of clarity and definition. Further, recognising impaired fitness to practise inevitably involves making a value judgment (see paragraphs 25.42 et seq.).
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> 66. Judicial guidance as to how the issue of impairment of fitness to practise should be approached now appears in a number of authorities. The Committee in this case were referred to the decision of Silber J in R (on the application of Cohen) v. General Medical Council [2008] EWHC 581 (Admin), and that of Mitting J, more recently in Nicholas-Pillai v. General Medical Council [2009] EWHC 1048 (Admin).

67. In Cohen Silber J was concerned with serious professional failings by a consultant anaesthetist, on an isolated occasion, in relation to a patient undergoing major surgery. There was little dispute as to the facts, most of which appear to have been admitted.

68. Against that background the judge said as follows, in relation to impairment of fitness to practise:

> "[62] Any approach to the issue of whether a doctor's fitness to practice should be regarded as 'impaired' must take account of 'the need to protect the individual patient, and the collective need to maintain confidence [in the] profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the' (*sic)*. In my view, at stage 2 when fitness to practice is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering whether by reason of the doctor's misconduct, his or her fitness to practice has been impaired. It must not be forgotten that a finding in respect of fitness to practice determines whether sanctions can be imposed: s 35D of the Act.
>
> [63] I must stress that the fact that the stage 2 is separate from stage 1 shows that it was not intended that every case of misconduct found at stage1 must automatically mean that the practitioner's fitness to practice is impaired.
>
> [64] There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practice has not been impaired. Indeed the Rules have been drafted on the basis that the once the Panel has found misconduct, it has to consider as a separate and discreet *(sic)* exercise whether the practitioner's fitness to practice has been impaired. Indeed s 35D (3) of the Act states that where the Panel finds that the practitioner's fitness to practice is not impaired, 'they may nevertheless give him a warning regarding his future conduct or performance'.
>
> [65] Indeed I am in respectful disagreement with the decision of the Panel which apparently concluded that

> it was not relevant at stage 2 to take into account the fact that the errors of the appellant were '*easily remediable*'. I concluded that they did not consider it relevant at [that] stage because they did not mention it in their findings at stage 2 but they did mention it at stage 3. That fact was only considered as significant by the Panel at a later stage when it was dealing with sanctions. It must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated. These are matters which the Panel should have considered at stage 2 but it apparently did not do so."

69. It is clear, notwithstanding the references in those passages to whether fitness to practise "has been" impaired, that the question is always whether it is impaired as at the date of the hearing, looking forward in the manner indicated by Silber J in his judgment. The question for this Committee as at 21 April 2010 was therefore "is this Registrant's current fitness to practise impaired?"

70. An assessment of current fitness to practise will nevertheless involve consideration of past misconduct and of any steps taken consequently by the practitioner to remedy it. Silber J recognised this when referring, at paragraph 65, to the necessity to determine whether the misconduct is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

71. However it is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations emphasised at the outset of this section of his judgment at paragraph 62, namely the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.

72. This need to have regard to the wider public interest in determining questions of impairment of fitness to practise was also referred to by Goldring J in R (on the application of Harry) v. General Medical Council [2006] EWHC 3050 (Admin) and by Mitting J in Nicholas-Pillai, where he held that the panel were entitled to take into account the fact that the practitioner had contested critical allegations of dishonest note-keeping, observing that:

> "[19] In the ordinary case such as this, the attitude of the practitioner to the events which give rise to the specific allegations against him is, in principle, something which can be taken into account either in his favour or against him by the panel, both at the stage when it considers whether his fitness to practise

> is impaired, and at the stage of determining what sanction should be imposed upon him."

