PUBLIC RECORD

Dates: 01/12/2025 - 10/12/2025

Doctor:	Dr Tijjani SHEHU
GMC reference number:	4455147
Primary medical qualification:	MB BS 1984 Ahmadu Bello University

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

Summary of outcome

Suspension, 6 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mr Simon Bond
Lay Tribunal Member:	Mrs Lorna Taylor
Registrant Tribunal Member:	Dr Charlotte Jones

Tribunal Clerk:	Mr Matt O'Reilly

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Chima Umezuruike, Counsel, directly instructed
GMC Representative:	Ms Elizabeth Dudley-Jones, 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 and Impairment - 08/12/2025

Background

1. At the time of the index event Dr Shehu was a locum Consultant Physician, working in the Acute Medicine Department at Kings Mill Hospital (KMH), Sherwood Forest NHS Foundation Trust (the Trust).

2. The allegations before this Tribunal can be summarised as relating to the care and treatment that Dr Shehu provided to Patient A. It is alleged that on 28 December 2022 Dr Shehu failed to provide appropriate care and treatment to Patient A. It is alleged that his actions included failing to recognise Patient A's documented history of symptoms; to take an adequate history; to consider an alternative diagnosis to deep vein thrombosis ('DVT'); to arrange appropriate further investigations; to implement an adequate treatment plan; and to make an adequate record of his consultation with Patient A. It is further alleged that Dr Shehu's actions delayed a diagnosis being made for Patient A, and delayed treatment being initiated for Patient A.

3. On 28 December 2022 Patient A woke up experiencing sudden onset of pain in her right calf, as well as swelling. She was also complaining of shivering, fever and vomiting. Patient A attended Newark Urgent Treatment Centre ('UTC') on the same day and had an examination, underwent various investigations (blood tests and a Doppler scan of the right leg) and then referred to KMH with a working diagnosis of possible DVT and rhabdomyolysis at 15:41. An ambulance was not available to transport Patient A to KMH, and she therefore made her own way there. Patient A arrived at KMH's Emergency Department ('ED') at approximately 16:00 on 28 December 2022. Patient A was initially assessed in KMH at 17:02

and subsequently transferred to KMH's Majors Department due to her pain score and heart rate. She was not assessed under the Trust's 'Adult Infection and Sepsis Screening Tool' upon arrival.

4. Patient A was reviewed by a number of members of staff at KMH including an ED Registrar, a Trauma and Orthopaedic training doctor, and at 20:00, by a Foundation Year 1 Doctor who was part of the Acute Medical Team. During Patient A's review at 20:00 it was documented that Patient A was very distressed, her right calf was hot and swollen, and a diagnosis of possible right calf DVT was made.

5. Patient A was seen by Dr Shehu in ED at KMH on 28 December 2022 at 20.55. Patient A was still awaiting a bed on the Emergency Assessment Unit due to lack of available beds.

6. Patient A remained at KMH until her death at 21:25 on 29 December 2022. After her death, Patient A's blood culture grew Group A streptococcus. Medical opinion determined that Patient A had developed toxic shock syndrome from the Group A streptococcal infection and necrotising fasciitis (a rare and life-threatening infection, also called the 'flesh-eating disease').

7. The circumstances of Patient A's death were the subject of an inquest in November 2023. At the conclusion of the inquest the Coroner made a number of criticisms of the standard of care provided to Patient A by Dr Shehu and others, who the Coroner said had fallen foul of confirmation bias. Dr Shehu was not present at the inquest nor was he called to give evidence at the inquest. However, Dr Shehu subsequently referred himself to the GMC in light of the Coroner's comments.

8. In light of Dr Shehu's self-referral, the GMC opened an investigation into the care and treatment Dr Shehu provided to Patient A on 28 December 2022, resulting in the Allegation.

The Outcome of Applications made during the Facts Stage

9. At the outset of the hearing, Ms Elizabeth Dudley-Jones, Counsel, on behalf of the GMC, made an application for Patient A to be anonymised, during the hearing and in the documentation. Mr Chima Umezuruike, Counsel, on behalf of Dr Shehu, made no objection to the application. The Tribunal granted the application pursuant to Rule 35(4) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules').

10. On day 2 of the hearing, Ms Dudley-Jones made an application to amend the Allegation pursuant to rule 17(6) of the Rules. There was a typographical error in paragraphs 1a-g of the Allegation, meaning that '*1e'* was omitted in the chronology. Ms Dudley-Jones invited the Tribunal to amend paragraph '*1f*' to become '*1e'*, and *'1g'* to become *'1f*'. Mr Umezuruike made no objection to the proposed amendment. The Tribunal was satisfied that the amendment could be made without any injustice. It determined to amend the Allegation as proposed, pursuant to Rule 17(6) of the Rules.

The Allegation and the Doctor's Response

11. The Allegation made against Dr Shehu is as follows:

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

1. On 28 December 2022 at 20:55 you reviewed Patient A in the Emergency Department of King's Mill Hospital at which time you failed to:

    a. recognise Patient A's documented history of:

        i. vomiting; **Admitted and found proved**

        ii. fever (shaking); **Admitted and found proved**

    b. take an adequate history from Patient A to include whether she had experienced the following symptoms:

        i. cough; **Admitted and found proved**

        ii. sputum; **Admitted and found proved**

        iii. dysuria; **Admitted and found proved**

        iv. diarrhoea; **Admitted and found proved**

    c. consider an alternative diagnosis to deep vein thrombosis; **Admitted and found proved**

    d. arrange appropriate further investigations for Patient A, namely:

        i. blood cultures; **Admitted and found proved**

        ii. urine cultures; **Admitted and found proved**

iii. a swab of the skin of Patient A's right leg;
Admitted and found proved

v. a chest x-ray; Admitted and found proved

vi. a repeat blood gas to include repeat lactate;
Admitted and found proved

vii. a liver ultrasound; Admitted and found proved

~~f~~. e. implement an adequate treatment plan for Patient A, to include:
Amended pursuant to Rule 17(6)

i. blood culture sampling; Admitted and found proved

ii. intravenous antibiotics; Admitted and found proved

i. intravenous fluids; Admitted and found proved

ii. assessment of Patient A's oxygen supply;
Admitted and found proved

~~g~~ f. record Patient A's: Amended pursuant to Rule 17(6)

i. history of fever (shaking) and vomiting;
Admitted and found proved

ii. blood test results; Admitted and found proved

iii. doppler ultrasound result; Admitted and found proved

iv. lactate result. Admitted and found proved

2. Your actions at paragraph 1 above caused a delay in the correct:

a. diagnosis of Patient A being made;
Admitted and found proved

b. treatment of Patient A being initiated.
Admitted and found proved

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

12. At the outset of these proceedings, through his Counsel, Mr Umezuruike, Dr Shehu made admissions to the entirety of the Allegation, as set out above, in accordance with Rule 17(2)(d) of 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.

Determination on Impairment

13. After announcing that the Allegation was admitted and found proved, the Tribunal had to decide, in accordance with Rule 17(2)(l) of the Rules, whether or not Dr Shehu's fitness to practise is currently impaired by reason of his misconduct.

Witness Evidence

14. 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:

- Dr B, Consultant in Emergency Medicine at KMH, dated 11 July 2025;
- Dr C, Clinical Research Fellow in Trauma and Orthopaedic Surgery at the Queen's Medical Centre, Nottingham University Hospitals NHS Trust, dated 22 July 2025;
- Dr D, Consultant in Anaesthesia and Intensive Care Medicine at KMH, dated 17 July 2025;
- Dr E, Consultant in Trauma and Orthopaedics at KMH, dated 10 July 2025;
- Nurse F, Quality Governance Facilitator at KMH, dated 22 July 2025;
- Dr G, Consultant in Acute Medicine at KMH, dated 23 July 2025.

Documentary Evidence

15. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to, the following:

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

- The Coroner's referral form in respect of Patient A, dated 3 January 2023;
- Digital Autopsy Radiology report, dated 17 January 2024;
- Toxicology report, dated 15 April 2023;
- Final post mortem examination report, dated 22 June 2023;
- HM Coroners Summary, dated 15 December 2023;

- Record of Inquest, dated 15 December 2023;
- Statements prepared for HM Coroner from Patient A's parents; Patient A's GP; several of the medical staff at KMH, various;
- Transcripts of evidence given by several of the medical staff at KMH, various;
- The Trust's Team Checklist 'Suspected deep vein thrombosis UCC pathway', dated 22 October 2021;
- Venous thromboembolism (VTE) management guidelines, dated 23 May 2021;
- Sepsis Guidelines – Recognition, Diagnosis and Early Management, dated 20 January 2022;
- Article: RCJ Review: Laboratory risk indicator for necrotising fasciitis (LRINEC) score for the assessment of early necrotising fasciitis: a systematic review of the literature, dated 14 February 2017;
- Article: The LRINEC (Laboratory Risk Indicator for Necrotising Fasciitis) score: A tool for distinguishing necrotising fasciitis from other soft tissue infections 2004;
- Patient A's GP medical records, various; Patient A's medical records relating her treatment at the Newark Urgent Treatment Centre on 28 December 2022; and Patient A's medical records relating to her treatment at KMH, including Governance Report and imaging, dated 28-29 December 2022.

On behalf of Dr Shehu

16. Dr Shehu provided a reflective statement, dated 21 February 2025 and a witness statement, dated 1 December 2025. He also provided a letter sent to him from the GMC dated 27 March 2025, relating to the GMC case examiner's decision to refer him to a Medical Practitioner's Tribunal.

