

PUBLIC RECORD**Dates:** 03/08/2026 - 19/08/2026

Doctor: Dr John WHITELEY

GMC reference number: 3340787

Primary medical qualification: MB BS 1989 University of London

Type of case	Outcome on facts	Outcome on impairment
New – Misconduct	Facts relevant to impairment found proved	Impaired
XXX	XXX	XXX
New – Conviction	Facts relevant to impairment found proved	Impaired

Summary of outcome

Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Ms Nessa Sharkett
Lay Tribunal Member:	Mr James Riley
Registrant Tribunal Member:	Dr Suzanne Joels
Tribunal Clerk:	Mr Laurence Millea

Attendance and Representation:

Doctor:	Not present, not represented
GMC Representative:	Ms Sarah Barlow, Counsel (03/08/2026 – 17/08/2026) Ms Fiona McNeill (18/08/2026 – 19/08/2026)

Attendance of Press / Public

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

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection 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 - 13/08/2026

1. The Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration or heard as evidence were confidential. This determination will be handed down in private but as this case concerns Dr Whiteley's alleged misconduct and conviction a redacted version will be published at the close of the hearing.

Background

2. Dr Whiteley qualified in 1989. Prior to the events which are the subject of the hearing, Dr Whiteley practised as a General Practitioner (GP). In 2004, Dr Whiteley moved to live in France for 14 years. During this time he practised medicine before returning to the UK

in 2017. On his return to the UK he secured a placement at the Flansham Park Health Centre in Bognor Regis where he was a returner under The Induction and Refresher Scheme. It was here that the alleged events pertaining to Patient A occurred. On completion of his placement at Flansham Park in June of 2017 Dr Whiteley commenced work as a Locum GP covering maternity leave at the Croft Surgery in Chichester. It was at this surgery that the alleged events pertaining to Patients B to G occurred. On 15 January 2018 he moved to another practice as a salaried GP.

3. The allegations that have led to Dr Whiteley's hearing relate to his clinical performance, XXX and conviction. It is alleged by the General Medical Council (GMC) that between 2017 to 2018, Dr Whiteley failed to provide good clinical care to seven patients. XXX It is also alleged that on 31 December 2024, at Worthing Magistrates Court, Dr Whiteley was convicted of fraud and theft and was subsequently sentenced to nine months' imprisonment suspended for 18 months and 200 hours of unpaid work.

4. Dr Whiteley's conviction for fraud was on the basis that while occupying a position, namely a General Practitioner, in which he was expected to safeguard, or not to act against, the financial interests of the Croft Practice, he dishonestly abused that position intending thereby to make a gain, namely writing prescriptions XXX, for himself; and for theft on the basis that he stole XXX, of a value unknown, belonging to the Croft Practice. He plead guilty to both charges.

5. The initial concerns were raised with the GMC on 25 January 2018 by NHS England, South East, following an audit of records at the Croft surgery and referral to NHS England. Dr Whiteley also self-referred to the GMC on 31 January 2018.

The outcome of applications made during the facts stage

6. The Tribunal determined that service of the notice of this hearing had been effected in accordance with Rule 40 of the GMC (Fitness to Practise Rules) 2004 as amended (the Rules). The Tribunal determined to proceed with the hearing in Dr Whiteley's absence in accordance with Rule 31 of the Rules. The Tribunal's full decision on this matter is included at Annex A.

7. The Tribunal refused Dr Whiteley's application, made pursuant to Rule 41 of the Rules, for the entirety of the proceedings to be heard in private. The Tribunal's full decision on the application is included at Annex B.

8. The Tribunal granted the GMC's application, made pursuant to Rule 35(4) of the Rules), to anonymise the names of Patients A to G throughout proceedings. The Tribunal's full decision on the application is included at Annex C.

9. The Tribunal granted the GMC's application, made pursuant to Rule 28 of the Rules, to withdraw paragraphs 9 to 11 of the Allegation. The Tribunal's full decision on the application is included at Annex D.

The Allegation and the doctor's response

10. The Allegation made against Dr Whiteley is as follows:

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

Misconduct

1. On 24 April 2017 and/or 2 May 2017, you consulted with Patient A and on each occasion you:
 - a. inappropriately administered 40mg Kenalog by injection in or around Patient A's Achilles tendon; **To be determined**
 - b. failed to arrange to see Patient A and/or review Patient A; **To be determined**
 - c. failed to adequately record your discussion with Patient A about:
 - i. the risks of administering Kenalog by injection; **To be determined**
 - ii. obtaining verbal consent from Patient A before you administered Kenalog by injection. **To be determined**
2. On 10 August 2017 and/or 21 December 2017, you consulted with Patient B and on each occasion you:
 - a. prescribed XXX when it was not clinically indicated; **To be determined**

- b. failed to adequately record any consideration of alternative treatment options for Patient B. **To be determined**
- 3. On 8 September 2017, 19 September 2017, 20 September 2017 and/or 7 October 2017, you consulted with Patient C and on each occasion you:
 - a. prescribed XXX when it was not clinically indicated; **To be determined**
 - b. failed to adequately record any consideration of alternative treatment options for Patient C. **To be determined**
- 4. On 7 November 2017 and/or 28 November 2017, you consulted with Patient D and on each occasion you:
 - a. prescribed XXX when it was not clinically indicated; **To be determined**
 - b. failed to adequately record any consideration of alternative treatment options for Patient D. **To be determined**
- 5. On 7 December 2017, 12 December 2017, 15 December 2017 and/or 20 December 2017, you consulted with Patient E and on each occasion you:
 - a. prescribed XXX when it was not clinically indicated; **To be determined**
 - b. failed to adequately record any consideration of alternative treatment options for Patient E. **To be determined**
- 6. On 3 January 2018 you consulted with Patient F and you:
 - a. prescribed XXX when it was not clinically indicated; **To be determined**
 - b. failed to adequately record:
 - i. Patient F's consent to administer XXX; **To be determined**

- ii. any consideration of alternative treatment options for Patient F. **To be determined**
7. On 5 January 2018, you consulted with Patient G and you:
- a. prescribed XXX when it was not clinically indicated; **To be determined**
 - b. failed to:
 - i. consider alternative treatment options for Patient G; **To be determined**
 - ii. provide adequate safety netting advice to Patient G. **To be determined**
8. In relation to paragraphs 1 to 6 above, your record keeping was inadequate in that you failed to adequately record any discussion about safety netting with Patients A, B, D, E and F. **To be determined**
- ~~9. Between 18 August 2017 and 3 January 2018, on one or more of the occasions set out in Schedule 1, you prescribed XXX to a patient and on one or more of the occasions:~~
- ~~a. the full dose of XXX you prescribed was not intended for use by the patient; **Withdrawn under Rule 28**~~
 - ~~b. you administered some of the XXX to the patient and self-administered some or all of the remaining dose of XXX. **Withdrawn under Rule 28**~~
- ~~10. On one or more of the occasions set out in Schedule 1, you knew that:~~
- ~~a. the full dose you had prescribed was not intended for use by the patient at the time you prescribed it; **Withdrawn under Rule 28**~~
 - ~~b. you would not be administering all the XXX to the patient at that time; **Withdrawn under Rule 28**~~

~~e. you would self administer some or all of the remaining dose of XXX.~~

Withdrawn under Rule 28

~~11. Your conduct as described at paragraph 9 was dishonest by reason of paragraph~~

~~10. **Withdrawn under Rule 28**~~

XXX

12. XXX

13. XXX

Conviction

14. On 31 December 2024, at Worthing Magistrates Court, you were convicted of, on or before 5 January 2018, at Eastergate:

a. committing fraud, in that while occupying a position, namely a general practitioner, in which you were expected to safeguard, or not to act against, the financial interests of the Croft Practice, you dishonestly abused that position intending thereby to make a gain, namely writing prescriptions XXX, for yourself; **Admitted and found proved**

b. theft, in that you stole XXX, of a value unknown, belonging to the Croft Practice. **Admitted and found proved**

15. On 3 February 2025, you were sentenced to:

a. imprisonment for 9 months, concurrent, suspended for 18 months;
Admitted and found proved

b. unpaid work of 200 hours, to be completed within 12 months. **Admitted and found proved**

And that by reason of the matters set out above your fitness to practise is impaired because of your:

- a. misconduct in respect of paragraphs 1 to ~~11~~ 8; **Amended under Rule 28, To be determined**
- b. XXX
- c. conviction in respect of paragraphs 14 and 15. **To be determined**

The admitted facts

11. In his Rule 7 response letter, provided via his legal representatives and dated 5 November 2025, Dr Whiteley made admissions to some paragraphs 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 of the Allegation as admitted and found proved.

The facts to be determined

12. In light of Dr Whiteley's response to the Allegation made against him the Tribunal is required to determine whether Dr Whiteley failed to provide good clinical care to Patients A to G.

Witness evidence

13. The GMC produced a witness statement prepared by Patient G dated 28 April 2026. Patient G was not called to give oral evidence before the Tribunal.

14. Through his representatives Dr Whiteley provided a Rule 7 response letter, dated 5 November 2025.

Expert witness evidence

15. XXX

16. The Tribunal also heard evidence from two expert witnesses who had been instructed to prepare reports on behalf of the GMC. Dr J, GP, provided an expert report dated 27 December 2017, followed by further reports dated 18 November 2021 and 25 March 2026. Further opinion of Dr J is contained in an email dated 24 June 2026. Dr K, GP, produced an

expert report dated 30 July 2019. The Tribunal was also provided with a joint report of the experts, Dr J and Dr K 18 May 2026.

17. Their evidence was directed at assisting the Tribunal in understanding the professional standards to be expected of a GP and the standard of care given by Dr Whiteley to Patients B to G. In respect of Patient A only Dr J was asked to produce an expert report.

Documentary evidence

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

- Certificate of Conviction dated 4 April 2025;
- Pre – sentencing report dated 30 January 2025;
- Documents from Sussex Police, various dates;
- Medical Records for Patients A to G.

The Tribunal's approach

19. In reaching its decision on the facts, the Tribunal will apply the civil standard of proof. This means that the Tribunal must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged. The burden of proof rests with the GMC and it is for the GMC to prove the case that it is presenting against Dr Whiteley. There is no burden on the doctor to prove or disprove anything.

20. The Tribunal will approach fact finding by firstly identifying agreed facts and evidence. Dr Whiteley has not denied that he administered the medications to the patients set out in the Allegation but denies that they were not clinically indicated. He further denies all allegations relating to record keeping. In reaching its decision the Tribunal will consider all oral and documentary evidence in the round and subject the same to careful scrutiny. It will not focus on parts of the evidence that supports an allegation but will ensure that all evidence is considered. It reminds itself that it is not bound by the evidence of the experts but where it determines that the opinion of one expert is preferred over the other it must give clear reasons for doing so. Similarly it is open to the Tribunal to accept or reject any part or parts of the reports but must give reasons for its decision. The Tribunal reminds itself that

the confidence or otherwise of a witness alone should not form the basis upon which reliability or credibility is established.

The Tribunal's analysis of the evidence and findings

21. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence to make its findings on the facts.

Paragraph 1

22. Dr Whiteley treated Patient A for Achilles Tendonitis by giving him Kenalog, a steroid injection in the vicinity of the tendon on two occasions. Patient A subsequently developed a ruptured Achilles tendon and attended Accident and Emergency ('A&E').

23. The medical notes of Patient A record that they were seen by Dr Whiteley on 21 April 2017 and complained of Achilles tendonitis. Patient A returned to see Dr Whiteley again on 25 April 2017 to complain that they were getting worse and there had been no improvement with the generic advice he had been given. At this consultation it is recorded that Dr Whiteley administered Kenalog, a steroid injection. On 2 May 2017 when Patient A returned to see Dr Whiteley he administered what is recorded to be a supplementary infiltration of steroid in a slightly higher location than before. Patient A subsequently suffered a rupture to the Achilles tendon which led to an intensive period of rehabilitation and permanent reduced mobility.

1(a)

24. In reaching its decision on whether it was inappropriate to administer 40mg of Kenalog by injection in or around Patient A's Achilles tendon the Tribunal has had regard to the expert report of Dr J, Dr Whiteley's Rule 7 response and the applicable medical records. It should be noted that Dr K has not been instructed to prepare a report in respect of Patient A.

25. Dr J is of the opinion that:

"The most appropriate referral was to physiotherapy, which had already been made.

...

Achilles tendinitis is a very clear cut diagnosis and had already been made and treatment initiated.

...

I have conducted a general internet search and cannot find any evidence that injection into or around the Achilles tendon is an authorised procedure in the UK. Furthermore, in it's Clinical knowledge Summary (Achilles tendinopathy), NICE specifically states; "Do not inject corticosteroids into or around the Achilles tendon". The reason for this is the high risk that the injection of corticosteroids will cause the Achilles tendon to rupture.

Dr Whiteley not only injected corticosteroid in or around the Achilles tendon, but he repeated this a week later. Additionally, Patient A was frail and already taking oral steroids. In my opinion this put Patient A at high risk of a ruptured Achilles tendon.

Patient A had already had physiotherapy and Dr Whiteley had tried topical anaesthesia. In my opinion the only other treatment would have been oral anti-inflammatory agents which would have been contraindicated because of Patient A's frailty and because he was taking warfarin. In my opinion Dr Whiteley should have continued existing treatment without attempting to inject steroids.

In my opinion, Dr Whiteley's use of steroid injections in or around the Achilles tendon was seriously below the standard expected of a reasonably competent General Practitioner. I say seriously below because of the very high risk that Patient A would suffer a ruptured Achilles tendon, which carries a significant morbidity."

26. In his Rule 7 letter Dr Whiteley explains that at the time he treated Patient A he was undertaking the Induction and Refresher scheme and placed at the surgery where Patient A was registered. He explained that Patient A had requested the injection as previous alternative and conservative treatments to treat their Achilles tendon problem had not been successful. In the Rule 7 letter he went on to explain that at the time of the consultations with Patient A Dr Whiteley believed that a corticosteroid injection was a suitable option to treat the Achilles tendon. He explained that over time and with developments in medicine, Dr Whiteley appreciated that an injection around load-bearing tendons was not advised as the risk of rupture may outweigh functional benefits. The Rule 7 letter goes on to state:

...

Dr Whiteley appreciates and understands the concerns that have been raised by the GMC's expert, Dr J, about Patient A in his report...

...

Dr Whiteley confirms that after he saw Patient A he discussed this case with a senior partner at Flansham Park Health Centre and it resulted in Dr Whiteley reflecting on this case and him attending an RCGP Minor Operations Course in 2017. Dr Whiteley also modified his clinical practice (in designing and implementing a written consent form to be scanned into patients notes) and confirms, with hindsight and with changes in how similar cases such as Patient A should be managed, that he would treat patients presenting in the same way differently."

27. In explaining his expertise in relation to the report he had been commissioned to prepare Dr J states:

"I have been and continue to be, a GP principal since 1985 covering the full range of GP services. In addition to this I have been using steroid injections for the treatment of musculoskeletal conditions since 1983 and continue to undertake an average of 5 such injections per week."

28. The Tribunal accepted the expert evidence of Dr J in respect of the inappropriateness of the procedure, noting his experience in this field and that both NICE guidelines and the *British National Formulary* (Medicine) demonstrate this was contraindicated. In oral evidence, Dr J's opinion was that such a procedure was never recommended as appropriate due to the known risk of rupture of the tendon and the potential lifelong mobility problems that can follow. Dr J recalls that this was not an approved method of treatment for Achilles tendonitis even when he was a student in 1978. In his report Dr J also refers to the NICE guidelines which in its Clinical knowledge Summary (Achilles tendinopathy), NICE specifically states; *"Do not inject corticosteroids into or around the Achilles tendon"*.

29. The Tribunal further noted that in a letter from Patient A's GP dated 13 June 2018 and in respect of the ruptured Achilles tendon, they write *"One of the factors involved in this condition was the injudicious use of steroid injections..."*

30. It was clear to the Tribunal on the basis of the evidence before it that the administration of 40mg of Kenalog by injection in or around Patient A's Achilles tendon was not accepted practice in the UK. The Tribunal did not accept Dr Whiteley's explanation of this being a practice that had changed "*Over time and with developments in medicine*". The Tribunal accepted Dr J's expert evidence that this was a procedure that had not been accepted practice since as far back as 1978 and consequently determined that it had been inappropriate to administer 40mg of Kenalog by injection in or around Patient A's Achilles tendon and found paragraph 1(a) proved.

1(b)

31. The Tribunal next considered whether Dr Whiteley failed to arrange to see Patient A and/or review Patient A.

32. Dr Whiteley's Rule 7 response states:

"As stated above, Dr Whiteley noted "advise sos" (see above) in his notes, meaning Patient A should contact the surgery if the problem persists in order to be reviewed. The record on 9 May 2017 ... shows that Patient A consulted with [Dr L]."

33. Dr J's expert report states that:

"At no point that I can see in the medical record did Dr Whiteley document that a review was necessary or document any safety netting.

