PUBLIC RECORD

Dates: 06/10/2025 - 09/10/2025

Doctor:	Dr Charles ANIGALA
GMC reference number:	6039186
Primary medical qualification:	MB BS 1998 University of Lagos

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

Summary of outcome

Suspension, 4 months.
Review hearing directed

Tribunal:

Legally Qualified Chair	Mrs Nessa Sharkett
Registrant Tribunal Member:	Dr Louis Savage
Registrant Tribunal Member:	Dr Eric Finlay

Tribunal Clerk:	Ms Jemine Pemu

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Lee Gledhill, Counsel, instructed by Doctors Defence Service
GMC Representative:	Ms Emma Gilsenan, 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 - 15/10/2025

Background

1. Dr Anigala qualified as a doctor at the University of Lagos in 1998. He initially practiced medicine in Nigeria before moving to Dublin in the Republic of Ireland, where he completed further examinations. Immediately prior to the events which have led to this hearing Dr Anigala had working as a long-term locum position at Altnagelvin Hospital in Northern Ireland ('the Hospital'). Immediately prior to the events which have led to this hearing, ('the Events') Dr Anigala had been working in this position for over 8 years.

2. The Allegation leading to Dr Anigala's hearing can be summarised as, on 7 November 2023, Dr Anigala had a discussion with the emergency department ("ED"), clinical lead of the Hospital Dr A, in respect of a patient who he had previously seen ('Patient B). Patient B had died two days following discharge from the Hospital, Dr A wanted to know if, in relation to Patient B, Dr Anigala had "*any contact with the neurosurgery team at the Royal Victoria Hospital in Belfast ('RVH')*", or words to that effect. Dr Anigala told Dr A that he had "*made contact with the neurosurgery team at the RVH and that they had advised that Patient B did not need to be transferred to the RVH*" or words to that effect. This information had not been included in the records of Patient B, Dr Anigala was asked by Dr A to make a retrospective note to be added to Patient B's medical records ('the Amendment'). The Amendment recorded that Dr Anigala had contacted a Neurosurgical Registrar regarding Patient B's case, and they confirmed that Patient B did not need to be transferred to the RVH.

3. It is alleged that Dr Anigala knew that his response to Dr A and the amendment to Patient B's medical record were false as he did not contact RVH or speak to a Neurosurgical Registrar to discuss Patient B's care. It is further alleged that Dr Anigala's actions were dishonest.

4. The background to the Allegation is that on 16 October 2023 Patient B, a young male with a ventriculoperitoneal (VP) shunt, was admitted to the ED of the Hospital via ambulance. He had been suffering with persistent headaches and vomiting. Patient B underwent a CT

scan which reported that there was: '*no obvious breakage of the shunt. No obvious acute intracerebral hemorrhage seen. No surface collections. No tonsillar herniation at the craniocervical junction. Minimal ethmoidal mucosal thickening. The bony calvarium is otherwise relatively intact*'.

5. The report added that '*neurosurgical input and referral is advised*.' Dr Anigala had clinically assessed Patient B and considered that following improvement of his symptoms, he was suitable for discharge home. Patient B was subsequently taken home by ambulance on the evening of 16 October. He died at home on 18 October 2023.

6. On 2 November 2023, as the clinical lead of the ED, Dr A was advised of the death of Patient B by a litigation assistant working at the Hospital. They informed Dr A that there was a new Coroner's Inquiry in relation to Patient B, and that the Coroner had requested statements from all relevant medical personnel who had treated Patient B. Dr A identified that Dr Anigala had been the attending physician and met to speak with him about the case on 7 November 2023. It was during the course of that meeting that Dr Anigala had told Dr A that prior to the discharge of Patient B, he had spoken with the neurosurgical team based at the RVH in Belfast. The patient records did not reflect this contact and Dr A asked Dr Anigala to prepare a retrospective note recording the same so that it could be added to the records of Patient B. He told Dr Anigala that he would also contact the neurosurgical team at RVH about the matter. However, on making enquiries with RVH it was confirmed to the satisfaction of Dr A that no such call had been made by Dr Anigala and that he had not spoken to a Neurosurgical Registrar on that day about Patient B.

7. The initial concerns were raised with the GMC on 7 December 2023 by Dr F, Medical Director of Western Health and Social Care Trust, Northern Ireland.

The Outcome of Applications Made during the Facts Stage

8. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to change the name of the Patient A to Patient B in paragraphs 1 and 2 of the Allegation). The Tribunal granted the application as it was satisfied that the amendments sought could be made without injustice to Dr Anigala.

The Allegation and the Doctor's Response

9. The Allegation made against Dr Anigala is as follows:

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

1. On 7 November 2023 you:
   a. had a discussion with Dr A regarding Patient ~~A~~ B in which Dr A asked you if you had "any contact with the neurosurgery team at the Royal Victoria Hospital in Belfast ('RVH')", or words to that effect, to which you replied that you had "made contact with the neurosurgery team at the RVH and that they had advised that Patient ~~A~~ B did not need to be transferred to the RVH" or words to that effect; Admitted and found proved Amended under Rule 17(6)

   b. made a retrospective note for the purpose of being added to Patient ~~A's~~ B's medical records ('the Amendment') which stated that:

      i. you contacted a Neurosurgical Registrar regarding Patient ~~A's~~ B's case; Admitted and found proved Amended under Rule 17(6)

      ii. the Neurosurgical Registrar confirmed Patient ~~A~~ B did not need to be transferred to the RVH. Admitted and found proved Amended under Rule 17(6)

2. You knew that:

   a. your response to Dr A was false as you did not contact a Neurosurgical Registrar to discuss Patient ~~A's~~ B's care; Admitted and found proved Amended under Rule 17(6)

   b. the Amendment to Patient ~~A's~~ B's medical record was false as you did not contact a Neurosurgical Registrar to discuss Patient ~~A's~~ B's care. Admitted and found proved Amended under Rule 17(6)

3. Your actions as set out in paragraph 1 were dishonest by reason of paragraph 2. 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

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

The Evidence

11. The Tribunal has taken into account all of the evidence received during this stage of the hearing, both oral and documentary. In particular, the Tribunal received the following documentary evidence:

- Patient B medical records from Western Health and Social Care,
- Patient B's hospital notes, various dates;
- Various exhibits from Patient B's medical records;
- Minutes of SAI investigation meeting held on 08 March 2024;
- CPD Duty of Candour in Healthcare Probity and Ethics, dated 7 June 2025;
- CPD How to ensure a similar mistake or misconduct will not be repeated in Future Probity and Ethics, dated 8 June 2025;
- CPD Module on Remediation Certificate of Completion Probity and Ethics, dated 19 November 2024;
- CPD Module on Insight Certificate of Completion Probity and Ethics, dated 17 November 2024;
- CPD Certificate of Completion Probity and Ethics Course, dated 18 August 2024;
- Dr Anigala's Reflective Statement on Index Offence, dated 1 July 2025;
- Dr Anigala's Reflection on *'How I Breached the Domains of Good Medical Practice'*, dated 10 November 2025;
- Dr Anigala's Reflection on Probity and Ethics Course, dated 28 August 2024;
- Dr Anigala's Reflection on Remediation Course, dated 28 November 2024;
- Additional undated reflective statements;
- Appraisal 2025 and Certificate of Appraisal, dated 30 July 2025.