17. Dr Shehu also provided:

- Certificate of Attendance: 6th Acute and General Medicine Conference, dated 20-21 September 2025;
- CME Certificate: Completed module on Sepsis, dated 29 October 2025;
- Certificate: Sepsis Awareness, dated 15 November 2025
- Certificate: E-learning component on Sepsis in Health And Social Care, dated 16 November 2025;
- Colleague Feedback Summary Report, dated 13 June 2025;
- Patient Feedback Summary Report, dated 13 June 2025;
- Two testimonial letters.

Expert Witness Evidence

18. The Tribunal received the record of a documented discussion between the GMC and the GMC's expert, Dr H, Consultant in Acute internal medicine, dated 24 June 2024. Dr H also provided an expert report, dated 18 November 2024, and a supplementary report, dated 18 July 2025. He also provided oral evidence during the proceedings.

Submissions on behalf of the GMC

19. Ms Dudley-Jones submitted that at this stage, it was a matter for the Tribunal, exercising its own independent judgement, as to whether Dr Shehu's fitness to practise is impaired. She submitted that by virtue and reason of the facts that Dr Shehu has admitted, his fitness to practise is currently impaired. Ms Dudley-Jones referred the Tribunal to the relevant case law in relation to misconduct and impairment. When considering misconduct, Ms Dudley-Jones referred the Tribunal in particular to the case of *Calhaem v GMC [2007] EWHC 2606 (Admin),* (as set out below). She submitted that there was little doubt that the Tribunal was likely to find that the misconduct in this case was serious. She said that Dr Shehu's failures were multiple, spanning the entire gamut of his consultation with a very poorly patient. Ms Dudley-Jones took the Tribunal through each of his failures, as set out in the Allegation and admitted by Dr Shehu.

20. Ms Dudley-Jones reminded the Tribunal of Dr H's criticisms, which were also captured by the GMC's Case Examiner letter where Dr H stated, *"The evidence indicates that Dr Shehu had a sole working differential diagnosis of DVT. This was clearly incorrect given the negative doppler scan which was available at the time of Dr Shehu's review, and the clinical history suggesting strongly an alternative pathology, namely sepsis…"* Ms Dudley-Jones submitted that Patient A clearly had an infection, but that the sole investigation requested by him was a Doppler of the right leg, which had already been completed and reported as negative approximately 7 hours previously. Ms Dudley-Jones set out Dr H's opinion. She informed the Tribunal that Dr Shehu did not implement an adequate treatment plan; that his omission of appropriate interventions led to a delay in the correct diagnosis being made; and the correct treatment being initiated for Patient A. Ms Dudley-Jones reminded the Tribunal that Dr Shehu has admitted in his Rule 7 reflection, that he made an inadequate study of Patient A, that he could have taken a more detailed history and that he should have gone through the previous notes. Further, that Dr Shehu said he did not consider an alternative diagnosis and that, had he done so, he would have arranged and implemented a different treatment plan.

21. Ms Dudley-Jones reminded the Tribunal of Dr H's expert report, in capturing the seriousness of Dr Shehu's misconduct. She set out the key features of Dr H's criticisms. She

said that Dr H stated that Dr Shehu was reviewing Patient A as an independent Consultant Physician and that Dr Shehu undertook a superficial or brief examination of Patient A's right leg. Dr Shehu noted it to be very tender, with no bruising but with some redness. Dr H opined that Dr Shehu had sufficient evidence available to enable him to reach the correct working diagnosis of sepsis including Patient A's clear presentation of a short acute history of fever, vomiting and an extremely painful, red right leg. Ms Dudley-Jones highlighted Dr H's opinion that Patient A's unrecordable blood pressure on admission; low temperature of 35.8; negative Doppler; CRP of 154; white cell count of 14.8; together with a markedly elevated lactate, all supported the presence of an infection consistent with sepsis. According to Dr H, there was no documentation that Dr Shehu considered any alternative diagnoses to DVT, nor did he ask any further questions. Ms Dudley-Jones said that Dr H concluded that, as a result, Dr Shehu failed to take an adequate history and failed to ask questions to elicit Patient A's history of symptoms. Further, she said that these were key, given the evidence that Patient A's thrombotic risk was negative, and that she was therefore at low risk of having DVT. Ms Dudley-Jones also submitted that Dr Shehu admitted that he reviewed the blood results and Doppler which was negative for DVT, yet his only working diagnosis was of DVT. She said that it was Dr H's view that this standard of care was seriously below the standard expected because of the clear lack of congruence between Dr Shehu's working diagnosis and the results of an appropriate diagnostic test which had ruled out that diagnosis.

22. Ms Dudley-Jones submitted that it was Dr H's view that Dr Shehu did not adequately document key factors in respect of Patient A's symptoms, assessment and presentation, which were core, basic elements of the clinical review and assessment of Patient A. She stated that Dr H also opined that had Dr Shehu documented the raised inflammatory markers and the negative Doppler test, this would have indicated clearly to colleagues providing follow-on care that Patient A was suffering from a condition other than DVT. Ms Dudley-Jones said that despite it being clear that Patient A had an infection, Dr Shehu failed to conduct or arrange clinically indicated tests and investigations, and further failed to implement an adequate treatment plan for his patient who was suffering from evolving sepsis.

23. Ms Dudley-Jones submitted that it was Dr H's view that this was not a case of some difference of opinion; there had been a complete omission by Dr Shehu of all aspects of ongoing management of Patient A in respect of infection, sepsis or suspected sepsis; and the care he provided fell seriously below the standard expected of a Consultant Physician.

24. In respect of impairment, Ms Dudley-Jones submitted that, given the admitted allegations, Dr Shehu not only put Patient A at unwarranted risk of significant harm, but his actions also caused a delay in the correct diagnosis being made for her, and for the correct

treatment being initiated. Ms Dudley-Jones submitted that Dr Shehu's actions not only resulted in a risk of harm, but ultimately did seriously harm his patient. She submitted that Dr Shehu was the Consultant on duty on the 28 December 2022 undertaking post ward round reviews; he was in charge of personally reviewing patients; verifying the accuracy of the history; ensuring any necessary examinations or investigations were conducted; and concluding the review with an appropriate diagnosis and management plan. Ms Dudley-Jones submitted that the Tribunal may consider the following paragraphs of Good Medical Practice ('2013')('GMP') to be relevant - paragraphs 1, 14, 15a-c, 16a-d, 19, 21a-e, and 65.

25. Ms Dudley-Jones submitted that Dr Shehu's actions seriously undermined public confidence in the profession, brought the profession into disrepute, and has breached one of the fundamental tenets of the profession. She submitted that this is a case which required a finding of impairment in order to uphold standards and maintain public confidence, even if there is evidence of remediation or a low risk of repetition. Ms Dudley-Jones said that Dr Shehu has provided testimonials, evidence of attendance on very recent courses, that he relies on his reflective statement from February 2025, and has admitted the allegations. She submitted however, that Dr Shehu did not originally accept all matters because there was, on the face of it, an acceptance that was equivocal in one respect, or certainly in conflict with Dr H's opinion.

26. Ms Dudley-Jones submitted that that these matters of serious clinical misconduct are in principle remediable. When considering whether they have been remedied, she said that the evidence produced by Dr Shehu is very recent in that courses were undertaken by him in September, October and November 2025. She said that there was no evidence of any reflections on those courses attached to Dr Shehu's reflective statement. She said that it appears Dr Shehu did not attend any courses between February and September 2025. Ms Dudley-Jones therefore invited the Tribunal to consider whether Dr Shehu has properly and fully understood his failures on 28 December 2022 - why they occurred, and what he has learned from the courses he has attended. Ms Dudley-Jones invited the Tribunal to consider that if Dr Shehu could not demonstrate his understanding of the problem that led to his serious misconduct, it may consider that there is limited evidence that Dr Shehu has remedied this serious clinical misconduct. She said the Tribunal could not therefore be satisfied that the conduct would not be repeated were he to find himself in a similar situation.

27. Ms Dudley-Jones submitted that this is a case where Dr Shehu's misconduct is so serious that a finding of impairment is justified, in order to reaffirm clear standards of professional conduct, and to maintain public confidence in the profession. She said that 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 of this case.

Submissions on behalf of Dr Shehu

28. Mr Umezuruike agreed with the legal principles referred to by Ms Dudley-Jones. He said that he makes no submissions on whether or not Dr Shehu's failings amount to misconduct, because that was a matter for the Tribunal. Mr Umezuruike referred the Tribunal to a letter from the GMC to Dr Shehu 27 March 2025 in respect of the GMC's case examiner's decision to refer Dr Shehu to a Tribunal. He submitted that the letter supported the proposition that the Tribunal should take into account whether Dr Shehu's failings were easily remediable, whether they have been remedied and to what extent, and whether they are likely to be repeated. He said the letter also stated:

> *"…this case is concerned with a single occasion in December 2022, in an otherwise unblemished career. Having regard to the nature and isolated nature of failings, we are satisfied that Dr Shehu's alleged failure to take an adequate history, consider an alternative diagnosis, arrange further investigations, and implement an adequate treatment plan, are easily remediable."*

29. Mr Umezuruike submitted that the letter also stated that in the assessment of the Case Manager, Dr Shehu's personal reflection is good evidence of his apology, his regrets and his remorse. Mr Umezuruike said that Dr Shehu has clearly accepted responsibility for his actions; recognised that there were failings on his part; self-referred to the GMC; has reviewed GMP and has undertaken some learning activity. Mr Umezuruike said that Dr Shehu has, for example, reviewed materials and a clinical presentation in respect of a swollen leg and differential diagnosis to refresh his knowledge. He said at the time of the GMC's letter, the reason why the GMC felt that Dr Shehu's remediation was lacking, was because of his failure to provide certificates to evidence his learning. Mr Umezuruike said the GMC's second concern was the content of paragraph 28 of Dr Shehu's reflective statement, which appeared to show that Dr Shehu did not have sufficient insight into his conduct. Mr Umezuruike submitted that these were the two reasons why the GMC concluded that Dr Shehu's conduct met the threshold for a realistic prospect of a finding of current impairment.

