PUBLIC RECORD

Dates: 28/04/2025 - 02/05/2025

Doctor:	Dr Babatunde ARANMOLATE
GMC reference number:	5186837
Primary medical qualification:	MB BS 1992 Ogun State University

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Erasure

Immediate order imposed

Tribunal:

Legally Qualified Chair	Mr Angus Macpherson
Lay Tribunal Member:	Ms Colette Neville
Registrant Tribunal Member:	Dr Eric Finlay

Tribunal Clerk:	Ms Hinna Safdar 28/04/2025 – 30/04/2025; Mr Andrew Ormsby 01/05/2025 – 02/05/2025

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Peter Lownds, Counsel, instructed by Medical Protection Society
GMC Representative:	Mr Mark Monaghan, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts & Impairment - 30/04/2025

Background

1. Dr Aranmolate qualified in 1995 from Ogun State University in Nigeria. At the time of the events in question, Dr Aranmolate was practising as a Locum GP at Hillingdon Hospital Urgent Treatment Centre (UTC).

2. The allegation that has led to Dr Aranmolate's hearing can be summarised as follows. In February 2023, Dr Aranmolate is alleged to have removed medications from the Hillingdon Hospitals NHS Trust ('the Trust') and provided them to Ms A when he knew that he was not entitled to remove the medications, and that Ms A did not require emergency treatment. It is alleged that Dr Aranmolate subsequently asked two colleagues to provide false statements to suggest that the incident had been dealt with by the issue of a verbal warning. It is alleged Dr Aranmolate's actions were dishonest.

3. Ms A reported Dr Aranmolate to the GMC in respect of his supplying her with the medications in July 2023. Dr F a Deputy Responsible Officer at the Hillingdon Hospital Foundation Trust raised the further concerns with the GMC on 13 November 2023.

The Allegation and the Doctor's Response

4. The Allegation made against Dr Aranmolate is as follows:

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

1. On or around 10 February 2023, you removed one or more of the medications as set out in Schedule 1(the 'Medications') from Hillingdon Hospitals NHS Trust ('the Trust') (the 'Incident'). Admitted and found proved

2. On or around 14 February 2023, you provided Ms A with one or more of the Medications. Admitted and found proved

3. You knew:
    a. you were not entitled to remove the Medications from the Trust;
    Admitted and found proved
    b. the Medications were intended for Trust patients only;
    Admitted and found proved
    c. Ms A was not a Trust patient;
    Admitted and found proved
    d. one of the Medications, namely Co-amoxiclav 500/125mgs, was prescribed to Patient B;
    Admitted and found proved
    e. you had a close personal relationship with Ms A;
    Admitted and found proved
    f. Ms A did not require emergency treatment.
    Admitted and found proved

4. On 24 October 2023, whilst at the Trust, you:
    a. informed Ms C of the Incident; Admitted and found proved
    b. asked Ms C to produce a report/statement confirming she had witnessed:
        i. a discussion you had with a colleague, Dr D about the Incident;
        Admitted and found proved
        ii. a verbal warning issued by Dr D to you addressing the Incident.
        Admitted and found proved

5. You knew Ms C had not witnessed:
    a. any discussion with Dr D as set out in paragraph 4bi;
    Admitted and found proved
    b. a verbal warning issued by Dr D as set out in paragraph 4bii.;
    Admitted and found proved

6. On 24 October 2023 you telephoned Ms E and you:
    a. informed Ms E of the Incident; Admitted and found proved
    b. asked Ms E to prepare a report for the GMC to confirm:
        i. you had previously disclosed the Incident to her;
        Admitted and found proved
        ii. Ms E had issued a verbal warning to you to address the Incident;
        Admitted and found proved
    c. indicated to Ms E you had already notified the GMC that she would write a statement to confirm the details as set out in paragraphs 6bi and 6bii.
    Admitted and found proved

7. You knew:
    a. you had not discussed the Incident with Ms E before 24 October 2023;
    Admitted and found proved
    b. Ms E had not issued you with a verbal warning to address the Incident;
    Admitted and found proved
    c. your comments at paragraph 6c were intended to persuade Ms E to write a false statement on your behalf. Admitted and found proved

8. Your actions as set out in paragraph:
    a. 1 and 2 were dishonest by reason of the matters set out in paragraph 3;
    Admitted and found proved
    b. 4bi were dishonest by reason of paragraph 5a;
    Admitted and found proved
    c. 4bii were dishonest by reason of paragraph 5b;
    Admitted and found proved
    d. 6bi were dishonest by reason of paragraph 7a;
    Admitted and found proved
    e. 6bii were dishonest by reason of paragraph 7b;
    Admitted and found proved
    f. 6c were dishonest by reason of paragraph 7c.
    Admitted and found proved
    g.

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

The Admitted Facts

5. At the outset of these proceedings, through his counsel, Mr Peter Lownds, Dr Aranmolate made admissions to all paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Impairment

6. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Aranmolate's fitness to practise is impaired by reason of misconduct.

Witness Evidence

7. The Tribunal received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Ms A, dated 12 December 2023.
- Ms C, service manager at Hillingdon Hospital, dated 19 April 2024 and supplemental statement dated 11 December 2024.
- Ms E, Lead Emergency Nurse in the UTC, Hillingdon Hospital dated 2 May 2024.
- Dr F, a Consultant Trauma and Orthopaedic Surgeon at the Trust since 2011 and Deputy Responsible Officer (RO) for the Trust dated 18 October 2024.
- Mr G, Chief Pharmacist at the Trust and responsible for the pharmacy services at the hospital dated 28 October 2024.
- Ms H, Deputy Head of Professional Standards for the London region of NHS England (NHSE) dated 18 October 2024 and supplemental witness statements dated 22 November 2024 and 6 March 2025.