12. The Tribunal also received evidence on behalf of the GMC in the form of written witness statements from :

- Dr A, Clinical Lead for Emergency Medicine in Altnagelvin Hospital, dated 22 May 2024;
- Mr C, Consultant Neurosurgeon at the Royal Victoria Hospital, Belfast Heath & Social Care Trust, dated 2 July 2024.

The witness evidence of these two witnesses had been agreed by the defence and they were not called to give oral evidence.

13. The Tribunal also received references and testimonials on behalf of Dr Anigala from the following individuals:

- Dr D, Clinical Director Emergency Medicine, Daisy Hill Hospital, undated, and a further character reference dated 6 October 2025;
- Dr E, dated 23 November 2024.

14. Dr Anigala provided his Rule 7 response to the Allegation, an undated reflection on Decision Making in Pressured Environments statement, and an undated remediation statement. These documents were adopted as his evidence in chief. Dr Anigala also gave oral evidence during Stage 2 of the hearing.

15. The Tribunal was further provided with an Agreed Statement of Facts.

Submissions

On behalf of the GMC

16. Ms Emma Gilsenan, Counsel, spoke to her written submissions which were read into the record in their entirety. She submitted that Dr Anigala's actions amount to serious misconduct and that his fitness to practise is currently impaired. Throughout her submissions, she referred the Tribunal to relevant authorities and paragraphs 15, 16, 19, 21 and 65 of Good Medical Practice (2013) ('GMP').

17. Ms Gilsenan also referred the Tribunal to the statutory overarching object and submitted that this case engages all three limbs. She reminded the Tribunal that Dr Anigala's responsibility as a GMC registrant is to be familiar with GMP and the professional standards it contains. She submitted that honesty is a fundamental tenet of the medical profession. She stated that the dishonesty in the index matter is very serious and occurred in the context of Dr Anigala's professional role and related to the care he provided to a patient who died. She reminded the Tribunal that Dr Anigala had discharged Patient B from the hospital without following the advice of the radiologist who reported the CT scan, which had been that Neurosurgical opinion was advised.

18. Ms Gilsenan submitted that the dishonesty occurred on two occasions, albeit relating to the same set of circumstances. The first occasion was when Dr Anigala lied to Dr A about having spoken to the neurosurgical team, and the second when he added a false retrospective note about this into Patient B's medical records. She submitted that despite having been told that Dr A would be looking into the details of the case and contacting RVH to make enquiries about his purported phone call, Dr Anigala compounded his dishonesty by

making a false retrospective addition to Patient B's medical records. Ms Gilsenan submitted that falsely amending patient records undermined the integrity of the medical records system which is there to provide an accurate record of the care provided, to a patient including when it was provided and by whom.

19. Ms Gilsenan reminded the Tribunal that in this case there was a Coroner's inquest and if the false information had remained in the records this may have affected the outcome of the inquest. It could also have led to negative consequences for the neurosurgical team at RVH, who may have faced allegations of providing suboptimal care. She submitted that Dr Anigala described later feeling uneasy about his dishonesty, but did not admit the truth until he was confronted with the findings of Dr A, who informed him that there was no evidence to support that he had contacted the team at RVH.

20. Ms Gilsenan accepts that whilst there are two occasions of dishonesty noted, this does not appear to be persistent dishonesty as they were so closely linked to each other and were in the context of a previously unblemished career. She confirmed that there had been no previous or similar concerns raised since that time.

21. Ms Gilsenan further submitted that it is possible that Dr Anigala had sought to conceal his error to prevent him from losing his job. As the sole financial provider for the family the loss of his employment she acknowledged that this would have had a disastrous financial effect on his family.

22. Ms Gilsenan accepted that Dr Anigala has shown insight into the concerns raised, and has undertaken relevant learning in this area to aid remediation. She confirmed that he has no fitness to practise history and has provided a number of positive testimonials.

23. Ms Gilsenan invited the Tribunal to consider the numerous breaches of GMP in the context of the collective need to maintain confidence in the profession and declaring and upholding proper standards of conduct and behaviour She submitted that, when considering the information as a whole, the balance weighs in favour of making a finding of impairment in Dr Anigala's case.

24. Ms Gilsenan addressed the Tribunal on the mitigating factors. She reminded the Tribunal that Dr Anigala has admitted the Allegation from an early stage., He has shown insight which the Tribunal may be consider to be developing; he has good character in the UK and there have been no further incidents since. In respect of remediation, Ms Gilsenan urged the Tribunal to consider remediation in the context of the Allegation, the seriousness of the

dishonesty, the difficulty in remediating dishonesty and whether dishonesty has in fact been remedied in this case.

25. Ms Gilsenan submitted that Dr Anigala, has practical experience of working within the UK. She submitted that Dr Anigala is not a doctor for whom lack of experience and/or the stage of his UK medical career should mitigate his actions in the current case. On the contrary, she submitted that this Tribunal may consider his standing is relevant in the context of the allegations of misconduct as a whole and the standard expected of someone in his position and experience. Ms Gilsenan submitted that the GMC relies on the public interest test set out by Mr Justice Eady in *Patel v GMC [2012] EWHC 3688*, that a reasonable and properly informed member of the public would be surprised to learn that Dr Anigala had been allowed to practise unrestricted in light of the admissions which were found proved by this Tribunal.

26. Ms Gilsenan submitted that Dr Anigala's fitness to practise is currently impaired by reason of his misconduct. She stated that the misconduct was serious, and his actions fell short of expected standards. Ms Gilsenan submitted that this is not an exceptional case which would justify a finding of no impairment. She submitted that a finding that Dr Anigala's fitness to practise is impaired is required so confidence in the profession is not undermined. Moreover, proper professional standards would not be maintained if a finding of impairment was not made.