30. Mr Umezuruike referred the Tribunal to Dr Shehu's witness statement which contained a statement of truth, and in which Dr Shehu accepted that paragraph 28 was wrong. He said that Dr Shehu had sought permission from the Tribunal to withdraw that part of the statement. Mr Umezuruike said that in the witness statement, Dr Shehu unequivocally

admitted the Allegation against him, sincerely apologised for his shortcomings, and said that he would do his best to ensure his failings did not occur again. Mr Umezuruike referred the Tribunal to Dr Shehu's CPD certificates (as have been set out above). Mr Umezuruike invited the Tribunal to consider that these certificates related directly to Dr Shehu's failings, and that they do not expire until well into 2026.

31. Mr Umezuruike highlighted feedback from 16 colleagues of Dr Shehu, dated 13 June 2025. He said that Dr Shehu received very positive feedback, with the majority of colleagues rating him as 'very good', 'fit to practise medicine', and with no issues about Dr Shehu's probity. Mr Umezuruike submitted that Dr Shehu is clearly a doctor who has earned great respect from his colleagues, that he clearly puts patients and their interests at the forefront of his work. Mr Umezuruike then referred the Tribunal to consider Dr Shehu's patient feedback, dated 13 June 2025, received from 26 patients. Mr Umezuruike highlighted that Dr Shehu scored a very high mark; he said there is clearly no issue with Dr Shehu's probity, and that he is well respected by his patients, with the majority of patients rating him as 'good' or 'very good'. He said that Dr Shehu had some excellent comments from patients and that the overall summary was very good, giving no cause for concern.

32. Mr Umezuruike also referred the Tribunal to the two positive testimonial letters provided in support of Dr Shehu. In addition, he highlighted Dr Shehu's Rule 7 response, dated 20 February 2025, in which Dr Shehu stated that since the incident occurred it has played heavily on his mind; that he has thought deeply about how it happened; his role in the care and treatment of Patient A; why he acted as he did; what he could have done differently and what he has learned since. Mr Umezuruike said that in his witness statement, Dr Shehu fully admits that he did not consider an alternative diagnosis to DVT, and that he sincerely apologises to Patient A's family. He said that Dr Shehu accepted that he made a serious error of judgement at that time, and that it was a personal error. Mr Umezuruike said that Dr Shehu is now mindful of GMP, consults colleagues to seek advice where appropriate, and keeps up to date with guidelines and available Trust protocols.

33. Mr Umezuruike submitted that Dr Shehu has now come to recognise and appreciate more deeply than ever before that his approach to detailed history taking and clinical examination has had to change. He stated that Dr Shehu will ensure detailed record keeping, treat patients as appropriate, and consider differential diagnoses in similar cases. Mr Umezuruike said that Dr Shehu acknowledged that his actions have not only affected the care and treatment he provided to Patient A, but also put his own professional standing at risk, and undermined the reputation of his colleagues and the wider medical community. He said that Dr Shehu was fully committed to engaging in continuous reflective learning.

34. Mr Umezuruike submitted that Dr Shehu has remediated the concerns raised, that there has been no repetition since the incident on 28 December 2022, and Dr Shehu will engage his best endeavours to ensure these failings will not happen again. He submitted that Dr Shehu's fitness to practise is not currently impaired and that such a finding would not undermine public confidence in the profession.

The Tribunal's Approach

35. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision on impairment is a matter for the Tribunal's judgement alone. When reaching its determination, the Tribunal had regard to the overarching objective and the standards set out in GMP.

36. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted when considering the allegations relating to misconduct. First, whether the facts as found proved amounted to misconduct; and then secondly, whether Dr Shehu's fitness to practise is currently impaired.

37. Regarding misconduct, the Tribunal was reminded of the guidance in the case of *Nandi v General Medical Council [2004] EWHC 2317 (Admin),* where misconduct was described as:

> *'"a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious". The adjective "serious" must be given its proper weight".*

38. The Tribunal also bore in mind the five principles Justice Jackson set out in the case of *Calhaem v GMC [2007] EWHC 2606 (Admin),* in which he stated:

> *(1) Mere negligence does not constitute "misconduct" within the meaning of section 35C(2)(a) of the Medical Act 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to "misconduct".*
>
> *(2) A single negligent act or omission is less likely to cross the threshold of "misconduct" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as "misconduct".*

(3) "Deficient professional performance" within the meaning of 35C(2)(b) is conceptually separate both from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work.

(4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute "deficient professional performance".

(5) It is neither necessary nor appropriate to extend the interpretation of "deficient professional performance" in order to encompass matters which constitute "misconduct".

39. The Tribunal was mindful however that this is a case of misconduct and not one of deficient professional performance.

40. The Tribunal considered whether Dr Shehu's fitness to practise is currently impaired at the time of this hearing, not whether impairment existed at the time of the index events.

41. The Tribunal also had in mind the threefold test set out in *Cohen v GMC [2008] EWHC 581 (Admin)*, where Mr Justice Silber identified criteria for assessing current impairment which can be summarised as follows. Firstly, is the conduct remediable; secondly, has it been remedied; and thirdly, is it highly unlikely to be repeated in the future?

42. Whilst there is no statutory definition of impairment, the LQC advised the Tribunal that it is assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report, as adopted by the High Court in *CHRE v NMC & Grant (2011) EWHC 927 (Admin.)* Dame Smith sets out some features that are likely to be present when impairment is found. Namely, whether the doctor:

a. 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 of harm; and/or

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

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;

d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.

43. In reaching its decision, the Tribunal has taken account of the statutory overarching objective, which includes protecting, promoting and maintaining the health, safety and wellbeing of the public, promoting and maintaining public confidence in the profession, and promoting and maintaining proper professional standards and conduct.

The Tribunal's Determination on Impairment

Misconduct

44. The Tribunal took into account all the evidence before it, and the submissions of both Ms Dudley-Jones and Mr Umezuruike. The Tribunal also had regard to the relevant paragraphs of the *'Guidance for MPTS tribunals (24 November 2024)'* ('the Guidance').

45. The Tribunal noted that the Guidance sets out how decision making should be made, with examples of typical case types including those relating to clinical concerns. The Tribunal reminded itself throughout its deliberations that this was a case of alleged misconduct, and not one of deficient professional performance.

46. The Tribunal began by reminding itself of the background and context of the matters which led to this hearing. It was assisted by the expert report in which Dr H set out a full chronology of events, including the following description of Dr Shehu's specific involvement in the care of Patient A:

> *Dr Shehu's specific Involvement in the Care of [Patient A]*
>
> *Dr Shehu was working as a Locum Consultant in Medicine when reviewing Patient [A].*
>
> *Dr Shehu reviewed Patient [A] at 20:55 on 28th December 2022. It is noted that this review occurred in the Emergency Department due to a lack of available bed capacity in the medical assessment unit.*
>
> *This appears to be the only occasion that Dr Shehu reviewed, and was involved in the care of, Patient [A].*
>
> *It would be a matter for the GMC to confirm, but the records relating to this review of Patient [A], are likely written by a colleague (junior doctor) of Dr Shehu.*

The following was documented:

" … year old female. Attends with intense R calf pain. Sudden swelling of Right calf. Very tender, no bruising, some redness. Non-smoker. Not on oral contraceptive pill. Usually independently mobile. No recent travel. No covid. Not pregnant. Very distressed and tearful. Asking for IV morphine – explained can have oral not iv. Seen by ortho – not compartment syndrome. Primary Diagnosis: Rt calf DVT. Plan: Treatment dose enoxaparin, Analgesia, Doppler tomorrow."

There are no further entries in the records to confirm that Dr Shehu had any further involvement in the care and management of Patient [A] thereafter..."

47. The Tribunal accepted the expert opinion of Dr H as set out in his documented discussion with the GMC dated 21 June 2024, his expert report dated 18 November 2024 and his supplementary expert report dated 18 July 2025.

48. During the documented discussion dated 21 June 2024, Dr H was of the opinion that:

"[Patient A's] *additional symptoms, which were previously recorded in the history and included recurrent vomiting and a shivery feeling were not documented* [by Dr Shehu], *nor were the results of blood tests that was accessible to Dr Shehu at the time and which included elevated CRP and white cell count. The expert also pointed out that the chest x-ray that was performed and the doppler ultrasound that was performed and reported eight hours earlier were not mentioned in the post-take review.*
The expert advised that overall, Dr Shehu's examination, diagnosis and management plan was inadequate and the working diagnosis of dvt [sic] in a young patient with no risk factors and a negative doppler was inappropriate"

"there was evidence that Dr Shehu failed to take appropriate action and arrange further tests when it would have been necessary to do so. It appears that the patient had an infection originating from the soft tissue of the right leg and it would have been necessary to manage the symptoms in line with the management of suspected sepsis…

"symptoms such as repeated vomiting and feeling shivery, tachycardia, raised inflammatory markers, raised lactate on blood tests and an acutely red, swollen limb that was the site of the infection were signs of sepsis…

"Dr Shehu didn't take appropriate action in regard to this and should have arranged treatment in line with the management of suspected sepsis. This would have included prescription of intravenous antibiotics, consideration of intravenous fluids, supplemental oxygen, blood cultures and as a consultant to put in place an escalation plan should the patient's condition deteriorate"

"the standard of care fell seriously below the standard expected of a reasonably competent doctor in the same grade. This was because the patient appeared to have quite clear signs and symptoms of severe infection and risk of developing severe sepsis, no risk factors for dvt and had a negative doppler for a dvt, yet this was the only working diagnosis by Dr Shehu which was incorrect

"the standard of review of a patient with severe infection was inadequate and Dr Shehu disregarded numerous aspects of the history of investigation available at the time which pointed toward sepsis. It was the expert's opinion that this made the doctor's care seriously below the standard expected.

