

Public Minutes of
the Investigation Committee

Date of hearing: 10 January 2022

Name of Doctor	Dr Olufisayo Oyinlola Olaore
Doctor's UID	7361534

Committee Members	Mr John Anderson
	Dr Laleh Morgan
	Mr David Hull

Legal Assessor	Mr David Marshall
Panel Secretary	Ms Gemma Wolstenholme

Attendance and Representation

GMC Representative	Ms Susanna Kitzing
Doctor's attendance	attended
Doctor's representative	Mr Christopher Geering

Outcome	Warning
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Determination

Dr Olaore,

- 1 At today's hearing the Investigation Committee carefully considered all the material before it including the submissions made by **Christopher Geering** on your behalf and those made on behalf of the GMC by **Susanna Kitzing**. It has accepted the advice of the Legal Assessor.

Background

- 2 At the time of the index events, you were working as an ST4 paediatric trainee at Russell's Hall Hospital ('RHH'). On 4 January 2021 your responsible officer (RO) at Health Education England (HEE) referred you to the GMC.
- 3 According to your RO, a local investigation had been carried out at RHH into allegations that you had worked a locum night shift (21.00-09.30) on 1 October 2019 at George Eliot Hospital NHS Trust (GEH) between two rostered day shifts (09.00-17.00) at RHH on 1 and 2 October 2019 and called in sick on the morning of 2 October 2019.
- 4 The conclusion of the investigation was that the allegations were upheld. RHH did not take any action against you, because by the time the investigation was completed you had rotated to a different employing Trust.
- 5 Following the conclusion of the investigation process, the GMC wrote to you on 30 September 2021 to inform you that the case examiners were minded to issue you with a warning.
- 6 On 28 October 2021, you responded to this letter via your representatives. Your representatives did not agree a warning was appropriate and requested an IC hearing.
- 7 On 19 November 2021, the GMC responded to acknowledge you were not prepared to accept the warning and that the Case Examiners had considered your comments and decided to refer the matter to the Investigation Committee.

GMC Submissions

- 8 Ms Kitzing, on behalf of the GMC, took the Committee through the history of the case as outlined above.
- 9 Ms Kitzing drew the Committee's attention to the Trust investigation report which stated that a colleague had seen your acceptance, via a WhatsApp group, of a locum night shift at GEH due to start at 21:00 on 01 October 2019. Your colleague, having been

part of the same WhatsApp group, reported your working of this locum night shift to your seniors after learning of your sickness absence on the 02 October 2019.

- 10** Ms Kitzing stated that in your statement to the Trust investigation on 06 November 2019, you said that you accepted the locum shift on 20 September 2019 without first checking your rota for RHH. On 26th September, you received confirmation of the locum shift via the WhatsApp group which you did not see until 29 September. Having realised the overlap in shifts, you stated that you felt obliged to continue with the locum shift rather than give them little notice of you withdrawing from it.
- 11** In this statement, you advised that when you didn't receive confirmation via the WhatsApp group, you thought the shift had been covered. You did not know your RHH rota verbatim and had not taken steps to cross check your shifts. In hindsight, you accepted it would have been a better course of action to seek advice from your seniors and expressed remorse for having not done so.
- 12** Ms Kitzing went on to discuss RHH's policy on working hours where it is stated that you should take appropriate breaks and inform your line manager of any additional work outside of RHH contracted hours. Ms Kitzing also drew the Committee's attention to a document entitled 'Terms and conditions of service for doctors and dentists in training' which stated that you should not work more than 60 hours in a week and that it is the individual doctor's responsibility to comply with this document. Ms Kitzing stated that you were unaware of this responsibility at the time.
- 13** Ms Kitzing submitted that you intended to attend work at RHH after the locum shift, leaving GEH as soon as possible. However, the locum shift did not end until 09:30 and you were meant to start at RHH at 09:00. Ms Kitzing stated that the journey time between the two trusts is approximately 1 hour and 16 minutes, meaning you would need to leave GEH much earlier than 09:30 in order to attend RHH on time.
- 14** Ms Kitzing noted that you have received positive feedback from your employers, clinically you are a good doctor, and you have good working relations with both team members and your supervisors. However, she submitted that the unit where you were due to work on the 02 October experienced a busy shift. Dr Nasir, in his statement, stated that they needed to transfer three babies, they were short staffed and felt unsafe.
- 15** Ms Kitzing submitted that your conduct represented a significant departure from the standards expected of doctors. Your behaviour does not meet with the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in Good medical practice (GMP) and associated guidance. In this case, paragraph 65 of GMP is particularly relevant:

'65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.'