<u>On behalf of Dr Anigala</u>

27. Mr Gledhill told the Tribunal that the doctor does not oppose a finding of impairment on public interest grounds. He submitted however, that in light of the deep reflection shown and the steps taken by Dr Anigala, his insight is now well developed, albeit he accepts that the Tribunal may find that it is an ongoing journey. He submitted that Dr Anigala knows that his actions are a serious lapse in his conduct and significant departure from the standards expected of a medical practitioner. He accepts that he should not have been dishonest and does not seek to minimise the gravity of his actions. Further he submits that Dr Anigala recognises his vulnerabilities and knows that he needs to be proactive in seeking to avoid repetition of his misconduct.

28. Mr Gledhill reminded the Tribunal that in oral evidence Dr Anigala had described what he had done as a profound turning point in both his personal and professional life. Dr Anigala had explained how he now understands that courage in medicine is not only about making difficult clinical decisions but also about having the integrity to admit mistakes openly. He had

told the Tribunal that he is determined that his future practice will embody the principles of GMP so that he can once again be worthy of the trust placed in him by patients, colleagues and the wider public.

29. Mr Gledhill also drew the Tribunal's attention to further reflections by Dr Anigala on privacy, ethics and professionalism, as well as his participation in remediation courses. He referred to Dr Anigala's appraisal, which demonstrates that he has discussed this matter openly and constructively with his appraiser. Mr Gledhill submitted that not all doctors are willing to discuss such matters in their appraisal, and it is to Dr Anigala's credit that he has done so, showing openness, maturity and genuine insight. The combination of the oral and documentary evidence before the Tribunal, he submitted, demonstrates that Dr Anigala is well advanced in his journey of remediation. While the process of learning and reflection will continue throughout his career, the progress he has made to date is substantial and genuine.

30. Mr Gledhill referred the Tribunal to the testimonials provided on behalf of Dr Anigala, which he submitted were highly positive and supportive. He submitted that the testimonials portray a doctor who is well-regarded by his colleagues and is respected for his clinical ability, professionalism, and humility. Mr Gledhill directed the Tribunal to Dr Anigala's reflective statement, which he submitted offers a detailed account of the index incident, the personal circumstances that prevailed at the time, and the process through which Dr Anigala has developed insight and undertaken remediation.

31. Mr Gledhill submitted that through his reflections, Dr Anigala has explained how profoundly humbling he has found this experience. He reminded the Tribunal that Dr Anigala accepted full responsibility for his lapse in clinical judgment, and, more seriously, the breach of probity when he lied about his actions. Mr Gledhill submitted that Dr Anigala has learned that, while clinical mistakes may sometimes be unavoidable, dishonesty is never acceptable. He has recognised that dishonesty compounds harm, prevents learning, and destroys trust. He expresses deep regret that he had not had the courage to be open at the time.

32. Mr Gledhill reminded the Tribunal that Dr Anigala has described the steps he has taken to address these failings, including attending courses on probity, ethics and patient safety, engaging in structured reflection with colleagues, reading GMC guidance in depth, practising open-disclosure conversations, and developing strategies to manage fear and pressure honestly. Dr Anigala, he submits is committed that in future he will follow safety recommendations and explicitly discuss and document any deviation; that he will escalate concerns and seek second opinions rather than making unilateral decisions, and that he will

be open and honest about his actions even when it is difficult. He has resolved to treat trust, probity and transparency as non-negotiable aspects of his professional conduct.

33. Mr Gledhill submitted that Dr Anigala has taken practical and meaningful steps to embed his learning in his day-to-day practice. He explained how Dr Anigala now maintains a weekly reflective journal in which he records and analyses his clinical decisions, identifying both areas of strength and those requiring improvement. He told the Tribunal that Dr Anigala meets regularly with a professional mentor and intends to continue this as a permanent part of his career so that he is continuously supported and constructively challenged. He reminded the Tribunal how Dr Anigala has described how he now engages more openly with colleagues, using team meetings and second opinions as opportunities to test his thinking. He ensures that his referrals are carefully documented so that his actions are transparent and auditable. These changes, he explained, have helped him to approach difficult situations with honesty rather than fear.

34. Mr Gledhill submitted that there has been no evidence of repetition since the Event and that Dr Anigala has taken onboard the seriousness of his actions and explained how he would deal with similar situations moving forward. Mr Gledhill asked the Tribunal to have regard to cultural and language differences which may impact on the way in which a person may express themselves, which he says is relevant here as Dr Anigala is from Nigeria. He submitted that Dr Anigala finds it easier to express himself more clearly in writing and reminded the Tribunal how in his written evidence Dr Anigala explained clearly how he would act differently if faced with a similar situation in the future This he submitted demonstrated insight and a commitment to sustained change. He submitted that the willingness of Dr Anigala to seek to work to improve himself with the input of others, and acknowledge what he needs to address, are signs of humility not arrogance. He submitted, the sincerity of his insight and remorse is evident throughout his written and oral evidence.

35. Mr Gledhill further submitted that the risk of repetition is low. He reminded the Tribunal that Dr Anigala has been working safely and effectively in a busy Accident and Emergency environment where decisions must be made quickly and under considerable pressure. There has been no evidence of any recurrence of dishonesty or any other lapse in integrity. This, he submitted, supports the conclusion that this was an isolated incident in an otherwise long and unblemished career. Mr Gledhill submitted that Dr Anigala fully acknowledges that his actions fell significantly below the standards expected of a doctor, but he has made genuine efforts to make amends, has developed meaningful insight and remorse, and has taken significant steps to ensure that such conduct will not be repeated. Mr

Gledhill invited the Tribunal to consider the progress made by Dr Anigala when reaching its decision on impairment.

The Relevant Legal Principles

36. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof, and the decision in relation to impairment of fitness to practise is a matter for the Tribunal's judgment alone.

37. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct which was serious, and then whether the finding of that misconduct which was serious could lead to a finding of impairment.

38. The Tribunal must determine whether Dr Anigala's fitness to practise is impaired today, taking into account his conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

39. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin.* The Tribunal noted that any of the following features are likely to be present when a doctor's fitness to practise is found to be impaired:

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 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; and/or

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

40. Throughout its deliberations, the Tribunal had regard to all the three limbs of the statutory overarching objective, namely to:

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

41. The Tribunal reminded itself that not every case of proven dishonesty will automatically lead to a finding of current impairment.