"the care was shockingly bad as there was a fundamental oversight of patient safety. The expert advised that the systemic upset and all investigations pointed to a serious infection or sepsis and it appears to have been completely disregarded.

49. Within his report dated 18 November 2024, Dr H opined the following aspects of Dr Shehu's care of Patient A fell seriously below the standard expected of a reasonably competent Consultant Physician:

"Dr Shehu did not take a satisfactory history… there were repeated significant omissions in the clinical history taken/documented including "woke up shivering, vomiting past 4 hours, feeling dizzy and faint"

"Dr Shehu did not review the physiological observations, blood tests already completed or the doppler result at the time of their review of Patient [A]. These are core aspects of a Consultant's clinical review..

"Dr Shehu had a sole working differential diagnosis of DVT. This was clearly incorrect given the negative doppler scan (which was available at the time of Dr Shehu's review) and the clinical history suggesting strongly an alternative pathology, namely sepsis.

"Dr Shehu did not arrange appropriate investigations (including blood and

urine cultures, swabbing, x-ray, repeat blood gas, liver ultrasound, repeat lactate, abdominal imaging) or ongoing management of Patient [A] (intravenous antibiotics and fluids and assessing oxygen supply).

"The omission of these interventions led to a delay in the correct diagnosis being made (Streptococcus A sepsis) and a delay in the correct treatment being initiated.

"To be clear, it is not a case of some difference of opinion with regards antibiotic selection or similar, there is a complete omission by Dr Shehu of all aspects of ongoing management of a patient with infection/sepsis/suspected sepsis, hence it is felt to be seriously below the standard of care".

50. Within his supplemental expert report dated 18 July 2025, Dr H stated that:

"It is my opinion that Dr Shehu should have documented that he had reviewed the blood tests and the doppler. It should have been documented that the lactate was elevated and the C-reactive protein was elevated also.

"It is my opinion that the failure to ensure that the pertinent blood tests … and the doppler result were documented falls seriously below the standard expected.

"the lack of a Trust pathway for Necrotising Fasciitis …. does not mitigate Dr Shehu's lack of documentation as the records do not indicated (sic) that Dr Shehu was considering an infective aetiology at all

"Dr Shehu has admitted that he reviewed the doppler, which was negative for a DVT. Despite this result being known to him, his only working diagnosis was DVT. This is a standard of care which is seriously below the expected standard".

51. The Tribunal was of the view that paragraphs 1, 7, 8, 15a and b, 16b and c, 18, 19 and 21a, b and e of GMP are engaged in this case.

"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…"

7. You must be competent in all aspects of your work…

8. You must keep your professional knowledge and skills up to date…

15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient

b. promptly provide or arrange suitable advice, investigations or treatment where necessary…

16. In providing clinical care you must:

…

b. provide effective treatments based on the best available evidence

c. take all possible steps to alleviate pain and distress whether or not a cure may be possible…

18. You must make good use of the resources available to you.

19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards…

21. Clinical records should include:

a. relevant clinical findings

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

…

e. who is making the record and when."

52. The Tribunal reminded itself that Dr Shehu unequivocally admitted all paragraphs of the Allegation. It was of the view that the failings demonstrated by Dr Shehu, and the delay in providing the correct treatment and care for Patient A did put her at unwarranted risk of harm. Dr Shehu was the Consultant ultimately responsible for Patient A on 28 December 2025. The Tribunal noted that the Allegation did not allege that Dr Shehu caused or contributed to Patient A' death, but Dr Shehu admitted that his failings caused a delay in Patient A's proper diagnosis, and in treatment being initiated.

53. The Tribunal took into account the remarks of HM Coroner, at the inquest into Patient A's that there were both systemic and individual failings by medical professionals involved in the care of Patient A.

54. The Tribunal was satisfied however, that Dr Shehu's' failings, as admitted and found proved in the Allegation, did fall below the standard expected of a reasonably competent Consultant Physician, and did amount to serious professional misconduct.

Impairment

55. The Tribunal then went on to consider whether Dr Shehu's fitness to practise is currently impaired by reason of his misconduct.

56. The Tribunal first considered Step 2a of the Guidance, namely whether there were legal grounds for impairment in the charges. The Guidance sets out under the heading of 'misconduct' that that:

> *"This is about behaviour. It could consist of acts and/or omissions arising in or outside of a doctor's working life and includes failing to act appropriately or demonstrating behaviour that falls short of what can reasonably be expected.*
> *To amount to misconduct, the behaviour will be a serious departure from the professional standards, as set out in Good medical practice. This includes single clinical acts or omissions that are serious, or a limited number of clinical acts or omissions that taken together are serious."*

57. In view of its finding that Dr Shehu's actions amounted to serious professional misconduct and involved a number of departures from the standards set out in GMP, the Tribunal was satisfied that there was a legal basis for a finding of impairment.

58. The Tribunal then went on to consider Step 2b of the Guidance, namely to decide where on the spectrum of seriousness Dr Shehu's misconduct lies.

59. The Tribunal noted paragraph 25 of the Guidance which states that:

> *"all proven allegations about a doctor's behaviour or performance will amount to a serious departure from the professional standards. However, there are differences in the inherent nature of allegations, including whether they are easily remediable, which will affect where on the spectrum of seriousness they fall (the lower, mid-range or higher end)".*

60. The Tribunal had regard to the nature of the Allegation against Dr Shehu. It considered that whilst the Allegation related to one single incident at 20:00 on 28 December 2022, Dr Shehu's conduct had fallen seriously below expected standards in a number of material respects. In addition, the consequences of Dr Shehu's actions were severe in that they caused a delay in the correct diagnosis and treatment of a patient who subsequently died. The Tribunal considered that Dr Shehu's failure to obtain an adequate history, diagnose Patient A's infection and to maintain a diagnosis of DVT, notwithstanding a Doppler test to the contrary, were basic and serious errors.

61. The Tribunal noted paragraph 28 of the Guidance which states:

> *"Allegations that usually fall at the lower end of the spectrum of seriousness and due to their nature are more likely to be easily remediable include, but are not limited to: clinical failings, including where a doctor has acted without regard for patients' rights or feelings provided this is not a wilful disregard of their wishes"*

62. The Tribunal also had regard to paragraph 31 of the Guidance which states that:

> *"clinical failings that are not considered to be easily remediable, including those amounting to gross negligence or recklessness about a risk of serious harm to patients".*

63. The Tribunal noted that the GMC acknowledged that Dr Shehu's failings were potentially remediable. The Tribunal agreed with that assessment given that the Allegations related to a single incident on 28 December 2022 in the context of an otherwise unblemished and lengthy career. In addition, the (albeit limited) evidence provided to the Tribunal suggested that Dr Shehu is an otherwise well regarded clinician, both by colleagues and patients.

64. The Tribunal also took into account that Dr Shehu did not attempt to hide or avoid taking responsibility for his actions. Dr Shehu had referred himself to the GMC after he received criticism from the Coroner.

65. However the Tribunal took the view that these factors needed to be balanced with the fundamental nature of Dr Shehu's failings and the serious consequences of them, when Dr Shehu was working as a Consultant Physician.

66. The Tribunal therefore concluded, by way of an initial assessment, that Dr Shehu's misconduct fell within the mid-range of the spectrum of seriousness.

67. The Tribunal next considered those factors as set out in the Guidance which might increase the seriousness of Dr Shehu's misconduct. The Tribunal considered that none of the factors set out after paragraph 36 of the Guidance applied in Dr Shehu's case. For example, the Tribunal was satisfied that Dr Shehu's misconduct was not repeated or persistent, and there was no evidence of any previous fitness to practise history. Although the Tribunal acknowledged that Patient A was extremely unwell and ultimately died, it was unable to conclude that Patient A had a particular vulnerability as envisaged by the Guidance at paragraph 36. The Tribunal also considered whether Dr Shehu's behaviour could be regarded as 'reckless'. However, it concluded that Dr Shehu's misconduct could not be described as reckless taking into account the ordinary dictionary definition of that word (i.e. '*heedless of danger or the consequences of one's actions; rash or impetuous*').

68. The Tribunal had regard to paragraph 42 of the Guidance which states that:

> *"Where an allegation falls at the mid-range of the spectrum of seriousness, the impact of one or more features that may increase seriousness could result in the overall seriousness of the allegation increasing"*

69. However, the Tribunal's assessment that Dr Shehu's misconduct fell within the mid-range of the spectrum of seriousness was unaffected by those factors set out in the Guidance at paragraph 36 which can increase the level of seriousness.

70. The Tribunal next had regard to step 2c of the Guidance, namely a consideration of the impact of any relevant context. The Tribunal took into account relevant workplace context including the busy nature of KMH on 28 December 2022 and the comments of MH Coroner, namely that the care afforded to Patient A had been impacted by systemic failures at the hospital, as well as individual failings by a number of clinicians, including Dr Shehu. The Tribunal noted the Coroner's observation that Dr Shehu had fallen foul of confirmation bias and that such bias had been a *'theme that sadly runs throughout this case, from the very moment that [Patient A] walked into the ED reception as an ambulatory patient, rather than being admitted by ambulance.'*

71. The Tribunal took into account evidence that on 28 December 2022 the emergency department at KMH had been exceptionally busy as it was the first working day back after the Christmas break. However, the Tribunal gave limited weight to that factor, because it took the view an experienced senior Consultant such as Dr Shehu should be used to working in a

busy and stressful environment. The Tribunal was of the view that it may have benefited in hearing from Dr Shehu during stage 2 of the hearing in order for him to provide more context in that regard.

