PUBLIC RECORD

Dates: 10/10/2022 - 14/10/2022

Medical Practitioner's name:	Dr Mark WELLS
GMC reference number:	3548293
Primary medical qualification:	MB ChB 1991 University of Sheffield

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

Summary of outcome

Suspension, 3 months.

Tribunal:

Legally Qualified Chair	Miss Gillian Temple-Bone
Lay Tribunal Member:	Mrs Ann Bishop
Medical Tribunal Member:	Dr Anita Clay

Tribunal Clerk:	Mr Andrew Ormsby

Attendance and Representation:

Medical Practitioner:	Present and not represented
GMC Representative:	Mr Ian Brook, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts & Impairment - 12/10/2022

Background

1. Dr Wells qualified in 1991 at the University of Sheffield, and completed his GP training between 1993 and 1995, working thereafter in South Wales. At the time of the events Dr Wells was the Practice Clinical Lead responsible for the day to day running and governance of the Bryntirion Surgery (the Surgery) in Bargoed, Wales.

2. The Allegation that has led to Dr Wells' hearing arose from concerns relating to Dr Wells' completion of Medical Certificates of Cause of Death (MCCD).

3. The Allegation related to Dr Wells' completion of MCCD for Patient A; Patient B, Patient C, Patient D, Patient E, Patient F and Patient G.

4. It is alleged that Dr Wells had dishonestly completed MCCD stating that he had seen the patients on specific dates prior to death when he knew that he had not seen the patients on those dates.

5. It is further alleged, that during a telephone call with the Deputy Registrar, Ms H (referred to as Mrs F in the Allegation), Dr Wells had dishonestly indicated that he had last seen Patient E alive on a specific date when he knew that he had not seen Patient E on that date.

6. The initial concerns were raised with the GMC on 16 April 2020 by Mrs I, Patient E's wife.

The Allegation and the Doctor's Response

7. The Allegation made against Dr Wells is as follows:

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

Patient A

1. On 27 December 2018, you completed a Medical Certificate of Cause of Death ('MCCD') in which you indicated that you had last seen Patient A alive on 13 December 2018. Admitted and Found proved

2. You knew that you had not seen Patient A alive on 13 December 2018.
Admitted and Found proved

3. Your actions as described at paragraph 1 were dishonest by reason of paragraph 2. Admitted and Found proved

Patient B

4. On 7 January 2019, you completed a MCCD in which you indicated that you had last seen Patient B alive on 2 January 2019.
Admitted and Found proved

5. You knew that you had not seen Patient B alive on 2 January 2019.
Admitted and Found proved

6. Your actions as described at paragraph 4 were dishonest by reason of paragraph 5. Admitted and Found proved

Patient C

7. On 4 March 2019, you completed a MCCD in which you indicated that you had last seen Patient C alive on 15 February 2019.
Admitted and Found proved

8. You knew that you had not seen Patient C alive on 15 February 2019.
Admitted and Found proved

9. Your actions as described at paragraph 7 were dishonest by reason of paragraph 8. Admitted and Found proved

Patient D

10. On 5 March 2019, you completed a MCCD in which you indicated that you had last seen Patient D alive on 14 February 2019.
Admitted and Found proved

11. You knew that you had not seen Patient D alive on 14 February 2019.
Admitted and Found proved

12. Your actions as described at paragraph 10 were dishonest by reason of paragraph 11. Admitted and Found proved

Patient E

13. On a date on or after 21 January 2020, you completed a MCCD in which you indicated you had last seen Patient E alive on 21 January 2020.
Admitted and Found proved

14. On 31 January 2020, you completed a further MCCD in which you indicated you had last seen Patient E alive on 21 January 2020.
Admitted and Found proved

15. You knew that you had not seen Patient E alive on 21 January 2020.
Admitted and Found proved

16. Your actions as described at paragraphs 13 and 14 were dishonest by reason of paragraph 15. Admitted and Found proved

17. On 6 February 2020, during a telephone call with the registrar Mrs F, you indicated that you had last seen Patient E alive on 31 October 2019.
Admitted and Found proved

18. On 14 February 2020, during a telephone call with the registrar Mrs F, you indicated that you had last seen Patient E alive on 31 October 2019.
Admitted and Found proved

19. You knew that you had not seen Patient E alive on 31 October 2019.
Admitted and Found proved

20. Your actions as described at paragraphs 17 and 18 were dishonest by reason of paragraph 19. Admitted and Found proved