The Tribunal's Determination on Impairment

42. At the time of the Event, Dr Anigala was working as a locum doctor within the Hospital. The matters that have led to this case arose out of the actions of Dr Anigala following the care and subsequent discharge of Patient B in October 2023 and his subsequent false declarations in November 2023.

43. On 16 October 2023, Patient B attended the Emergency Department of the Hospital at approximately 06:48 hours. A CT scan was ordered and conducted later that day. The results of the scan were subsequently reviewed and considered by Dr Anigala. Although the radiologist report included that neurosurgical input and referral was advised, having reviewed the patient and observed an improvement in his symptoms Dr Anigala determined that Patient B was suitable for discharge home. That decision was taken at 16:40 and Patient B was subsequently transported home by ambulance at approximately 19:20. Patient B died two days later on 18 October 2023.

44. On 2 November 2023, Dr A the clinical lead of the ED at the Hospital, was advised of the death of Patient B by a litigation assistant working at the Hospital They informed Dr A that there was a new Coroner's Inquiry in relation to Patient B, and that the Coroner had requested statements from all relevant medical personnel who had treated Patient B. Dr A identified that Dr Anigala had been the attending physician and met to speak with him about it on 7 November 2023. It was during the course of that meeting that when asked by Dr A whether he had followed the radiologist's recommendation to contact the Neurosurgical team at the RVH, Dr Anigala told Dr A that he had spoken with the neurosurgical team at RVH in Belfast, prior to discharging Patient B. He told Dr A that the registrar had advised that the transfer of Patient B to RVH was not required.

45. The patient records did not reflect this contact and discussion and Dr A asked Dr Anigala to prepare a retrospective note recording the same so that is could be added to the records of Patient B. He told Dr Anigala that he would be contacting the neurosurgical team at RVH about the matter.

46. Later that same day, on 7 November 2023 at 15:05, Dr Anigala made a retrospective entry in Patient B's notes which included the following:

> *….."I followed the radiology report advice and contacted the Neurosurgical Registrar at the RVH to discuss Patient B's case and request a review of the CT scan of his brain. The Neurosurgical Registrar commented that he was content with the CT scan and he advised there was no need for transfer of Patient A to RVH under the care of the Neurosurgery team."…….*

47. Subsequent investigations revealed that no phone call had been received at RVH, nor was there any evidence that Dr Anigala had spoken to the Neurosurgical Registrar or that Patient B's CT scan had been accessed by anyone at RVH. This information was communicated to Dr A by colleagues at the RVH, who confirmed that following a robust enquiry of their systems there was no record of any call or discussion relating to Patient B on or around the relevant date.

48. When Dr A learned that RVH had no record of any contact relating to Patient B, he met with Dr Anigala again. On 16 November2023. In his witness statement dated 22 May 2024, Dr A recalled:

> *"Dr Anigala was not on duty at the time that I had spoken to [RVH}, so I pulled him in the next day he was on duty and explained that we needed to get to the bottom of the matter. He then volunteered that he had reflected and that actually the call was not made. He said that it had been on his mind that he hadn't been truthful previously and he was very regretful of that. At that point, I explained that it is okay to make mistakes and there had clearly been a clinical mistake made. However, this had now been compounded with an ethical mistake.*
>
> *On 18 November 2023, I telephoned Dr Anigala and explained that he would now need to document that it in fact was not the case that he spoke to the neurosurgery team and we would take the matter from there. Dr Anigala therefore made a second retrospective entry to the notes in order to correct the position."*

49. The Tribunal noted that some 9 days had passed since Dr Anigala had made his false declaration to Dr A and provided a false entry to be placed in the notes of Patient B. The Tribunal considered that this was a period of time in which Dr Anigala would have had an opportunity to reflect on his actions and take steps to remedy the same had his actions just been, as he suggests, a reaction to panic. However, it was not until Dr Anigala was confronted with evidence that no contact had been made, and that further investigation would be undertaken, that he admitted he had not made the call. On 18 November 2023, two days after the second meeting with Dr A, Dr Anigala was instructed to amend Patient B's record once more to accurately reflect the position. On 23 November 2023, he made the following corrective retrospective entry:

> *"I am writing to make a correction to my initial report 7/11/23 concerning the death of my Patient [B] I wrote in my report that I contacted the neurosurgeon about the CT brain report of Patient A.*
>
> *In truth I did not contact or spoke to the neurosurgeon as I stated, I wrote the report regrettably in a state of shock about news of Patient [B]'s death and of far of the consequence of my clinical decision and outcome of it.*
>
> *I am deeply sorry and I regret making any false report and also regret the outcome of my clinical decision."*

50. In oral evidence, Dr Anigala accepted that he should have taken a different course of action and followed the radiologist's advice to contact the neurosurgical team. His clinical judgment on that day does not form part of the Allegation and is not a matter for the Tribunal's consideration in that respect. He has acknowledged that his fear of being perceived as incompetent by his colleagues contributed to his dishonest actions.

51. When questioned by Ms Gilsenan, on behalf of the GMC, in oral evidence, Dr Anigala accepted that his conduct breached paragraphs 15(b), 15(c), and 16(d) of Good Medical Practice (2013). He accepted that his actions fell seriously below the standards expected of a registered medical practitioner.

Misconduct

52. In determining whether Dr Anigala's fitness to practise is impaired by reason of misconduct, the Tribunal first considered whether the admitted facts found proved amounted to misconduct which was serious.

53. In considering the issue of misconduct, the Tribunal had regard to all the evidence before it, including Dr Anigala's admissions, his oral evidence, and the submissions made on his behalf.

54. The Tribunal had regard to paragraphs 1, 15(b)(c), 16(d), 19, 35, 36, 65 and 68 of GMP, which provide:

> *'1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.*
>
> *15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> *b promptly provide or arrange suitable advice, investigations or treatment where necessary*
> *c refer a patient to another practitioner when this serves the patient's needs*
>
> *16 In providing clinical care you must:*
> *d consult colleagues where appropriate*
>
> *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*
>
> *35 You must work collaboratively with colleagues, respecting their skills and contributions*
>
> *36 You must treat colleagues fairly and with respect.*
>
> *65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
> *68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.'*

55. The Tribunal did not consider paragraphs 15(a), 16(a)(b)(c)(e)(f) and (g) and 21 of GMP to be currently engaged as proposed by Ms Gilsenan as misconduct in relation to clinical care does not form part of the Allegation. The doctor's admitted breaches of those paragraphs however goes to the seriousness of Dr Anigala's conduct when taken in the round.