In my opinion at the consultation of 21/4/2017, when Dr Whiteley simply prescribed topical treatment for an ongoing condition it was not necessary to arrange review or to safety net.

However, on 24/4/2017 and 25/4/2017, Dr Whiteley injected steroids which I have already explained was a high risk procedure that did not have approval in the UK. In my opinion, given that Patient A was frail and was on warfarin, which could increase the risk of haematoma formation Dr Whiteley should have safety netted by at least stating to Patient A that if he had any concerns at all he should contact Dr Whiteley. In my opinion, given the risks involved, Dr Whiteley should have also arranged to see Patient A and ensure that he was not running into problems. I note that on 25/4/2017,

Dr Whiteley documents “advice sos” though it is not clear what this means and I do not consider this to be sufficient given the circumstances.

In my opinion, in this case where steroid injections were administered in or around the Achilles tendon, Dr Whiteley failed to adequately review or safety net. In my opinion this was seriously below the standard expected of a reasonably competent General Practitioner because of the significant risk Patient A was exposed to.”

34. Furthermore, in his additional report which addresses Dr Whiteley’s response in the Rule 7 letter, Dr J states:

“Dr Whiteley does say he explained some of the risks and benefits however, given that steroid injections to the Achilles tendon are absolutely contraindicated not only by NICE but also by The BNF 72 September 2016 to March 2017 page 1000, Dr Whitely would have had to explain to Patient A that the injection was being given against medical advice (on two occasions).”

35. The Tribunal had regard to the fact that Dr Whiteley’s clinical judgment was that the administration of Kenalog in the circumstances of Patient A was appropriate. However, the Tribunal accept that this was a procedure that was positively rejected as being appropriate by NICE as set out above. The Tribunal reminded itself that all medical practitioners have a duty to keep their knowledge and practice up to date. It noted that at the time of these events Dr Whiteley was undergoing a period of induction and refreshment of his knowledge and practice. Dr J explained to the Tribunal that in circumstances where a medical practitioner is administering medication that is not approved in the UK and has a high degree of risk associated with it he would expect a reasonably competent GP to review the patient 2-3 days later and to give express advice about contacting A&E if there were problems before then. The Tribunal accepted the evidence of Dr J and determined that a lack of knowledge of the extent of the risk to Patient A did not abdicate Dr Whiteley of his responsibility to arrange a review of Patient A who was in their 80s with co-morbidities.

36. The Tribunal had regard to Dr Whiteley’s explanation that the use of shorthand such as “SOS PRN” in the record he made is indicative of the fact that he told Patient A that he should contact the surgery if the problem persisted in order to be reviewed and that this had in fact happened. In his oral evidence, Dr J stated that all GPs use abbreviations and in the majority of simple cases in general practice it is quite standard and reasonable to use shorthand and accepted that ‘SOS’ is often used. However, he reiterated his position that the

use of such shorthand was insufficient in the circumstances of this particular case because it was such a dangerous and unapproved procedure. Dr J's opinion was that he would have expected Patient A to be told that if he had any problems at all to contact Dr Whiteley straight away and for Patient A to be seen again in two or three days to check that he was not developing any significant problems.

37. The Tribunal had regard to the use of the shorthand adopted by medical practitioners and in considering the evidence in the round, the evidence of Dr K in respect of this as set out below, albeit in relation to patients B-G on whom she had been asked to opine. However, the Tribunal considered that whilst the note *"advise sos"* may have been appropriate to use generally or for common, or low-risk procedures, in the circumstances of this case something more was required for the reasons set out above. The Tribunal accepted that Dr Whiteley should have arranged an appropriate review, in line with Dr J's expert opinion and he did not.

38. The Tribunal therefore found paragraph 1(b) of the Allegation proved.

1(c)(i)

39. The Tribunal had regard to the medical record made by Dr Whiteley in respect of the risk of administering Kenalog by injection. In doing so it reminded itself that this was an unapproved practice and was contraindicated by NICE and the BNF. It is Dr Whiteley's case that he did record the discussion he had with Patient A about the risks and benefits and in his Rule 7 response states:

"Dr Whiteley confirms that "R vs B" is his shorthand for recording "risks vs benefits". He confirms that he did explain the risks and benefits of administering Kenalog to Patient A. This includes discussing localised pain, therapeutic failure, the risk of a rupture (1 per 1000) and localised infection.

40. In respect of the discussion about the risks of administering Kenalog by injection and consent the relevant entries in the notes are as follows:

*"25 April 2017 include Plan: IVC RvBs infiltration advise 'sos' and
2 May 2017 include "Plan: Steroid injection for tenosynovitis (XaPsJ) asvise [sic] sos".*

41. In his oral evidence, Dr J accepted that the notes were an indication that some risks and benefits were possibly discussed, but it was his opinion that in this particular case, because of the high risks, it was important to document that the patient was informed that there was a very high risk of rupturing the tendon which could lead to permanent mobility problems, especially at his age and frailty. In addition to this, Patient A should have been told and it should have been documented this was not an approved practice in the UK.

42. In his Rule 7 response, Dr Whiteley accepted that he should have written out the risks and benefits that were discussed in more detail.

43. In reaching its decision the Tribunal also noted paragraph 21(c) of Good medical practice (2013) (GMP), which states:

21 Clinical records should include:

...

c the information given to patients

...

44. The Tribunal determined that although the use of shorthand may be an acceptable form of record keeping for a number of situations in medical practice today, it was not adequate for the recording of the risks and benefits associated in the administration of unapproved and contraindicated medications such as this. The Tribunal accepted Dr J's evidence that the risks and benefits of administering Kenalog by injection to Patient A should have been set out in more detail given the high level of risk and that there should have been clear documentation that what was being administered was not approved and contraindicated in current practice. The Tribunal determined that Dr Whiteley had failed to adequately record his discussion with Patient A about the risks of administering Kenalog by injection and found paragraph 1(c)(i) of the Allegation proved.

1(c)(ii)

45. In respect of Dr Whiteley's record keeping of the discussion about the consent obtained by Patient A, to the treatment Dr J's opinion is that:

“In my opinion Dr Whiteley did not document adequate review or safety netting.

In my opinion Dr Whiteley should have documented verbal consent on 25/4/2017 and 2/5/2017 when he administered steroid injections. In my opinion not only should verbal consent have been obtained and documented Dr Whiteley should have documented that he had explained the high risks to Patient A.

In my opinion, in this case Dr Whiteley’s record keeping was inadequate and seriously below the standard expected of a reasonably competent General Practitioner. I say seriously below because of the lack of review or safety netting ... and the lack of documented verbal informed consent.”

46. During his oral evidence, in response to a query from Ms Barlow, Dr J explained that in a lot of cases in general practice you can rely on verbal consent, but that for something as serious as this written consent should be obtained.

47. In his Rule 7 response Dr Whiteley states:

“...

The letters “IVC” in the note of 25 April 2017 above is an abbreviation for “Informed Verbal Consent” and signifies that Dr Whiteley did explain the risks and benefits of the Kenalog injection to Patient A (see above) and that he obtained Patient A’s verbal consent to proceed with the injection.

Although Dr Whiteley did not note “IVC” on 2 May 2017, he did obtain Patient A’s consent in the previous consultation on 25 April 2017. The note of 2 May 2017 includes “advise” and Dr Whiteley confirms that he would have advised / repeated the same advice regarding Kenalog to Patient A.

However, in hindsight, Dr Whiteley accepts that he should have recorded “IVC” again on 2 May 2017 and written out the risks and benefits that were discussed in more detail and noted that verbal consent was obtained clearly.

...

Dr Whiteley, on reflection, accepts that his notes could have been fuller; however, the fact is he did make notes.”

48. The Tribunal had regard to the edition of GMC guidance on Consent: *Patients and Doctors making decisions together*, (the Guidance) that was in force at the time of these events.

49. In particular it noted at paragraph 36 the obligation to keep up to date with developments in a doctor’s particular area of practice which may affect a doctor’s knowledge and understanding of the risks associated with investigations or treatments they provide, and at paragraph 47 that, in cases which involve higher risk it is important that the written consent of the patient is obtained. The paragraph states that this is so everyone involved understands what was explained and agreed.

50. The Tribunal considered that the administration of Kenalog by injection to Patient A was the type of higher risk envisaged at paragraph 47 of the Guidance. The Tribunal determined that whilst the procedure undertaken was in breach of NICE guidelines and carried a high level of risk, consent could still be given if the risks and benefits had been adequately discussed with the patient. It concluded that in the absence of further detail of such a discussion and given that the only reference to consent in the records was the inclusion of “IVC” on the first occasion, Dr Whiteley had failed to adequately record any conversation around consent. Whilst the evidence before the Tribunal was that “IVC” is a term used commonly in practice, the Tribunal accepted the evidence of Dr J that this was insufficient given the nature of the procedure and the associated risks, particularly given Patient A’s age and condition.

51. The Tribunal therefore found paragraph 1(c)(ii) of the Allegation proved.

52. The Tribunal also considered paragraph 8 of the Allegation in respect of Patient A, namely that Dr Whiteley’s record keeping was inadequate in that he failed to adequately record any discussion about safety netting with Patient A. In determining this paragraph the Tribunal considered that in the absence of a definition, the term “*safety netting*” refers to information given to patients or carers so they know how and when to seek further medical help if their symptoms change, worsen, or fail to improve.

53. The Tribunal considered that Dr Whiteley could not have given adequate safety netting advice to Patient A because at the time he did not fully appreciate the risk of the

procedure or that it was outside the applicable guidance and was contraindicated. The Tribunal noted there was no record of any discussion about safety netting save for the inclusion of “RVB” and “SOS” within Patient A’s records.

54. For the same reasons as set out above, the Tribunal determined that Dr Whiteley had a duty to provide and record safety netting advice to Patient A but that no such advice was included within the medical records. Accordingly, the Tribunal found paragraph 8 of the Allegation proved in respect of Patient A.

Paragraph 2 - 8

55. For Patients B to G the Tribunal had been provided with the expert opinions of both GMC expert witnesses, Dr J and Dr K. Whilst it considered the opinions of both experts in respect of each allegation individually, as set out below, it first identified the specific areas of agreement and disagreement which were set out in the joint report of 18 May 2026.

56. The Tribunal identified two key areas where the experts, at least to some extent, disagreed. The first was in respect of circumstances where the administration of XXX was or was not clinically indicated and the second on the circumstances in which the shorthand form of record keeping adopted by Dr Whiteley was adequate for the purposes of achieving the standard expected of a reasonably competent GP.

57. The Tribunal had been made aware that both expert witnesses had prepared their reports and gave evidence on the basis of acceptable clinical practice only and had not been made aware that XXX. Neither had been made aware of the fact or detail of his conviction relating to the dishonest abuse of his position in order to obtain prescriptions XXX for his personal use.

58. The Tribunal was satisfied that both experts had the necessary experience and expertise to provide the opinion asked, although their experiences had not been identical. The Tribunal noted that Dr J had qualified as a doctor prior to Dr Whiteley and has considerable experience as a GP, and in XXX. He explained that whilst XXX in general practice used to be frowned upon many years ago he had been one of the first to be trained in XXX and had been doing so since 1983. He confirmed that he continued to XXX on a regular basis although he no longer worked as many hours now. Dr K, also has considerable experience as a GP having been in practice for over 20 years. In addition to her role as a GP she also handles complaints at the practice in which she is a partner. In oral evidence Dr K confirmed that she

no longer carried out XXX. The standard to be considered in respect of Dr Whiteley's actions was that of a reasonably competent GP measured by the standards and practice at the time of the alleged events and the Tribunal was therefore required to, where possible, reach a decision on which expert's evidence it preferred and why.

59. In terms of the use and administration of XXX in general practice Dr K's opinion was that in the past the administration of XXX had been common practice and was current practice at the time of Dr Whiteley's qualification as a doctor. Her evidence was that whilst it is not current practice for GPs to carry or frequently administer XXX now, historically this was more frequent and considered acceptable. Dr K explained that whether or not XXX was clinically indicated for any particular patient was not as simple as deciding whether there were now more modern XXX available for patients. She was of the opinion that whether or not a doctor chose to prescribe XXX would depend on how the patient presented and the training a doctor had received in respect of XXX. Her opinion was that if XXX was used appropriately she would not be critical of the choice of the same. She further explained that as Dr Whiteley had trained a considerable number of years ago when XXX had perhaps been used more frequently for XXX, she was prepared to give him the benefit of the doubt in respect of his choice of treatment as long as there was no risk of harm to the patient. She therefore assessed his practice more within this context.

60. Dr J's opinion differed to that of Dr K in that he generally took a stricter view on the use of XXX and did not accept either that its historic use was as prevalent as suggested by Dr K, or that it was appropriate to assess its current use by historical standards and practice. In oral evidence Dr J accepted that XXX had in the past been routinely carried by GPs but that this was not the case now. He explained that in the past GPs used to XXX. He explained that GPs no longer do out of hours on-call and it would be paramedics who were the First Responders not GPs. XXX

61. Both experts agreed that the routine administration of XXX when XXX was not appropriate.

62. In respect of the use of shorthand in record keeping, both experts agreed that it was generally common practice amongst GPs who were under considerable time pressure. In oral evidence when questioned about the use of such terms as '*SOS PRN*' and '*RVB*'s Dr K confirmed that these were all references familiar to her and commonly used in practice. She described it was not only common practice but also acceptable practice which would not cause confusion to other medical practitioners. She explained that she would consider the

use of the same to be normal medical practice and that seeing it in the notes would mean she would have no concerns as she would expect that a reasonably competent GP would have given the correct advice. She explained that this type of shorthand had been adopted for practical purposes because there was not the time to document detailed transcripts of discussions. She accepted that she did not use shorthand herself but explained that she had stopped using it as a result of her experience in handling complaints for the surgery. Whilst she encouraged colleagues to make more detailed notes where necessary she accepted that more detailed record keeping had led to her being the last person out of the surgery each night, usually about 8pm.

63. In respect of the administration of XXX and XXX, Dr K, in oral evidence explained that written consent for XXX is not and never has been obtained, but it would be necessary to obtain verbal consent. However, she further explained that many doctors do not write down that consent has been given for XXX and for that reason she had no concerns. Dr J agreed that only verbal consent for XXX would need to be obtained.

64. Dr J accepted that all GPs, including himself, use abbreviations or shorthand and that in the majority of cases it is standard practice and reasonable to use such terms such as ‘SOS’. However, his opinion was that there are occasions such as the giving of XXX or the use of XXX where it would be important to document what the patient had been told. Dr J acknowledged the pressure of time placed on GPs but whilst not being able to give an opinion on where the extra time would be found to keep detailed records on patients, he insisted that to fail to do so would be seriously below the standard expected of a reasonably competent GP.

65. Broadly speaking, both Dr J and Dr K agreed that when dealing with common, low-risk procedures succinct, abbreviated notes were acceptable, but that for more complicated or high-risk practices more detailed and explicit notes were required. The main area of disagreement between them in this respect was the circumstances in which more detailed recording would be expected. Dr J’s opinion was that the use of XXX fell within the scope of procedures requiring more thorough records, whereas Dr K’s opinion was that whilst there may be circumstances in which it did, generally speaking it did not. The Tribunal were of the view that whilst full and detailed notes would obviously be the preferred ‘gold standard’ option the reality of the situation was that this was not always possible given the very real time pressures placed on GPs today. The Tribunal accepted that terms such as “RVB” (risks versus benefits), “SOS” (seek help if condition worsens or changes) and “PRN” (as needed) were a common and acceptable use of shorthand in general practice and gave no cause for

concern amongst GPs in the majority of situations. However, the Tribunal accepted the opinion of both experts that there were occasions when more detailed records of discussions would be required. The Tribunal has assessed the appropriateness or otherwise of their use, where possible, in respect of each relevant paragraph of the allegations and the particular circumstances of each patient.

2(a)

66. Over the period from 4 July 2017 to 21 December 2017, Patient B had multiple consultations with Dr Whiteley and other GPs at the Croft Surgery. The two consultations specifically relevant to the Allegation were those in which XXX was administered, on 10 August 2017 and 21 December 2017.

67. On 20 July 2017 it is recorded in Patient B's notes that he attended the surgery with XXX. He attended again on 3 August when Dr Whiteley administered XXX. It is recorded that XXX was given at the request of Patient B.

68. On 10 August 2017 Patient B attended the surgery with his wife and is recorded as experiencing XXX Dr Whiteley administered XXX and XXX. Dr Whiteley also prescribed XXX and administered XXX.

69. XXX appears to have been effective by 24 August 2017 and he was advised to continue with XXX. By 6 November 2017 Patient B has already been prescribed XXX by Dr M.

70. On 21 December 2017, Patient B had XXX. It is recorded that Patient B requested XXX. Prior to administering XXX, Dr Whiteley prescribed XXX and administered XXX to Patient B.