8. Dr Aranmolate provided his own witness statement, dated 13 March 2025 and also gave oral evidence at the hearing.

Documentary Evidence

9. The Tribunal had regard to the documentary evidence provided by the GMC. This evidence included but was not limited to:

- WhatsApp messages received from Dr Aranmolate by Ms A
- Photographs of medications
- Trust Policy for the Prescribing, Administration and Security of Medicines, dated 15 May 2023
- WhatsApp messages exchanged between Ms C and Dr Aranmolate, dated 24 October 2023
- Trust statement of Ms E, dated 25 October 2023
- Email from Ms C to Trust, dated 25 October 2023
- WhatsApp message exchange between Ms E and Dr Aranmolate, dated between 24 October 2023 to 23 November 2023
- Email from Ms I, copied to Dr F, attaching statement of Ms C, dated 26 October 2023
- GMC referral – submitted by Dr F, dated 13 November 2023
- Notes of Trust meeting with staff, dated 5 August 2024
- Email exchange between Ms H and Dr Aranmolate, dated between 7 August 2023 to 15 August 2023
- Notes of Trust meeting with Dr Aranmolate, dated 10 July 2024
- GMC FTP Erasure determination, dated 26 March 2009
- MPTS Restoration determination, dated 15 March 2017

10. The Tribunal had regard to the documentary evidence provided by Dr Aranmolate through his representative. This evidence included but was not limited to:

- Dr Aranmolate's CV
- Testimonials including a further (redacted) Testimonial from Mr J, dated 24 March 2025
- Dr Aranmolate's reflections
- CPD certificates
- XXX and risk assessment prepared by Dr K, dated 18 March 2025
- Appraisal documentation, dated 6 February 2025

Submissions

<u>On behalf of the GMC</u>

11. Mr Mark Monaghan submitted that, as set out in the case of *Nandi v GMC [2004] EWHC 2317 (Admin),* serious misconduct was defined as conduct that would be regarded as "*deplorable by fellow practitioners".* Mr Monaghan argued that Dr Aranmolate's actions meet this threshold due to multiple instances of dishonesty, including taking medication from the Trust without permission or justification, falsely claiming to have received a verbal warning from Dr D, requesting colleagues (Ms C and Ms E) to provide false statements to the GMC, in Ms C's case regarding her witnessing Dr D give Dr Aranmolate a verbal warning for having taken the medications and, in Ms E's case, regarding her having given Dr Aranmolate such a verbal warning, drafting a false report to be sent to Dr D by Ms C to induce him to give false evidence and mislead the investigation.

12. Mr Monaghan cited *Zygmunt v GMC [2008] EWHC 2643 (Admin),* which confirms that past conduct is relevant in assessing current fitness to practise, as it indicates likely future behaviour. He submitted, in this case, Dr Aranmolate's lack of candour and insight—particularly his misleading statements during the investigation and his delayed admissions (only made in March 2025)—suggest there are ongoing concerns.

13. Mr Monaghan argued that remediation is key as set out in *Cohen v GMC [2008] EWHC 581 (Admin),* in that the Tribunal should consider whether the conduct is remediable, whether it has been remedied and whether it is highly unlikely to be repeated. He submitted that Dr Aranmolate's lack of honest reflection (e.g., downplaying his communication with colleagues in October 2023 in his accounts with NHS England as mere "rhetorical questions") suggests inadequate remediation.

14. Mr Monaghan submitted that the Tribunal must consider Dr Aranmolate's history of dishonesty, including, his false payment claims (1999), breaching suspension conditions (2004, 2006), misleading the GMC, employers, and a GP trainer via false declarations and his inappropriate prescription use. Mr Monaghan contended that, despite being restored to the register in 2017, Dr Aranmolate's 2023 dishonesty (including inciting colleagues to lie) indicates a pattern of misconduct, raising concerns about his capacity for remediation.

15. Mr Monaghan submitted that, even if remediation were demonstrated, public confidence in the profession is a critical factor. Dishonesty undermines trust, and given Dr Aranmolate's repeated breaches, a finding of impairment is necessary to uphold the reputation of the profession and to declare and uphold standards of conduct for members of the profession. Mr Monaghan stressed that dishonesty cases differ from clinical errors, as

they involve a doctor's integrity. While remediation may mitigate impairment in competence cases, dishonesty often warrants a finding of impairment to reaffirm professional standards.

16. Given the seriousness, repetition, and lack of full insight, Mr Monaghan submitted that Dr Aranmolate's fitness to practise is currently impaired. Such a finding is not intended to be punitive but serves to protect the public, maintain trust in the profession and uphold standards. He urged the Tribunal to consider the cumulative effect of Dr Aranmolate's conduct, his failure to demonstrate genuine remediation, and the public interest in declaring his fitness to practise impaired.

On behalf of Dr Aranmolate

17. Mr Lownds submitted that Dr Aranmolate concedes that his admitted actions constitute misconduct, particularly given the element of dishonesty. He explained that his submissions focused on contextualising the seriousness of the misconduct with the intention to assisting the Tribunal in assessing whether Dr Aranmolate's fitness to practise is currently impaired, and if so, to what extent.