73. Sales J also referred to the importance of the wider public interest in assessing fitness to practice in Yeong v. GMC [2009] EWHC 1923 (Admin), a case involving a doctor's sexual relationship with a patient. Pointing out that Cohen was concerned with misconduct by a doctor in the form of clinical errors and incompetence, where the question of remedial action taken by the doctor to address his areas of weakness may be highly relevant to the question whether his fitness to practise is currently impaired, Sales J considered that the facts of Yeong merited a different approach. He upheld the submission of counsel for the GMC that:

> "… Where a FTPP considers that the case is one where the misconduct consists of violating such a fundamental rule of the professional relationship between medical practitioner and patient and thereby undermining public confidence in the medical profession, a finding of impairment of fitness to practise may be justified on the grounds that it is necessary to reaffirm clear standards of professional conduct so as to maintain public confidence in the practitioner and in the profession. In such as case, the efforts made by the medical practitioner in question to address his behaviour for the future may carry very less weight than in case where the misconduct consists of clinical errors or incompetence."

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

75……

76. I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dames Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view that test would be equally applicable to other practitioners governed by different regulatory schemes.

"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, convictions,

caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

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

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

i) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession: and/or

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

20. Cranston J. gave further guidance in *Cheatle v General Medical Council* [2009] EWHC 645 (Admin):

> "21. There is clear authority that in determining impairment of fitness to practise at the time of the hearing regard must be had to the way the person has acted or failed to act in the past. As Sir Anthony Clarke MR put it in Meadow v General Medical Council [2006] EWCA Civ 1390; [2007] 1 QB 462:
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> > "In short, the purpose of [fitness to practise] proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past" (para 32).
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> 22. In my judgment this means that the context of the doctor's behaviour must be examined. In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both at the time of the misconduct and to the present time, is such as to mean that his/her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, the panel is persuaded that the doctor is simply not fit to practise medicine, without restrictions or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, the fitness to practise panel could conclude that, looking forward, his/her fitness to practise is not impaired, despite the misconduct."

21. In *Hassan v General Optical Council* [2013] EWHC 1887 (Admin), Leggatt J. said at [39]:

> "Dishonesty encompasses a very wide range of different facts and circumstances. Any instance of it is likely to impair a professional person's fitness to practise and in that sense is a serious matter. But it is wrong in my view to approach the question of sanction on the basis that there is only a small residual category of exceptional cases where erasure would be a disproportionate sanction …."

22. In *Professional Standards Authority for Health and Social Care v General Medical Council & Uppal* [2015] EWHC 1304 (Admin) Lang J. said at [27] and [29]:

> "27. ….even in cases of dishonesty, a separate assessment of impairment is required, and not every act of dishonesty results in impairment…."
>
> "29. ….the Panel was correct to assess whether or not Dr Uppal's fitness to practise was currently impaired, having regard to her conduct since the misconduct occurred, as well as the nature and extent of her misconduct. Thus, her apology, insight and remediation were all relevant to that assessment, as was the extremely low risk of recurrence."

Conclusions

Ground 1

23. When considering whether the allegations found proved amounted to misconduct, the Panel did not analyse the facts and the nature of the misconduct in any detail. I acknowledge that it would have been good practice to give a fuller determination at this stage, and if the Panel had done so, it might have assisted the members in their deliberations on impairment. However, I am not able to accept that the findings on misconduct were so inadequate as to justify quashing the decision on appeal.

24. The key points were covered in paragraphs 21 and 22 under the heading "Misconduct". This was a summary of the factual findings made in the formal "Allegation and Findings of Fact" which, in fairness, ought to be read together with that section. For example, the final sentence of paragraph 21 in respect of the report on patient H, has to be read together with the details in paragraphs 11 to 14 of the "Allegations and Findings of Fact".

25. I am satisfied that the Panel would have been well aware of the additional points which the PSA submit were wrongly omitted (set out in paragraph 28 of Mr Bradly's skeleton argument) as they had the benefit of the extensive oral and documentary evidence which was adduced, and the detailed submissions made by Mr Simon Jackson QC who was instructed to present the case on behalf of the GMC. Most of the PSA's points are obvious (e.g. that the misconduct occurred in the course of his practice and that he was misleading the regulatory body), and are implicit in paragraphs 21 and 22, even though not expressly stated. Overall, I consider, therefore, that the Panel's findings on misconduct, though sparse, were adequate.