71. The experts agreed that Patient B was experiencing XXX functional impairment, that Dr Whiteley's clinical assessment was not itself criticised, and nor was the use of XXX. The experts disagreed on whether the administration of XXX was clinically indicated and on whether the documented safety-netting was adequate.

72. The Tribunal noted that XXX on two occasions alongside XXX. The medical records clearly indicate that XXX on 10 August was XXX. In respect of this consultation Dr J records in his report:

10/8/2017 Patient B was given [XXX], whilst concurrently been given [XXX].

73. In the absence of any evidence to the contrary the Tribunal concluded that neither XXX nor XXX would have contributed to XXX experienced by Patient B XXX. It determined that for the reasons set out above the opinion given in respect of XXX administered on 10 August 2017 could not be relied upon.

74. Dr K has predicated her opinion that the administration of XXX to Patient B was appropriate primarily because she was of the opinion that he was not XXX by 6 November 2026. In her report she opines:

“On both occasions Patient B complained of [XXX] in the consultation and based on his medication history at the time (he was already on [XXX]) I consider that [XXX] and the dosage used was clinically indicated and as such of a standard expected of a reasonably competent General Practitioner”.

75. The Tribunal has carefully scrutinised the medical records available for Patient B and can find no evidence that Patient B was on XXX on 10 August when he first received XXX.

76. Dr K’s written opinion was that the prescription and administration XXX was not inappropriate in the circumstances, she considered that Patient B had XXX during the relevant period. Dr K considered XXX to be a low dose in the context of Patient B’s XXX background and did not consider that Dr Whiteley’s management fell below the standard expected.

77. Whilst this conclusion may be relevant to her opinion in respect of XXX administered on 21 December 2017, for the reasons set out above it cannot be relied upon for the opinion reached in respect of 10 August 2017. The Tribunal find that the conclusion in relation to XXX administered on 10 August 2017, was reached on a false premise and cannot be relied upon.

78. Given the absence of reliable evidence in respect of the administration of XXX on 10 August 2017, the Tribunal find that the GMC has failed to discharge the burden to show that on the balance of probabilities it was not clinically indicated.

79. However, on 21 December 2017, Patient B had attended in respect of his ongoing XXX and requested a further XXX for this. Since the consultation on 10 August 2017, Patient B had attended XXX and by no later than 6 November 2017 had been prescribed XXX. The dosage of

these XXX had been increased and it was not clear on what basis XXX was clinically indicated. Dr J's opinion was:

21/12/2017. Patient B was given [XXX] before being given [XXX]. In my opinion whilst being eminently treatable with [XXX] it would, in my opinion, be extremely unusual for [XXX] to be given at the same time. I have [XXX] for over 30 years and have never had to consider giving [XXX] at the same time. In my opinion [XXX] was not clinically indicated on either occasion when it was given

80. Dr K's opinion was that XXX administered on 21 December 2017 was clinically indicated and a low dose in light of Patient B's XXX background. Dr K explained in oral evidence that hypothetically if she had been faced with the same situation XXX she would have increased the medication and given the patient something for XXX.

81. The Tribunal having regard to the evidence in the round noted that this was an approach that was agreed as appropriate by both experts in respect of patients who were already on XXX with an opportunity to increase the dosage of the same to optimise XXX. Whilst the Tribunal accepted that there was no general prohibition on prescribing XXX it was clearly not something that was common practice at that time. The Tribunal did not agree that Dr Whiteley's practice should be measured against the background in which he had trained. Dr Whiteley had left the UK to work in France and in order to renew his registration with the GMC on his return was required to undergo an induction and refresher course into practice in the UK. It also noted the obligation for Doctors in the UK to keep their knowledge and practice up to date. Against this background the Tribunal noted that Dr Whiteley had XXX. It further noted that he had prescribed XXX in excess of the dosage given to Patient B which had not been accounted for elsewhere as would be required of a controlled drug. The Tribunal heard evidence that XXX comes in XXX, and it is usual practice for any remainder to be safely disposed of after treating the patient. It noted that by his own admission to NHS England and to the police Dr Whiteley had prescribed the additional XXX for his own personal use.

82. In these circumstances the Tribunal found that whilst there may have been a need to provide XXX to Patient B on 21 December 2017 by reason of XXX, the use XXX as opposed to XXX, was not clinically indicated. On the balance of probabilities and having regard to all the evidence in the round, the Tribunal found that it was more likely than not that Dr Whiteley chose not to use the alternatives methods XXX available to him for reasons related to him personally and not by reason of being clinically indicated for Patient B.

83. The Tribunal therefore found paragraph 2(a) of the Allegation not proved in respect of 10 August 2017 but proved in respect of 21 December 2017.

2(b)

84. The Tribunal then went on to consider whether Dr Whiteley failed to adequately record any consideration of alternative treatment options for Patient B on 10 August 2017 and/or 21 December 2017.

85. Dr K's opinion was that *"based on the history documented in the clinical records, Dr Whiteley's administration of [XXX] and consideration of alternative treatment options was appropriate and as such of the standard expected of a reasonably competent General Practitioner."* The records referred to previous measures, including XXX. Dr K therefore considered that there was an adequate record of alternative treatment options.

86. Dr J's opinion was that alternative management options were not adequately considered in relation to the decision to administer XXX and that the standard of care fell seriously below that expected. His view was that an appropriate alternative would have been to administer XXX alone and review the patient's response before considering any further XXX escalation.

87. The Tribunal had regard to the records made by Dr Whiteley and agreed with the opinion of Dr K that he had recorded consideration of alternative treatment options, as set out in his records. The Tribunal accepted that the notes of 21 December 2017 lacked the detail of 10 August 2017, that latter consultation followed the history and context set out and recorded in August.

88. Accordingly, the Tribunal determined that irrespective of its finding that the administration of XXX was not clinically indicated, Dr Whiteley had recorded consideration of alternative treatment options and found paragraph 2(b) of the Allegation not proved.

89. The Tribunal also considered paragraph 8 of the Allegation in respect of Patient B, namely that Dr Whiteley's record keeping was inadequate in that he failed to adequately record any discussion about safety netting with Patient B.

90. The opinion of Dr J was that as XXX was administered, clearer documentation should have been made of XXX observation, side-effect advice, XXX, safe transport home, and confirmation that Patient B's wife could monitor him. Dr J accepted that whilst the shorthand used by Dr Whiteley in his records indicated that something had been discussed it was not possible to identify precisely what.

91. Dr K's opinion was that Dr Whiteley had documented risk versus benefit, written consent and SOS/PRN advice, which for the reasons as set out above in relation to her expert evidence, she considered to be evidence that safety-netting had been appropriately discussed and documented.

92. The Tribunal also considered the evidence of Dr K that where reference is made to risks versus benefits being discussed it would be reasonable to expect to be able to rely on the fact that a reasonably competent general practitioner would have given the relevant advice needed.

93. Having had regard to all the evidence in the round, including the use of shorthand in general practice and the difficulties experienced by GPs in being able to complete more comprehensive notes relating to matters that would be obvious to other practitioners, it preferred the opinion of Dr K. Dr K was quite clear about how she, as someone working in full time general practice and dealing with complaints arising within the practice in which she worked, would interpret the shorthand used by GPs working today. The Tribunal determined that Dr Whiteley had, in respect of the particular circumstances of this case, adequately recorded consideration of alternative treatments for Patient B.

94. Similarly and for the same reasons set out above, the Tribunal found that the GMC has failed to discharge the burden of showing that Dr Whiteley had failed to adequately record any discussion about safety netting. Accordingly, it found paragraph 8 of the Allegation not proved in respect of Patient B.

Paragraph 3

95. Dr Whiteley admits that he prescribed XXX to Patient C on the dates alleged but denies that the prescriptions were not clinically indicated. Patient C was an elderly patient who had presented on 8 September 2017 with XXX. The records also refer to multiple consultations for other medical problems, including XXX. Patient C was prescribed multiple medications, including XXX, and there were concerns about polypharmacy.

3(a)

96. The medical record of 8 September 2017, records that Patient C was already taking XXX. The consultation recorded XXX. Dr Whiteley prescribed XXX and administered XXX to Patient C and also gave XXX. The notes record that XXX was administered to XXX. The plan documented by Dr Whiteley was to stop XXX and move the patient onto XXX twice daily. The rationale appears to have been that XXX.

97. Dr K's view was that this followed a reasonable XXX pathway, particularly given that the patient was already on XXX. XXX, she was of the opinion that the administered XXX dose was not considered XXX compared with the patient's XXX.

98. Dr J's view was that, despite XXX, giving XXX to a frail 78-year-old patient in a community setting was risky, particularly where XXX appeared to be used to facilitate XXX, rather than to treat an acute emergency.

99. Following the consultation on 8 September 2017, Dr Whiteley prescribed XXX and advised that XXX should be stopped or weaned. Patient C was therefore on XXX and XXX. On 19 September 2017, the notes record that Dr Whiteley visited the patient at home and whilst they reported an improvement with XXX they complained of XXX. On this occasion Dr Whiteley prescribed XXX and recorded the administration of XXX to Patient C, who continued to have XXX. The experts disagreed about whether repeated XXX were an appropriate or safe way to manage Patient C at this time.

100. On 20 September 2017, a further XXX was administered. By this stage, Patient C had already been started on XXX, and which may have been increased to XXX. It is recorded that Dr Whiteley understood that the patient had stopped XXX, although it later became apparent that she may have continued taking it. Patient C reportedly felt "*fantastic*" after XXX. It was however noted that symptomatic improvement after XXX does not necessarily mean that the treatment was clinically appropriate or safe. Dr K's opinion was that, by this point, the patient was XXX and therefore a further XXX would not have represented a dangerous XXX in context. Dr J's view was that repeated XXX in a frail, largely bedbound elderly patient remained unsafe, particularly without clear evidence of monitoring, structured safety netting or consideration of safer alternatives.

101. On 7 October 2017, a further XXX was administered. This was identified by the experts as forming part of a pattern of repeated XXX use for ongoing XXX. Dr J raised that repeated XXX for XXX in a frail elderly patient was not what would generally be expected of a reasonably competent GP. Dr K's opinion was that while this was not common or current practice, the key issue was whether it crossed the threshold into unsafe or seriously inappropriate practice and she did not feel that it did.

102. Both experts agreed that, by 7 October 2017, Patient C was prescribed XXX. As such, there was no clear clinical indication to administer XXX, as her XXX could have been safely adjusted instead, and this would have been preferable to the administration of XXX.

103. Dr Whiteley's Rule 7 response states that: *"On 8 September 2017, Patient C reported [XXX] to Dr Whiteley. [XXX] improved by use of [XXX] and they assisted Patient C with [XXX] on each occasion. In fact, on 7 October 2017, it has been noted that [XXX] was getting progressively worse [XXX] without [XXX] and, in the circumstances, and in accordance with normal practice at that time, [XXX] were reasonable and clinically indicated."*

104. In considering the differing opinion of the experts in respect of the first three administrations of XXX, the Tribunal noted that by 8 September 2017 Patient C was on XXX and XXX and it is further recorded in their notes that XXX had been prescribed.

105. Dr J's opinion was that Dr Whiteley should have looked at other options including XXX whilst Dr K's opinion was that due to Patient C's history and current medication usage the administration of XXX was not necessarily high risk. The Tribunal noted that the wording of the Allegation did not refer to whether the use of XXX in these circumstances was high risk but rather whether it was clinically indicated. Dr K's opinion was that whilst XXX was not common or current practice, the key issue was whether it crossed the threshold into unsafe or seriously inappropriate practice and she did not feel that it did. The Tribunal did not accept this opinion because it found that a doctor has a duty to keep their current practice and knowledge up to date so that they are able to inform and advise patients appropriately before they give their consent to treatment. For the reasons set out above the Tribunal did not accept Dr K's evidence that a doctor's choice of treatment should be measured having regard to what they would have been taught when they were first trained – as long as that choice did not cause harm to the patient. Whilst it may be that the administration of XXX may not have been unsafe the Tribunal agreed with Dr J that at the time of the alleged events there were more preferable and safer routes for the administration of XXX rather than XXX.

106. The Tribunal accepted Dr J's evidence that XXX could have been given to XXX in order to XXX. It further agreed that although XXX would have been slower acting, it could have been given in advance of any procedure to be carried out on Patient C.

107. Whilst accepting the evidence of Dr K that due to her history and current medication usage, the administration of XXX was not necessarily high risk, it considered that other more up to date, safer and less intrusive treatment options or routes of administration were available.

108. The Tribunal therefore concluded that the administration of XXX was not clinically indicated and found paragraph 3(a) of the Allegation proved.

3(b)

109. In respect of consideration of alternative treatment options, the Tribunal noted the differing opinions of the experts as set out in the joint report.

110. Dr J considered that Dr Whiteley failed to adequately consider safer alternative treatment options. In his view, the patient's XXX medication could have been adjusted, including use or adjustment of XXX for XXX and review of the XXX. He also questioned the rationale for giving XXX to enable the patient to XXX, when alternatives such as XXX could have been considered. His opinion was that this fell seriously below the standard of care to be expected of a reasonably competent GP.

111. Dr K partially agreed and accepted that XXX alternatives could and should have been considered, particularly by 7 October 2017, when the patient was already established on XXX. She agreed that the failure to do this fell below the standard of care expected. However, she did not consider that the earlier consultations necessarily showed a failure to consider alternatives, as Dr Whiteley was attempting to rationalise XXX by XXX. In her view, that represented an attempt to move towards a more appropriate XXX, which was a reasonable standard of care, even though she did not consider this a modern-day general practice way of working.

112. The Tribunal had regard to the records of Patient C and in rejecting Dr K's opinion on whether Dr Whiteley had failed to adequately record any consideration of alternative treatment options available it concluded that whilst there was some reference to consideration of alternative treatment options in the consultation of 8 September 2017 there

was an absence of the same for the remaining three consultations that formed part of the Allegation.

113. The Tribunal therefore found paragraph 3(b) of the Allegation not proved in respect of 8 September 2017, but proved for 19 September 2017, 20 September 2017 and 7 October 2017.

Paragraph 4

114. Patient D's background, as set out in the joint expert report, was that she was an elderly patient with chronic XXX. She was already under the care of XXX and was on the hospital waiting list for XXX, which she reportedly received the following month. The records note that Patient D had XXX. The concern related to clinical decision making, particularly the use of XXX on 7 and 28 November 2017, alongside, or in the context of, treatment for XXX.

115. The patient records show that Dr Whiteley reviewed Patient D on 7 November 2017 for XXX and during the course of that consultation he administered XXX. The record of that consultation is briefer than others seen by the Tribunal during the course of this hearing and does not record route of administration. In his report Dr J noted that he felt unable to comment extensively on this consultation because he was unsure whether the complete records were available and felt the notes may have been cut off. Dr K's position was that there was evidence from the background records, including XXX, that clearly indicated XXX experienced by the patient. Dr K considered that Dr Whiteley had enough clinical information to recognise that Patient D was significantly symptomatic. However, the issue remained whether XXX was clinically indicated, particularly in the context of XXX and pending specialist intervention.

116. On 23 November it is recorded that Patient D had been on XXX and XXX neither of which had been effective and that she had previously XXX. She was commenced on a trial of XXX. The notes also record that Patient D was still awaiting an appointment for XXX which Dr Whiteley was going to chase up as, he recorded, there were limited other options available to her. On 24 November Dr Whiteley spoke to Patient D to update her in relation to the XXX appointment. He records that the only alternative treatment available to her whilst waiting for an appointment was XXX. According to the medical records Patient D attended the surgery later that day and was given XXX together with XXX.

117. On 28 November 2017, Dr Whiteley administered XXX and XXX. This consultation appears to be the main focus of concern. Dr J's concern was that while XXX were unlikely to cause significant harm, the addition of XXX was not clinically indicated. He considered this to be part of a wider pattern in which Dr Whiteley appeared to give XXX in addition to XXX treatment, when XXX was not necessary. Dr K accepted that this appeared to reflect a recurring theme of giving XXX at the same time as XXX which was not common or current practice.

118. The experts agreed that XXX was not required simply because a patient was receiving XXX. They also agreed that repeated use of XXX would not represent usual modern GP practice.

4(a)

119. The Tribunal noted that whilst the experts disagreed on whether the administration of XXX was unsafe or below the standard expected of a reasonably competent GP, there appeared to be agreement that its use did not represent usual modern GP practice, although only Dr J explicitly stated that it was not clinically indicated.

120. The Tribunal was satisfied that on the basis of the evidence before it, the routine administration of XXX when giving XXX was not clinically indicated and accepted the opinion of Dr J in this respect. Whilst Patient D may not have been exposed to harm from XXX Dr K accepted that XXX does not need to be administered alongside every XXX. She further accepted that in administering XXX to Patient D, Dr Whiteley may have been responding to her distress whilst awaiting specialist treatment, this was not common modern day General Practice. For the reasons set out previously the Tribunal determined that the standard by which Dr Whiteley should be assessed is by current practice and not reliant on historical practices that may or may not have existed at the time when Dr Whiteley was training. Accordingly for the reasons set out above it found paragraph 4(a) of the Allegation proved.