18. Regarding the first set of allegations concerning the removal and provision of antibiotics and other medications to XXX (Ms A), Mr Lownds argued that while this was undoubtedly misconduct, it should be viewed in its proper context. One of the packs of antibiotics was no longer intended for the specific patient named on the label but was returned stock, left on his desk. It did not consist of controlled drugs; there was no risk of misuse. The incident was isolated and opportunistic, not part of an ongoing pattern of behaviour. The matter was not reported to the police, suggesting it was not considered serious enough to warrant criminal investigation. Mr Lownds emphasised that the doctor's actions were motivated by a misguided but genuine concern for someone he cared about, rather than any financial gain. No harm resulted from the incident, as the antibiotics were appropriate for the recipient's condition. Later, a colleague confirmed they carried no risk of misuse. He added that the medication concerned was not expensive. While this does not excuse the conduct, Mr Lownds submited that it should be seen as an emotional, impulsive lapse in judgment rather than a calculated act of dishonesty.

19. Turning to the October 2023 matters whereby Dr Aranmolate attempted to secure false statements from colleagues, Mr Lownds conceded that this was a serious failing but argued it must be understood in the context of the doctor's state of mind at the time. Upon learning of the GMC investigation, Dr Aranmolate panicked, fearing the consequences for his

career given his prior fitness to practise history. His attempts to influence colleagues were poorly planned and quickly unravelled, as he gave inconsistent accounts that made detection inevitable. No benefit was gained from this conduct; in fact, it only worsened his position. Mr Lownds stressed that this was not a premeditated act of deceit but rather a "*harebrained, desperate*" reaction under pressure. While inexcusable, Mr Lownds submitted that this behaviour reflected a momentary lapse in judgment rather than a deep-seated lack of integrity.

20. Mr Lownds then addressed Dr Aranmolate's fitness to practise history, noting that his past misconduct between 1999 and 2006 involved multiple acts of dishonesty, including false claims, breaches of suspension, and misleading employers and the GMC. This had led to his erasure in 2009. However, he highlighted the significant efforts Dr Aranmolate made to rehabilitate himself, culminating in his readmission to the register in 2017 after an eight-year absence. Since then, he had maintained a clean record until these incidents in 2023. Mr Lownds contrasted the current case with the past, pointing out that Dr Aranmolate has admitted all allegations here, whereas in 2009 the charges had to be proved in his absence. He also noted that the recent misconduct was limited in duration compared to the seven-year pattern of dishonesty in the past. This, Mr Lownds submitted, suggested genuine progress and a capacity for reform.

21. On the issue of impairment, Mr Lownds acknowledged that the Tribunal may well find current impairment given the seriousness of the misconduct. However, he argued that the misconduct was not systemic but rather contextually driven by panic and fear of consequences. He highlighted Dr Aranmolate's strong evidence of remediation—his admissions, insight, mentorship, and positive workplace conduct since 2023—as factors mitigating against a finding of ongoing risk. Importantly, there is no suggestion of any patient safety concerns; his clinical competence remains unimpaired, and testimonials affirm his current reliability. On public confidence, Mr Lownds submited that Dr Aranmolate's readmission in 2017 already addressed his past dishonesty, and his recent transparency in admitting faults supports rather than undermines trust in the profession. He referred the Tribunal to the Psychiatric and Risk Assessment report of Dr K, and observed that Dr Aranmolate had developed a new recognition of his character weaknesses.

The Relevant Legal Principles

22. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof, and the decision of impairment is a matter for the Tribunal's judgement alone.

23. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct and whether the misconduct, if found, was serious and then whether any such misconduct found should lead to a finding of impairment.

24. The Tribunal must determine whether Dr Aranmolate's fitness to practise is impaired today, taking into account Dr Aranmolate's conduct at the time of the events, the context of that misconduct and any relevant factors subsequent matters including whether the misconduct found is remediable, whether it has been remedied and the likelihood of repetition. It should also have regard to the public interest in upholding the reputation of the profession and declaring and upholding standards of conduct for members of the profession.

25. The LQC highlighted the case of *Roylance v GMC (no2) (2000) 1 AC 311* in which 'misconduct' was defined as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. He acknowledged that in the case *Nandi v GMC [2004] EWHC 2317 (Admin)*, it was said that serious misconduct is sometimes described as misconduct which would be considered deplorable by fellow practitioners. He also referred to *Remedy v GMC [2010] EWHC 1245 (Admin)* in which Elias J. as he then was, stated:

> *(1) Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession.*
>
> *(2) Conduct falls into the second limb if it is dishonourable or disgraceful or attracts some kind of opprobrium; that fact may be sufficient to bring the profession of medicine into disrepute. It matters not whether such conduct is directly related to the exercise of professional skills.*

26. The LQC reminded the Tribunal of the need to take into account the overarching objective which is to protect the public and which includes to:

a protect and promote the health, safety and wellbeing of the public;
b promote and maintain public confidence in the medical profession;
c promote and maintain proper professional standards and conduct for the members of the profession.

The Tribunal's Determination on Impairment

Misconduct

27. In reaching its decision on misconduct, the Tribunal noted that the submissions made on behalf of both the GMC and Dr Aranmolate were to the effect that his actions amounted to misconduct. While there was agreement between the parties, the Tribunal exercised its own judgment.

28. The Tribunal determined to divide its consideraiton of the Allegation into two main sections.

Paragraphs 1-3: Removal and Provision of Medications (February 2023) and Paragraph 8(a): Dishonesty

29. In his admissions and evidence, Dr Aranmolate accepted the following:

- On 10 February 2023, Dr Aranmolate removed medications from Hillingdon Hospitals NHS Trust without authorisation.
- On 14 February 2023, he provided these medications to Ms A, who was not a patient registered with the Trust and with whom he had a close personal relationship.
- He knew his actions were improper:
    - The medications were for Trust patients only.
    - Ms A did not require emergency treatment.
- He accepted that his actions were dishonest.