56. The Tribunal noted that the dishonesty occurred in a professional context and involved both a false oral statement to a senior colleague and a knowingly false retrospective entry in a patient's medical record. These were serious matters which struck at the heart of probity and honesty, which are fundamental tenets of the medical profession.

57. The Tribunal found that Dr Anigala's conduct was deliberate. The Tribunal did not accept Dr Anigala's evidence that he was in no way consciously or knowingly trying to hide his errors. When asked by Dr A whether he had contacted the neurosurgical team, he knowingly gave a false response. He then compounded that dishonesty by making a retrospective note which he knew to be untrue. By his own admission he was worried about what others would think of him and that his means of earning a living may be put at risk because, as he wrote in his reflective statement *" for the first time in my career my clinical judgment failed me".* The Tribunal also find that by implicating the Neurosurgical Registrar at RVH in the decision not to transfer Patient B the Tribunal find he was attempting to deflect any error away from himself. In the absence of any other explanation there can be no other reason for making such a false statement other than to hide a perceived or actual error. The purpose of his actions was to give the impression that he had acted in accordance with professional advice when in fact he had not.

58. The Tribunal considered the potential consequences of this dishonesty. The Tribunal found that the false statements made by Dr Anigala had the potential to cause significant adverse consequences. The false information caused the hospital to spend the time and resource of Dr A in making enquiries that Dr Anigala knew were futile. Similarly, RVH had to waste valuable time and resource investigating their systems and conducting enquiries of staff which would have been unnecessary because RVH had not had any involvement with Patient B's care. Statements from staff at RVH were not required for the purposes of the Coroner's Inquiry. Given the demands placed on healthcare resources in Northern Ireland, it is clear that this time and money could have been put to much better use for the benefit of patients.

59. Additional consequences are that the Registrar on duty at RVH that day would have been clearly identifiable and exposed to either perceived or real scrutiny during that time, thus increasing pressure on professional colleagues and the potential to cause damage to that doctor's professional reputation and standing. Had the truth not been discovered this could have also led to an erroneous outcome to the Coroner's Inquiry. The Tribunal considered this an aggravating factor, demonstrating a lack of thought for the wider impact of his conduct on others.

60. The Tribunal was particularly concerned that, at the time of the incident, Dr Anigala's motivation appeared to be self-preservation. His instinct was to protect himself from potential criticism rather than to acknowledge his error. The Tribunal observed that, at the time, he did not express remorse or concern for the difficulties his dishonesty caused to others, including his colleagues at RVH. It concluded that, at the time, Dr Anigala had not considered the ripple effect of his actions such as, the cost in time, the reputational harm, and the stress caused to others as he had acted solely with his own interests in mind.

61. The Tribunal determined that Dr Anigala's actions constituted a clear breach of the principles of honesty and integrity set out in GMP. His conduct fell seriously below the standards expected of a registered medical practitioner and was capable of undermining public confidence in the profession.

62. Having regard to the seriousness of the dishonesty, the potential consequences of his actions, and the deliberate nature of the false record, the Tribunal concluded that Dr Anigala's behaviour represented a serious departure from the standards of conduct expected of doctors.

63. Accordingly, the Tribunal determined that Dr Anigala's actions amounted to serious misconduct.

Impairment by reason of misconduct

64. In determining whether Dr Anigala's fitness to practise is currently impaired by reason of his misconduct, the Tribunal had regard to the overarching objective of the GMC: to protect, promote and maintain the health, safety and wellbeing 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.

65. The Tribunal considered whether the conduct found proved is capable of remediation, whether it has been remediated, and the extent to which Dr Anigala has developed insight into his behaviour.

66. The Tribunal first considered the nature and degree of the dishonesty involved. It accepted that the dishonesty was isolated to the extent that it related to one specific set of circumstances. However, it noted that there were two occasions on which he carried out dishonest acts. In addition, the Tribunal noted that there was a period of 9 days that had passed from making his false statements before Dr Anigala admitted the truth. The dishonesty was not repeated or persistent, but it was deliberate and maintained over that period until he was confronted with evidence that no contact had been made with the neurosurgical team.

67. The Tribunal acknowledged that dishonesty is inherently difficult to remediate. Nonetheless, it is not incapable of remediation, particularly where the doctor demonstrates meaningful insight and sustained efforts to address the root causes of their behaviour.

68. The Tribunal considered the steps Dr Anigala has taken since these events. The Tribunal had regard to the number and content of the courses he has undertaken starting from August 2024. These include on-line modules on remediation, insight, reflection, ethics, duty of candour, how to avoid making similar mistakes again and a course of decision making for individuals and groups. He has also provided reflective statements in which he addresses his understanding of his actions. In addition, Dr Anigala has told the Tribunal that he has started to keep a journal of reflection which the Tribunal has not had sight of. He has also participated in trust-level and regulatory investigations, including these proceedings before the GMC and the MPTS. Through these processes he has experienced, in a very direct way, the personal and professional consequences of dishonest conduct.

69. The Tribunal accepted that Dr Anigala's insight is developing well but is not yet complete. He has admitted in his evidence that he remains unable to know why he took what he refers to as the unusual decision to be dishonest. This is somewhat inconsistent with his evidence that the reason he did it was out of fear of the consequences of his clinical decision and a fear of being blamed or perceived to be incompetent. It is clear that in hindsight Dr Anigala perceives that he let himself down when exercising his clinical judgment that day and that this is a source of great concern to him.

70. The Tribunal accepts that he now knows the importance of honesty in his practice and dealings with patients and colleagues but it finds that whilst he knows that it is wrong and

unacceptable he does not yet fully understand the magnitude and wider impact of his dishonesty. The Tribunal accepted that Dr Anigala he explained the steps he would take to avoid poor clinical decision to ensure his clinical judgement was not impaired. This was not the case in respect of his dishonesty. He has been unable to fully demonstrate either verbally or in writing how, if faced with a situation where his reputation, job or family security could be compromised, he would act differently in the future. Whilst his insight is developing and he is exploring different aspects of why he thinks he made bad judgments in the past he does not seem to recognise dishonest conduct is not solely associated with making good clinical decisions.