121. The Tribunal further noted the observation of both experts that there was a recurring pattern in Dr Whiteley's prescribing and administration of XXX at the same time as XXX, which they both agreed was not common practice. The Tribunal had regard to XXX, Dr Whiteley's subsequent admissions to the police and NHS England of the appropriation of XXX prescribed to patients for his own personal use, and his subsequent conviction. The Tribunal concluded that in order to obtain XXX, he would over prescribe XXX to patients so that he would have access to the surplus prescribed. Given the evidence that the use of XXX is no longer common

in General Practice today, the Tribunal find that on the balance of probabilities XXX prescribed by Dr Whiteley was not because it was clinically indicated, which it finds it was not, but rather was done to enable his access to the drug for personal use.

4(b)

122. Dr J's opinion was that safer and more conventional alternatives should have been considered, including optimising XXX, awaiting or expediting the planned XXX, using XXX, and liaising with XXX. Dr J noted that he did not comment extensively on the 7 November 2017 consultation because he was unsure whether the complete records were available and felt the notes may have been cut off.

123. Dr K's opinion was that Dr Whiteley did attempt to expedite a hospital appointment and had agreed to a trial of XXX and XXX, and therefore did not consider that alternatives were wholly ignored.

124. The Tribunal had regard to the brief entry of 7 November and compared this to the other entries made by Dr Whiteley in respect of this patient. The Tribunal noted that there were a number of entries all within a few days of 28 November when Dr Whiteley was chasing up Patient D's appointment for XXX. In these entries it found that there was clear evidence recorded of alternative options and one reference to XXX being the only option available to Patient D whilst waiting for specialist treatment. The Tribunal had regard to the concern raised by Dr J that part of the 7 November entry in the bundle may have been missing. It noted that no further enquiry of this appears to have been made and therefore the issue remains extant. In the circumstances the Tribunal find that the GMC has failed to discharge the burden of proving that Dr Whiteley failed to record any consideration of alternative treatment options for Patient D in respect of 7 November 2017. In respect of the other entries, it concluded that the GMC had failed to prove its case to the required standard and found paragraph 4(b) of the Allegation not proved.

125. The Tribunal also considered paragraph 8 of the Allegation in respect of Patient D, namely that Dr Whiteley's record keeping was inadequate in that he failed to adequately record any discussion about safety netting with Patient D.

126. Dr J placed weight on the apparent lack of safety netting and considered it part of the reason the prescribing was unsafe, stating that Dr Whiteley should have safety netted on 28 November 2017 warning Patient D of the possible side effects from XXX such as XXX. His

opinion was that, XXX were given in the surgery and Dr Whiteley should have ensured that Patient D had XXX. Patient D should have been warned XXX. In Dr J's opinion Dr Whiteley's failure to adequately safety net was seriously below the standard expected of a reasonably competent General Practitioner because of the risks posed by XXX to a patient who was not normally XXX.

127. Dr K's opinion was that whilst she agreed that the documentation appeared limited, she was more cautious about concluding that safety-netting was not provided as it is common practice for doctors to note safety netting as 'SOS'. Her opinion was that Dr Whiteley had consistently documented a worsening statement 'SOS PRN' (loosely interpreted as seek medical attention for deterioration if required) throughout Patient D's records or had regularly reviewed Patient D. In her opinion the follow-up and safety netting were consistent with the standard expected of a reasonably competent General Practitioner.

128. In his Rule 7 letter Dr Whiteley accepts that his notes were brief in respect of the entries for 7 and 28 November 2017 and that whilst safety netting is not recorded relies upon his usual practice which would be to advise them in terms akin to those expected by Dr J.

129. The Tribunal, whilst acknowledging that the use of shorthand or abbreviations such as 'SOS', 'PRN', 'RvB' was appropriate in normal circumstances, noted that there was an absence of such references or any safety netting discussion, recorded in the notes of 7 November or 28 November 2017. Anyone reading the notes could not therefore be confident that a discussion in relation to safety netting had taken place. Accordingly, the Tribunal determined that Dr Whiteley had failed to adequately record any discussion about safety netting with Patient D on the relevant dates, and found paragraph 8 of the Allegation proved in respect of Patient D.

Paragraph 5

130. Patient E was treated by Dr Whiteley over a period of approximately three weeks, between 7 December 2017 and 27 December 2017. The clinical issue was worsening XXX, which had originally been managed by another doctor in the Practice. Patient E had already been referred to XXX and had undergone a scan shortly before Dr Whiteley's first consultation. He was due to be reviewed by XXX following the scan. The patient notes record that Patient E was experiencing XXX. The issue for the experts to consider was whether the repeated use of XXX was clinically indicated, particularly once XXX and XXX had been commenced and escalated.

131. On 7 December 2017 when Dr Whiteley reviewed Patient E for his worsening XXX Patient E had already been scanned and was waiting for an appointment with XXX. Dr Whiteley noted XXX. He prescribed XXX, and further prescribed XXX. He recorded that he had administered XXX to Patient E, increased the patient's XXX, and arranged a review. Dr K noted that, historically, giving XXX for XXX was not unheard of in general practice, particularly where a patient was XXX and was in severe distress. However, she accepted that this is historic rather than current usual practice. Dr J's concern was that, although the patient was clearly XXX, the use of XXX for XXX was not a sustainable or appropriate way to manage XXX.

132. On 12 December 2017 Patient E requested another XXX, reporting that the previous XXX had helped. Dr Whiteley administered a further XXX, started XXX, and continued XXX. Dr K accepted that starting XXX rather than simply advising repeated increases in XXX would be viewed as safer XXX prescribing in principle, although she would not usually advocate initiating XXX for XXX without specialist involvement.

133. On 15 December 2017 Dr Whiteley noted that Patient E was experiencing better XXX with XXX, the experts presumed that this was a reference to XXX which had been prescribed. Despite this improvement, Dr Whiteley administered a further XXX, the reason for which was not recorded. The administration of XXX was considered concerning by both experts because the patient had already been started on XXX and there was evidence of some improvement. The experts both agreed that the rationale for giving an additional XXX was therefore unclear.

134. On 20 December 2017 Dr Whiteley reviewed Patient E again. The patient had reportedly had a 'terrible day' the previous day and had increased his XXX. Dr Whiteley increased the XXX and gave another XXX. This consultation was identified by the experts as particularly difficult to justify. The opinion of the experts was that by this stage, the patient was already on XXX and had XXX. Dr K agreed that, at this point, giving an additional XXX did not make clinical sense. The patient was already being managed with both XXX and XXX, so further XXX adjustment could have been made XXX rather than XXX. Dr J's concern was that XXX, and that this should have prompted Dr Whiteley to seek help rather than continue to give further XXX.

5(a)

135. In respect of Patient E both experts agreed that by 20 December 2017 there was no clear rationale for giving another XXX because the patient was already on XXX. Both agreed

that in light of the patient's XXX Dr Whiteley should have sought further advice or support. In respect of XXX administered prior to 20 December, Dr J considered that these were inappropriate for the reasons set out in the joint report whereas Dr K was of the opinion that whilst XXX are not current practice she contextualised that historically some GPs did give XXX and in this case did not consider the dose given to be necessarily unsafe.

136. The Tribunal acknowledged that Patient E was experiencing XXX which needed to be reviewed and controlled pending being seen by XXX. The Tribunal noted the experts' agreement that the use of XXX for XXX would not represent modern GP practice. The Tribunal reminded itself of Dr Whiteley's duty to keep his knowledge and skills up to date and its determination that Dr Whiteley's practice should be assessed with reference to current practice at the time, not historical practices that had become outdated. The Tribunal accepted the expert evidence that XXX for XXX should be approached cautiously and that repeated XXX for XXX would not represent usual modern GP practice. For this reason, the Tribunal preferred the opinion of Dr J that the administration of XXX was not clinically indicated in this case and that current practice at the time would be to use the alternatives available and where necessary seek help and support from colleagues.

137. Having regard to all the evidence in the round including XXX and Dr Whiteley's admissions in respect of the appropriation of excess XXX prescribed for patients for his own personal use. The Tribunal determined that the use of XXX for XXX was not clinically indicated.

138. The Tribunal therefore found paragraph 5(a) of the Allegation proved.

5(b)

139. Dr Whiteley's Rule 7 response states that:

"The GP notes that Dr Whiteley made clearly demonstrate that, in each consultation, Dr Whiteley reviewed medication and considered alternative treatment options.

For example, on 7 December 2017, Dr Whiteley has noted "discussed options" /Patient E had a "wide knowledge of meds +options"/ "advise" (signifying that Dr Whiteley did discuss options - this example being the very first consultation with Patient E."

140. Dr Whiteley's Rule 7 response also referenced Dr K's expert report where she states:

“Dr Whiteley managed Patient E [XXX] by starting him on [XXX] and monitoring him. This occurred whilst Patient E was under the care of the [XXX] department. In my opinion Dr Whiteley considered alternative treatment options and his care is consistent with that expected of a reasonably competent General Practitioner.”

141. Dr J’s opinion was that:

“Dr Whiteley should have considered an [XXX] alternative to frequent [XXX], in conjunction with alternatives to the [XXX] already prescribed. In my opinion if Dr Whiteley was so concerned about [XXX] he should have discussed the issue with [XXX] to look at alternatives to [XXX] and perhaps [XXX].”

142. As summarised in the joint experts’ report, Dr J placed greater emphasis on the failure to seek help as a significant clinical failing. Dr K accepted that further advice would have been appropriate but gave more weight to the practical challenges faced by locums in unfamiliar systems and the historical context of XXX used in XXX and that it may be an issue of training and keeping up to date with current practice.

143. The Tribunal considered that Dr Whiteley had recorded discussion and information relating to alternative treatments within his records and whilst he did not choose to use alternative treatment options, he had recorded the options available. Whilst acknowledging the criticism of Dr Whiteley’s approach by the experts, the Tribunal concluded that he had not failed to adequately record any consideration of alternative treatment options for Patient E.

144. Accordingly, the Tribunal found paragraph 5(b) of the Allegation not proved.

145. The Tribunal also considered paragraph 8 of the Allegation in respect of Patient E, namely that Dr Whiteley’s record keeping was inadequate in that he failed to adequately record any discussion about safety netting with Patient E.

146. Dr J’s opinion was that he would expect clear safety-netting where XXX were being used, which should include advice on XXX. He was concerned that repeated XXX should have prompted clearer monitoring, safety netting and review arrangements. In his opinion this fell seriously below the standard of care expected.

147. Dr K agreed that safety netting should be documented when giving XXX. She noted that Dr Whiteley did review the patient regularly over the three-week period, which provided some monitoring instructions and that he had written 'SOS' – which is common shorthand used for 'safety netting' and thus it was not possible to extrapolate that appropriate safety netting advice was not given. Her opinion was that this represented a reasonable standard of care.

148. For the reasons previously set out above, the Tribunal accepted the evidence of Dr K that 'SOS' is common shorthand used for 'safety netting' and noted that on the records for 7, 12 and 15 December 2017, Dr Whiteley had included "*SOS PRN*". However, it noted that no such reference was included for 20 December 2017.

149. The Tribunal therefore determined that Dr Whiteley had not failed to adequately record any discussion about safety netting with Patient E on 7, 12 and 15 December 2017, but had failed to do so for 20 December 2017. Accordingly it found paragraph 8 of the Allegation proved in respect of Patient E for 20 December 2017 only.

Paragraph 6

150. The agreed findings of the experts are that Patient F was reviewed by Dr Whiteley in January 2018 in relation to XXX. The patient had attended A&E the previous day and had been given XXX. The information before the experts indicates that the patient was XXX. The relevant allegation concerns the decision to administer XXX in this clinical context, alongside XXX. The experts considered whether this represented appropriate XXX, whether consent was adequately obtained and documented, whether alternative treatment options were considered, and whether adequate safety-netting advice was provided. The central issue was not whether Patient F was experiencing XXX. Both experts accepted that the patient XXX. The concern was whether it was clinically appropriate to escalate from XXX to XXX the following day, and whether this fitted an appropriate XXX pathway.

6(a)

151. In respect of whether Dr Whiteley's administration of XXX was clinically indicated, both experts agreed that XXX was significant, but that XXX was not clinically indicated. Both agreed that this did not fit XXX. Both agreed that the case reflected the wider pattern noted across the patient cases identified of giving XXX alongside XXX, which was not appropriate.

152. Dr Whiteley's Rule 7 response states:

"Mindful that Patient F was [XXX] and "preferred to do something now" about [XXX], Dr Whiteley believed that the most suitable and effective treatment for Patient F was to administer [XXX]. Dr Whiteley noted that other [XXX] were not working.

Dr Whiteley fully appreciates Dr K's comments and has reflected upon them at length. If he were to continue practising medicine, which is not going to happen, he confirms that he would modify his approach when treating [XXX] and he would use [XXX] guidance highlighted by Dr K. Although Dr K states that by administering [XXX] in the first instance rather than prescribing [XXX] was "heavy handed", she does not believe that Dr Whiteley's treatment was below the standard expected and nor was it inappropriate. Patient F was also not put at any risk."

153. The Tribunal had regard to the joint report of the experts, who both agreed that the use of XXX was not clinically indicated. It noted that whilst there is no prohibition on the use of XXX, it was unusual and was not clinically indicated in the circumstances of Patient F. The Tribunal considered Dr Whiteley's Rule 7 response, which stated that Patient F was not put at any risk, but noted that prior to the administration of XXX he prescribed she was XXX, and so Dr Whiteley would not have known how she would react.

154. The allegation was that XXX was not clinically indicated in this case, and the Tribunal was satisfied to the relevant standard that this had been satisfactorily proven on the basis of the evidence before it.

155. Accordingly, the Tribunal found paragraph 6(a) of the Allegation proved.

6(b)

6(b)(i)

156. The Tribunal considered the expert opinions of Dr J and Dr K. The experts differed in their interpretation of the issue of consent. Dr J considered that XXX-specific consent should have been documented. He accepted that there was a consent form but understood this to relate to XXX rather than specifically to XXX. His view was that XXX should not be administered without clear discussion with the patient and, ideally, documentation. Dr K considered that, on balance, consent was likely to have been obtained. There was a signed

consent form for XXX and the notes referred to “*fully informed consent*”. Although this did not clearly specify consent for XXX, Dr K considered it difficult to conclude that the patient had not consented at all. Both experts agreed that the documentation was not ideal because it did not clearly distinguish consent for XXX from consent for XXX. They also agreed that a XXX-specific discussion would ideally have been documented.

157. The Tribunal considered the additional evidence before it. Whilst there was a written consent form, this only referred to XXX, and did not contain any reference to XXX. The Tribunal was however satisfied that Patient F had been administered XXX as recorded.

158. The Tribunal noted that Dr Whiteley documented on the medical record that fully informed consent had been given and risks versus benefits discussed, although this did not specify this was in relation to XXX.

159. In reaching its decision on this part of the allegation the Tribunal had regard to the oral evidence of Dr K who had explained that written consent is not required for the administration of XXX. She accepted that verbal consent would be required but said that this would not necessarily be recorded in patient notes. In the circumstances Dr K, considered it difficult to conclude that Patient F had not consented to XXX at all. The Tribunal recognised that both experts agreed that the documentation could have been more thorough. The Tribunal agreed that ideally all record keeping would be at the standard expected by Dr J but for the reasons previously set out above accepted that this was not possible in general and not usual practice. Her evidence was that given time constraints it would not always be the case that specific reference to consent for XXX was explicitly recorded, and the fact that Patient F allowed him to administer it implies that verbal consent was given. The Tribunal noted that XXX. The Tribunal was satisfied that on the balance of probabilities, Patient E would have been aware that XXX given XXX. Consequently, it could not be satisfied that consent had not been given. It further accepted the evidence of Dr K that current practice is that consent to XXX will not necessarily be recorded by GPs.

160. The Tribunal concluded that the GMC had not proved to the requisite standard that Dr Whiteley had failed to adequately record Patient F’s consent to administer XXX. It therefore found paragraph 6(b)(i) of the Allegation not proved.

6(b)(ii)

161. Both experts agreed that alternative treatment options were not adequately considered before administering XXX. Such options were said to have included further assessment, review of the A&E findings, XXX depending on the clinical picture. Dr K agreed that the usual XXX pathway had not been followed. Patient F had been on XXX and XXX, had been given XXX in A&E the previous day, and was then moved directly to XXX. Dr K considered this excessive and agreed that other options should have been considered first. There was therefore no material disagreement between the experts on this point and both agreed that a reasonable GP would have considered other XXX options and/or further assessment before using XXX.

162. Having regard to the above the Tribunal reminded itself that the Allegation was that there was a failure to adequately record consideration of alternative treatment options for Patient F.