30. In reaching this decision, the Tribunal was mindful of the following paragraphs of *Good Medical Practice (2013)* ('GMP'):

'1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.

3 *Good medical practice* describes what is expected of all doctors registered with the General Medical Council (GMC). It is your responsibility to be familiar with *Good medical practice* and the explanatory guidance2 which supports it, and to follow the guidance they contain.

11 You must be familiar with guidelines and developments that affect your work.

12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.

16 In providing clinical care you must:

a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs

g wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.

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

31. The Tribunal was of the view these paragraphs of GMP set out that doctors are required to act with honesty and integrity and ensure that any medications are prescribed and used appropriately. By removing Trust medications without authorisation and providing them to a person who was not a patient registered with the Trust, with whom he had a close personal relationship, Dr Aranmolate breached these fundamental principles.

32. While he admitted his wrongdoing, the Tribunal considered that his account of his actions was confused and lacked transparency. For example, he did not challenge Ms A's account that the delivery to her of the medications came as a complete surprise, yet his

evidence suggested that she was a party to his obtaining the medications, and that he could not say "No". Nevertheless, he contended that the pressure he experienced was self-imposed, as the situation arose from his own decisions rather than external factors, contrary to his assertions in his reflective pieces written for the Tribunal approximately a month before this hearing. The Tribunal found that his account lacked consistency and therefore credibility. In his submissions Mr Lownds invited the Tribunal to determine that Dr Aranmolate's reflective piece did not seek to excuse his behaviour. However, the Tribunal found that this did not mitigate the fact that his conduct was fundamentally incompatible with professional standards.

Paragraphs 4-6: Attempts to Influence Colleagues (October 2023) and Paragraphs 7-8(b) to (f): Dishonesty

33. In his admissions and evidence, Dr Aranmolate accepted the following:

- On 24 October 2023, he:
  - Asked Ms C to falsely confirm she witnessed:
    - A discussion with Dr D about the incident.
    - A verbal warning from Dr D (neither occurred).
  - Called Ms E, asking her to falsely confirm:
    - He had previously disclosed the incident to her;
    - She had issued him a verbal warning
  - Misled Ms E by claiming he had already told the GMC she would support him.

- His actions in attempting to secure false statements and in telling Ms E that he had already informed the GMC what she would support him were all dishonest.

34. The Tribunal considered that these allegations also engaged multiple GMP provisions as follows:

> '23 To help keep patients safe you must:
>
> a contribute to confidential inquiries
>
> 36 You must treat colleagues fairly and with respect.

37 You must be aware of how your behaviour may influence others within and outside the team.

61 You must respond promptly, fully and honestly to complaints and apologise when appropriate. You must not allow a patient's complaint to adversely affect the care or treatment you provide or arrange.

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

68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

72 You must be honest and trustworthy when giving evidence to courts or tribunals. You must make sure that any evidence you give or documents you write or sign are not false or misleading.
a You must take reasonable steps to check the information is correct.
b You must not deliberately leave out relevant information.'

35. The Tribunal found that Dr Aranmolate's actions—asking colleagues (Ms C and Ms E) to provide false statements to the GMC—were a deliberate and dishonest attempt to minimise the consequences of his actions which led to Ms A's complaint against him.

36. The Tribunal was not satisfied with Dr Aranmolate's suggestion that his attendance at the UTC was merely to seek managerial assistance. Instead, it concluded that his true intention was to fabricate an account which would have the effect of portraying the February 2023 incident as less serious than it actually was by falsely claiming he had received a verbal reprimand. This was a clumsy but premeditated attempt to deceive the GMC and the Trust about his actions in February 2023. It was compounded by his drafting an email report for Dr D to send, which, had it been sent, would have further perpetuated the dishonesty.

37. The Tribunal determined that both sets of Allegations 1-3, and 8(a) and 4-8 (b) to (f) constituted misconduct which was serious. Dr Aranmolate's actions in removing and misusing medications breached core professional obligations, while his subsequent dishonest attempts to influence colleagues to themselves make false statements demonstrated a willingness to compromise the integrity of others to protect himself.

38. The Tribunal concluded that Dr Aranmolate's actions were a desperate and dishonest reaction to the complaint—an entirely self-created predicament—and were particularly concerning, as it showed a pattern of unethical decision-making under pressure. The Tribunal emphasised that dishonesty of this nature undermines public trust in the profession and warranted a finding of serious professional misconduct.

Impairment

39. The Tribunal having found that the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct, Dr Aranmolate's fitness to practise is currently impaired.

40. The Tribunal noted that Dr Aranmolate made full admissions. However, it did note that, notwithstanding that the evidence against him was clear and compelling, his decision so to do was not made until 13 March 2025. It recognised that he has taken steps to address his failings, including completing a prescribing course following the medication incident, undertaking CPD on probity and ethics, and referring himself for support on the advice of his defence team.

41. The Tribunal considered the expert opinion of Dr K, who highlighted improvements in Dr Aranmolate's insight and behaviour. Dr K noted Dr Aranmolate's remorse for past misconduct and criminality, his efforts to manage conflict and impulsivity (linked to his upbringing and culture), his willingness to seek help and share mistakes with colleagues/family, and structural changes, such as peer consultation and supervision, to reduce the risk of recurrence. Dr K concluded these factors "significantly diminish the risk of further misconduct". This was on the proviso that the recently implemented safeguards remained in place. He then set out a list of recommended actions. Dr Aranmolate indicated that he intended to follow those recommendations, some of which he contended he had already commenced.