Ground 2

26. On the issue of impairment, I consider that the Panel was right to find, at paragraph 24, that:

> "It is clear that your misconduct breached the principles of probity as set out in GMP and the Panel is satisfied that, at the time of your misconduct, your fitness to practise was impaired."

27. The Panel was entitled, if it thought it appropriate to do so, to place weight on Dr Igwilo's mitigation, and to accept his evidence, supported by character references, that this was an isolated period of dishonesty which occurred at a particularly stressful time for him, and that he had since undergone an extensive period of reflection and remediation, which meant that there was no risk of repetition.

28. However, I consider that the Panel was unduly lenient in concluding that Dr Igwilo's fitness to practise was not currently impaired, given the very serious and sustained deception of the regulator which he embarked upon, purely to advance his career. He falsified a large number of documents: 24 documents described as reports in respect of different patients, 5 documents described as reports for Courts or Tribunals in respect of different patients, 7 sets of documents described as section 48 paperwork for different patients, 1 set of documents described as section 37 paperwork, 4 referral letters, 2 letters to patients' general medical practitioners and correspondence confirming appointments and placements and other correspondence. The scale of the falsification indicated it was an elaborate deception which must have taken some considerable time to plan and implement. His dishonesty affected his professional colleagues, as he represented their work as his own, or claimed that they had approved of his work when they had not done so.

29. The Panel was overly generous in accepting his submission that when his deception came to light he admitted his guilt and apologised immediately. Before his deception came to light as a result of independent investigation by the GMC, he maintained the falsehood. From the evidence, it appears that he only admitted his guilt and apologised once he realised that he was going to be exposed. He did not confess to the falsifications of the other documents until later, once the disciplinary proceedings were brought against him.

30. Dishonesty constitutes a breach of a fundamental tenet of the profession of medicine: honesty, openness and integrity are listed amongst the fundamental duties of doctors in 'Good Medical Practice' and being honest and trustworthy and acting with integrity are described by 'Good Medical Practice' as being at the heart of medical professionalism. Plainly cases of dishonesty vary in severity; in my view, this case was at the more serious end of the scale.

31. The purpose of the Specialist Medical Lists and the GMC's regulation of them is to protect the public interest, including the safety of patients, and in the case of forensic psychiatrists, to maintain the standards of expert evidence submitted in court cases. Dr Igwilo's applications had not met the required standard for the Specialist Register of Forensic Psychiatrists on two previous occasions. He responded to the guidance given by the GMC as to how he might improve his prospects of success by using deception and deceit to try to obtain inclusion in the list when he was unable to do so

by legitimate means. Such conduct jeopardised the integrity of the Specialist Medical List system, and the GMC's ability to regulate it. In my judgment, the Panel did not sufficiently recognise the seriousness of these factors, and indeed, made no mention of them.

32. I consider that the Panel made an error of judgment in concluding that the need to maintain public confidence in the profession and the regulator, and to declare and uphold proper standards of conduct and behaviour, was met by the fact that Dr Igwilo had been subject to fitness to practise proceedings and that he had shown insight and remorse. I do not consider that a Panel, properly directed, could reasonably reach such a decision on the facts of this case.

33. In all the circumstances, the Panel's finding that Dr Igwilo's fitness to practise was not impaired was an unduly lenient decision, which was wrong.

34. In view of my conclusion on ground 2, it is unnecessary for me to decide ground 3.

35. In the exercise of my powers under section 29(8) of the 2002 Act, I allow the appeal, quash the Panel's decision on impairment, and substitute a decision that Dr Igwilo's fitness to practise is impaired. I remit the question of sanction to be determined by a freshly-constituted Panel.