Patient F

21. On 24 January 2020, you completed a MCCD in which you indicated that you had last seen Patient F alive on 20 January 2020.
Admitted and Found proved

22. You knew that you had not seen Patient F alive on 20 January 2020.
Admitted and Found proved

23. Your actions as described at paragraph 21 were dishonest by reason of paragraph 22. Admitted and Found proved

Patient G

24. On 7 February 2020, you completed a MCCD in which you indicated that you had last seen Patient G alive on 31 January 2020.
Admitted and Found proved

25. You knew that you had not seen Patient G alive on 31 January 2020.
Admitted and Found proved

26. Your actions as described at paragraph 24 were dishonest by reason of paragraph 25. Admitted and Found proved

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

The Admitted Facts

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

9. In light of the full admissions made by Dr Wells, 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, Dr Wells' fitness to practise is impaired by reason of his misconduct.

Further Background

Patient E's wife (Mrs I)

10. On 16 April 2020, the GMC received a complaint from Mrs I (Patient E's wife) regarding an MCCD completed by Dr Wells, a GP, in respect of her late husband, Patient E.

11. Patient E died on 31 January 2020, at Ashville Care Home, New Tredegar, in Wales.

12. Dr Wells was said to have completed the relevant MCCD for Patient E at the Surgery and incorrectly stated he had last seen Patient E alive on 21 January 2020.

13. Patient E's wife, in her witness statement dated 26 April 2021, records that the MCCD completed by Dr Wells recorded the cause of Patient E's death as dementia and described her initial concerns:

> *'..When I got home, I looked at the certificate again and saw that the date of death was incorrect. It was written as 21 January 2020 when it should have been 31 January 2020. The certificate was also signed by Dr Mark Wells who said that he had seen* [Patient E] *which was incorrect…'*

14. When Patient E's wife attended the Registry Office with the amended MCCD to register her husband's death, she was advised that they could not accept the MCCD completed by Dr Wells because it was out of date.

15. Patient E's wife stated that she '*requested a copy of the coroner's report who stated that* [Patient E] *had died from ischaemic heart disease, coronary artery atheroma and secondary vascular dementia'.*

16. Patient E's wife, in her complaint to the GMC, claimed that Patient E was last seen alive by a GP on 20 December 2019 and that GP was not Dr Wells.

17. Patient E's wife stated that she obtained the second medical certificate after the coroner's report only three days before Patient E's funeral, and, as the funeral could not take place without a death certificate, she had to rush to collect the certificate and take it to the funeral director. She went on to emphasise the impact of this situation *'was terrible as there was a month delay in obtaining the certificate which added more stress on top of an already very difficult time'*.

18. Dr Wells did not dispute the evidence of Patient E's wife.

19. Ms J, Deputy Manager at Ashville Residential Care Home, provided a witness statement, dated 27 November 2020, in which she confirmed that Patient E was a resident there from 27 January 2020 until his death on 31 January 2020.

20. Ms J stated that on the day of Patient E's death a staff member had noticed that Patient E's breathing was *'quite shallow'*. She went on to state that, consequently, he was reviewed by the care home's resident nurse who then contacted Patient E's GP practice and the staff member was informed that a GP was unavailable and that he should contact 999.

21. Ms J confirmed in her witness statement, dated 27 November 2020. that a paramedic arrived a few minutes after Patient E passed away. As the death was sudden, and in a care home, Ms J notified the police.

22. According to Ms J's chronology of events, both the police officer who attended, and the paramedic, agreed that the paramedic could verify the cause of death in the absence of a GP and Ms J agreed to allow the paramedic to do this.

23. Ms J confirmed that Dr Wells was not present at Ashville Residential Care Home on the day of Patient E's death.

24. Dr Wells did not dispute Ms J's evidence.

25. The post-mortem report dated 26 March 2020 stated the following:

> *'It would appear that the GP stated on the MCCD that he last saw* [Patient E] *on 21.1.20, this was challenged by the family, and he then said 31.10.19. This was again challenged and Dr Wells then accepted that he had never seen the deceased. Offered cause of death Ia. Dementia II. Cerebrovascular Disease.'*

26. The post-mortem report went on to conclude that:

> *'The deceased was known to suffer from vascular dementia. He, however, had evidence of severe narrowing of all three coronary arteries and this provides the likely acute cause of death on this occasion.'*

Registry Office

27. Ms H, Deputy Registrar, prepared a statement dated 29 March 2021 in which she described the process for registering a death. It usually starts when the registrar is issued with a medical certificate confirming the cause of death, and the date on which a certifying practitioner last attended to the person. The rules, pre-Covid, required that the doctor who signed the medical certificate had to be in attendance on the deceased in his/her last illness. The doctor had to state the date that he/she last saw the deceased alive. Before 26 March 2020, if this date was not within 14 days of death, it had to be referred to the coroner.

