Dr. Amos AKINBIYI

Charges

Date Charge(s) Laid:	January 20, 2024
Hearing:	Not Required
Charge(s):	Unprofessional Conduct
Outcome Date:	January 8, 2026 (Alternative Dispute Resolution)

NOTE: Allegations of unprofessional conduct as set out in the charge below have been referred to the discipline committee. The allegations in the charge have not been admitted, nor has there been a hearing before the discipline committee to determine whether the allegations in the charge will be proved.

A physician who denies some or all of the allegations in a charge is entitled to a hearing before the discipline committee to determine if the allegations in the charge are established by the evidence at the hearing.

The Council of the College of Physicians and Surgeons directs that, pursuant to section 47.5 of *The Medical Profession Act, 1981*, the Discipline Committee hear the following charge against Dr. Amos Akinbiyi:

You Dr. Amos Akinbiyi are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of Section 46(o) and 46(p) of *The Medical Profession Act, 1981*, S.S. 1980- 81, c. M-10.1; and/or paragraph (c) and paragraph 5 under the heading "Patient-physician relationship" of the Code of Ethics contained in bylaw 7.1; and/or paragraph (b) and one or more of paragraphs (a), (b), (c), or (d) under the heading "Accountability" and/or paragraph (a) under the heading "Respect for Others" and/or paragraph (y) under the heading "Responsible Behaviour" of the Code of Conduct contained in bylaw 7.2; and/or bylaw 8.1(b)(ix) of the Regulatory bylaws. Particulars of which are that you provided inaccurate or misleading information to a patient and/or failed to comply with the College policy Disclosure of Adverse Incidents.

The evidence that will be led in support of this charge will include one or more of the following:

1) A female person referred to in this charge as Patient #1 was your patient.
2) On or about March 22, 2022, you performed a forceps delivery of Patient #1 at the Regina General Hospital (RGH) and subsequently repaired her vagina and perineum.
3) During the course of the repair, you utilized gauze sponges included in the vaginal delivery equipment pack.
4) On or about March 30, 2022, Patient #1's family physician removed a gauze sponge with a blue cord from her vagina.
5) The sponge removed was the type included in the vaginal delivery equipment packs at RGH.

6) You advised Patient #1 that you had not inserted the sponge in her vagina and suggested that a nurse must have placed it there.
7) That statement was inaccurate or misleading.
8) You advised Patient #1 that an equipment count was performed at the end of the delivery, and nothing was found to be missing.
9) That statement was inaccurate or misleading.
10) In the alternative, you failed to exercise due diligence to ensure that you provided accurate information to Patient #1 after the discovery of the sponge in her vagina.