- 16** Ms Kitzing concluded that a formal response is necessary because, in accepting a locum shift that overlapped with your substantive shift, you would have known that you would not be able to fulfil the requirements of one or the other employer. This behaviour had the potential to put patients at risk and any repetition may have the potential to call into question your fitness to practise.
- 17** Ms Kitzing stated the GMC's overarching objective, which includes promoting and maintaining proper standards and conduct for members of the profession. Ms Kitzing submitted that in all of the circumstances of this case and notwithstanding any mitigation present, a warning was necessary and proportionate. Your conduct did not meet the standards expected; therefore, a warning is required, both to remind you of your own responsibilities with respect to professionalism and probity and to serve as a reminder of such responsibilities to the wider profession.

Defence Submissions

- 18** Mr Geering stated that it is accepted you took the locum shift knowing your prior commitments to RHH. However, when you came across the email from GEH, you believed it was too late to cancel and felt you had to undertake the shift. Mr Geering submitted that you thought you would be able to get some rest during the locum shift.
- 19** Mr Geering stated that you began to feel unwell during the night shift, and therefore phoned Dr AP on the morning of 2 October 2019 to tell her that you were ill.
- 20** Mr Geering stated there was no question that you are a good doctor, and that no clinical concerns had been raised about your practice. You had made a mistake, which you have acknowledged and learned from, which will stay with you for the rest of your career.
- 21** Mr Geering submitted that, to issue a warning, the concerns needed to fall, 'just below' the threshold for a finding of impairment.' Whilst you have accepted that this conduct was wrong, you clearly made a mistake. Mr Geering submitted that to fall 'just below' a finding of impairment sets a high bar. You admitted booking 'back-to-back shifts' with a degree of overlap which you have accepted is not appropriate behaviour.
- 22** Mr Geering submitted that you were under significant personal and emotional pressure to do locum shifts. However, you were not deliberately seeking to book back-to-back shifts and had not appreciated that this would occur. GEH did not confirm the locum shift in a timely manner and you only realised your mistake shortly before you were due to attend that shift. Mr Geering stated that you realised your mistake but felt committed to attend the locum shift rather than give short notice that you could not work.

- 23** Mr Geering submitted that this was not a 'deliberate and nefarious' attempt to cram in as many locum shifts as possible. Having completed the locum shift, you felt unwell and correctly called in sick. This behaviour amounted to disorganisation on your part, having forgotten your rota and resulting in you attempting to fulfil your professional obligations.
- 24** Mr Geering submitted that this behaviour did not amount to such a 'sufficiently significant' departure from GMP that a warning is an appropriate or proportionate response. It does not fall just below the threshold for a finding of impairment; therefore, your conduct does not meet the test for a warning to be issued today.
- 25** Mr Geering stated that you have reflected at significant length, not only accepting that your conduct was wrong, but seeking to understand the root cause as to why you made those decisions and why you didn't reach out to a senior. Mr Geering submitted that you have shown demonstrable remediation and have consistently shown your contrition from the start, which is echoed in the submissions today.
- 26** Mr Geering submitted that your reflections show your understanding of the 'ripple effect' your conduct had on others, including patients and colleagues. These actions show that your remorse is heartfelt and sincere.
- 27** Mr Geering stated that it was clear this was an isolated incident. You have continued to work for a significant passage of time with no repetition. You have a previous good history demonstrated by witness statements and the testimonials provided today. There is no likelihood of repetition of this conduct occurring, as you now have strategies and a package of support in place to guard against any such repetition.
- 28** In summary, Mr Geering submitted that this conduct amounted to one, isolated mistake in particular circumstances. He further submitted that there is no public interest in marking these circumstances as the public would be satisfied that the GMC had discharged its function through the thorough investigation and today's hearing.
- 29** Therefore, it was his submission that in all the circumstances, your conduct firstly did not fall below the standard expected to a degree requiring a warning and further that any warning given today would be a disproportionate response.

Committee Determination

- 30** The Committee is aware that it must have in mind the GMC's role of protecting the public, which includes:
- a. Protecting, promoting and maintaining the health, safety and well-being of the public
 - b. Promoting and maintaining public confidence in the medical profession, and

- c. Promoting and maintaining proper professional standards and conduct for members of that profession.