42. Despite these efforts, the Tribunal did not consider that Dr Aranmolate would not become enmeshed in further incidents of dishonesty. The Tribunal was concerned about the frankness of his accounts as they varied, and as to how and why he removed medications from the UTC in Hillingdon Hospital on 10 February 2023. Indeed, the Tribunal was disappointed that Dr Aranmolate could have allowed himself to have behaved in that way,

having persuaded a Tribunal in 2015 that he had remediated his past significant dishonest behaviour.

43. The Tribunal was further concerned that, notwithstanding that self-same apparent remediation, he made attempts to involve colleagues in deceiving the GMC.

44. The Tribunal was still further concerned that he lied to Dr G about the circumstances of his theft of medications from the UTC in February 2023 when she interviewed him on 10 July 2024 on behalf of NHS England. That was long after October 2023 when it might be suggested that he had experienced a panic reaction. He told her that Ms A had gone to UTC with him on 10 February 2023, that he had given her instructions about how to take the medication, that he had sent her home. He said that he had seen her using the medication the following day. He said he had removed the medication from a cardboard box in the cabinet room which contained returned medication. That latter untruth caused NHS England to embark upon an enquiry as to whether medication was stored appropriately in UTC.

45. The Tribunal further noted that Dr Aranmolate did not disclose to his Appraiser at his Appraisal anything about the October 2023 matter. Indeed, all he seems to have told his appraiser in February 2025 was:

> *"There is an ongoing GMC investigation into a matter that evolved whilst i worked at UCC Hillingdon in 2023. I have reflected and appreciated that my action (treating a friend and the manner in which i carried that out was not the best)."*

That in itself was not a transparent account of the theft of medication in February 2023.

46. It follows that the period of Dr Aranmolate's remediation since the events in question really commenced this year in about March 2025 when he admitted the Allegation and when he consulted Dr K. The Tribunal recognised the importance of the assistance Dr K may have given Dr Aranmolate. It noted Dr Aranmolate's recognition of the need to be wary of impulsivity and the importance of a "pyramid of responsibility" which should oblige him to put his professional responsibilities before any other. However, the Tribunal was far from satisfied that this assistance will have achieved at this juncture the desired remediation. The Tribunal could not help but notice the historical parallels between his misconduct which was found proved in 2009 and which led to his erasure at that time and the misconduct which is the subject of this Allegation. It could not help but note that the remediation which satisfied the 2015 Tribunal on his application for restoration has not had any profound or lasting

effect. It therefore entertains doubts as to the extent that the very late attempts at remediation will have had upon Dr Aranmolate.

47. The Tribunal therefore concluded that all three limbs of the overarching objective were engaged.

48. The Tribunal considered for the above reasons that a finding of impairment is warranted on public protection grounds.

49. The Tribunal also considered that it had a duty to maintain the public's confidence in the profession. It was of the view that the public would be dismayed if it did not mark the seriousness and repetition of Dr Aranmolate's dishonesty and in particular by his attempts to corrupt colleagues into providing false evidence with a finding of impairment.

50. Further, the Tribunal determined that in order to uphold professional standards in the profession, a finding of impairment was required to maintain and preserve public trust in the profession, send a message to the profession to deter others from similar misconduct.

51. The Tribunal has therefore determined that Dr Aranmolate's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 02/05/2025

1. Having determined that Dr Aranmolate's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

2. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

3. The Tribunal received further evidence on behalf of the GMC including:

- Dr Aranmolate's Fitness to Practise hearing unredacted record of determination, dated 16 – 26 March 2009, at which his registration was erased;

- Dr Aranmolate's Medical Practitioners Tribunal unredacted record of determination, dated 13 – 15 March 2017, at which his registration was restored; and
- Documentation relating to the timing of the testimonials of Dr L and Ms M.

Submissions

Submissions on behalf of the GMC

4. On behalf of the GMC, Mr Monaghan referred the Tribunal to the relevant paragraphs of the *Sanctions Guidance* (2024) (SG) and submitted that, given the history of repetition and extent of the dishonesty involved in this case, the appropriate sanction was erasure.

5. Mr Monaghan stated that although Dr Aranmolate had accepted his dishonest conduct, this had been far from timely. He further asserted that Dr Aranmolate's promises of remediation echoed those which had been made at the doctor's earlier restoration hearing and which had been instrumental in persuading that tribunal to reinstate him.

6. Mr Monaghan submitted that Dr Aranmolate's dishonest actions showed a wholly misconceived attitude towards the provision of prescription medications. He stated that the doctor's dishonest acts also represented a concerted effort to subvert the GMC investigation by inciting others to provide false evidence and that his attempt to cover up his misconduct was particularly serious.

7. Mr Monaghan submitted that Dr Aranmolate's attempts to cover up his misconduct was not simply a reluctance on the doctor's part to own up to his ill-judged and unacceptable behaviour but instead amounted to positive steps that were designed to strike at the very heart of the disciplinary process and regulation of the profession.

8. Mr Monaghan stated that the overarching objective will be thwarted if an investigation into a doctor's conduct is misled by the presentation of false information. He submitted that this was Dr Aranmolate's intention, and that, regardless of whether the doctor was motivated by panic, his actions were premeditated.