163. Dr Whiteley's Rule 7 response states:

"...alternative treatments for Patient F were considered by Dr Whiteley... Specifically, Dr Whiteley has noted "options R vs B" and "options do nothing/ MATT etc".

...

Dr Whiteley confirms that the speed of access to alternative treatment options needs to be taken into account when considering alternative treatment options and consideration is made on a case-by-case basis which is also discussed with the patient (e.g. access to [XXX] or specialist)."

164. In reaching its decision, the Tribunal had regard to the relevant entry in Patient F's records. It noted there was reference to discussion about XXX and some reference to the ineffectiveness of XXX. However, the notes make no further reference to any alternative XXX, but merely record the prescription of XXX. The Tribunal noted the agreed expert opinion that a reasonably competent GP would not usually administer XXX and XXX together in this context.

165. Given the alternative treatments that the experts agreed should have been considered by a reasonably competent GP, the Tribunal found that the record of this consultation made by Dr Whiteley makes no mention of the alternative XXX available. Whilst the Tribunal accepted that the use of shorthand or abbreviations was common practice, it

found that in these particular circumstances the record made was insufficient to enable a fellow practitioner to have confidence that the alternatives available to Dr Whiteley in this consultation had been considered.

166. The Tribunal was satisfied that on the basis of the evidence before it, Dr Whiteley had failed to adequately record any consideration of alternative treatment options for Patient F. Accordingly, it found paragraph 6(b)(ii) of the Allegation proved.

167. The Tribunal also considered paragraph 8 of the Allegation in respect of Patient F, namely that Dr Whiteley's record keeping was inadequate in that he failed to adequately record any discussion about safety netting with Patient F.

168. Both experts agreed that safety-netting is important when XXX, particularly in relation to XXX.

169. Dr J considered that the documented safety-netting was inadequate and that generic wording such as "*advise SOS PRN*" was not sufficient for XXX. He would have expected specific advice and documentation relating to the risks of XXX.

170. Dr K agreed that the documentation was not specific for XXX. However, she noted that clinicians sometimes use shorthand such as "*SOS PRN*", and that this makes it difficult to know exactly what was said verbally to the patient. Her view was that the records may not fully reflect the entirety of the discussion.

171. The Tribunal noted that Patient F was XXX and that the safety netting recorded was limited to "*advise SOS PRN*". The Tribunal considered that whilst the record of safety netting discussed could have been more thorough, the evidence of Dr K, which it accepted, was that practitioners including herself could reasonably expect that the use of these shorthand entries would be sufficient to rely on as evidence that the relevant advice of a reasonably competent GP had been given in relation to the effects of XXX in these circumstances.

172. Accordingly, the Tribunal determined that Dr Whiteley had failed to adequately record any discussion about safety netting with Patient F on the relevant date, and found paragraph 8 of the Allegation proved in respect of Patient F.

Paragraph 7

173. The joint report of the experts sets out that Patient G was reviewed by Dr Whiteley on 5 January 2018 with XXX. They found that this appeared to have been a single relevant consultation. The patient was described as a man in his early seventies who had experienced XXX for approximately five months. He was XXX and was due to travel to Spain. He wanted XXX before travelling. Dr Whiteley assessed the patient and in the experts' opinions appeared to have undertaken an adequate clinical examination. There was no significant criticism of Dr Whiteley's assessment or documentation of the presenting complaint. The concern relates to his treatment decision, specifically the administration of XXX alongside XXX. The experts considered this case in the context of the wider pattern identified across the previous cases, namely the administration of XXX in association with XXX. In this case, the clinical circumstances did not support a clear rationale for XXX, and the experts agreed that the concern was the treatment decision rather than the examination.

7(a)

174. The Tribunal noted that whilst in her first report Dr K had considered XXX and XXX could be described as being clinically indicated she changed her opinion in the joint report to an opinion that XXX was not clinically indicated for the reasons set out within the report. Dr J agreed with that opinion and in their joint report opined that

"...there was no clear clinical indication for [XXX] in this consultation. [XXX] does not require [XXX] to be administered alongside it, and [XXX] was unlikely to provide meaningful benefit in relation to the underlying [XXX] condition. Both experts agreed that this case fits the wider theme seen across the other patients, where Dr Whiteley appeared to give [XXX] routinely with [XXX]. Both agreed that this was not usual practice.

...and that usual [XXX] options should have been used instead."

175. Whilst in his Rule 7 letter Dr Whiteley has addressed Dr K's initial opinion that XXX was clinically indicated he has not provided any comment in respect of the joint report, which the Tribunal is satisfied he has had sight of. Having considered the agreed opinion of both experts that XXX was not clinically indicated in this case, the Tribunal found paragraph 7(a) of the Allegation proved.

7(b)

7(b)(i)

176. Dr Whiteley's Rule 7 response states:

"It is submitted that Dr Whiteley did consider alternative treatment options for Patient G Dr Whiteley has recorded "options etc" which indicates options were discussed. Specifically, Dr K, in her report ... also confirms that alternative treatment options were considered as she states the following:

Dr Whiteley consulted with Patient G on one occasion in relation to his [XXX] and administered [XXX] on the background that Patient G had already attended [XXX] and had been suffering from [XXX] for 5 months. [XXX] are commonly used to help [XXX]. They are a safe and effective treatment option for many patients and generally perceived to be a low-risk intervention. There is little firm evidence on which to base best practice in this area and as a result there is variability regarding exactly how and when [XXX] are used in clinical practice. In my opinion based on the history documented in the clinical records, Dr Whiteley's administration of [XXX] and consideration of alternative treatment options was appropriate and as such of the standard expected of a reasonably competent General Practitioner."

177. However, the Tribunal noted that this assessment pertained to the use of XXX and not the administration of XXX.

178. The joint experts' report sets out Dr K's position in relation to XXX as:

"Dr K considered that there was no need to escalate to [XXX] for [XXX], particularly where the patient was being treated with [XXX]. The more appropriate approach would have been to manage [XXX] directly and use standard [XXX] measures if required."

It also includes:

"Both experts agreed that [XXX] was not an appropriate alternative or adjunct to [XXX]. Both agreed that routine [XXX] options should have been used instead."

179. The Tribunal reminded itself that the allegation was that Dr Whiteley had failed to adequately record considerations of alternatives. To this extent the Tribunal had regard to the patient records and noted the inclusion of “options etc” It was however not satisfied that this adequately demonstrated consideration of alternative treatment options.

180. The Tribunal had regard to the witness statement of Patient G. In doing so it noted that some 8 years had passed at the time Patient G provided his witness statement to the GMC. It contains the following:

“During the consultation, Dr Whiteley examined [XXX]. [XXX] He advised that [XXX] was one option but, given my upcoming holiday, suggested administering [XXX] to provide [XXX]. He mentioned that it involved [XXX]. He also said he would give me [XXX].

...

After I was given [XXX], I was not really given any detailed information or advice. [XXX]

I cannot recall whether anything else was said about what to expect afterwards or what to be aware of. I do recall that Dr Whiteley said I might [XXX] once [XXX].”

181. Having carefully considered the patient records for the relevant date, the Tribunal concluded that there was no evidence that Dr Whiteley had considered alternative treatment options, and therefore found paragraph 7(b)(i) of the Allegation proved.

7(b)(ii)

182. The Tribunal noted that there was some disagreement between the experts in relation to whether Dr Whiteley provided adequate safety netting advice to Patient G.

183. Dr J’s position was that he would expect specific safety-netting if XXX was administered, including advice about XXX. If this was not documented, he would consider the safety-netting inadequate and seriously below standard of care expected.

184. In the joint experts’ report Dr K’s position was that XXX-specific safety netting should be documented whenever XXX is administered. However, she remained of the opinion that the use of ‘SOS PRN’ was an acceptable and adequate documentation and that fellow

practitioners could be confident that a reasonably competent GP would have given XXX-specific advice.

185. The Tribunal accepted for the reasons set out above that the shorthand of SOS PRN was a term commonly adopted by GPs in current practice and acknowledged that it is not always feasible or realistic to expect full, detailed notes to be included in patient records.

186. In reaching its decision, the Tribunal had regard to the witness statement of Patient G and in particular his inability to recall with accuracy everything that was said to him. This is not meant as any criticism of Patient G as it is clear that it would be difficult for anyone to remember events that had occurred 8 years ago with complete clarity. In respect of determining whether or not adequate safety netting had been given the Tribunal found the entry in the patient records to be a more reliable account as it was contemporaneous. Within the record for 3 January 2018 Dr Whiteley has recorded “ADVISE SOS PRN”. For the reasons previously set out above the tribunal found that this would indicate that appropriate advice of a reasonably competent GP had been given.

187. Accordingly, the Tribunal found paragraph 7(b)(ii) of the Allegation not proved.

Paragraph 8

188. For the reasons set out above in respect of each individual patient the Tribunal made the following findings in respect of paragraph 8 of the Allegation.

189. Determined and found proved in respect of Patient A, Patient D, and Patient E for 20 December 2017.

190. Not proved in respect of Patient B, Patient E for 7, 12 and 15 December 2017, Patient F.

The Tribunal’s overall determination on the facts

191. The Tribunal has determined the facts as follows:

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

Misconduct

1. On 24 April 2017 and/or 2 May 2017, you consulted with Patient A and on each occasion you:
 - a. inappropriately administered 40mg Kenalog by injection in or around Patient A's Achilles tendon; **Determined and found proved**
 - b. failed to arrange to see Patient A and/or review Patient A; **Determined and found proved**
 - c. failed to adequately record your discussion with Patient A about:
 - i. the risks of administering Kenalog by injection; **Determined and found proved**
 - ii. obtaining verbal consent from Patient A before you administered Kenalog by injection. **Determined and found proved**
2. On 10 August 2017 and/or 21 December 2017, you consulted with Patient B and on each occasion you:
 - a. prescribed XXX when it was not clinically indicated; **Not proved in respect of 10 August 2017, Determined and found proved in respect of 21 December 2017**
 - b. failed to adequately record any consideration of alternative treatment options for Patient B. **Not proved**
3. On 8 September 2017, 19 September 2017, 20 September 2017 and/or 7 October 2017, you consulted with Patient C and on each occasion you:
 - a. prescribed XXX when it was not clinically indicated; **Determined and found proved**
 - b. failed to adequately record any consideration of alternative treatment options for Patient C. **Not proved in respect of 8 September 2017,**

Determined and found proved for 19 September 2017, 20 September 2017 and 7 October 2017

4. On 7 November 2017 and/or 28 November 2017, you consulted with Patient D and on each occasion you:
 - a. prescribed XXX when it was not clinically indicated; **Determined and found proved**
 - b. failed to adequately record any consideration of alternative treatment options for Patient D. **Not proved**
5. On 7 December 2017, 12 December 2017, 15 December 2017 and/or 20 December 2017, you consulted with Patient E and on each occasion you:
 - a. prescribed XXX when it was not clinically indicated; **Determined and found proved**
 - b. failed to adequately record any consideration of alternative treatment options for Patient E. **Not proved**
6. On 3 January 2018 you consulted with Patient F and you:
 - a. prescribed XXX when it was not clinically indicated; **Determined and found proved**
 - b. failed to adequately record:
 - i. Patient F's consent to administer XXX; **Not proved**
 - ii. any consideration of alternative treatment options for Patient F. **Determined and found proved**
7. On 5 January 2018, you consulted with Patient G and you:
 - a. prescribed XXX when it was not clinically indicated; **Determined and found proved**

- b. failed to:
 - i. consider alternative treatment options for Patient G; **Determined and found proved**
 - ii. provide adequate safety netting advice to Patient G. **Not proved**
- 8. In relation to paragraphs 1 to 6 above, your record keeping was inadequate in that you failed to adequately record any discussion about safety netting with Patients A, B, D, E and F. **Determined and found proved in respect of Patient A, Patient D, Patient E for 20 December 2017, Patient F, Not proved in respect of Patient B, Patient E for 7, 12 and 15 December 2017**
- 9. ~~Between 18 August 2017 and 3 January 2018, on one or more of the occasions set out in Schedule 1, you prescribed XXX to a patient and on one or more of the occasions:~~
 - a. ~~the full dose of XXX you prescribed was not intended for use by the patient;~~ **Withdrawn under Rule 28**
 - b. ~~you administered some of the XXX to the patient and self-administered some or all of the remaining dose of XXX.~~ **Withdrawn under Rule 28**
- 10. ~~On one or more of the occasions set out in Schedule 1, you knew that:~~
 - a. ~~the full dose you had prescribed was not intended for use by the patient at the time you prescribed it;~~ **Withdrawn under Rule 28**
 - b. ~~you would not be administering all the XXX to the patient at that time;~~ **Withdrawn under Rule 28**
 - c. ~~you would self-administer some or all of the remaining dose of XXX.~~ **Withdrawn under Rule 28**
- 11. ~~Your conduct as described at paragraph 9 was dishonest by reason of paragraph 10.~~ **Withdrawn under Rule 28**

XXX

12. XXX

13. XXX

Conviction

14. On 31 December 2024, at Worthing Magistrates Court, you were convicted of, on or before 5 January 2018, at Eastergate:

- a. committing fraud, in that while occupying a position, namely a general practitioner, in which you were expected to safeguard, or not to act against, the financial interests of the Croft Practice, you dishonestly abused that position intending thereby to make a gain, namely writing prescriptions of XXX, for yourself; **Admitted and found proved**
- b. theft, in that you stole XXX, of a value unknown, belonging to the Croft Practice. **Admitted and found proved**

15. On 3 February 2025, you were sentenced to:

- a. imprisonment for 9 months, concurrent, suspended for 18 months;
Admitted and found proved
- b. unpaid work of 200 hours, to be completed within 12 months. **Admitted and found proved**

And that by reason of the matters set out above your fitness to practise is impaired because of your:

- a. misconduct in respect of paragraphs 1 to ~~11~~ 8; **Amended under Rule 28, To be determined**
- b. XXX
- c. conviction in respect of paragraphs 14 and 15. **To be determined**

Determination on Impairment - 17/08/2026

1. The Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential. This determination will be handed down in private due to the confidential nature of some of the matters under consideration. However, as this case concerns Dr Whiteley's misconduct and conviction a redacted version will be published at the close of the hearing.

2. The Tribunal now has to decide, in accordance with Rule 17(2)(l) of the Rules whether on the basis of the facts which it has found proved as set out before, Dr Whiteley's fitness to practise is impaired by reason of misconduct, XXX or conviction. Dr Whiteley was not present or represented but had produced a stage two bundle which included but was not limited to:

- CPD (Continuous Professional Development) certificates, various dates 2017 – 2021;
- Patient reviews for Dr Whiteley dated 12 April 2017 to 12 May 2017, and 10 March 2017;
- A number of testimonials from XXX and colleagues.

Submissions

3. On behalf of the GMC Ms Barlow, of Counsel, submitted that in respect of misconduct, Dr Whiteley's conduct fell below the standards set out within the relevant paragraphs of Good Medical Practice (2013) (GMP). She submitted that any one of the prescriptions of XXX that were prescribed and given without clinical indication would be action that falls seriously below the required standard. She reminded the Tribunal that although neither of the experts had been aware of the background to this case in respect of XXX the finding of XXX or conviction, both agreed that if a doctor were to administer XXX when it was not clinically indicated in order to obtain it for themselves then this would fall seriously below the standard required of a competent GP. Ms Barlow reminded the Tribunal that, unlike the experts, it did have all the background facts including the admissions made by Dr Whiteley. She submitted that this was highly relevant background that the Tribunal should consider when determining the seriousness of the conduct found proven at the facts stage.

4. In respect of Patient A, Ms Barlow submitted that there had been a serious failing on the part of Dr Whiteley both in the administration of a drug which was not approved in the UK and contraindicated by NICE, and in the adequate recording of the advice given to Patient A in relation to the administration of the drug and his aftercare.

5. Ms Barlow reminded the Tribunal of the circumstances surrounding the treatment of Patients B-G and the findings of the experts, including those areas of disagreement. However, she submitted that it was relevant that these findings had been made in the absence of the surrounding circumstances, which was relevant. She submitted that the facts of the conviction give a clear explanation of why XXX medication was given by Dr Whiteley to these patients as opposed to other XXX. She invited the Tribunal to consider whether, in those patients where XXX was clinically indicated, the reason Dr Whiteley chose the pathway he did was because it was clinically indicated or because it was a means to an end. Ms Barlow submitted that looking at the evidence as a whole, prescribing XXX was not a common practice, that there had been other alternatives available and that neither expert would have actually treated the patients in the way chosen by Dr Whiteley.

6. In respect of the failure found proven in respect of record keeping Ms Barlow accepted that this was not such a clear area, but she submitted, it inevitably goes hand in hand with the motivation for the treatment that was provided to the various patients especially as it was done so often. She submitted that looking at the overall conduct, whether aspects of record keeping fell below or seriously below the required standard does not alter the overarching position that conduct which amounts to prescribing when it is not clinically indicated because of a motivation to obtain drugs for personal use falls seriously below the standards expected. She submitted that if one adds into that the record keeping which goes hand in hand with that prescribing, the overall conduct would fall seriously below that which would be expected and the GMC would say unquestionably amounts to misconduct.