28. Patient E's wife visited Ms H on 6 February 2020, who told her of a number of concerns about Patient E's death including her concern as to the stated cause of death on the death certificate. Prompted by those concerns, Ms H telephoned Dr Wells on 6 February and 14 February. Transcripts of each call and audio recordings are within the evidence filed.

29. Ms H stated that during a telephone conversation on 6 February 2020, Dr Wells confirmed that the home visit on 21 January 2020 had not in fact been undertaken by him, but rather by a paramedic who was attached to the Surgery.

30. Ms H explained to Dr Wells that if that was the case, he should not have entered that date on the form and that what he should have entered was the last date that he had personally seen Patient E. She then asked him to clarify when this was. Dr Wells' response was *'unfortunately* [that] *is going back a little bit further…(pause) we're talking back into October.'* Dr Wells later clarified it was on 31 October 2019.

31. Ms H went on ask Dr Wells to confirm whether he had seen Patient E '…*within his last illness then, I mean the cause of death being dementia, ….*' Dr Wells responded '*yes*'.

32. During the second telephone conversation on 14 February 2020 Dr Wells was informed that Patient E's wife had been with Ms H that morning and that she was adamant that Dr Wells had never seen Patient E personally on either 21 January 2020 or 31 October 2019.

33. In that telephone call Ms H asked Dr Wells to confirm that he had seen Patient E on 31 October 2019, as he had stated in the earlier telephone discussion. Dr Wells stated Patient E had been seen and then explained it was not by him.

34. He was asked again about 31 October 2019, and said "*Let's have a check*." When Ms H informed him '*because the reason why is this didn't go over as uncertified afterwards* [was] *because you'd seen him previously and now we've got paperwork to register and his widow is absolutely adamant that she's never seen you.'* Dr Wells then said '*sorry that was, it's my mistake, it was the GP actually, Dr* […]'.

35. Dr Wells then admitted that he had *'never seen'* Patient E.

36. Ms H stated that shortly after concerns regarding Patient E's MCCD were raised, a further MCCD arrived in the registry office, regarding Patient G, signed by Dr Wells. This was brought to her attention by her colleague, and it raised concerns as Ms H recalled Dr Wells having informed her during their telephone discussions that '*he did not make any house calls*.' The patient's next of kin had confirmed that the patient was in receipt of palliative care for cancer and that no doctor had come to visit, and they could not recall seeing Dr Wells. Ms H went on to state:

> *'My colleague said to Dr Wells he should not have signed the certificate to state that he had last seen that patient alive if he hadn't seen them on that date. Dr Wells apologised and said he was not aware that he was not supposed to put a date for last seen alive that is not factual or correct.'*

37. Ms H stated that in the circumstances Patient G's death could, therefore, not be registered, and had to be referred to the Coroner.

38. Ms H stated that the Registry Office, due to having two MCCD concerns both completed by Dr Wells, reported the matter to the local Health Board.

39. Dr Wells did not dispute the telephone transcript evidence or the witness statement of Ms H.

Aneurin Bevan University Health Board investigation

40. Aneurin Bevan University Health Board (the Health Board) instructed Dr K, Clinical Director for Primary Care at Bryntirion Surgery to carry out an investigation into the formal complaint made by Patient E's family. The complaint was that the issuing doctor did not follow the correct procedure.

41. The Health Board investigation established, having reviewed the recordings of telephone conversations between the Registrar and Dr Wells that when discussing the completion of the death certificate Dr Wells '*initially gave incorrect information to the registrar in respect of his involvement in the care of the deceased prior to death*.'

42. When reviewing the concerns raised by Patient E's family, Dr K checked back through the certificate book for instances where Dr Wells had issued an MCCD. He identified eleven certificates signed by Dr Wells, of which six had a date last seen alive that related to episodes of care from another clinician or a telephone call.

43. These further cases noted by the Health Board relate to Patient A, Patient B, Patient C, Patient D, Patient F, and Patient G.