9. Mr Monaghan submitted that, when Dr Aranmolate's attempts to persuade his two colleagues to lie on his behalf failed, he thereafter took time to prepare what appeared to be a draft false statement for Dr D to approve, thereby compounding his dishonesty, in a further attempt to minimise his misconduct.

10. Mr Monaghan submitted that, although the Tribunal noted that Dr Aranmolate had accepted his dishonest conduct and had provided evidence of some remediation, this was *'too little too late'* and was not adequate.

11. Mr Monaghan referenced Dr Aranmolate's previous remediation at his restoration hearing and asserted that this had failed to prevent repetition of dishonest conduct despite the restoration tribunal's conclusions. In those circumstances, he argued, the risk of repetition was very real. He submitted that the doctor's previous fitness to practise history exacerbated the doctor's extremely serious misconduct.

12. Mr Monaghan concluded by stating that Dr Aranmolate's misconduct was fundamentally incompatible with being a doctor and, on the grounds of both risk to the public and reputation of the profession, erasure was the appropriate sanction.

Submissions of Dr Aranmolate

13. Mr Lownds stated that Dr Aranmolate had accepted that the only realistically applicable sanction options that would be considered by the Tribunal were those of a lengthy suspension or erasure. He submitted that this was a case where suspension would be the appropriate and proportionate sanction.

14. Mr Lownds submitted that the Tribunal had recognised that Dr Aranmolate had undertaken efforts to remediate and address issues in his own character. He submitted that this was a case where remediation was possible and that Dr K had provided much assistance in term of the doctor's remediation, albeit with the proviso that there was significant further work needed in relation to remediation, especially given his previous history.

15. Mr Lownds submitted that Dr Aranmolate's full admissions evidenced progress in taking responsibility for his actions and that the doctor's reflections show a candid understanding of the cause of his misconduct. He stated that Dr Aranmolate sought to learn, to change his work approach, and to put in place support systems to ensure that he regulates his conduct in the future and guards against repetition.

16. Mr Lownds referenced the SG and stated that Dr Aranmolate accepted that he should have behaved differently. He further stated that, although Dr Aranmolate's remediation and

insight did not have '*the deepest of roots*' in terms of timeliness, steps had been taken and those steps did pre-date the hearing.

17. Mr Lownds submitted that Dr Aranmolate accepted his mistakes and did apologise for his actions and had been very open and honest when answering questions under oath at the hearing.

18. Mr Lownds urged that matters relating to Dr Aranmolate's previous fitness to practise history needed to be carefully weighed when considering the appropriateness of sanction. He conceded that this was an aggravating factor and raised issues about the doctor's ability to fully remediate, but emphasised that these were matters related to conduct from 17 years ago, which was not admitted in those proceedings. He stated that this present hearing related to a trigger incident compounded by subsequent dishonesty relating to that incident, and that Dr Aranmolate had admitted the allegation.

19. Mr Lownds asked that the Tribunal remind itself that there were no allegations of any other incident since Dr Aranmolate returned to work and that he is supported by detailed and extremely complementary testimonials from colleagues.

20. Mr Lownds submitted that there was evidence to show that Dr Aranmolate had acknowledged fault, and that, bearing in mind his remediation evidence and openness, it was unlikely that this misconduct would be repeated.

21. Mr Lownds submitted that a twelve-month suspension with a review would give adequate time for further remediation and would address the serious misconduct aggravated by the doctor's previous fitness to practise history. He asserted that a suspension would take account of the steps that the doctor had taken in the development of his insight.

22. Mr Lownds referred to Dr Aranmolate's domestic circumstances and the impact that erasure would have on his family.

23. Mr Lownds stated that obviously this was a case that involved repeated dishonesty but asserted that this was not misconduct involving careful pre-planning or sophistication and was plainly haplessly conducted.

24. Mr Lownds emphasised that remediation was possible as there was an awareness by Dr Aranmolate of his character weaknesses, impulsivity and panic, traits which were evident

in committing the several acts which amounted to misconduct. These were matters that the doctor had now come to understand with the help of Dr K. This understanding had led to the doctor setting up a support network and changing the way he operates professionally and also outside of work.

25. Mr Lownds concluded by stating that a long order of suspension would be the fair, appropriate and proportionate sanction in this case.

The Tribunal's Determination on Sanction

26. The decision as to the appropriate sanction to impose, if any, was a matter for the Tribunal exercising its own judgement. There was no burden or standard of proof at this stage. It recognised that every case will necessarily turn on its own facts.

27. In reaching its decision, the Tribunal had given careful consideration to the SG. It had borne in mind that the purpose of a sanction is not to be punitive although it may have a punitive effect.

28. The Tribunal had borne in mind that in deciding what sanction, if any, to impose, it should consider the sanctions available, starting with the least restrictive.

29. Throughout its deliberations, the Tribunal had taken into account the overarching objective, and applied the principle of proportionality, balancing Dr Aranmolate's interests with the public interest.

30. When considering the principle of proportionality, the Tribunal had regard to the judgment in the case of *Bolton v. Law Society* [1994] 1 WLR 512, in which Sir Thomas Bingham stated that '*the reputation of the profession is more important than the fortunes of any one individual member. Membership of a profession brings many benefits, but that is part of the price'.*

31. The Tribunal has taken into account its earlier determinations on the facts and on impairment, the SG and GMP, the further documentation received, the submissions of Mr Monaghan on behalf of the GMC, and the submissions of Mr Lownds on behalf of Dr Aranmolate.