7. In respect of impairment, Ms Barlow reminded the Tribunal of the conviction for dishonesty, which she submitted was not the result of a single act, but multiple instances involving numerous patients where he admitted dishonestly taking XXX from the Croft Practice.

8. XXX

9. XXX

10. Ms Barlow submitted that whilst Dr Whiteley does seem to have a degree of insight into XXX, his insight is not complete because he has never accepted that he administered XXX when it was not clinically indicated. Ms Barlow submitted that whilst his personal remediation is excellent his professional remediation, in the sense of his return to practice as a doctor, is lacking. This goes hand in hand with his lack of insight into his reasons for prescribing XXX generally.

11. Ms Barlow directed the Tribunal to the legal basis upon which it could proceed to consider impairment and submitted that whilst an assessment of current and ongoing risk must be made in respect of each ground of impairment individually, that does not preclude there being an overarching assessment of its findings because doing things in isolation and not then making that overarching assessment would be difficult and not in line with the relevant legal principles.

12. Ms Barlow submitted that Dr Whiteley's dishonesty falls within the higher end of the spectrum of seriousness as it is directly linked to the treatment of patients and Dr Whiteley's professional role in terms of the trust that his patients could expect to have had in him. She submitted that his dishonesty was persistent, repeated and that whilst the value in monetary terms was perhaps not significant, the benefit that Dr Whiteley derived was the driving force behind his behaviour.

13. Ms Barlow submitted that the clinical failings found were underpinned by the same motivation; they go beyond gross negligence and amount to dishonesty. She submitted that in considering the *Guidance for MPTS Tribunals* ('the Guidance'), it is clear they fall towards the serious end of the spectrum in the context of this case.

14. Ms Barlow submitted that the criminal conviction resulted in a custodial sentence of nine months, albeit suspended for eighteen months, and so also falls at the higher end of the spectrum of seriousness.

15. Ms Barlow submitted that the following features which may increase the seriousness, as set out in the Guidance, are applicable in this case:

- The behaviour was directed towards, or the poor performance involved interaction with, a person with impaired capacity or a person with a particular vulnerability; Ms Barlow accepts that this is not a case dealing directly with vulnerability but that some of the patients were frail;

- Premeditated behaviour;
- Abuse of professional position;
- A reckless disregard for patient safety or professional standards;
- Putting their own interests before those of patients.

16. Ms Barlow submitted that in light of these features, taking the allegations together or individually, they fall towards the higher end of the spectrum of seriousness.

17. Ms Barlow referred the Tribunal to the guidance in (Grant v NMC) and submitted that despite the level of insight shown by Dr Whiteley, and the steps that he has taken to remediate his actions, the seriousness of his misconduct, conviction, and XXX all mean that he:

has in the past and is liable in the future to put patients at unwarranted risk of harm;
has brought the medical profession into disrepute and is liable to in the future;
has undoubtedly and admittedly breached one of the fundamental tenets of the medical profession and would be at risk of doing so in the future if he returned to general practice and;
has in the past acted dishonestly and is liable to do so in the future.

18. Ms Barlow submitted that Dr Whiteley has spoken candidly about the context for his behaviour, namely that he found working as a GP extremely stressful, that it was XXX and that he has sought to deal with that by XXX. She submitted that in light of what Dr Whiteley has said, the Tribunal should look at whether he would be safe to return to unrestricted practice. She submitted that given the history in this case there remained a high risk of repetition and he cannot therefore safely return to medical practice.

19. Ms Barlow submitted that for these reasons, a finding of impairment was necessary in order to uphold all three limbs of public protection.

The relevant legal principles

20. There is no burden or standard of proof at this stage of the proceedings and the decision of impairment is a matter for the Tribunal's judgment alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of

public protection which is likely to require restrictive action in response. The three parts of public protection are to protect, promote and maintain the health, safety and well-being 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.

21. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious and then whether the finding of that misconduct which was serious poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

22. Paragraph 11 of Part B: stage two - impairment of the new MPT Hearings Guidance provides a description as to what may constitute misconduct. The Tribunal was further reminded that misconduct has been defined by the Privy Council in the case of *Roylance v GMC (No.2) [2000] 1 AC 311* as ‘a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.’ In that case, the Privy Council went on to say that ‘The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.’

23. The relevant standards to be applied to the current case are set out in the 2013 version of Good Medical Practice. The Tribunal should ask itself how far short of those standards the doctor’s conduct has fallen.

24. As to seriousness, this must be given its proper weight: it is conduct which would be regarded as deplorable by fellow practitioners (*Nandi v GMC [2004] EWHC 2317 (Admin)* at paragraph 31, approved by *Meadow v GMC [2007] QB 462* at paragraph 200).

25. To assess whether Dr Whiteley poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal will consider:

- where on the spectrum of seriousness the allegation lies, based on the facts found proved the impact of any relevant context known about Dr Whiteley and/or their working environment, and
- how Dr Whiteley has responded to the allegations.

26. As the allegations fall under more than one ground for impairment, an assessment of current and ongoing risk to public protection must be made in respect of each of them.

The Tribunal's determination on impairment

Is there a legal basis for considering impairment?

Misconduct

27. In considering misconduct, the Tribunal first considered whether the facts found proved constituted a sufficiently serious departure from the standards of conduct reasonably expected of Dr Whiteley as a registered medical practitioner so as to amount to misconduct. In doing so it had regard to Good Medical Practice ("GMP") (2013 edition).

Patient A

28. In respect of Patient A, the Tribunal reminded itself of its findings at the facts stage, where it accepted the expert evidence of Dr J that Kenalog was a drug that was not approved for use in the UK for the treatment of Achilles tendonitis and that it was contra-indicated in both NICE guidelines and the *British National Formulary* (Medicine). In oral evidence, Dr J's opinion was that since he had commenced practice as a doctor in 1978, the use of Kenalog for this purpose had never been recommended due to the known risk of rupture of the tendon and the potential lifelong mobility problems that can follow. In his report Dr J also refers to the NICE guidelines and the Clinical knowledge Summary (Achilles tendinopathy), NICE specifically states; *"Do not inject corticosteroids into or around the Achilles tendon"*.

29. Dr J's opinion was that *"Dr Whiteley's use of steroid injections in or around the Achilles tendon was seriously below the standard expected of a reasonably competent General Practitioner. I say seriously below because of the very high risk that Patient A would suffer a ruptured Achilles tendon, which carries a significant morbidity."*

30. The Tribunal also considered paragraphs 1, 8 and 16(b) of GMP, which state:

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.

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

16 In providing clinical care you must:

...

b provide effective treatments based on the best available evidence.

...

31. The Tribunal was satisfied that Dr Whiteley had an obligation to ensure that his knowledge and skills were up to date, and that the procedure had never been accepted practice, due to the risk involved. His actions were in breach of the relevant guidance and fell seriously below the standards expected of a reasonably competent practitioner.

32. The Tribunal also considered that Dr Whiteley's actions caused harm to Patient A, who suffered a ruptured Achilles tendon, which was one of the known side effects of the procedure. Patient A experienced permanent mobility issues as a result of this.

33. In respect of Dr Whiteley's failure to see or review Patient A, Dr J's opinion was that he would have expected Patient A to be told that if he had any problems at all to contact Dr Whiteley straight away and for Patient A to be seen again in two or three days to check that he was not developing any significant problems.

34. In his supplementary expert report, Dr J states:

"In this case where steroid injections were administered in or around the Achilles tendon, Dr Whiteley failed to adequately review or safety net. In my opinion this was seriously below the standard expected of a reasonably competent General Practitioner because of the significant risk Patient A was exposed to."

35. The Tribunal accepted that Dr Whiteley should have arranged an appropriate review, in line with Dr J's expert opinion and that his actions in failing to do so in the circumstances of this case fell seriously below the standard expected of a reasonably competent General Practitioner.

36. In his Rule 7 response, Dr Whiteley accepted that he should have written out the risks and benefits that were discussed in more detail. Dr J's evidence was that Dr Whiteley's record keeping was inadequate and seriously below the standard expected of a reasonably competent General Practitioner because of the lack of review or safety netting and the lack of documented verbal informed consent. The Tribunal reminded itself that it had found that Dr Whiteley could not have given the relevant information which should have included the fact that the drug was not approved for use and was contraindicated by NICE guidelines and the BNF, because at the time he gave the injection he "*believed that a corticoid injection was a suitable option for treatment*"

37. In reaching its decision the Tribunal also noted paragraphs 16(a), (b), 19 and 21(c) of GMP, which states:

16 *In providing clinical care you must:*

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

b provide effective treatments based on the best available evidence.

...

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:*

...

c the information given to patients

...

38. The Tribunal accepted Dr J's reasoning for why he considered the standard of care of Patient A set out in paragraph 1(a), (b), (c) and 8 of the Allegation fell seriously below the

standards expected and amounted to misconduct, both individually and collectively. In respect of the record keeping in this case the Tribunal found that the failure to record matters of such importance as the fact that the use of Kenalog was not approved for use in the UK and was contraindicated by both NICE and the BNF, and the high risk associated with the administration of Kenalog into the Achilles tendon of Patient A was a serious failing on the part of Dr Whiteley. The Tribunal found that the use of shorthand in circumstances such as these was inappropriate and fell seriously below the standard expected of a reasonably competent GP.

Administration of XXX

39. The Tribunal next considered whether Dr Whiteley's administration of XXX to Patients B-G in the circumstances of this case amounted to misconduct.

40. The Tribunal noted that these were not one-off incidences, but rather had been found to reflect a pattern of inappropriate prescribing which was not clinically indicated.

41. The Tribunal had regard to its findings at the facts stage that the administration of XXX to XXX patients was not appropriate, and that in multiple instances, Dr Whiteley had not followed XXX or XXX as would be expected. The expert evidence, which the Tribunal had accepted, was that giving XXX alongside XXX was not appropriate and that the practice of administering XXX in the circumstances of these patients was not current practice at the time of the events. In addition the experts confirmed that it was not a course of action that would have been adopted by either of them.

42. The Tribunal determined that those instances where the Tribunal had found that Dr Whiteley had inappropriately administered XXX to Patients B-G fell seriously below the standard expected.

43. The Tribunal had also found that by his own admission Dr Whiteley had prescribed additional XXX to patients for his own personal use and found that his choice of XXX for the patients had been influenced by his intention to do this. Whilst the experts were not aware that Dr Whiteley had been obtaining and using XXX for his own personal use, they did confirm in their evidence that if a doctor chose to prescribe XXX where not clinically indicated in order to obtain XXX for their own personal use, this would fall seriously below the standards expected.

44. In reaching this decision the Tribunal had regard to the record of Dr Whiteley's interview with NHS England on 23 January 2018. In response to questions asked of him about the prescriptions of XXX he told the investigating officer that he was using XXX he had prescribed for the patient for his own personal use, XXX. In respect of XXX that had been unaccounted for, he admitted that he had used all these XXX for self-administration.

45. XXX

46. The Tribunal considered that this was a clear indication of the basis upon which Dr Whiteley prescribed XXX to Patients B-G and the reason for doing so.

47. The Tribunal had regard to the following paragraphs of GMP, which it considered were applicable 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, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.

16 In providing clinical care you must:

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

b provide effective treatments based on the best available evidence.

...

XXX

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

48. The Tribunal was satisfied that the circumstances in which Dr Whiteley prescribed XXX to Patients B-G fell seriously below the standards expected and amounted to serious

misconduct, and that the seriousness of this misconduct was exacerbated by the abuse of his position to obtain XXX for his own personal use XXX.

Record-Keeping – Patients B-F

49. The Tribunal next considered whether Dr Whiteley's failure to keep adequate records in relation to Patients B-F amounted to misconduct.

50. In doing so, it reminded itself that save for Patient A, which is covered above, it had found two patients where Dr Whiteley had failed to adequately record any consideration of alternative treatment options and four patients where he failed to adequately record any discussion about safety netting.

51. In reaching its decision the Tribunal noted paragraphs 19 and 21(c) of GMP, which states:

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:

...

c the information given to patients

...

52. The Tribunal considered whether the findings of failures in respect of record keeping of Patients B-F amounted to serious misconduct for the purpose of considering impairment. The Tribunal had regard to the different opinions held by the experts in respect of the level of record keeping that was required by a GP in practice at that time, and the reasons given by both. As set out previously whilst it would be desirable for records to be made to the standard expected by Dr J the fact remains that this is not always possible. The Tribunal has also accepted Dr K's opinion that the use of shorthand generally is not only common but accepted practice that would not give rise to concerns from fellow practitioners save for in certain circumstances, such as those set out above. The Tribunal concluded that the

individual failures of Dr Whiteley in this respect did fall below the standard expected of a reasonably competent GP however it did not fall seriously below that standard for the reasons set out above.

53. The Tribunal then went on to consider whether looked at cumulatively the failure in record keeping amounted to misconduct. In doing so, the Tribunal noted the positive comments made by the experts in respect of some entries made by Dr Whiteley but noted that this was not always consistent and at times he fell below the standard expected. However it had not made a finding that the brevity of some entries were deliberate or made in order to hide his prescribing practice. It therefore determined that when considered collectively, while Dr Whiteley's record keeping fell below the standards expected on some occasions, it did not fall seriously below, and did not amount to serious misconduct.

Consideration of alternative treatment options for Patient G

54. The Tribunal then considered whether the finding that Dr Whiteley had failed to consider alternative treatment options for Patient G fell below or seriously below the standard expected. The Tribunal reminded itself of the agreement between the experts who had considered this case in the context of the wider pattern they had identified across the previous cases, namely the administration of XXX in association with XXX. Both had agreed that an alternative to XXX was available and should have been used on this occasion. Dr J placed greater weight on the absence of documentation to reach the conclusion that alternatives had not been considered, whereas Dr K did not consider the administration of XXX to be unsafe.

55. The Tribunal agreed with the opinion of Dr K and found that whilst the use of XXX in these circumstances was unusual, the failure on the part of Dr Whiteley to consider alternative treatment options did not put Patient G at significant risk. Therefore, it found that it fell below but not seriously below the standards expected.

56. On the basis of its findings that multiple aspects of the care given by Dr Whiteley amounted to serious misconduct, the Tribunal concluded that there was a legal basis on which a finding of impairment by reason of misconduct could be made.

Conviction

57. The Tribunal considered the Guidance, which states at paragraph 11:

A conviction or caution in the British Islands for a criminal offence, or a conviction elsewhere for an offence which, if committed in England or Wales, would constitute a criminal offence can indicate that a doctor poses a current and ongoing risk to public protection.

58. The Tribunal had regard to the Certificate of Conviction dated 4 April 2025, and was satisfied that on these grounds there was a legal basis for considering impairment.

XXX

59. XXX

60. XXX

Where on the spectrum of seriousness does the allegation lie?

Misconduct

61. In respect of Dr Whiteley's clinical failings the Tribunal had regard to paragraph 28 of the Guidance, which states that 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:

- *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 found that Dr Whiteley had administered a drug that was not approved and contraindicated by NICE and the BNF when treating Patient A for Achilles tendonitis. This exposed Patient A to a risk of rupture of his Achilles tendon and had ultimately resulted in such rupture and led to lifelong mobility issues. In light of this failing, the failure to arrange a review and the failings in respect of his record keeping, the Tribunal determined that this conduct fell within the middle range of the spectrum of seriousness.

63. The Tribunal considered that the administration of XXX when other routes of administration were available fell at the lower end of the spectrum of seriousness. However, in considering the background and circumstances in which XXX had been prescribed and administered in the round, the Tribunal determined that this reflected far more serious

failings and a pattern of dishonest conduct. For this reason, the Tribunal found that the conduct fell at the higher end of the spectrum of seriousness.

64. The Tribunal considered paragraph 31 of the Guidance, which states that allegations that are likely to fall at the higher end of the spectrum of seriousness include:

- *dishonesty, other than where it occurred outside of the doctor's professional role and was not persistent or repeated, and the value or other benefit derived was not significant*

65. The Introduction to the Guidance also states at paragraph 87:

Whilst a range of behaviour can be seen, the nature of the departure from the standards expected may mean that a concern or allegation relating to dishonesty falls at the high end of the spectrum of seriousness. Even a single incident of dishonesty can have a significant harmful impact and pose a risk to public protection.

Conviction

66. The Tribunal considered paragraph 31 of the Guidance, which states that allegations that are likely to fall at the higher end of the spectrum of seriousness include:

- *a criminal conviction or other court sanction resulting in a custodial sentence (whether immediate or suspended)*

67. The Tribunal also considered that the paragraphs of the Guidance relating to dishonesty as set out above were also applicable in relation to Dr Whiteley's conviction.