44. Dr Wells did not dispute the evidence of that investigation.

Medical Practitioners Tribunal June 2016

45. Dr Wells' fitness to practise had previously been found to be impaired by reason of misconduct by a Medical Practitioners Tribunal in June 2016. Dr Wells submitted the determination and review determination to this Tribunal.

46. Between 13 – 17 June 2016 Dr Wells appeared before a Tribunal. The following is an extract from the September 2016 Tribunal's determination:

> "1. The Tribunal has been provided with the background to your case. The initial Fitness to Practise Hearing took place in June 2016 (the June tribunal). In summary, on 7 October 2013, you appeared before a Medical Performers List (MPL) Reference Panel of the Aneurin Bevan Health Board (the Board), following your persistent failure to comply with the requirements of the GMS contract regulations and the MPL that GPs have an annual appraisal. The Reference Panel determined to contingently remove you from the Board MPL, imposing three conditions on your subsequent inclusion, as follows:
>
> i. You were required to successfully complete an appraisal within 12 weeks of the date of hearing;
> ii. You were required to undertake an annual appraisal within your allocated quarter (October - December) every year for the next two years;
> iii. You were required to successfully revalidate in June 2015.
>
> The GMC alleged that you subsequently failed to:
>
> - disclose to two appraisers, and when applying for entry onto the National Performers List in England, that you had appeared before the Reference Panel, and that your inclusion on the Board MPL was subject to conditions;
> - failed to disclose to two appraisers that you were subject to a XXX;
> - failed to comply with GMC requests that you return a completed Work Details Form (WDF) to assist their investigation.
>
> 2. At the outset of the hearing, you admitted and the tribunal found proved, some of the charges. The June tribunal then considered and found proved the outstanding charges and determined that your actions amounted to serious misconduct. As a result of the concerns relating to your misconduct and dishonesty, the June tribunal determined to suspend your name from the Medical Register for a period of 3 months. The June tribunal concluded that a period of suspension would maintain public confidence in the profession and promote and maintain proper standards and conduct. Further, it would allow you to continue to gain insight into, and reflect upon, your misconduct and its consequences, and also allow you time to

demonstrate that you had addressed the concerns. The June tribunal determined that an immediate order was not necessary"

47. Dr Wells' registration was suspended for a period of three months with a review hearing directed. At a Review Hearing on 15 September 2016, Dr Wells submitted reflective statements on modules he had studied, and reflections on the ethical failings leading to his suspension from the medical register, and gave oral evidence. At that hearing, his fitness to practise was found to be no longer impaired.

Witness Evidence

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

- Ms J, Deputy Manager for Ashville Residential Care Home (Ashville), dated 27 November 2020;
- Ms H (Mrs F), Deputy Superintendent Registrar and deputy registrar at Caerphilly Register Office, dated 29 March 2021;
- Mrs I (Patient E's wife), 26 April 2021, and supplemental statement dated 13 September 2022;
- Dr K, Clinical Director of Primary Care at Bryntirion Surgery, dated 23 June 2021;
- Mrs L, senior business manager, Bryntirion Surgery, dated 31 January 2022;

49. Dr Wells did not provide a witness statement but did give oral evidence on affirmation which was tested in cross-examination at the hearing.

50. In addition, the Tribunal received testimonials from the following witnesses on Dr Wells' behalf:

- Dr M, GP at the Surgery, dated 27 September 2022;
- Mrs L, Senior Business Manager for the Surgery, dated 31 January 2022; and
- Dr N, Aneurin Bevan University Health Board, Responsible Officer, dated 22 July 2022.

Documentary Evidence

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

- MCCD – Patient E, dated 31 January 2020;
- Online Complaint Form attaching previous complaint, dated 16 April 2020;
- Post Mortem Report, dated 26 March 2020;
- Assessment by Dr K – Patient E, dated 23 March 2020;

- MCCD – Patient G, dated 7 February 2020
- Coroners Certificate – Patient G, dated 12 February 2020
- MCCD – Patient C, dated 4 March 2018;
- MCCD – Patient D, dated 5 March 2019;
- MCCD – Patient F, dated 24 January 2020;
- MCCD – Patient B, dated 7 January 2019;
- MCCD – Patient A, dated 27 December 2018;
- Various Patient Coroners' Certificates, various dates;
- Various Patient Medical Records, various dates;
- Telephone call audios and telephone transcripts, dated 6 February 2020 and 14 February 2020;
- Appraisal Summary, dated 15 September 2022;
- Certificate – Maintaining Professional Ethics, dated 6 – 8 September 2022; and
- Certificate – Core Learning Resource, dated 5 July 2022;

Submissions

Submissions on behalf of the GMC

52. Mr Brook submitted that Dr Wells' fitness to practise was currently impaired by reason of his misconduct.

53. Mr Brook reminded the Tribunal of the relevant paragraphs of *Good Medical Practice* (2013) (GMP) which he submitted Dr Wells had breached through his actions and referred to relevant case law.