Incidents

10 February 2023

32. The taking of medicine from UTC involved going into a locked room and a locked cupboard and removing several different medications which are potent, including Cyclizine Hydrochloride and Prednisolone.

33. The Tribunal did not consider that it would be appropriate to view this as an entirely impulsive 'spur of the moment' action, which might have been the case had Dr Aranmolate simply been removing some antibiotics. The action was thought through. Moreover, Dr Aranmolate had time to reflect on the implications of his actions as he did not deliver the medications to Ms A until 14 February 2023.

34. The Tribunal did not find Dr Aranmolate's account of the incident to be transparent. Moreover, it considered that the doctor's actions in removing a significant quantity of medications were reckless, particularly in the absence of being able to give clear instruction to Ms A as to how to take the medications, and in circumstances whereby he did not have detailed knowledge of her medical history.

24 October 2023

35. The Tribunal recognised that Dr Aranmolate was facing a potentially devastating enquiry from the GMC when he learnt that Ms A had reported him. It accepted that his actions on 24 October 2023 were 'panic measures'. However, it also considered that they were thought out. Dr Aranmolate recognised that he could not contest the compelling account which Ms A will have had given to the GMC and determined to minimise the implications of his behaviour. He planned to achieve this by approaching members of staff and asking them to tell lies. Further, he sought to ask a senior member of staff, who had left the Trust, to endorse his false report as to his behaviour in taking the medication and how it was dealt with in the Trust. That plan reflected a level of sophistication comparable to that which he adopted in seeking to deceive Dr N in relation to Patient K's report about him in 2006.

36. Dr Aranmolate continued to behave dishonestly in giving his account as to what happened on 10 February 2023 in his interview with Dr Galloway of NHS England in July 2024. Further, he failed to disclose the full nature of the allegations which the GMC were bringing against him in his appraisal in February 2025.

37. The Tribunal concluded that it would be wrong to characterise Dr Aranmolate's behaviour as impulsive. It considered that the reality was that he sought to deceive on multiple occasions in order to extricate himself from his own dishonest actions in taking medications for Ms A.

38. When considering the said incidents, the Tribunal reminded itself of the SG, in particular the following paragraphs:

> '*52 A doctor is likely to lack insight if they:*
>
> *b promise to remediate, but fail to take appropriate steps, or only do so when prompted immediately before or during the hearing*
>
> *c do not demonstrate the timely development of insight*
>
> *54 Where the GMC, or another regulator, has previously made findings of impaired fitness to practise and imposed a sanction on the doctor's registration, the tribunal may wish to consider this as an aggravating factor in relation to the case before it.*
>
> *55 Aggravating factors that are likely to lead the tribunal to consider taking more serious action include:*
>
> *a a failure to raise concerns* […]
>
> *b a failure to work collaboratively with colleagues* […]
>
> *d abuse of professional position*
>
> *56 Tribunals are also likely to take more serious action where certain conduct arises in a doctor's personal life, such as (this list is not exhaustive):*
>
> *a issues relating to probity – ie being honest and trustworthy and acting with integrity* […]'

Aggravating and Mitigating Factors

Aggravating Factors

39. The Tribunal noted that Dr Aranmolate's misconduct involved multiple elements of dishonesty over a prolonged period and involved attempts to cover up his misconduct.

40. The Tribunal further considered that, whilst there were admissions and apparent contrition, these were not forthcoming until March this year.

41. Dr Aranmolate's procurement of medication for Ms A without a detailed medical history had the potential to put Ms A's health at risk.

42. The Tribunal did not consider that Dr Aranmolate's actions in procuring medications for Ms A was a spontaneous event and noted that, after having taking medications from a locked room, the doctor had waited four days until he gave the medications to Ms A. It concluded that these actions evidenced a degree of premeditation or, at the very least, allowed Dr Aranmolate time to reflect upon what he had done before delivering the medication to Ms A.

43. Dr Aranmolate sought to compromise the honesty and integrity of colleagues at the Trust and put them at risk of disciplinary action.

44. The Tribunal considered that Dr Aranmolate's previous fitness to practise history was an aggravating factor.

Mitigating Factors

45. The Tribunal noted that Dr Aranmolate's had provided honest answers to Tribunal questions even when they were incriminating.

46. The Tribunal took account of Dr Aranmolate's attempts at remediation and noted that he had been working well during the last year in the run up to the hearing.

47. The Tribunal noted that Dr Aranmolate's initial dishonesty was undertaken to assist Ms A.

48. The Tribunal recognised that Dr Aranmolate had submitted a number of references which were very supportive of him as a doctor.

No Action

49. The Tribunal first considered whether to conclude the case by taking no action.

50. The Tribunal determined that to take no action would be inappropriate. The Tribunal did not consider that there were any exceptional circumstances that would justify such a course. It would not be sufficient, proportionate or in the public interest to conclude the case by taking no action.

Undertakings

51. The Tribunal noted that no undertakings had been agreed in this case.

Conditions

52. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Aranmolate's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable.

53. The Tribunal determined that the imposition of conditions on Dr Aranmolate's registration would be unworkable given the doctor's attitudinal issues in relation to dishonesty.

54. The Tribunal further considered that the imposition of conditions on Dr Aranmolate's registration would be inappropriate as it would not send a sufficiently robust message to the public or the profession as to the inappropriateness and seriousness of his misconduct. In the circumstances, the Tribunal determined that a period of conditional registration would not meet the public interest.

Suspension

55. The Tribunal then went on to consider whether imposing a period of suspension on Dr Aranmolate's registration would be appropriate and proportionate.