72. The Tribunal considered the Coroner's comments around systemic failings at KMH, the failings of other clinicians and the operation of confirmation bias as being relevant workplace factors. It appeared from the medical evidence that Dr Shehu was not alone in failing to correctly diagnose Patient A or at least fully appreciating the nature of her symptoms. The Tribunal considered that whilst such factors were not an excuse for Dr Shehu's serious misconduct, they did provide relevant context. Nevertheless, the Tribunal concluded that such factors did not affect its overall assessment that Dr Shehu's conduct lay within the mid-range of the band of seriousness.

73. The Tribunal noted that it had not received any evidence regarding any relevant personal context for Dr Shehu's misconduct.

74. The Tribunal next considered step 2d of the Guidance, namely how the doctor has responded to the Allegation.

75. In response to the criticisms Dr Shehu received from the Coroner, and having been notified of the GMC investigation, Dr Shehu undertook some remedial work, expressed regret and apologised in his Rule 7 response to the family of Patient A. He also stated that he would act differently in the future and he recognised the impact on his colleagues and the reputation of the profession. Dr Shehu also had positive patient and colleague feedback, and provided supportive testimonial letters.

76. The Tribunal noted however that Dr Shehu has not explained why he acted as he did. It considered that there was a distinct lack of evidence that Dr Shehu has effectively and deeply reflected on what happened, why it happened, and were he to be in a similar situation again, how exactly he would act differently in the future. Whilst Dr Shehu alluded to a similar case in which he had reached a different diagnosis, the Tribunal was provided with few details of that particular case. However, Dr Shehu stated that he would change the way in which he takes clinical histories in the future. As Dr Shehu did not give evidence at stage 2 of the hearing the Tribunal had limited evidence of how Dr Shehu had put his learning and/ or changed mindset into practice. The Tribunal considered that without some explanation as to how these failings came about or detailed evidence of what steps he has taken to prevent a recurrence, it was not able to be satisfied that he has sufficient insight into his misconduct.

77. The Tribunal noted that Dr Shehu had undertaken some targeted remediation, namely e-module courses relating to sepsis. However, the evidence of his learning (and reflections on that learning) was limited. The Tribunal noted that Dr Shehu had been aware of the GMC's concern from around May 2024, and yet there was no objective evidence of any targeted learning relating to sepsis and leg pain undertaken by Dr Shehu prior to October 2025.

78. Dr Shehu also referred to a study he read in respect of leg pain. The Tribunal was of the view that the learning from this was vague. The Tribunal considered that Dr Shehu's efforts at remediation were limited at best. Given the limited remediation, the Tribunal was of the view that whilst Dr Shehu has some insight into his misconduct, that insight was developing and was not yet complete.

79. The Tribunal noted that there was no evidence that Dr Shehu had repeated his misconduct, or indeed that there were any other concerns about his performance. However, the Tribunal determined that given Dr Shehu's level of insight, a risk of repetition remained.

80. The Tribunal had limited objective evidence that Dr Shehu's has kept his knowledge and skills up to date. It would have been assisted by being able to question Dr Shehu about his efforts in that regard. However, the Tribunal took some (albeit limited) reassurance from the fact that Dr Shehu is working as a locum Consultant Physician at KMH and would be subject to annual appraisal and five yearly revalidation as per GMC requirements.

81. The Tribunal considered that whilst Dr Shehu's insight was limited, he had made some efforts in that regard and there was some evidence of developing insight. It determined that, in all the circumstances in this case, Dr Shehu's misconduct was at the mid-range of the spectrum of seriousness, and fell just below the higher end of the spectrum.

82. The Tribunal next considered Step 2e of the Guidance, namely to decide on the basis of the conclusions reached in steps 2b, 2c and 2d decide if the doctor poses any current and ongoing risk to public protection and make a finding on impairment

83. The Tribunal was of the view that public confidence in the profession has been undermined by Dr Shehu's misconduct. It took the view that all three limbs of the overarching objective were engaged namely: to protect, promote and maintain the health, safety and wellbeing of the public; to promote and maintain public confidence in the profession, and to promote and maintain proper professional standards and conduct for members of the profession. In reaching this conclusion the Tribunal bore in mind Dr H's

expert evidence that Dr Shehu's misconduct was a serious departure from the expected standard of care.

84. The Tribunal reminded itself that Dr Shehu has in the past acted so as to put a patient at unwarranted risk of harm; has in the past brought the medical profession into disrepute; and has breached one of the fundamental tenets of the medical profession. Dr Shehu has a senior role of responsibility as a Consultant Physician and demonstrated a series of failures in his care and treatment of Patient A.

85. Dr Shehu put Patient A at unwarranted risk of harm because her correct diagnosis and correct treatment had been delayed. The reputation of the profession and public confidence in the profession has been undermined, in that a member of the public with knowledge of this case would be alarmed at Dr Shehu's failings and multiple breaches of GMP. The Tribunal also considered that Dr Shehu has failed to maintain those proper professional standards expected of members of the profession.

86. The Tribunal concluded that Dr Shehu does pose a current and ongoing risk to all three limbs of public protection, given the seriousness of his misconduct, his incomplete insight and remediation, and given the risk of repetition.

87. Accordingly, in all these circumstances of this case, the Tribunal concluded that Dr Shehu's fitness to practise is currently impaired by reason of his misconduct.

Determination on Sanction - 10/12/2025

88. Having determined that Dr Shehu'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, the appropriate sanction, if any, to impose.

The Evidence

89. The Tribunal has reviewed its findings at the facts and impairment stage and taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction. It also considered Dr Shehu's oral evidence, which he provided at the sanction stage of the hearing.

Summary of Dr Shehu's oral evidence

90. Dr Shehu said that the impact of these proceedings have put strain on him and his family; that he had found it difficult to find employment in view of the interim restrictions on his practice and that he had been under a financial burden. He confirmed that upon the expiry of the targeted training courses he had undertaken, he will repeat that learning. Mr Umezuruike asked if Dr Shehu was aware of any other medical professional who had been referred to the GMC for misconduct in relation to the care of Patient A. Dr Shehu replied that he was not.

91. In cross examination by Ms Dudley-Jones, Dr Shehu confirmed that he had ceased working at KMH in February 2025. He confirmed that he was unaware that Patient A had died on 29 December 2022, as Patient A had been taken off the ward. Dr Shehu said that he had not been contacted about providing evidence at Patient A's inquest, although KMH had his telephone number and email address. He stated that he found out about the inquest and the Coroner's criticisms of him when he received a letter from the GMC in May 2024.

92. Dr Shehu accepted that he had been the Consultant on duty on 28 December 2022 and had been in charge of personally reviewing patients; verifying the accuracy of their histories; ensuring that any necessary examinations or investigations were conducted and concluding his reviews with appropriate diagnoses and management plans. Dr Shehu also confirmed that Patient A had been 34 years of age and did not have a very significant past medical history. Dr Shehu also accepted that Patient A had evidence of systemic upset (for example vomiting repeatedly), raised inflammatory markers on their blood test and tachycardia. Dr Shehu agreed that Patient A had no obvious clinical risk factors for DVT.

93. Ms Dudley-Jones took Dr Shehu through the medical notes of Patient A's care and treatment when he was responsible for her. Dr Shehu accepted all of those failings in his care of Patient A that had been identified by Dr H. Dr Shehu stated that he should have considered an alternative diagnosis to DVT. He said that that he has reflected on this, that it was a mistake, and that he would now consider a differential diagnosis. Ms Dudley-Jones asked Dr Shehu what he would do if he were to be faced with similar circumstances. Dr Shehu replied that he would look at the Doppler test; look at the patient; think of differential diagnoses; take a proper history; undertake a proper examination; do proper tests and institute proper treatment. Dr Shehu stated that he could not recall the reasons behind the events on that day, nor could he particularly recall his consultation with Patient A. However, he explained that the consultation had occurred at 20:55 on 28 December 2022 just before his shift was due to end at 21:00.

94. Dr Shehu expressed the view that whilst confirmation bias may have played a role in his flawed diagnosis of Patient A, he did not believe that such any bias could explain it. Dr

Shehu said that he could not recall any personal matters which may have affected his judgement on 28 December 2022.

95. Dr Shehu clarified that this case, and his subsequent learning, had reinforced the need for him to consider differential diagnoses, and to improve his note writing. He said that these matters have taught him a lesson, namely to ensure that this did not happen again. Dr Shehu stated that he has had an unblemished career of over 30 years, and has never previously had a complaint. He described the steps he had taken to ensure that he keeps himself up to date, and he confirmed that he now takes patients' histories and undertakes a review of further investigations himself. Dr Shehu confirmed that he has been working as a locum Consultant in General Medicine in Taunton since March 2025. He said that he had been working continuously since the index event, and that he has had interim conditions on his practice since April 2025.

96. In response to questions from the Tribunal, Dr Shehu explained that he had undertaken a literature study review on leg pain which had reinforced that it was important to take a good history and consider differential diagnoses, including for example whether there was any history of trauma, infection, or any evidence of a thrombotic episode. Dr Shehu gave a detailed overview how he would approach a patient with leg pain in the future. Dr Shehu highlighted that necrotising fasciitis is extremely rare, and that a clinician would perhaps only see two such cases in their entire career.

97. Dr Shehu stated that he had already put his learning into practice and, for example, he institutes a management plan as quickly as possible and makes sure that he reviews all his cases. He said that he reviews journals to keep his knowledge up to date and described a 2-day conference that he attended in Birmingham which reinforced his general medical knowledge. He confirmed that the course had covered a wide range of topics including issues relating to respiratory, cardiology, abdomen, neurology and psychiatry. Dr Shehu explained that the course had highlighted new clinical practices, for example in the treatment of asthma and rheumatoid arthritis – outlining his learning from the same. He said that acute medicine was all about doing it efficiently, quickly, as well as having a differential diagnosis and instituting a management plan immediately.