71. The Tribunal finds that Dr Anigala has worked hard to remediate his conduct and has made good progress to date. However, his journey is not complete as he needs to develop further insight into his own dishonest conduct and the steps he would take to avoid repetition in the future.

72. The Tribunal noted that nothing in his most recent appraisal reflected personal reflection or concern about his conduct. However, it accepted that cultural differences may play a part in how remorse and shame are expressed. The Tribunal considered it possible that Dr Anigala found it difficult to articulate his emotions openly for fear of losing face or appearing weak. It also accepted that he may have struggled to separate clinical misjudgement from dishonesty in his reflective process, sometimes conflating the two.

73. Nevertheless, the Tribunal was satisfied that Dr Anigala has begun to understand the seriousness of his dishonesty and the importance of transparency and candour. It was encouraged by evidence that he now feels better supported within his working environment, has greater trust in the system, and has developed the confidence to seek advice and second opinions where appropriate.

74. The Tribunal applied the Dame Janet Smith test, as approved in *CHRE v NMC and Grant,* and concluded that limbs (b), (c) and (d) were engaged. It found that members of the public, knowing the facts of this case, would be concerned by a doctor who acted dishonestly in this way. It also found that such conduct could pose a risk to patients if repeated, as dishonesty undermines the trust essential to safe and effective medical practice.

75. In assessing whether the misconduct has been remedied, the Tribunal found that Dr Anigala has made tangible progress towards remediation but has not yet fully remediated his dishonesty. His insight remains partial, and his tendency to conflate the seriousness of his dishonesty with issues of clinical judgment, albeit perhaps subconsciously, remains an area of

concern. The Tribunal noted that Dr Anigala has been working in a demanding clinical environment at Daisy Hill Hospital, where he acts as the senior doctor in charge overnight. This position requires independent decision-making and may have the potential to expose him to similar pressures that led to his initial dishonesty. However, it notes that there has been no repetition of his behaviour, and his employers have no concern in this respect.

76. The Tribunal considered the risk of repetition. It accepted that there remains a risk of repetition but that this has been reduced since the index events due to insight developed by Dr Anigala. The Tribunal are satisfied that this will no doubt be reduced further as his insight continues to develop.

77. The Tribunal concluded that while Dr Anigala has made considerable progress in developing insight and has taken meaningful steps towards remediation, his understanding of the wider impact of his dishonesty is not yet fully developed. He remains on a journey of learning, reflection, and professional growth.

78. Having balanced all these factors, the Tribunal determined that although the risk of repetition is low, it cannot be said to be negligible. In light of the seriousness of the dishonesty, the difficulty of remediating such behaviour, and the fact that Dr Anigala's insight is still developing, the Tribunal found that a finding of impairment is required to maintain public confidence in the profession and to uphold proper standards of conduct.

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

Determination on Sanction - 09/10/2025

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

The Evidence

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

Submissions

On behalf of the GMC

82. Ms Gilsenan submitted that the appropriate sanction is one of suspension. She submitted that, although the misconduct found proved was very serious and included findings of dishonesty, the appropriate and proportionate sanction was one of suspension rather than erasure. She reminded the Tribunal that the ultimate decision on sanction rested with the Tribunal exercising its own independent judgment. She invited the Tribunal to impose an order of suspension at the upper end of the available range. In addition, she submitted that a review hearing was also appropriate in this case.

83. Ms Gilsenan referred the Tribunal to the overarching objective and to relevant paragraphs of the Sanctions Guidance ('the SG') which could assist the Tribunal in reaching a decision, reminding it of the principle of proportionality. She further reminded the Tribunal that in considering what, if any, sanction to impose it should consider any aggravating and mitigating circumstances relevant to this case and start with the least restrictive sanction first.

84. By way of mitigation, Ms Gilsenan reminded the Tribunal that Dr Anigala had no previous fitness to practise history and was otherwise of good character. In addition, she suggested the Tribunal may wish to consider the lapse of time since the index event in November 2023, together with the fact there had been no further reported concerns. She submitted that the time was relevant as Dr Anigala had continued to practice in a senior post at Daisy Hill Hospital since December 2023. Ms Gilsenan submitted that Dr Anigala was an experienced doctor who should fully understand the principles of GMP, in particular the duties to be honest, trustworthy, and accurate in patient records. She submitted that, in view of his experience and seniority this was not a doctor for whom allowances should be made in respect of the stage of his career in the UK. She did however submit that it was fair to acknowledge his expressions of regret and apology and the steps he had taken to remediate his misconduct. She reminded the Tribunal of its previous findings on impairment that Dr Anigala's insight is not yet complete.

85. Ms Gilsenan reminded the Tribunal of its previous findings that Dr Anigala had not yet demonstrated full understanding of the impact of his dishonesty on patient safety, public confidence, and his obligations to the regulator. Ms Gilsenan submitted that while there remained a risk of repetition, this should be seen in the context of there being no repetition since 2023.

86. By way of aggravating features, Ms Gilsenan submitted that Dr Anigala's conduct involved deliberate dishonesty intended to conceal a serious clinical error. She highlighted that the dishonesty was maintained over a nine-day period before being uncovered by Dr A following enquiries with RVH. This, Ms Gilsenan submitted demonstrated an ongoing decision to mislead rather than solely an impulsive act.

87. Ms Gilsenan submitted that this was not a case where there are exceptional circumstances to justify taking no action particularly given the seriousness of the misconduct. Similarly, she submitted that Conditions would be wholly inappropriate and that it would be difficult to envisage a condition that would be capable of addressing the issue of dishonesty. Conditions, she submitted would be neither appropriate nor workable in this case.

88. Ms Gilsenan submitted that the appropriate sanction to impose in this case was one of suspension. She accepted that a sanction of suspension would have a punitive effect on the doctor, even though unintentional. She submitted this sanction was necessary as it would send a clear signal to the doctor, the profession, and the wider public that conduct of this nature is not acceptable.

89. Ms Gilsenan referred the Tribunal to paragraphs of the SG which indicated that a sanction of suspension was appropriate in this case. In particular she referred to paragraph 92 and 93 and submitted that this was a case where the departure was serious but falls short of being fundamentally incompatible with continued registration. She accepted that there had been an acknowledgement of that fault, remediation was ongoing and there was evidence that repetition was unlikely. She further submitted that paragraphs 97(a), (e), (f) and (g) were also engaged.