54. Mr Brook referenced Dr Wells' previous MPT hearing, which involved dishonesty, and stated that the doctor's current dishonesty was not an isolated case and that an aggravating feature of the facts was that the index events took place over a period of 23 months and involved seven instances where the doctor had dishonestly completed MCCD. Mr Brook submitted that Dr Wells' dishonest completion of MCCD was misleading and a breach of a fundamental tenet of the profession.

55. Mr Brook concluded by submitting that, given the dishonesty involved in this case, it was necessary for Dr Wells' fitness to practise to be found impaired by reason of misconduct in order to uphold the overarching objective.

Dr Wells' submissions

56. Dr Wells submitted that he accepted that he had fallen a long way below what was expected of him and that he expected to be given a sanction. In explaining his actions he said '*I rationalised that the patient had been seen by a member of the clinical team and there was enough information to issue an accurate death certificate and it didn't delay the family's*

bereavement process … our practice relies very heavily on locum staff who are transitory but often only for a few days and then not back for a few weeks.' Dr Wells explained that if a locum had left it would not be possible for that locum to sign the MCCD.

57. Dr Wells apologised for his actions which gave rise to these proceedings. In response to the question as to how he thought his actions had affected Patient E's wife, he said *'Very badly and I let the family down and caused far more suffering than needed to have happened…. I completely accept that what I did was not appropriate and I hurt a lot of people and I was very sorry for how this affected the family especially Patient E's family.'*

58. Asked how the public might view his actions, he stated '*I think they would be annoyed because my behaviour was dishonest and I did fall far short of the standards expected of a practising doctor and it would also affect their trust in the profession ... Can we be sure other doctors don't do other things which are inappropriate.'*

59. Dr Wells stated '*I didn't take anything out of it …. there was no benefit to me to save five minutes of time when I was very busy but I had nothing to gain. I was trying to help people through very poor mis-judgement, I completely failed and I made life harder for my colleagues at work and the management team as I play an important role in the practice. We work in an area where it is virtually impossible to recruit staff. We have three posts filled and one is retiring in a few months' time. There are two vacant positions, one which we have never filled and one vacant for the last 18 months*.'

60. Dr Wells emphasised that he worked in a GP practice and noted that the sanction would have an adverse effect on his patients and colleagues.

61. Dr Wells submitted that he was confident that his misconduct would not happen again and that he had *'done a lot of work on this'*. Further, he stated that, whilst he was not making excuses, his misconduct may have been the result of not being assertive enough and from taking on work and not accepting his limitations.

62. Dr Wells acknowledged that he had been before a Medical Practitioners' Tribunal several years ago and that, at that time, his personal life was going through a crisis.

63. Dr Wells stated that he had tried to remediate but appreciated it is difficult to remediate dishonesty. He found the Professional Ethics Course helpful and also the course on death certification.

64. Dr Wells concluded by stating that he now works closer with his colleagues and that he would like to be given the chance to continue to work as a GP for his patients.

The Tribunal's Approach

65. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Wells does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

66. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted in relation to a finding of impairment based on misconduct: firstly, whether the facts found proved amounted to misconduct, which in this context connoted a serious departure from generally accepted professional standards, and then whether the finding of that misconduct should lead to a finding of current impairment of fitness to practise.

67. The Tribunal must determine whether Dr Wells' fitness to practise is impaired today, taking into account Dr Wells' conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remediated and whether there is any likelihood of repetition. The Tribunal was also obliged to consider whether a finding of impairment was required on public interest grounds.