98. Dr Shehu said that he underwent his last appraisal in June 2025, and that he had discussed Patient A in his Case-Based Discussion with his appraiser. Dr Shehu stated that he keeps himself up to date by reading medical journals in the library, that he is a member of the BMA and reads the British Medical Journal. He said that his next revalidation is in November 2026 and that he has discussed with his appraiser that he will do an audit of leg pain as his quality improvement activity in his Personal Development Plan. Dr Shehu

acknowledged that his actions had heavily impacted upon the family and friends of Patient A, and on the community at large.

Submissions on behalf of the GMC

99. Ms Dudley-Jones submitted that the decision as to which sanction, if any, to impose was a matter for the Tribunal, exercising its own independent judgement. She submitted that the appropriate and proportionate sanction in this serious case of clinical misconduct is one of suspension from the medical register. Ms Dudley-Jones reminded the Tribunal that it has found that on 28 December 2022, Dr Shehu failed to provide appropriate care and treatment to Patient A and that his actions included failing to - recognise Patient A's documented history of symptoms; take an adequate history to consider an alternative diagnosis to DVT; arrange appropriate further investigations; implement an adequate treatment plan and make an adequate record of his consultation with his patient. Ms Dudley-Jones submitted that these admitted allegations delayed a proper diagnosis being made for Dr Shehu's patient and treatment being initiated for her.

100. Ms Dudley-Jones referred the Tribunal in detail to all the relevant paragraphs of the Guidance for MPTS Tribunals ('the Guidance'). She reminded the Tribunal that it has determined that the level of seriousness of Dr Shehu's misconduct was of a "*Medium level of risk to public protection"*. She submitted that the sanctions banding in the Guidance suggests *"Conditions 24 to 36 months to Suspension 6 months"* for cases involving clinical concerns, where there is a medium level risk to public protection. When determining the length of any sanction within that band, Ms Dudley- Jones referred the Tribunal to the Guidance as to factors it should consider.

101. Ms Dudley-Jones reminded the Tribunal of its findings on facts and impairment and she highlighted a number of sections of the Tribunal's determination on impairment. She said that the Tribunal had identified a number of breaches of GMP in a number of different ways. Ms Dudley-Jones submitted that Dr Shehu was a locum Consultant Physician who was ultimately responsible for Patient A and that his failings had put her at unwarranted risk of harm. Ms Dudley-Jones noted the Tribunal's finding that the Allegation did not allege that Dr Shehu caused or contributed to Patient A's death. However, she submitted that he had admitted that his failings had caused a delay in Patient A's proper diagnosis and in treatment being initiated for her. Ms Dudley-Jones reminded the Tribunal of its conclusion that this was serious professional misconduct, which had involved a number of departures from the standards set out in GMP.

102. Ms Dudley-Jones highlighted the Tribunal's finding that although the Allegation related to one single incident on 28 December 2022, Dr Shehu's conduct had fallen seriously below the standard expected in a number of material respects. She said that the consequence of the doctor's actions were severe in that they caused a delay to the correct diagnosis and treatment for Patient A who subsequently died.

103. Ms Dudley-Jones submitted that Dr Shehu's failure to obtain an adequate history, diagnose Patient A's infection, and his actions in maintaining a diagnosis of DVT notwithstanding a negative Doppler test, were basic and serious errors. She said the Tribunal's view was that the fundamental nature of Dr Shehu's failings, and the serious consequences of them when he was working as a Consultant Physician, could not be understated. Ms Dudley-Jones reminded the Tribunal that Dr Shehu's misconduct was not repeated or persistent, and there was no evidence of any previous fitness to practise history.

104. Ms Dudley-Jones submitted that Dr Shehu has undertaken some remedial work; has expressed regret and apologised to the family of Patient A; has stated he would act differently in the future; has recognised the impact on colleagues and the reputation of the profession; has provided positive patient and colleague feedback and testimonial letters. She submitted however that Dr Shehu has not explained why he acted as he did and remains unable to answer that question. She invited the Tribunal to consider that this was a doctor who has admitted the Allegation and has said he has reflected on what happened, but had advanced no real explanation or reflective understanding of why he acted so inexplicably and against the weight of the clinical evidence.

105. Ms Dudley-Jones reminded the Tribunal that at the impairment stage, it determined that there was a distinct lack of evidence that Dr Shehu had effectively and deeply reflected on what happened, why it happened, and how he would act differently in the future. She submitted that Dr Shehu's failure to be able to explain and understand what happened and why, impacts on what he would do differently if he were in a similar situation again. Ms Dudley-Jones reminded the Tribunal that Dr Shehu knew of the concerns from around May 2024, and yet there was no objective evidence of any targeted learning related to sepsis and leg pain undertaken by him prior to October 2025.

106. Ms Dudley-Jones highlighted that the Tribunal determined that Dr Shehu has limited insight, poses a current and ongoing risk to all three limbs of public protection, that his remediation is incomplete, and that a risk of repetition remains. She submitted that conditions were not appropriate, measurable, or workable in this case. Ms Dudley-Jones stated that whilst the Tribunal had heard evidence of Dr Shehu's interim conditions, they did not provide clinical restrictions related to the concerns in this case. She submitted that

conditions would be unlikely to be workable and measurable as the key and significant failure which led to the other failures was the working diagnosis that Dr Shehu came to, and persisted with. She submitted that a period of suspension would enable Dr Shehu time to gain insight into his deficiencies and to properly remediate. Ms Dudley-Jones submitted that whilst patient safety is a potential concern, suspension would also ensure that public confidence in the profession is maintained. She submitted that a review hearing was essential given the concerns about Dr Shehu's insight and remediation.

Submissions on behalf of Dr Shehu

107. Mr Umezuruike referred the Tribunal to its determination in respect of impairment and reminded the Tribunal that it found Dr Shehu's misconduct fell within the mid-range of the spectrum of seriousness. He reminded the Tribunal that it was satisfied that Dr Shehu's misconduct was not repeated or persistent, and there was no evidence of any previous fitness to practise history. He submitted that the Tribunal had also concluded that Dr Shehu's conduct was not reckless.

108. Mr Umezuruike referred the Tribunal to the Coroner's comments that the care afforded to Patient A had been impacted by systemic failures at the hospital, as well as individual failings by other medical professionals. Mr Umezuruike reminded the Tribunal that it determined that Dr Shehu did not have sufficient insight into his misconduct, but that he did have some insight and that his remediation was limited.

109. In respect of what sanction to impose, Mr Umezuruike invited the Tribunal to take no action. He submitted that there were exceptional circumstances in this case. He submitted that there were other clinicians who were on duty on 28 December 2022, who failed to diagnose sepsis. He said that Dr Shehu is the only one who has been brought before a Tribunal and that it was unfair for him to suffer further sanctions. Mr Umezuruike submitted that these proceedings have had a very serious financial impact on Dr Shehu in that he had spent around XXX on legal costs. In addition, Mr Umezuruike stated that the interim order of conditions on Dr Shehu's registration have required him to notify the GMC of his place of work and to notify any employers of the GMC's investigation. Mr Umezuruike stated that these conditions have impacted on Dr Shehu's ability to obtain employment. Mr Umezuruike submitted that these were exceptional circumstances.

110. Mr Umezuruike submitted that public confidence in the profession would be maintained by taking no action, as the public would know that Dr Shehu has had a finding of misconduct against him and that the experience will have been stressful for him and his family.

111. Mr Umezuruike said that if the Tribunal did not accept his submission on taking no action, he submitted that the next sanction it could impose on Dr Shehu was conditions. He invited the Tribunal to consider the terms of the interim conditions imposed on Dr Shehu's registration in April 2025. He invited the Tribunal to consider imposing conditions for a year or two, and to require Dr Shehu to undertake further remediation. Mr Umezuruike submitted that Dr Shehu is willing to undertake further courses, especially in relation to those courses whose certificates which will expire next year.

112. Mr Umezuruike submitted that a period of suspension would not be in the public interest. He submitted that Dr Shehu has already suffered great financial loss and that suspending him from work would deepen his financial difficulties. Mr Umezuruike submitted that Dr Shehu could still undertake remediation without being suspended and that public confidence could be maintained. Mr Umezuruike reminded the Tribunal that Dr Shehu has been working since these events took place on 28 December 2022, without any further complaint. He urged the Tribunal to consider the testimonial evidence and CPD evidence provided. Mr Umezuruike submitted that were the Tribunal minded to suspend Dr Shehu, it should impose the shortest possible period.

Further submission on behalf of the GMC

113. Ms Dudley-Jones submitted that she was duty bound to clarify that whilst the Coroner expressed concerns about more than one clinician, it was only Dr Shehu's conduct that was taken forward by the GMC. She said that this was because it was Dr Shehu's conduct that was found to have fallen below the standard expected.

The Tribunal's Approach

114. The Tribunal reminded itself that the decision as to the appropriate sanction, if any, to impose was a matter for its independent judgement.

115. The Tribunal considered the Guidance, and in particular Section 3, Part C, "Stage Three – Sanction". The Tribunal was mindful that the purpose of a sanction is not to be punitive, albeit that a sanction may have a punitive effect on a doctor.

116. The Tribunal also reminded itself that, in determining whether or not to impose a sanction, it should have regard to the principle of proportionality. It also bore in mind that the reputation of the medical profession as a whole is more important than the interests of an individual doctor.

The Tribunal's Determination on Sanction

117. The Tribunal considered that, having heard oral evidence from Dr Shehu at the sanction stage, it should balance this evidence against its risk assessment and the level of seriousness it determined at the impairment Stage. The Tribunal considered whether there were any factors provided in Dr Shehu's oral evidence which would affect the level of seriousness it had previously determined, either to a lesser degree, or to a higher degree.