90. Turning to erasure, Ms Gilsenan referred to paragraphs 108–109 and 120–128 of the SG, acknowledging that these address dishonesty that may be fundamentally incompatible with continued registration. She accepted that while elements of paragraph 109(d) and (h) were engaged, this was not a case of persistent dishonesty, and the misconduct fell just short of the threshold for erasure.

91. In conclusion, Ms Gilsenan submitted that a suspension at the upper end of the scale, followed by a review hearing, would be a proportionate and sufficient sanction to protect the public, maintain public confidence in the profession, and uphold proper standards of conduct. She referred to paragraph 164 of the SG, which confirms that a review hearing is likely to be necessary to assess whether Dr Anigala has fully appreciated the gravity of his misconduct and maintained his skills and knowledge during the period of suspension.

On behalf of Dr Anigala

92. Mr Gledhill submitted that Dr Anigala accepted the Tribunal's findings and recognised that further time may be required to demonstrate full insight. He stated that Dr Anigala was willing to engage fully in further reflection on professionalism, integrity, and decision-making, particularly regarding the impact of his actions on others.

93. Mr Gledhill reminded the Tribunal that any sanction must be proportionate and directed its attention to the SG, in particular paragraphs 91–93 and 97(a), (e), (f) and (g). He submitted that this case fell squarely within the category where a period of suspension was appropriate and proportionate, and that erasure or a lengthy suspension would be unduly severe in all the circumstances.

94. Mr Gledhill reminded the Tribunal that Dr Anigala had continued to practise at Daisy Hill Hospital, where he remained a respected and valued member of the team. He submitted that there had been no further concerns since the index incident, and his colleagues continued to speak highly of his professionalism and contribution to patient care. Mr Gledhill submitted that Dr Anigala was deeply remorseful for his misconduct, which arose in a moment of panic, and that he had reflected on the causes and consequences of his actions. His insight was well developed, though not yet complete, and his remediation was demonstrably in progress.

95. Referring to the SG, Mr Gledhill relied on paragraph 97(a), which recognises that suspension may be appropriate where there has been a serious but remediable departure from GMP; paragraph 97(e), where remediation is likely to succeed; paragraph 97(f), where there has been no repetition of similar behaviour; and paragraph 97(g), where a doctor has developing insight and poses no significant risk of repetition.

96. Mr Gledhill invited the Tribunal to impose a short to mid-range suspension, which would adequately mark the seriousness of the misconduct and protect the public, while avoiding the risks of deskilling or loss of employment associated with a longer suspension. Mr Gledhill emphasised that maintaining Dr Anigala's competence and employability was also in the public interest. He further submitted that Dr Anigala intended to use any period of suspension constructively by undertaking further remediation courses, working with a remediation specialist, and engaging with senior colleagues to deepen his reflection. Dr Anigala did not oppose the imposition of a review hearing, recognising that it would provide an opportunity to demonstrate his progress.

97. In conclusion, Mr Gledhill submitted that while the misconduct was serious, it was not fundamentally incompatible with continued registration. He therefore invited the Tribunal to impose a short or mid-range period of suspension, rather than an upper end suspension or erasure. This, he submitted, would be a fair, proportionate, and sufficient outcome that would protect the public while recognising Dr Anigala's genuine remorse, insight, and commitment to remediation.

The Tribunal's Determination on Sanction

98. The Tribunal's decision as to the appropriate sanction to impose on Dr Anigala's registration, if any, is a matter for the Tribunal exercising its independent judgment. In reaching its decision, the Tribunal should take account of the SG and the overarching objective.

99. In reaching its decision, the Tribunal should have regard to the principle of proportionality, balancing Dr Anigala's interests with those of the public. Throughout its deliberations the Tribunal should bear in mind that the purpose of a sanction is not to punish a doctor, although a sanction may have a punitive effect. The Tribunal was reminded of the case of *Bolton v The Law Society [1994] 1 WLR 512*, in which Sir Thomas Bingham stated, "*in cases of significant professional dishonesty, mitigation has a necessarily limited role"* and *'The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price.'*

100. The Tribunal must also bear in mind that in deciding what, if any, sanction to impose, it should consider all the sanctions available, starting with the least restrictive and consider each sanction in ascending order until the overarching objective is met.

Aggravating & Mitigating Factors

101. In reaching its decision, the Tribunal first considered the aggravating and mitigating factors present in this case. The Tribunal considered whether there were any aggravating factors in this case.

Aggravating factors

102. The Tribunal noted as relevant, that this was a case that involved an act of deliberate dishonesty that was further compounded by his false written statement inserted into the

records of Patient B. It was further noted that although Dr Anigala subsequently said his actions had been playing on his mind, he failed to take any action to rectify his information during the nine days that passed before he was confronted with the findings of Dr A. The Tribunal considered this to be a serious breach of the principles of honesty and integrity expected of a registered medical practitioner. The dishonesty occurred in the context of an attempt to conceal a serious clinical error.

Mitigating factors

103. The Tribunal accepted that Dr Anigala had acknowledged his fault and expressed genuine remorse and regret for his actions. Dr Anigala had provided evidence of developing insight and had taken considerable steps towards remediation, including reflecting on the causes and consequences of his conduct. The Tribunal further noted that whilst continuing to practise at Daisy Hill Hospital, where he remained a respected member of the clinical team, there had been no further incidents since the Events.

104. The Tribunal then went on to consider the appropriate and proportionate sanction on the facts of this case, working up from the least serious.

No action

105. In reaching its decision as to the appropriate sanction, if any, to impose in this case, the Tribunal first considered whether to take no action.

106. The Tribunal considered that there were no exceptional circumstances in this case which could justify it taking no action.

107. Given the serious findings against Dr Anigala, the Tribunal determined that to take no action would be neither appropriate nor proportionate and would fail to uphold the statutory overarching objective.

Conditions

108. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Anigala's registration. In doing so the Tribunal had regard to paragraph 81 and 85 of the SG which states:

> *'In which cases can conditions be imposed?*

81 Conditions might be most appropriate in cases:
a involving the doctor's health
b involving issues around the doctor's performance
c where there is evidence of shortcomings in a specific area or areas of the doctor's practice
d where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision.
…

85 Conditions should be appropriate, proportionate, workable and measurable.'

109. The Tribunal determined that conditions would be neither workable nor measurable in this case given the nature of the misconduct The Tribunal did not consider that any conditions could be formulated to address the risks identified in this case. The further work that is needed to develop Dr Anigala's insight involves personal development of insight into dishonesty of a broader nature, not just in clinical decision making.