68. With regard to impairment, the Tribunal had regard to the case of *CHRE v NMC and Grant* [2011] EWHC 927 where Dame Janet Smith's observations in the Fifth Report of the Shipman Inquiry were endorsed. Dame Janet Smith suggested that questions of impairment could be considered in the light of the following considerations:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> > *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
> >
> > *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
> >
> > *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
> >
> > *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

69. The Tribunal also had regard to the case of *Meadow v General Medical Council* [2006] EWCA Civ 1390 in which Auld LJ quoted Collins J approvingly in the case of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) where he said that serious misconduct would be *'conduct which would be regarded as deplorable by fellow practitioners'.*

70. Further, the Tribunal also took into account the case of *Makki v GMC* [2009] EWHC 3180 (Admin), referenced in *GMC v Theodoropoulos* [2017] EWHC 1984 (Admin), which dealt

with a doctor who had misrepresented the extent of their experience when applying for a post in a hospital, and in which Irwin J stated:

> *'the degree of dishonesty here and its nature, affecting not registration, but qualification and the integrity of the system of job applications, affects something which is every bit as fundamental to the proper respect for the system, to the proper operation of the system of medicine and of appointments to medical positions, as is the system of registration.'*

The Tribunal's Determination on Impairment

Misconduct

71. In reaching its determination on whether Dr Wells' actions amounted to misconduct, the Tribunal first reminded itself of the findings of fact that it had made.

72. When considering Dr Wells' dishonest completion of MCCDs, the Tribunal had regard to the duties of a doctor registered with the General Medical Council as stated in the first paragraph of GMP:

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

73. When considering whether Dr Wells' actions amounted to misconduct, the Tribunal also had regard to the following further paragraphs of GMP:

> *'65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.'*
>
> *'68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.'*
>
> *'71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.*
>
> *a You must take reasonable steps to check the information is correct.*
>
> *b You must not deliberately leave out relevant information.'*

74. The Tribunal considered that the seriousness of Dr Wells' erroneous completion of death certificates, which was dishonest, fell so far short of the standards of conduct reasonably expected of a doctor as to amount to misconduct.

75. It took into account the distress caused to Patient E's family. It noted that Dr Wells' dishonesty regarding the MCCDs took place over a period of twenty-three months and involved seven patients.

76. Dr Wells knew that the information he was writing on the MCCDs indicating when he had last seen each of the seven patients alive was untrue.

77. The Tribunal therefore considered that Dr Wells' misconduct was serious.

Impairment

78. The Tribunal, having found that the facts found proved in relation to Dr Wells' dishonest entries of MCCD on seven occasions amounted to serious misconduct, then went on to consider whether, as a result of that serious misconduct, Dr Wells' fitness to practise is currently impaired.

79. The Tribunal found that Dr Wells' dishonesty was at the lower end of the scale and took into account the fact that he had not gained any personal benefit, financially or otherwise, from the dishonesty. It considered that he had engaged in falsely completing the relevant MCCD in order to circumnavigate the system and had not appreciated the significance of his misconduct at the time of the index events.

80. The Tribunal acknowledged that Dr Wells admitted his dishonesty and that his fitness to practise was impaired in 2020. Asked whether his fitness to practise is currently impaired, Dr Wells denied that was so.

81. The Tribunal considered that Dr Wells' misconduct regarding dishonest entries in MCCD could be remediated but took into account that dishonesty is difficult to remediate.

82. Dr Wells' actions have clearly brought the profession into disrepute as he acknowledged in his oral evidence. He has through these actions, and previously, breached the same fundamental tenet of the profession. He has acted dishonestly between 2013-2015 and between 2018-2020 albeit he did not put patients at risk of harm.

83. Nonetheless, it was concerned that Dr Wells had previously appeared before a Medical Practitioners Tribunal in 2016 in a case that had also involved dishonesty. The Tribunal was concerned that Dr Wells' behaviour might suggest a weakness, or inclination to be dishonest regarding matters that do not, initially, appear significant to him. Both matters before the Tribunal in 2016 and 2022 involved a failure to accurately complete forms but equally both involved his dishonestly recording inaccurate information.

84. The Tribunal considered that it is unlikely that Dr Wells would be dishonest again in the future when completing MCCD. Nonetheless, the Tribunal determined that there remains a low risk of a repetition of dishonesty. This is because it is the second time this doctor has appeared before a Tribunal in relation to matters of probity.

85. The Tribunal found that Dr Wells has insight which is continuing to develop. He has apologised to the Tribunal repeatedly stating that he should not have done it. Dr Wells said that he had taken *'ownership of my actions'*. He acknowledged that he had hurt a lot of people and that was the opposite of what he had wanted to do. He appreciates the distress he caused to Patient E's wife and family and is deeply apologetic. He recognised that his actions may have saved him only a little time whereas the consequences for Patient E's wife were very distressing. Dr Wells recognised his actions fell far short of the standards expected and *'reflects badly on the profession'*. He said his behaviour has had an adverse effect on his colleagues and that public confidence in the profession would have been undermined.