118. The Tribunal bore in mind that when considering the impact of any relevant context, paragraph 2c of the Guidance sets out the following steps:

- Identify if there is any relevant context - working environment, role and experience or personal context
- Consider whether it directly or indirectly affected the doctor's behaviour, performance or health
- If so, is it appropriate to take that context into account?
- If so, confirm what impact it has on the level of risk (decreases, no impact, increases)

119. The Tribunal considered that the only factor Dr Shehu provided in respect of the working environment was that the index event occurred towards the end of his working day, and about 5 minutes before his shift was scheduled to end. However, the Tribunal gave this limited weight. It reminded itself that Dr Shehu was the Consultant Physician in charge of Patient A's care during that shift, and this responsibility was unaffected by the fact that she may have been his last patient of the day. In addition, whilst Dr Shehu had noted that his consultation with Patient A fell towards the end of his shift, he had not explicitly stated that this was a factor which had affected his care of Patient A.

120. Dr Shehu confirmed in oral evidence that there was no personal context which had directly or indirectly affected his behaviour, performance or health at work on 28 December 2022.

121. The Tribunal then considered, based on his oral evidence, how Dr Shehu has responded to the allegation. Paragraph 2d of the Guidance states:

- *"Consider what evidence there is relating to insight and assess if insight is genuine*
- *Consider what evidence there is relating to remediation to assess if the allegation is remediable, has been remedied and is likely to be repeated*
- *Consider if the doctor has kept their knowledge and skills up to date*

- *Confirm what impact these factors have on the level of risk (decreases, no impact, increases)"*

122. It also considered paragraph 74, which refers to how has the doctor responded to the allegations:

> *"74. The MPT should consider the evidence available to them to establish if the doctor has:*
>
> *a. shown insight into their own practice, behaviour and/or impact of a health condition*
>
> *b. taken steps which have reduced the risk of similar allegations occurring again (remediation), such as participating in training, supervision, coaching or mentoring relevant to the allegation, and*
>
> *c. kept their knowledge and skills up to date."*

123. In addition, the Tribunal noted that paragraph 81 of the Guidance states that:

> *"to demonstrate insight, and insight which is genuine, the doctor will need to show they understand what happened and accept how they could have acted differently… This involves showing, where relevant, that they have: considered the allegation, understanding what went wrong and accept they should have acted differently"*

124. The Tribunal considered that Dr Shehu does have a degree of insight insofar as he accepts that he should have acted differently on 28 December 2022. In addition, he appears to have taken some steps to remedy deficiencies in his practice. The Tribunal also took into account that Dr Shehu is genuinely remorseful for his misconduct and has expressed an apology to the family of Patient A. He also acknowledged the impact of his actions on the wider profession and the public.

125. Dr Shehu told the Tribunal that he would do things differently, think for himself and come up with his own diagnosis. He also spoke about the management of care, handing over care to others and he recognised there had been a communication issue in this case. The Tribunal considered that this was some acknowledgement by Dr Shehu of some of the Coroner's concerns around confirmation bias.

126. However it was troubling that Dr Shehu could not articulate why he made such basic and fundamental errors in relation to Patient A's care, particularly given that Dr Shehu is an

experienced Consultant with many years' experience. Despite Dr Shehu stating that he had thought deeply about his actions and how the incident happened, he was unable to explain to the Tribunal why or how he acted as he did.

127. The Tribunal also noted some inconsistencies in Dr Shehu's evidence. For example, Dr Shehu appeared to alter his position as he could not actively recall his consultation with Patient A having previously attested to reviewing her blood and Doppler scan results. Whilst the Tribunal acknowledged that the index event took place three years ago, and that Dr Shehu might not recall the detail of his consultation with Patient A, his inconsistencies were at odds with his claim to have reflected deeply about the incident.

128. As a result the Tribunal concluded that, although Dr Shehu has some degree of limited insight, his insight is far from fully developed. Accordingly, a risk of repetition remains until Dr Shehu can show that he understands what happened and can gain sufficient insight into the underlying reasons for his misconduct.

129. The Tribunal considered that Dr Shehu's attempts at remediation were somewhat late, in that he could only evidence targeted learning in relation to sepsis from October 2025, despite being aware of the GMC's concerns in May 2024. Dr Shehu suggested that he had undertaken some relevant learning prior to October 2025, but the Tribunal was presented with no objective evidence to support that assertion. In addition, Dr Shehu's reflections on the learning that he had undertaken were somewhat vague and limited. Dr Shehu told the Tribunal that he has encountered two cases of leg pain since the index events, and that he had been able to make an accurate diagnosis; he was also able to describe red flag symptoms of sepsis. However, he was unable to explain why he had not identified these issues on 28 December 2022.

130. The Tribunal noted that Dr Shehu was candid about reviewing and improving his documentation and he acknowledged that this was a development area for him.

131. The Tribunal concluded that whilst Dr Shehu's misconduct was potentially remediable, the evidence suggested that his misconduct was not yet fully remediated.

132. The Tribunal considered that Dr Shehu's evidence was credible in respect of keeping his skills up to date and having a plan for improvement. It noted that he has had an appraisal during which he discussed Patient A's case with his appraiser as part of a Case-Based Discussion. In addition, Dr Shehu was able to talk about his next appraisal plan which will be just ahead of his revalidation date, albeit that there was no objective evidence to support

this. Dr Shehu said that he had been going to the library to keep his knowledge up to date for example by reading journals from the British Medical Journal and discussion with colleagues.

133. The Tribunal concluded that Dr Shehu's oral evidence, at the sanction stage, had not changed its view of his level of insight, remediation, or risk of repetition. It considered that, notwithstanding his oral evidence, Dr Shehu's misconduct lay at the top end of the medium level of risk to public protection. The Tribunal reminded itself that this is a case in which all three limbs of public protection are engaged, namely: to protect, promote and maintain the health, safety and wellbeing of the public; promote and maintain public confidence in the profession, and promote and maintain proper professional standards and conduct for members of the profession.

134. Whilst the decision on what sanction, if any, to impose, is a matter for the Tribunal exercising its own independent judgment, it noted that the Guidance sets out a Sanction Banding for it to consider. The Guidance advises that where a Tribunal has found a medium level of risk to public protection, it suggests a period of conditions for 24 to 36 months, or a period of suspension of up to 6 months.

No action

135. The Tribunal considered whether to take no action in this case. It had regard to the Guidance, which states:

> *"13. Where a doctor's fitness to practise is impaired, it will usually be necessary for the MPT to restrict the doctor's registration to achieve public protection. But there may be exceptional circumstances to justify an MPT taking no action. Exceptional circumstances are unusual, special, or uncommon, so such cases are likely to be very rare."*

136. The Tribunal then had regard to the submissions made by Mr Umezuruike. It noted that whilst there was criticism of other clinicians by the Coroner in respect of the care and treatment of Patient A, it appeared that Dr Shehu was the only one who had been subject to regulatory action. Dr Shehu was the clinician ultimately responsible for Patient A and he admitted that his conduct had fallen below the standard expected of a Consultant Physician. The Tribunal did not consider those to amount to exceptional circumstances justifying no action being taken.

137. In respect the financial impact on Dr Shehu, the Tribunal was of the view that this a common occurrence for doctors who face legal or regulatory proceedings. However, the

Tribunal did not regard it as an exceptional circumstance which would lead it to taking no action.

138. The Tribunal considered that whilst the interim order of conditions imposed upon Dr Shehu may have impacted his ability to obtain employment, this was not unusual or exceptional because regulatory actions can have a punitive effect, although that is not their intention.

139. The Tribunal was satisfied that there were no exceptional circumstances in this case for it to consider concluding matters by taking no action.

Conditions

140. The Tribunal considered whether this case could be addressed with the imposition of a period of conditional registration. It had particular regard to paragraphs 17, 19, 20, 21, 23 and 28 of the Guidance:

> *"17. Conditions are suitable for those cases where the doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is currently incompatible with unrestricted registration. This means the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting their registration for a period of time, with the aim they should be able to safely return to unrestricted practice in the future."*
>
> *"19. Conditions restrict a doctor's ability to practise and/or require them to do something. The purpose of putting in place a sanction of conditions is to provide a doctor with time to address identified failings to demonstrate they are fit to practise on an unrestricted basis, whilst ensuring that the current and ongoing risk posed to public protection is being adequately managed.*
>
> *20. Where conditions are put in place, they should be appropriate, workable, and measurable.*
>
> ### *Appropriate*
>
> *21. To be appropriate, conditions must address the specific findings about the current and ongoing risk to public protection posed by the doctor."*
>
> *"23. Conditions are likely to be workable where:*

a. the doctor has shown insight

b. time is needed for the doctor to take steps to address the findings (remediate), for example through retraining, study, supervision and/or seeking medical treatment

c. the doctor is willing to remediate, and

d. the MPT is satisfied the doctor will comply with them."

"28. Conditions may be proportionate in cases where the doctor has shown a degree of insight into the allegation and some, or all, of the following factors are present:

a. the doctor has demonstrated they are willing and/or able to remediate

b. identifiable areas of the doctor's practice need prohibiting, monitoring, or retraining

c. the doctor has demonstrated they are willing to be open and honest with patients and others they work with if things go wrong

d. the doctor will not put patients at harm, either directly or indirectly, by having conditions on their registration."

141. The Tribunal considered that Dr Shehu requires further time to develop his insight, which is currently limited. He also requires further time to fully remediate his misconduct. The Tribunal was satisfied that Dr Shehu is willing to remediate his conduct and develop insight and that he would comply with any conditions imposed on his registration.