31 The Committee has concluded that your actions represent a clear and specific breach Paragraph 65 of GMP. By your own admission you acknowledged, the multidimensional impact of your actions on patients and colleagues. You undertook a day shift until 17:00 and then a night shift from 21:00 until 09:30 the next morning when you were already committed to working the day shift at your substantive post at 09:00 where the hospitals were more than an hour's travel apart. This represents a clear and specific breach of Paragraph 65 of GMP.

'65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.'

32 The Committee accepts there is no definition of 'significant' in the Medical Act or in the Fitness to Practise Rules, however, the combination of the cumulative effect of your proposed hours and putting yourself in a position where you needed to be in two places at once, renders your conduct significant. The public would rightly be concerned if they learned a doctor had booked overlapping shifts in different locations.

33 Your behaviour represented a significant departure from GMP Paragraph 65 as it had the potential to put patients at risk and compromise the delivery of medical care. This conduct does not meet the standards expected of a doctor and could serve to damage the public's trust and confidence in the profession.

34 The Committee must be satisfied that the particular conduct, behaviour or performance approaches, but falls just short of, the threshold for the realistic prospect test. The realistic prospect test requires a genuine possibility of a finding of impaired fitness to practise, justifying action on the doctor's registration. The Committee is satisfied that the realistic prospect test in this case is not met, there is no evidence before it today that you are currently impaired by way of your misconduct.

35 The Committee has determined that the concerns displayed are sufficiently serious that if there were repetition, they would likely result in a finding of impairment. Repetition of your behaviour could affect patient and public confidence in the profession and the reputation of the profession. Therefore, for the reasons above, the test for issuing a warning is met and indeed appropriate.

36 In deciding whether it is appropriate to issue a warning, the Committee must apply the principle of proportionality and balance the interests of the public with those of the practitioner.

37 The Committee noted that if you had not called in sick, you would have been working 28 hours with a 4 hour rest. You hoped you would have been able to get away from the

locum shift early and hoped your bleep would not go off so you could rest. A registrant should not go into a shift in this mindset nor with this expectation.

- 38** The Committee accepted that no harm was caused by your conduct however it had regard to the potential harm that could have occurred. The Committee found it to be an aggravating factor that had you not been sick, and attended the second day shift as you planned, getting in the car to make a long journey under time pressure following extended working hours would also serve to put yourself and others at risk.
- 39** The Committee accepted there was no malign intention on your part and took full account of the extensive remediation provided. Your reflections have been of substance, you recognised your conduct early on and have shown both genuine remorse and a well developed insight. It accepted the work you have also done on the root causes of your decision making, ensuring that the Committee can be confident that the risk of repetition is very remote.
- 40** As you finished your night shift at GEH at 09:30 and were due to start another shift at RHH at 09:00 which was another hospital more than an hour away, it's a fundamental premise that it was simply not possible to fulfil both commitments. You cannot be in two places at once. There was no way you were going to be able to attend the second shift as aside of any excessive hours worked, your shifts booked were overlapped. There was potential for patient harm to occur.
- 41** The Committee very carefully considered the mitigation and remediation provided and in finely balancing the mitigation with all of the circumstances today, on balance still found it proportionate to issue you with a warning.
- 42** Despite the mitigation presented in this case, your conduct in regard to patient safety runs the risk of damaging public confidence in the profession and does not meet with the standards required of a doctor. The Committee has determined that a warning would be appropriate and proportionate in this case to maintain the public's confidence in the profession, promote the standards expected of a doctor and send a message to the wider profession that this conduct is not acceptable.
- 43** The warning will be documented as follows, this has been amended slightly from the draft for additional clarity:

'On 1 and 2 October 2019 you were scheduled to work day shifts from 9am to 5pm with your primary employer. You worked the first day shift and, without your primary employer's knowledge and in breach of your contractual obligations, a locum night shift from 9pm on 1 October to 9.30am on 2 October at another hospital. This overlapped with your second scheduled day shift with your primary employer which was in another hospital some distance away. You called in sick to your day shift on 2 October.'

This conduct does not meet with the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in Good medical practice and associated guidance. In this case, paragraph 65 of Good medical practice is particularly relevant:

65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

Whilst this failing in itself is not so serious as to require any restriction on your registration, it is necessary in response to issue this formal warning.

This warning will be published on the List of Registered Medical Practitioners (LRMP) in line with our publication and disclosure policy, which can be found at www.gmc.uk.org/disclosurepolicy

That concludes the determination of the Investigation Committee in this case.