XXX

68. XXX

69. XXX

70. XXX

71. The Tribunal then went on to consider the presence of any features which might increase the seriousness of Dr Whiteley's actions. In doing so, it considered Dr Whiteley's misconduct and conviction together, as there was significant overlap and they both reflected a pattern of dishonest and deceptive behaviour in order to obtain XXX for his own personal use.

72. The Tribunal had regard to the features set out in paragraph 36 of the Guidance which includes a reckless disregard for patient safety or professional standards. The guidance explains this as:

"A reckless disregard for patient safety is where a doctor knew, or ought to have known, that their behaviour, poor performance or the impact of a health condition was causing harm, or risked causing harm, to patients and should have taken steps to prevent this, or where they deliberately closed their mind to the existence of such a risk."

73. The Tribunal considered this was applicable in the case along with the following factors contained in the Guidance:

- The behaviour was directed towards, or the poor performance involved interaction with, a person with impaired capacity or a person with a particular vulnerability;
- Premeditated behaviour;
- Abuse of professional position;
- Putting their own interests before those of patients

74. The Tribunal therefore concluded that Dr Whiteley's misconduct, conviction and XXX all fell at the higher end of the spectrum of seriousness and that the starting point for assessing the risk to public protection was therefore high in respect of each of these.

What is the impact of any relevant context known about Dr Whiteley and/or their working environment?

75. In assessing the impact of any context, the Tribunal considered Dr Whiteley's circumstances in respect of all XXX heads of impairment together, as XXX were inextricably linked, with XXX being relevant context in regard to his misconduct and conviction.

76. In respect of Dr Whiteley's working environment, the Tribunal received evidence that he found practising as a GP stressful and found it easier to XXX once he ceased practising as a GP. However, there was nothing to suggest that at the time of the events Dr Whiteley had been placed under any additional pressure in either his workload or working environment would affect the Tribunal's assessment of the seriousness of his actions or the risk to public protection. The Tribunal acknowledged that the stress Dr Whiteley felt may have been XXX, which was a factor which contributed to his misconduct and conviction. However, the Tribunal considered that Dr Whiteley had a duty to recognise XXX and take steps to bring the matter to the attention of his responsible officer and XXX. The Tribunal did not consider that this was relevant context such as to affect the Tribunal's assessment of the seriousness of his misconduct and conviction and the risk posed to public protection.

77. The Tribunal considered that there was no relevant context in regard to his role and experience.

78. In terms of personal context, the Tribunal had regard to the financial difficulties Dr Whiteley found himself in on his return to the UK and XXX at that time. The Tribunal considered that this was relevant context but did not amount to mitigation which would affect its assessment of seriousness or risk.

79. In considering the context the Tribunal noted that many practitioners will experience stresses, both professional and personal, without resorting to such actions. Whilst Dr Whiteley's XXX contributed to his misconduct and conviction, he failed to seek to address XXX but rather consciously chose to embark on a course of action where he dishonestly obtained XXX for his own personal use, which was not a direct or inevitable consequence of XXX.

How has Dr Whiteley responded to the allegation(s)?

80. In respect of Patient A, the Tribunal was of the opinion that this misconduct was remediable. In his Rule 7 response, Dr Whiteley had acknowledged his mistake and accepted that the use of Kenalog for the treatment of Achilles tendonitis was wrong and that this would no longer be a practice that he would use. Dr Whiteley had also attended a relevant RCGP Minor Operations Course in 2017. The Tribunal was satisfied that Dr Whiteley had demonstrated insight and remediated in this respect of the administration of Kenalog and that the risk of repetition was low.

81. In respect of his failure to arrange to see or review Patient A Dr Whiteley's Rule 7 response states: *"...Dr Whiteley noted "advise sos" (see above) in his notes, meaning Patient A should contact the surgery if the problem persists in order to be reviewed. The record on 9 May 2017... shows that Patient A did in fact make contact with the surgery again and consulted with [Dr L]."*

82. The Tribunal considered that this demonstrated little insight and did not demonstrate that the doctor had taken any steps to remediate these failures. The Tribunal found that some risk of repetition remained.

83. In respect of his failure to keep adequate records, Dr Whiteley's Rule 7 response states:

"Dr Whiteley, on reflection, accepts that his notes could have been fuller; however, the fact is he did make notes.

...

Dr Whiteley also modified his clinical practice (in designing and implementing a written consent form to be scanned into patients notes)..."

84. The Tribunal considered that this demonstrated some insight and remediation in relation to these failures and that the risk of repetition was low.

85. The Tribunal reminded itself of the particular circumstances of the treatment of Patient A and the fact that a drug that was unapproved for the treatment of Achilles tendonitis and contraindicated by NICE and the BNF was administered to him. For the reasons set out above the Tribunal found that this amounted to serious misconduct and the Tribunal has not seen any recognition or acceptance by Dr Whiteley that the use of shorthand in these circumstances was inappropriate. Consequently the Tribunal find that there is little evidence of insight or remediation and there remains a risk of repetition.

86. In regard to his inappropriate prescribing of XXX, to Patients B-G Dr Whiteley continues to maintain that XXX that he administered to these patients was clinically indicated and therefore acceptable. The Tribunal has not received any explanation from Dr Whiteley of why he chose the method of administration that he did, although he did admit from the outset, once confronted, that he had used the excess XXX for his own use.

87. The Tribunal considered that the misconduct in this case including dishonesty would be possible but difficult to remediate. It found this not only because of the dishonest conduct but the fact that his conduct was inextricably linked to XXX.

88. The Tribunal agreed with the submissions of Ms Barlow that in respect of his personal remediation Dr Whiteley has taken steps to address XXX. However, it noted that this is in the context of Dr Whiteley having removed himself from practising as a doctor and thereby removing himself from the stress that is said to have triggered his dishonest conduct. The Tribunal further agreed with Ms Barlow that there was little or no evidence of insight in respect of his management and treatment of Patients B-G save for his recognition of XXX and his intention to follow the same in the future.

89. The Tribunal had regard to the testimonials provided on behalf of Dr Whiteley and noted that these had been prepared for the purposes of the criminal proceedings that had led to his conviction. Consequently they did not reference the Allegations nor provide material evidence of any insight or remediation of his treatment of the affected patients or his dishonest behaviour. Consequently it was able to attach little weight to the same.

90. The Tribunal also had regard to the evidence of CPD courses attended by Dr Whiteley. It noted that save for the course attended in 2017 relating to the treatment of minor injuries, none of the courses were relevant to the areas of practice set out in the Allegation such as probity and ethics, or appropriate prescribing. Consequently the Tribunal were able to attach little weight to the same.

91. The Tribunal reminded itself that whilst Dr Whiteley was not currently practising medicine, thereby obviating the risk of repetition, the risk of repetition would be present if Dr Whiteley was to return to unrestricted practice. The Tribunal found that given the limited insight and remediation there remained a risk of repetition were he to return to practise medicine and find himself in similar circumstances.

92. In respect of Dr Whiteley's conviction, the Tribunal noted that he had admitted his actions once concerns were raised by his employer, had made candid admissions had entered a plea of guilty to the Charges brought by the Crown and had apologised for his actions.

93. Whilst the Tribunal considered that this demonstrated some insight into his conviction and the actions leading to it, the Tribunal concluded that this reflected the same motivations and pattern of behaviour as his misconduct in respect of his inappropriate administering of XXX. Therefore, the level of insight, remediation and risk of repetition was necessarily constrained by his lack of insight or meaningful remediation in that regard.

94. XXX

95. XXX

96. XXX

97. XXX

98. XXX

99. XXX

100. The Tribunal also considered that it had been provided with no meaningful evidence that Dr Whiteley, who was no longer practising medicine, had kept his clinical knowledge or skills up to date.

Tribunal's decision as to whether Dr Whiteley poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

101. In deciding what risk, if any, Dr Whiteley posed to public protection, the Tribunal was mindful of paragraphs 44 and 80 of the Guidance:

In all cases where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current and ongoing risk to public protection will be high. Evidence of relevant context known about the doctor and/or their working environment and evidence of how the doctor has responded to the concern that decrease risk, will usually have less impact and carry less weight. This is because the risk to public protection arising from allegations at the higher end of the spectrum of seriousness are generally more difficult to mitigate and address.

However, in cases where the allegation falls at the higher end of the spectrum of seriousness, and therefore the starting point for assessing current and ongoing risk to public protection is high, evidence of insight and remediation will usually carry less weight and therefore will have less impact, if any, on the assessment of current and ongoing risk to public protection. This is because the risk to public protection arising from these allegations is generally more difficult to address, particularly where the allegation is connected to deep seated attitude issues and beliefs.

102. In respect of misconduct, particularly regarding Dr Whiteley's inappropriate prescription and administration of XXX where not clinically indicated and the fact that his actions were influenced by his own personal needs, the Tribunal determined that there were no applicable features which would reduce the level of seriousness or the risk to public protection, which both remained high.

103. It determined that all three limbs of public protection were engaged and that Dr Whiteley's fitness to practise was impaired by reason of misconduct, particularly given the absence of meaningful insight or remediation and the ongoing risk of repetition.

104. In respect of Dr Whiteley's conviction, the Tribunal determined that there were no applicable features which would reduce the level of seriousness or the risk to public protection, which both remained high.

105. It determined that all three limbs of public protection were engaged and that Dr Whiteley's fitness to practise was impaired by reason of his conviction. Although there was some evidence of insight, the Tribunal was concerned that in relation to the misconduct as set out above, the lack of evidence of insight applied equally to the conviction as that was inextricably linked to the misconduct. It determined that there remained a risk of repetition. It also noted that the Guidance sets out that such mitigating features carry less weight in cases where the allegation falls at the higher end of the spectrum of seriousness.

106. XXX

107. XXX

108. The Tribunal has therefore determined that Dr Whiteley's fitness to practise is impaired by reason of misconduct, a conviction or caution for a criminal offence XXX.

Determination on Sanction - 19/08/2026

1. The Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential. This determination will be handed down in private due to the confidential nature of some of the matters under consideration. However, as this case concerns Dr Whiteley's misconduct and conviction a redacted version will be published at the close of the hearing.

The evidence

2. The Tribunal has reviewed its findings at the facts and impairment stages and taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

Submissions

3. On behalf of the GMC, Ms McNeill reminded the Tribunal that it had found that the misconduct relating to the prescribing of XXX and the conviction were motivated by XXX. The Tribunal had also found that there were serious failings, a pattern of dishonest conduct, and multiple failures to follow the requirements of *Good Medical Practice* (2013) ('GMP'). The Tribunal also found that as a result, patients were exposed to unnecessary risk of harm.

4. Ms McNeill reminded the Tribunal of the features it had identified which it found to have increased the seriousness of the allegations, including: a reckless disregard for patient safety; the behaviour was directed towards persons with impaired capacity or a particular vulnerability; premeditation, abuse of a professional position and putting his individual interests before those of patients.

5. Ms McNeill submitted that Dr Whiteley has demonstrated limited insight and remediation and that the misconduct, conviction XXX allegations were all found to fall at the higher end of the spectrum of seriousness. She submitted that the Tribunal found that there was a high risk of repetition were Dr Whiteley to return to unrestricted practice and that all three limbs of public protection were engaged.

6. Ms McNeill submitted that the indicative sanctions bandings as set out in the *MPTS Guidance for tribunals* ('the Guidance') indicate that in relation to dishonesty and conviction, a sanction of suspension to erasure may be appropriate. She further submitted that in relation to the impact of XXX.

7. Ms McNeill submitted that in reaching its decision on sanction, the Tribunal should assess the totality of the allegations and findings, and that in this case the necessary and proportionate outcome in order to achieve public protection was that of erasure. She submitted that the conduct was so serious that no other available sanction would meet all three limbs of public protection or be sufficient to address the ongoing risk identified.

8. Ms McNeill referred the Tribunal to the relevant paragraphs of the Guidance and submitted that this was not a case where conditions would be appropriate, measurable or workable in the context of this case and that suspension would not be sufficient to protect the public. She submitted that the ongoing lack of insight, and the seriousness of the findings mean that the effect of Dr Whiteley continuing to hold registration was such that it would undermine public confidence in the profession. She submitted that given the seriousness of the findings, erasure was the only sanction that would satisfy the public in that regard.

9. Ms McNeill noted that in this case the testimonials were provided for separate proceedings and that findings had already been made by the Tribunal in relation to the limited weight that could be attached to them.

10. Ms McNeill submitted that the overall conduct of Dr Whiteley was fundamentally incompatible with continued registration, and therefore the proportionate and appropriate sanction in this case was that of erasure.

The Tribunal's approach

11. The Tribunal accepted the legal advice given and the procedure to be adopted under MPTS Guidance (section 3, Part C). It reminded itself that the decision as to the appropriate sanction, if any, to impose is a matter for its independent judgement having regard to its findings at the facts and impairment stage. When determining what, if any sanction to impose it should have regard to the principle of proportionality and should start by considering the least restrictive option.

The Tribunal's determination on sanction

12. In making its decision on sanction, the Tribunal has reviewed its decision on facts and impairment and has considered the level of current and ongoing risk the doctor poses to public protection. The Tribunal has referred to the Guidance relating to sanction as set out in Part C and referred to the sanctions banding(s) for misconduct, convictions and adverse health as set out in Paragraph 62 of Part C of the Guidance.

13. The Tribunal noted that the indicative sanctions banding set out in the Guidance at paragraph 62 (“the Bandings”) indicate a period of suspension of 9 months to erasure for cases of dishonesty with a high level of risk to public protection.

14. In respect of the conduct relating to clinical concerns, the Bandings indicate a period of conditions for 24 to 36 months to suspension for a period of 6 months for those cases found to present a medium level of risk to public protection and a period of suspension for 6 months to erasure for cases found to present a high level of risk (to public protection).

15. The Bandings relating to convictions indicate a period of suspension of 12 months to erasure for cases involving convictions with a high level of risk to public protection.

16. XXX

17. The Tribunal reminded itself that the Bandings are intended to provide a guide and that there may be evidence relevant to the individual circumstances of the case that indicates a sanction which is more, or less, restrictive than that suggested in the Bandings.

No action

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

19. The Tribunal reminded itself of the nature of Dr Whiteley’s conduct which had involved serious clinical failings and acts of dishonesty. He had put patients at unnecessary risk and had abused his position as a doctor, in some instances with patients who were vulnerable, to obtain XXX drugs XXX. In doing so he had put his own interests before those of his patients and had demonstrated a reckless disregard for both the safety of his patients and professional standards. The Tribunal had found this premeditated conduct to pose a high level of risk to public protection and had found no factors which reduced the seriousness of its findings or the level of risk to public protection.

20. The Tribunal determined that there were no exceptional circumstances which would warrant the taking of no action, particularly in the context of the facts found proved and the Tribunal's determination on impairment. It reminded itself that it had found that Dr Whiteley poses a current and ongoing risk to all three parts of public protection and concluded that taking no action would not be proportionate, or sufficient to protect the public.

Conditions

21. The Tribunal next considered whether a period of conditions would be the appropriate and proportionate sanction in the circumstances. In doing so, it reminded itself that where conditions are put in place, they should be appropriate, workable, and measurable.

22. The Tribunal noted that the Bandings for the conduct and nature of Dr Whiteley's misconduct and conviction do not indicate that conditions would be an appropriate and proportionate sanction for cases of this type where there is a high level of risk to public protection. It therefore XXX

23. XXX

24. The Tribunal also considered that any conditions would not be workable or measurable as Dr Whiteley has completely left clinical practice and the medical profession, albeit he could return at some point.

25. The Tribunal was also of the opinion that given the seriousness of its findings in relation to Dr Whiteley's conduct and conviction, conditions would not be proportionate or sufficient to uphold the three limbs of public protection. The Tribunal considered that even if working under conditional registration, if Dr Whiteley decided to return to practice in the future and was faced with similar stressors, there would remain a risk that given the opportunity, he would repeat the same or similar behaviour because he had failed to demonstrate any meaningful insight.

Suspension

26. The Tribunal next considered whether to impose a period of suspension on Dr Whiteley's registration. The Tribunal reminded itself that the purpose of suspension is to

remove a doctor from practice to manage the current and ongoing risk they pose to public protection with the aim that they should be able to return to unrestricted practice in the future. In addition suspension can have a deterrent effect and send a signal to the individual doctor, the profession and the public about what is regarded as behaviour unbefitting a registered medical practitioner.

27. The Tribunal had regard to paragraph 62 of the Guidance and the Bandings which indicate that a lengthy period of suspension or erasure may be appropriate in circumstances such as those found by this Tribunal. It further had regard to paragraph 45 of the Guidance, which states:

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*
- b. the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or*
- 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.*

28. The Tribunal considered that the above sub-paragraphs were applicable in this case, indicating that conditions would not satisfactorily address the ongoing risk to public protection, and that a period of suspension may be appropriate and proportionate.