142. The Tribunal considered, however, that it was unable to formulate workable or measurable conditions which could properly address the concerns in this case. The Tribunal took the view that although Dr Shehu's misconduct had included basic, fundamental errors and failings, it would be difficult to formulate conditions to address the underlying reasons for the misconduct in this case.

143. The Tribunal reminded itself that this was not a case of deficient professional performance, but a case of serious professional misconduct in the context of a patient death.

The Tribunal considered that conditions would be insufficient to address the public confidence concerns around Dr Shehu's misconduct, particularly given the ongoing risk of repetition.

144. The Tribunal determined that it could not formulate conditions that were workable in this case and that, in any event, conditions would not be appropriate given its risk assessment of the seriousness of this case and the risk of repetition.

Suspension

145. The Tribunal then considered whether a period of suspension would be the appropriate response in this case. It had regard to the Guidance in respect of suspension, and in particular paragraphs 41 and 45a and c:

> *"41. Suspension is for those cases where the doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is currently incompatible with unrestricted registration. This means the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting their registration for a period, with the aim they should be able to safely return to unrestricted practice in the future."*
>
> *"45. Suspension may be proportionate in cases where some, or all, of the following factors are present:*
>
> *a. conditions are not appropriate, measurable and/or workable*
>
> *….*
>
> *c. the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards."*

146. The Tribunal was satisfied that paragraphs 45a and c of the Guidance is engaged in this case. It was of the view that a period of suspension could be an appropriate response to Dr Shehu's misconduct as it would give him additional time to complete his insight and remediation, as well as provide reassurance that he is safe to return to unrestricted practice. The Tribunal considered that suspension would also send a signal to Dr Shehu, the public and profession about the seriousness of the failings identified in this case and the need to uphold proper professional standards and maintain public confidence in the profession.

Erasure

147. Before determining whether suspension was the appropriate and proportionate sanction to impose in this case, the Tribunal considered whether erasure would address the misconduct in this case. It had regard to paragraph 55 and 57a-d of the Guidance:

> *"55. Erasure is action available for those cases where a doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is incompatible with continued registration at this point in time. It means the level of current and ongoing risk the doctor poses to public protection is so significant that they should not be allowed to practise."*
>
> *"57. Erasure may be the proportionate response where:*
>
> *a. conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public*
>
> *b. the doctor's behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place*
>
> *c. the doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and/or*
>
> *d. the seriousness of the facts found proven and/or impact of any relevant context that increased the current and ongoing risk to public protection mean the effect of the doctor continuing to hold registration is such that it will undermine public confidence in the profession."*

148. The Tribunal was satisfied that Dr Shehu's conduct was not fundamentally incompatible with continued registration, nor that the level of current and ongoing risk the doctor poses to public protection is so significant that he should not be allowed to practise.

149. The Tribunal considered that Dr Shehu has not demonstrated a persistent lack of insight into the seriousness of the misconduct and the potential or actual consequences. The Tribunal took the view that Dr Shehu's misconduct was potentially remediable and that a proportionate response was to allow him time to complete his remediation, and gain further insight, during a period of suspension.

150. The Tribunal concluded that erasure would be a disproportionate response to Dr Shehu's misconduct.

Conclusion on Sanction

151. When considering the appropriate sanction in this case, the Tribunal took into account Dr Shehu's testimonial evidence and feedback from patients and colleagues. However, it noted that there was no evidence that the referees or colleagues were aware of the concerns about Dr Shehu's conduct. In addition, the testimonials and colleague feedback forms did not adequately address the Tribunals concerns about Dr Shehu's level of insight or incomplete remediation. Accordingly, the Tribunal gave the testimonials and feedback forms limited weight.

152. The Tribunal concluded therefore that a period of suspension was the appropriate and proportionate response to Dr Shehu's misconduct in order to protect the public, maintain public confidence in the profession and uphold proper professional standards of conduct for members of the profession.

153. The Tribunal had regard to the Guidance in respect of determining the length of suspension. Paragraphs 46a-d, 47 and 52 state:

> *"46. The MPT will need to decide the appropriate length of time that suspension should be put in place for, up to the maximum of 12 months. The following factors will be relevant:*
>
> *a. the assessment of the level of current and ongoing risk to public protection posed by the doctor*
>
> *b. the reasons for assessing suspension as being the proportionate response*
>
> *c. the amount of time the doctor is likely to need to remediate, complete treatment for and/or recover from a health condition that is having, or is likely to have, an impact on their ability to practise safely and effectively, and/or*
>
> *d. the amount of time the parties will reasonably need to prepare for any review of whether the doctor continues to pose a current and ongoing risk to public protection requiring restrictive action in response or is safe to return to unrestricted practice.*

47. …It might also be appropriate in relation to a very small number of clinical cases where a doctor's performance was such that although unlikely to recur, the nature of the allegation was so serious as to undermine the public's trust in the profession."

"52. The question of whether the doctor can safely return to unrestricted practice will need to be considered before a period of suspension concludes and so a review should be directed. The exception to this is where a short suspension (usually three months or less) has been imposed on public confidence grounds and/or to maintain professional standards."

154. The Tribunal determined that suspension for a period of 6 months was necessary in this case to provide Dr Shehu with time to develop sufficient insight, fully remediate and reflect on his misconduct. It also considered that suspension for 6 months was necessary in order to address the public interest in this case, namely to maintain public confidence in the medical profession and to uphold proper professional standards for members of the profession.

Review hearing

155. The Tribunal directed that before the period of suspension comes to an end, a review hearing take place. At the review hearing the onus will be on Dr Shehu to demonstrate how he has addressed the concerns of this Tribunal. A reviewing Tribunal may be assisted by:

- An updated statement of reflection on his further insight and learning regarding the circumstances surrounding his misconduct, which may include addressing the specific concerns of this Tribunal as to what happened and why it happened;
- Evidence of any CPD (including reflective learning from the same) which has been included in his 2025 and 2026 appraisals, or any other CPD undertaken, including that to address the concerns of this Tribunal;
- Dr Shehu's Personal Development Plan (which may include evidence of his quality improvement activity/ evidence of audit(s) undertaken/ evidence of Case-Based Discussion);
- Evidence of any e-modules and/or reflective learning in respect of, but not limited to: working with colleagues; communication skills; effective record keeping; history taking;
- Any testimonial evidence Dr Shehu would like to adduce for reference aware of the circumstances before this Tribunal and of its outcome;

- Any other evidence Dr Shehu considers may assist the reviewing Tribunal.

Determination on Immediate Order - 10/12/2025

156. Having determined that Dr Shehu's registration should be suspended for a period of six months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order of suspension.

Submissions

157. Ms Dudley-Jones submitted that an immediate order is entirely appropriate in this serious case. She referred the Tribunal to the relevant Parts of Section 3 of the MPTS Guidance. Ms Dudley-Jones submitted that the factors are that Dr Shehu does have a degree of insight, but the Tribunal concluded that it is currently limited insight and far from fully developed. She said there remains a risk of repetition until Dr Shehu can understand, or demonstrate, that he understands what happened. Ms Dudley-Jones submitted that the Tribunal have identified that Dr Shehu's misconduct is not yet fully remediated and for all of those reasons, it is the position of the GMC that each of the three limbs of the overarching objective are engaged. She said in those circumstances an immediate order is entirely appropriate.

158. Mr Umezuruike submitted there has not been any complaint since 28 December 2022. He said Dr Shehu has a right of appeal to the High Court which he can exercise for 28 days and if he does appeal, he has a right to apply for a stay pending the determination of the appeal. He submitted that the suspension should be deferred for a period of 28 days to enable Dr Shehu time to consider whether he wants to appeal. He said that this would allow Dr Shehu time to obtain advice from another Counsel who has not been involved in these proceedings. Mr Umezuruike submitted that if Dr Shehu then decides to appeal, he may wish to apply for his stay within 28 days. He said that the public would not be at risk if the suspension is deferred for the 28 day period.

The Tribunal's Determination

159. Pursuant to section 38(1) of the 1983 Act, on giving a direction for suspension, the Tribunal may impose an immediate order (suspension in this case) if it considers it necessary for the protection of members of the public or is otherwise in the public interest.

160. The Tribunal had regard to the relevant paragraphs of the MPTS Guidance, including:

"83 The decision whether to impose an immediate order is at the discretion of the MPT based on the facts of the case. When deciding if an immediate order is needed the MPT should consider the seriousness of the proved allegation and the level of current and ongoing risk to public protection posed by the doctor.

84 It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:

a. the doctor poses a risk to patient safety
b. the risk to one or more parts of public protection is high, and/or
c. immediate action is needed to maintain public confidence in the medical profession."

161. The Tribunal considered its findings at previous stages in relation to Dr Shehu's misconduct. It assessed the level of current and ongoing risk posed to public protection in relation to all three limbs of the overarching objective.

162. The Tribunal considered that there is an ongoing risk of repetition. It has identified the level of seriousness of the misconduct as being at the top end of the mid-range. It also considered that this case involved a patient death and that Dr Shehu's misconduct was serious. The Tribunal took the view that all three limbs of the overarching objective would be undermined if it did not impose an immediate order of suspension.

163. The Tribunal considered that whilst an immediate order would have an impact on Dr Shehu, it heard no evidence as to the impact on him or on his working environment. The Tribunal noted that Dr Shehu has the right to appeal but there would be no prejudice to him in that regard if it were to impose an immediate order.

164. The Tribunal determined that an immediate order of suspension is necessary in this case in order to protect the public and is otherwise in the public interest. It considered that the only way to manage the current and ongoing risk is to impose an immediate order.

165. This means that Dr Shehu'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.

166. The interim order of conditions currently imposed on Dr Shehu's registration is revoked with immediate effect.

167. That concludes this case.