86. The Tribunal noted that his attendance on the Professional Ethics Course was suggested by his appraiser earlier this year and only recently completed in September 2022. Dr Wells has not filed a reflective statement regarding the course and his consequent thoughts about his behaviour following his attendance on that course and online learning. He stated that the course was very demanding, quite soul-searching and it is '*difficult to admit your failings in public.'*

87. Time will demonstrate whether he will accurately record information on important forms and whether again act dishonestly. He has remediated the aspect of 'inaccuracy' in the completion of death certificates through attending relevant courses, making active changes to his practice [reported by Dr N] and retaining the confidence of his line manager Dr K. Remediation of dishonesty is harder to demonstrate.

88. The Tribunal did not consider that Dr Wells' misconduct had put patients at risk of harm and that he does not pose a risk to patients in the future.

89. The Tribunal concluded that public confidence in the medical profession would be undermined and that there would be a failure to uphold professional standards if a finding of current impairment was not made.

90. The Tribunal considered that Dr Wells' misconduct undermined public trust in the profession, breached a fundamental tenet of the profession and would be regarded as deplorable by fellow practitioners.

91. The Tribunal considered that a finding of impairment is necessary to promote and maintain public confidence in the medical profession and to promote and maintain proper professional standards and conduct for members of the profession.

92. Accordingly, the Tribunal determined that Dr Wells' fitness to practise is impaired by reason of his misconduct.

Determination on Sanction - 14/10/2022

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

The Evidence

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

3. The Tribunal received 'Reflections on Remediation Activities' from Dr Wells, dated September 2022. This was available and intended for consideration at the impairment stage but had not been made available through an administrative oversight.

4. Dr Wells gave oral evidence at the sanction stage during which he emphasised his admissions, his sense of guilt and deep sense of remorse for his dishonesty. He asserted that his actions were without malice or for personal gain but were taken because he was acting under pressure of work and lacked assertiveness. Previously he had explained that the Surgery has 11,000 patients on two sites with 2.8 full time GPs. The average doctor/patient ratio is 1,800 per full time GP, so that their Surgery is excessively above the national average.

5. Dr Wells described the insight that he had gained from attending courses, in particular the three-day course on Professional Ethics which he described as '*soul-searching.*' He also provided the Tribunal with information regarding the day-to-day running of the Surgery and stated that his prolonged absence could have a negative effect on the practice.

6. When asked about his remediation following the hearing in 2016, he explained that, whereas he completed online training, he could not at that time afford to attend a Professional Ethics Course. He explained that the previous proceedings had been a steep learning curve, and as a result, following these allegations, he has wanted to do all that he could to ensure there is no repetition of his dishonesty.

Submissions

<u>Submissions on behalf of the GMC</u>

7. Mr Brook submitted that the appropriate and proportionate sanction in this case was one of suspension.

8. Mr Brook referred the Tribunal to the *Sanctions Guidance* (November 2020) (SG) and submitted that Dr Wells' misconduct involved a serious breach of GMP and that this was not the first time that the doctor's fitness to practise had been impaired by misconduct.

9. Mr Brook submitted that Dr Wells had gained some insight into his behaviour, and that the doctor did not pose a significant risk of repeating his dishonesty and that this was a case where the misconduct involved fell short of being fundamentally incompatible with continued registration.

10. Mr Brook concluded by submitting that the public interest required that a suspension be imposed on Dr Wells registration to send a message to the public and the profession that the doctor's dishonesty was not acceptable.

Dr Wells' Submissions

11. Dr Wells chose not to give submissions but rather asked that the Tribunal bore in mind the oral evidence that he gave at the sanction stage. He particularly asked that the Tribunal were mindful of his apology to Patient E's wife given at this hearing, the Tribunal and the profession as a whole.

12. Dr Wells also asked that the Tribunal took into account his earlier acknowledgement that his actions had fallen a long way below what was expected of him as a medical professional, and that he was confident that his misconduct would not be repeated, given his remediation and his acceptance of his limitations.

13. Dr Wells asked the Tribunal to take into consideration his assertion in his oral evidence that, whilst he acknowledged that he would receive a sanction, a suspension would negatively affect his Surgery and his patients as well as his family circumstances.