29. The Tribunal reminded itself again of its findings at the facts and impairment stage that his premeditated behaviour had led to serious clinical failings and acts of dishonesty putting patients at unnecessary risk and abusing his position as a doctor to XXX. The Tribunal had found that Dr Whiteley's actions had put patient safety at risk, brought the profession into disrepute, breached fundamental tenets of the medical profession and fallen far short of the standards expected of a medical practitioner.

30. The Tribunal also reminded itself of the evidence of XXX. The Tribunal noted that Dr Whiteley had not produced any information about how he would act if he was placed with a similar situation in the future in a position where he would have access to controlled drugs.

31. The Tribunal reminded itself that for suspension to be an appropriate and proportionate sanction there must be a reasonable prospect of Dr Whiteley's safe return to unrestricted practice. It had found that the dishonest conduct was repeated over a period of time, and whilst Dr Whiteley has taken significant steps to address XXX and has accepted that he would change elements of his practice if he was to return to it in the future, he has not shown any meaningful insight of the impact of his actions on the patients concerned or the wider profession. Similarly, he has not undertaken any meaningful remediation since the time of the events or when his actions were discovered in 2018 and has not demonstrated any indication that he intends to do so.

32. Having considered all three heads upon which the Tribunal had found impairment, for the reasons set out above and given the seriousness of its findings and the risk of repetition, the Tribunal concluded that a period of suspension would not be sufficient to maintain the three limbs of public protection, namely: to protect, promote and maintain the health, safety and well-being 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.

Erasure

33. The Tribunal went on to consider whether to erase Dr Whiteley's name from the Medical Register. In doing so it had regard to paragraph 57 of the Guidance, which states:

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.

34. The Tribunal considered that the above paragraph was applicable as it had determined that a period of conditions or suspension would not be proportionate and would fail to uphold public protection. It considered that as Dr Whiteley's XXX was the driver for his dishonest conduct, the ongoing risk could not be fully mitigated by a period of suspension and also found that Dr Whiteley had shown a persistent lack of insight.

35. The Tribunal determined that Dr Whiteley's actions were fundamentally incompatible with continued registration and that the seriousness of the findings meant that public confidence would be undermined were Dr Whiteley to continue to hold registration.

36. The Tribunal reminded itself that the Bandings set out in the Guidance were only indicative of sanctions which may be appropriate in relation to the type of conduct in this case. It concluded that Dr Whiteley's behaviour is fundamentally incompatible with continued registration as a doctor and that the high level of current and ongoing risk to public protection is such that he should not be allowed to practise.

37. For the same reasons as found at impairment, the Tribunal was unable to attach any significant weight to the references and testimonials provided on behalf of Dr Whiteley.

38. The Tribunal acknowledged that this sanction would have a reputational impact on Dr Whiteley but did not find evidence of any other direct impact given that he had already ceased practising as a doctor and found employment elsewhere. Given he is not currently working in practice and had not intended to do so in the future, his permanent removal from the same would not have any detrimental impact on patients or the public.

39. The Tribunal therefore determined to erase Dr Whiteley's name from the Medical Register.

Determination on Immediate Order - 19/08/2026

1. The Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential. This determination will be handed down in

private due to the confidential nature of some of the matters under consideration. However, as this case concerns Dr Whiteley's misconduct and conviction a redacted version will be published at the close of the hearing.

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

Submissions

3. On behalf of the GMC, Ms McNeill submitted an immediate order should be imposed given the Tribunal's findings.

4. Ms McNeill submitted that the relevant paragraphs of the Guidance for MPTS Tribunals ('the Guidance') indicate that an immediate order is appropriate in the circumstances. She submitted that Dr Whiteley poses a risk to patient safety, and that in this case all three elements of public protection are engaged and the risk is high in each case.

5. Ms McNeill submitted that action is needed to maintain public confidence and it would be inconsistent with the findings that the conduct was incompatible with continued registration to allow for any period of abeyance.

The Tribunal's determination

6. The Tribunal considered that it may impose an immediate order if it considers it necessary for the protection of members of the public or is otherwise in the public interest.

7. The Tribunal had regard to the paragraphs 80, 83 and 84 of the Guidance, which set out:

In the context of an immediate order, the best interests of the doctor includes avoiding putting them in a position where they may come under pressure from patients and/or may repeat the behaviour or poor performance giving rise to the allegation, particularly where this may also put the doctor at risk of committing a criminal offence. It may also include where the doctor's ability to practise safely and effectively may be impacted by an ongoing health condition.

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.

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”*

8. The Tribunal found that there was a risk of repetition, and that Dr Whiteley’s ability to practise safely and effectively was impacted by XXX.

9. The Tribunal considered that given it found the level of risk to public protection to be high and the seriousness of its findings, an immediate order was necessary in the circumstances of this case.

10. The Tribunal determined that it would be inconsistent with its earlier findings to allow Dr Whiteley to practise unrestricted for the appeal period or the duration of any appeal, and would fail to maintain public confidence.

11. This means that Dr Whiteley’s registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction, as already announced, will take effect 28 days from that date, 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.

12. The interim order currently in place on Dr Whiteley’s registration will be revoked when the immediate order takes effect.

ANNEX A – 13/08/2026

Service & Proceeding in Absence

1. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential.

Service

2. Dr Whiteley was neither present nor represented at this hearing.

3. Ms Barlow, Counsel, on behalf of the GMC, submitted that notice of this hearing had been properly served on Dr Whiteley pursuant to Rule 40 of the Rules and referred the Tribunal to the Proof of Service bundle and documents therein, which included:

- Email from GMC to Dr Whiteley with Allegation, dated 30 June 2026;
- GMC Rule 34(9) Letter Attachment, dated 30 June 2026;
- Rule 15 Allegation Attachment, dated 30 June 2026;
- Email from Dr Whiteley to GMC acknowledging Notice of Allegation, dated 1 July 2026;
- Email from representative of Dr Whiteley to GMC confirming Dr Whiteley will not attend Hearing, dated 1 July 2026;
- Email from MPTS to Dr Whiteley with Notice of Hearing, dated 30 June 2026;
- Email chaser from MPTS to Dr Whiteley RE Response to Notice of Hearing, dated 1 July 2026;
- Email from Dr Whiteley to MPTS acknowledging Notice of Hearing, dated 1 July 2026.

4. Ms Barlow submitted that Dr Whiteley had been properly notified, furnished with the relevant documents as required by the Rules, and had confirmed receipt of the notice and said documents.

5. The Tribunal had regard to the service bundle provided by the GMC as well as the submissions made by Ms Barlow.

6. The Tribunal noted that the Proof of Service Bundle included confirmation of receipt from Dr Whiteley for both the Notice of Allegation and the Notice of Hearing.

7. The Tribunal therefore determined that notice of this hearing had been served in accordance with the relevant provisions and went on to consider whether to proceed in the doctor's absence pursuant to Rule 31.

Proceeding in Dr Whiteley's absence

8. Ms Barlow invited the Tribunal to proceed in Dr Whiteley's absence. She submitted that in the circumstances Dr Whiteley was well aware of the hearing and had chosen not to attend. She submitted that Dr Whiteley had been engaging with the GMC, had provided skeleton arguments via his representatives, and had given every party notice that he did not intend to attend the hearing.

9. Ms Barlow submitted that an adjournment would not resolve Dr Whiteley's absence as he had confirmed that he was not intending to attend the hearing, and had voluntarily absented himself, making it plain that whilst he did not intend any disrespect to anybody he would not be attending.

10. Ms Barlow submitted that Dr Whiteley had provided a Rule 7 response letter and that there would be no disadvantage to him in not being able to present his case. She submitted that the expeditious, fair, economical, and efficient disposal of the case was important and that in the circumstances, the Tribunal should determine to proceed in Dr Whiteley's absence.

The Tribunal's Determination on Proceeding in Absence

11. The Tribunal has balanced Dr Whiteley's interests with the public interest in deciding whether to proceed in his absence.

12. The Tribunal considered the correspondence from Dr Whiteley stating that he would not be attending or represented at the hearing and that he understood that the Tribunal would proceed to hear the case in his absence.

13. The Tribunal considered that there was no good reason to adjourn or that an adjournment would likely result in Dr Whiteley's attendance at any future date.

14. The Tribunal concluded that it was in the interests of justice and public safety to proceed and that it was fair and proper to do so.

15. In accordance with Rule 31 of The Rules, the Tribunal therefore determined that that it was appropriate to proceed in Dr Whiteley's absence.

ANNEX B – 13/08/2026

Application to hear proceedings entirely in private

1. The Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential. This determination will be handed down in private due to the confidential nature of some of the matters under consideration. However, as this case concerns Dr Whiteley's alleged misconduct and conviction a redacted version will be published at the close of the hearing.

2. Prior to the commencement of the hearing, via his legal representatives, Dr Whiteley made an application for the entirety of the proceedings to be heard in private, pursuant to Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules).

3. Rule 41 states:

41.

(1) Subject to paragraphs (2) to (6) below, hearings before the Committee and a Medical Practitioners Tribunal shall be held in public.

(2) The Committee or Medical Practitioners Tribunal may determine that the public shall be excluded from the proceedings or any part of the proceedings, where they consider that the particular circumstances of the case outweigh the public interest in holding the hearing in public.

(3) Subject to paragraphs (4) to (6), the Committee or a Tribunal shall sit in private, where they are considering- (a) whether to make or review an interim order; or (b) the physical or mental health of the practitioner.

...

Submissions

4. Both parties provided written submissions to the Tribunal and Ms Barlow, Counsel on behalf of the GMC, also summarised her submissions orally during the hearing.

On behalf of Dr Whiteley

5. It was submitted that whilst the aspects of the case XXX would XXX be heard in private under the Rules, the misconduct and conviction aspects of the case were so inextricably linked with XXX that they should also be heard in private.

6. It was submitted that it would be extremely difficult and impractical to consider a handful of differently numbered allegations during public session at the hearing as a lot of the allegations were inextricably linked and intertwined with the context, history and background of other allegations which should remain private and confidential and be heard in private session.

7. XXX

8. It was submitted that the allegations (especially the allegations relating to the treatment provided to patients) were now historic, that Dr Whiteley was no longer practising medicine and that it was Dr Whiteley's intention never to practise medicine again as he has changed his life path and career choice. Therefore, there was no risk to patient safety at all and it was not in the public interest to publish information that would only be detrimental and prejudicial to Dr Whiteley when no patients would be put at risk in the future.

9. It was submitted that the adverse impact on Dr Whiteley outweighed the probative value or the public interest if the case were to be published or if any of the hearing was to be heard in public.

On behalf of the GMC

10. Ms Barlow submitted that the allegations in relation to misconduct (prescription of XXX) and to conviction (fraud and theft) should be heard in public. She submitted that the convictions of Dr Whiteley for fraud and theft related to the self-administration of XXX obtained by retaining XXX prescribed to patients and that the facts of those convictions, any mitigation put before the criminal court by Dr Whiteley and the sentence in respect of the convictions were already in the public domain.

11. Ms Barlow submitted that relevant case law sets out that the requirement for public hearings is not absolute, however, a derogation from the principle of open justice can only be made if it is strictly necessary. She submitted that the default position in professional conduct proceedings, save for where the Rules provide otherwise, is that the hearing should take place in public and that this is the default position that ought not to be departed from unless it is considered that the particular circumstances of the case outweigh the public interest in holding the hearing in public.

12. Ms Barlow submitted that there was no factual basis for, nor evidence to support the suggestion that, any party would mention XXX in public session and that the historic nature of the allegations, that Dr Whiteley is no longer practising medicine and that he poses no current risk to patient safety are not matters that are relevant to the issue of departing from the default position of open justice.

13. Ms Barlow submitted that the allegations that relate to misconduct and conviction are separate and distinct from XXX and whilst XXX aspects of the case may provide overall mitigation this is a separate and distinct area. She submitted that this is a case in which XXX aspects can easily be referred to separately and distinctly, that there was no reason to suspect that any witness or party would refer to XXX in public session, and that Dr Whiteley has provided no cogent reason to depart from the principle of open justice in relation to the remainder of the case.

The Tribunal's Decision

14. The Tribunal was mindful of Rule 41, as set out above, and the case of *Miller v GMC [2013] EWHC 1934 (Admin)*, which is authority for the principle that public hearings are the default position and if that position is to be departed from, it should be to the least extent possible. It is also necessary to explain with adequate reasons a decision to depart from the default position. The onus to justify the derogation rests on the party seeking to establish and

justify the need. A curtailment of open justice may be necessary to avoid a violation of a person's rights under the European Convention of Human Rights, for example, where Article 8 rights are asserted, or in relation to others whose personal details may be identified at the hearing. The decision to sit in private may relate to all or part of a hearing. As conducting proceedings in private is regarded as the exception to the general principle, a tribunal should always consider first whether it would be possible to conduct different parts of a hearing in private, before deciding whether to conduct the hearing wholly in private.

15. In reaching its decision, the Tribunal noted that Dr Whiteley's conviction was already in the public domain and was relatively recent, the case having been heard on 31 December 2024.

16. The Tribunal considered that there was no evidence that this was a case which warranted the hearing being heard entirely in private and that Dr Whiteley had failed to provide sufficient evidence or reason to discharge the burden that a derogation from the principle of open justice is necessary.

17. Those matters relating to XXX would XXX be heard in private and the Tribunal was satisfied that it would be possible to separate XXX aspects from the conviction and misconduct aspects sufficiently that the latter could be heard in public session.

18. The Tribunal considered that hearing those matters relating to misconduct and Dr Whiteley's conviction in public was in keeping with the principles set out in relevant case law and the need to maintain public confidence in the profession. The Tribunal was of the opinion that as the alleged misconduct related to Dr Whiteley's clinical practice it was important that it be heard in public in the absence of any compelling evidence or reason to the contrary.

19. In reaching its decision the Tribunal noted the submission that Dr Whiteley had left the profession and no longer intended to practise as a doctor. The Tribunal did not consider that this was an adequate reason to justify a derogation from the principle of open justice.

20. The Tribunal therefore determined to refuse the application for proceedings to be heard entirely in private and to hear those parts of the case not directly relating to XXX in public.

ANNEX C – 13/08/2026

Application to anonymise patients

1. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential.

2. At the outset of proceedings, Ms Barlow, Counsel, made an application on behalf of the GMC to anonymise the names of Patients A to G throughout proceedings, pursuant to Rule 35(4), which states:

35.

...

(4) The Committee or Tribunal may, upon the application of a party, agree that the identity of a witness should not be revealed in public.

Submissions

3. Ms Barlow submitted that the issue for the Tribunal to consider was whether non-disclosure was necessary to protect the interests of the relevant parties, which it overwhelmingly was in the case of patients.

4. Ms Barlow submitted that that this would be in accordance with the MPTS guidance where confidential health information of individual patients will be considered.

5. Ms Barlow submitted that Dr Whiteley was aware of the application and had not made any suggestion that the anonymisation should not be applied.

The Tribunal's Decision

6. The Tribunal had regard to Rule 35(4) and the MPTS circular of 9 September 2025 which sets out that an application for the anonymisation of any witness, party or patient must be made to the Tribunal. The guidance also sets out the type of circumstances where it

may be appropriate to grant such an application. This includes patients who form part of the Allegation and whose confidential health information will form part of the evidence presented.

7. The Tribunal considered that the application related to patients whose confidential health information would be considered and that it would be appropriate to anonymise them in the circumstances. This would afford them their right to privacy in respect of their confidential information and avoid any risk of jigsaw identification by those associated with the practices with which they were registered and identified in these proceedings.

8. The Tribunal therefore granted the GMC's application.

ANNEX D – 13/08/2026

Application to withdraw allegations

1. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential.

2. At the outset of proceedings, Ms Barlow, Counsel, made an application on behalf of the GMC to withdraw paragraphs 9 to 11 of the Allegation, pursuant to Rule 28 of the Rules.

Submissions

3. Ms Barlow submitted that the GMC was seeking to withdraw paragraphs 9 to 11, which related to dishonesty. She submitted that these paragraphs reflected the findings set out at paragraphs 14 and 15 of the Allegation, which related to Dr Whiteley's conviction for theft and fraud.

4. Ms Barlow submitted that the application could not be made prior to the hearing commencing as the conviction occurred at a magistrate's court hearing, which was not a court of record. As such, it had taken some time to obtain the police documents that underpinned that conviction.

5. Ms Barlow submitted that on receipt and review, it was clear that paragraphs 9 to 11 of the Allegation represented a duplication of paragraphs 14 and 15. She submitted that whilst Dr Whiteley had admitted these allegations, it would not be proper for the Tribunal to consider duplicate charges or for these aspects of the case to be ‘double-charged’.

The Tribunal’s Decision

6. The Tribunal considered that the information pertaining to paragraphs 9 to 11 of the Allegation were clearly a duplication of the details of Dr Whiteley’s conviction. Therefore, there would be no prejudice to the doctor and it would be fair to amend the Allegation to withdraw paragraphs 9 to 11.

7. The Tribunal therefore granted the GMC’s application.

Schedule 1

XXX