56. The Tribunal acknowledged that suspension has a deterrent effect and can be used as a signal to the doctor, the profession, and to the public about what is regarded as behaviour unbefitting a registered doctor.

57. The Tribunal took account of the following paragraph of the SG which indicate circumstances in which it may be appropriate to impose a sanction of suspension:

> *'92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).'*

58. The Tribunal was cognisant of the fact that no clinical issues had been raised as to Dr Aranmolate's practice.

59. However, it considered that while the public needs good doctors, it also needs honest doctors, and that probity and honesty were fundamental to the profession.

60. The Tribunal noted that the development of Dr Aranmolate's insight into his persistent and maintained dishonesty only commenced at a very late stage of this inquiry, albeit before the hearing. It did not consider that he has provided convincing evidence of remediation, although it accepted he has acknowledged the need for remediation. The Tribunal acknowledged that Dr Aranmolate has taken considerable steps towards understanding that he should not accede to pressure to provide medication inappropriately. However, the Tribunal did not consider that this addressed the attitudinal shortcomings which led him to behave as he did. Further, it noted that his previous remediation failed to prevent the further dishonesty which is the subject of this Allegation. In all these circumstances the Tribunal concluded that there remains a significant risk of repetition of dishonest conduct.

61. It further noted that his misconduct was of particular concern in that it had the potential to put Ms A's health at risk of harm, it could have undermined the integrity and honesty of his colleagues and damaged the reputation of the profession.

62. The Tribunal considered that Dr Aranmolate's dishonesty was persistent; he attempted to cover it up on multiple occasions. In the absence of his having provided convincing and timely evidence of remediation, it considered that there is a real risk of repetition, particularly in light of his previous fitness to practise history.

63. In these circumstances, the Tribunal did not consider that a suspension order, even with a review was an appropriate or proportionate sanction.

Erasure

64. The Tribunal considered the following paragraphs of the SG:

> *'107 The tribunal may erase a doctor from the medical register in any case – except one that relates solely to the doctor's health and/or knowledge of English – where this is the only means of protecting the public*
>
> *108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor*
>
> *109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate*
>
> *b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety*
>
> […]
>
> *d Abuse of position/trust (see Good medical practice, paragraph* [65]*: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').*

h Dishonesty, especially where persistent and/or covered up […]

j Persistent lack of insight into the seriousness of their actions or the consequences.'

65. The Tribunal considered that Dr Aranmolate's dishonesty, his efforts to subvert the investigatory process by seeking to persuade colleagues to tell lies for his benefit, and his reckless disregard for Ms A's health was at odds with the fundamental tenets of the profession and the principles as set out in GMP.

66. The Tribunal further noted that, although it had received no evidence indicating that Dr Aranmolate was anything other than clinically competent, this could not mitigate his dishonesty.

67. The Tribunal also took into account paragraph 128 of the SG that states:

'128 Dishonesty, if persistent and/or covered up, is likely to result in erasure […]'

68. The Tribunal had regard to the principle of proportionality, weighing the interests of the public against those of the doctor. It took into account all the circumstances of the case and all three limbs of the overarching objective.

69. The Tribunal concluded that Dr Aranmolate's misconduct was of such a serious nature that erasure was the only appropriate and proportionate sanction to protect, promote and maintain the health, safety and well-being of the public; maintain public confidence in the medical profession, and to uphold proper professional standards and conduct for members of the profession.

70. The Tribunal therefore directed that Dr Aranmolate's name be erased from the Medical Register.

Determination on Immediate Order - 02/05/2025

1. Having determined that Dr Aranmolate's name should be erased from the Medical Register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Aranmolate's registration should be subject to an immediate order.

Submissions

Submissions on behalf of the GMC

2. Mr Monaghan submitted that the imposition of an immediate order upon Dr Aranmolate's registration was required.

3. Mr Monaghan argued that, given the Tribunal's findings at the sanction stage, the imposition of an immediate order was necessary to uphold public confidence in the profession and to declare and uphold standards for the profession.

4. Mr Monaghan submitted that it would be a matter of surprise for the wider public if Dr Aranmolate was allowed to continue practising in light of the gravity of the findings in this case and the sanction that had been imposed.

Submissions on behalf of Dr Aranmolate

5. Mr Lownds did not make any submissions relating to the imposition of an immediate order.

The Tribunal's Determination

6. In reaching its decision, the Tribunal has exercised its own judgement, and has taken account of the principle of proportionality. The Tribunal has borne in mind that it may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public, is in the public interest, or is in the best interests of the practitioner.

7. The Tribunal had regard to the following paragraphs of the SG:

> *'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order*

173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.'

8. The Tribunal considered that, due to the serious nature of Dr Aranmolate's misconduct, an immediate order was both necessary and proportionate.

9. It considered that, given the risk of repetition, an immediate order was necessary to protect the public, to uphold proper professional standards and conduct for members of the profession and to maintain public confidence in the profession.

10. Further, the Tribunal concluded that public confidence in the profession would be undermined if an immediate order was not imposed given the nature of Dr Aranmolate's misconduct.

11. Accordingly, the Tribunal determined to impose an immediate order upon Dr Aranmolate's registration.

12. This means that Dr Aranmolate's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

13. The interim order is hereby revoked.

14. That concludes this case.

SCHEDULE 1

- Cefalexin 500mgs;
- Cyclizine Hydrochloride 50mgs;
- Prednisone 5mgs;
- Salbutamol 100mgs inhaler;
- Ibuprofen 200mgs
- A box of Co-amoxiclav 500/125mgs prescribed for Patient B.