110. The Tribunal therefore concluded that conditions would be neither an appropriate nor proportionate means of upholding the over-arching objective.

Suspension

111. The Tribunal reminded itself that the purpose of a sanction is not to punish the doctor but to protect the public and uphold the overarching objective. In doing so, it must maintain public confidence in the profession and uphold proper professional standards and conduct for members of the medical profession.

112. The Tribunal had regard to the relevant paragraphs of the SG. In particular it considered paragraphs 91–93 and 97(a), (e), (f), and (g). It considered each sanction in ascending order of seriousness, bearing in mind the principles of proportionality.

91 *Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*

92 *Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for*

conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated…

97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a) A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.
…
e) No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage…

f) No evidence of repetition of similar behaviour since incident.

g) The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'

113. The Tribunal had regard to its previous finding that Dr Anigala's admitted misconduct represented a serious departures from GMP and that there were also aggravating factors involved. It found that his deliberate dishonesty was directly linked to his clinical practice and maintained for a period of nine days until it was uncovered by Dr A. This was compounded by the fact that he sought to deflect responsibility onto another professional, representing a significant breach of honesty and integrity. The Tribunal considered that such conduct was capable of undermining public confidence in the profession and the trust placed in doctors to act with candour and probity. However, the Tribunal considered that Dr Anigala's behaviour, whilst serious, was not fundamentally incompatible with continued registration.

114. The Tribunal determined that, in light of the relevant paragraphs of the SG and its findings at the impairment stage of proceedings, a period of suspension was the appropriate and proportionate sanction to impose that would satisfactorily uphold the second and third limbs of the overarching objective.

Length of suspension

115. The Tribunal then went on to consider the appropriate length of suspension to impose. In doing so it bore in mind paragraph 100 of the SG, which states:

> *100 The following factors will be relevant when determining the length of suspension:*
>
> *a the risk to patient safety/public protection*
>
> *b the seriousness of the findings and any mitigating or aggravating factors*
>
> *c ensuring the doctor has adequate time to remediate.*

116. In determining the appropriate length of suspension, the Tribunal had regard to the seriousness of the dishonesty, the nine-day concealment, and the attempt to attribute responsibility to another professional. It also considered the mitigating factors, including Dr Anigala's acknowledgement of fault, his developing insight, and the absence of any repetition over a two-year period.

117. The Tribunal considered that the period of suspension must be long enough to mark the seriousness of the misconduct and to allow Dr Anigala time to demonstrate that his understanding of dishonesty extends beyond clinical decision-making to the broader principles of probity and honesty in medical practice.

118. In particular, the Tribunal was reassured that Dr Anigala now understands that it is not a weakness to seek the view of others, he understands the need to work as part of a clinical team and to ask for help and guidance when needed. However, in respect of full insight it found that Dr Anigala had failed to demonstrate a complete understanding that honesty and integrity encompass both his personal and working life. It may be that his mind was wholly focused on the clinical matters that led to his dishonesty on this occasion. However, it is important that his understanding of the need for honesty and probity encompasses all aspects of his professional and personal and working life and he needs to be able to demonstrate his understanding of this in order to have full insight.

119. The Tribunal therefore determined that a period of four months suspension from the medical register was appropriate and proportionate. This period would allow Dr Anigala sufficient time to reflect and to prepare further evidence of meaningful insight and remediation, without being unduly punitive or contrary to the public interest.

120. The Tribunal directed that the case be reviewed before the end of the period of suspension in accordance with paragraph 164 of the SG. The reviewing Tribunal would be assisted by evidence of reflection demonstrating that Dr Anigala fully understands the broader importance of probity and honesty, particularly in circumstances beyond clinical judgment, and by evidence that he has maintained his professional skills and undertaken appropriate continuing professional development during the suspension period.

Determination on Immediate Order - 09/10/2025

121. Having determined that Dr Anigala's registration should be suspended, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

122. On behalf of the GMC, Ms Gilsenan submitted that the imposition of an immediate order is in the public interest given the findings made in this case. She submitted that the public would expect an immediate order if a doctor is suspended for serious dishonesty to uphold confidence in the profession.

123. On behalf of Dr Anigala, Mr Gledhill submitted that an immediate order was not necessary. He submitted that Dr Anigala has continued to work without any patient safety concerns or repetition of any similar misconduct. He reminded the Tribunal that this is an isolated short period of dishonesty and the Tribunal has found that Dr Anigala's insight is developing, and is sufficiently developed at this point in time that the risk of repetition is low.

124. Mr Gledhill submitted that Dr Anigala's employer has been aware from the outset of his employment at Daisy Hill Hospital about these proceedings. He submitted that the public looking at this case in the round, taking into account all of the facts, would recognise that Dr Anigala is a very capable doctor who has worked without any restrictions.

125. Mr Gledhill submitted that there is no interim order currently in place as the GMC did not see fit to impose any restrictions.

The Tribunal's Determination

126. In its deliberations, the Tribunal had regard to the following paragraphs of the SG:

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

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

178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'

127. The Tribunal had regard to the basis on which it may find it necessary to impose an immediate order, which is: If necessary to protect members of the public or is otherwise in the public interest or, in the best interest of the doctor.

128. In reaching its decision, the Tribunal has balanced the relevant interests of Dr Anigala against the wider public interest.

129. The GMC, through Ms Gilsenan, makes an application for an immediate order on the grounds of public interest as set out above.

130. The Tribunal had regard to the fact that the nature and the seriousness of Dr Anigala's conduct has not changed since his initial admissions on 18 November 2023. In the intervening period, and prior to coming before this Tribunal, Dr Anigala has continued to work with no interim order placed upon him. Throughout this period there has been no concern raised about his conduct or clinical abilities, matters which are confirmed in the testimony of Dr D.

131. The Tribunal found that whilst his insight is not yet fully developed, the area in which further development is necessary is of a discreet nature as set out in the Tribunal's previous determination. Consequently, the Tribunal found that confidence in the medical profession would not be undermined by allowing Dr Anigala to return to practice pending commencement of the period of suspension if the public had full knowledge of the facts of this case.

132. The Tribunal therefore did not consider that the imposition of an immediate order would be in the public interest nor is there a need to impose the same in the doctor's interest.

133. This means that Dr Anigala's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless he lodges an appeal. If Dr Anigala does lodge an appeal, he will remain free to practise unrestricted until the outcome of any appeal is known.

134. That concludes the case.