14. Dr Wells further asked the Tribunal to be mindful of his oral evidence and in particular that he was deeply sorry for his actions and that he had not had the opportunity to apologise to Patient E's family before the present hearing as he stated he was advised by his medical protection body not to make direct contact.

15. Dr Wells concluded by stating that he had been a GP since 1995 and emphasised that it was a job he loved and that he believed he was competent in the role. He further stated that the current hearing was a huge reminder of how important honesty was and apologised for having caused harm and distress to anyone at a vulnerable time in their life, emphasising that the fault was purely his.

The Tribunal's Determination on Sanction

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

17. In reaching its decision, the Tribunal has borne in mind that the purpose of a sanction is not to be punitive although it may have a punitive effect.

18. The Tribunal in deciding what sanction, if any, to impose has considered the sanctions available, starting with the least restrictive.

19. Throughout its deliberations, the Tribunal has taken into account all three limbs of the overarching objective, and applied the principle of proportionality, balancing Dr Wells' interests with the public interest.

20. The Tribunal has taken into account its earlier determinations on the facts and on impairment, the SG and GMP, the submissions of Mr Brook on behalf of the GMC, and the submissions and oral evidence of Dr Wells.

21. The Tribunal further took into account the case of *Bolton v Law Society* [1994] 1 WLR 512 in which Lord Bingham stated:

> *'It often happens that a solicitor appearing before the Tribunal can adduce a wealth of glowing tributes from his professional brethren. He can often show that for him and his family the consequences of striking off or suspension would be little short of tragic. Often he will say, convincingly, that he has learned his lesson and will not offend again… All these matters are relevant and should be considered. But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be a person of unquestionable integrity, probity and trustworthiness.'*

Aggravating and Mitigating Factors

22. The Tribunal first considered the aggravating factors:

- Dr Wells' misconduct involved seven instances of dishonesty and spanned a period of twenty-three months;
- Dr Wells' fitness to practise had previously been found to be impaired by reason of misconduct, involving dishonesty, at an MPT hearing in 2016;
- Dr Wells through his actions put at risk, public confidence in the profession.

23. The Tribunal then considered the mitigating factors in relation to Dr Wells' case:

- Dr Wells complied with the GMC investigation and engaged with the regulatory process;

- Dr Wells admitted the Allegation in its entirety at the outset of the proceedings and made admissions from the outset as to his wrongdoing;
- Dr Wells demonstrated significant insight into his dishonesty;
- Dr Wells accepts he should have behaved differently, has caused hurt and distress which was unintentional, and has taken steps to remediate;
- Dr Wells attended an online course of about twenty hours looking at the role of death certification, the process of certification and the roles of the professionals who work in this area such as the Coroner and the Coroner's officers;
- Dr Wells attended a three day 'Maintaining Professional Ethics' course which he said was intense and soul searching. He reflected on the consequences of his actions on the bereaved widow, his colleagues and patients, and considered his motivation and strategies to prevent recurrence;
- Dr Wells expressed deep remorse during these proceedings and in his reflective statement towards the families of the deceased, to his colleagues, patients, the profession, and to the Tribunal for his actions;
- The Tribunal accepted the evidence of Dr Wells and his colleagues that his GP practice is under greater pressures than some and he had assumed additional roles which added to those pressures;
- The Tribunal received testimonials from colleagues which were very positive;
- The Tribunal received a positive statement from the Responsible Officer.

24. The Tribunal noted that Dr Wells was self-represented at the hearing. The Responsible Officer's statement and the testimonials attested to there being no current concerns about his clinical practice, that he has the confidence of his colleagues and carries out all the duties expected of him. One testimonial from the Senior Business Manager at the Surgery and the Health Board stated *'Fundamentally, this practice runs and evolves around Dr Wells, his leadership, willingness to support the team, and his desire for patient care*.' A colleague stated in another testimonial *'We work in a deprived area of Caerphilly with a population with multiple comorbidities and known to be demanding …. the fact that he won't be with us, will have a detrimental impact on our workload, and has consequences for our patients.*' Referring to Dr Wells' work she stated *'There are no clinical concerns … he also taught medical students as well as mentor Paramedics and Pharmacists to move to primary care …. he has motivated young students through work experience to become doctors…. he is an experienced GP and remains passionate with General Practice*'.

25. The Tribunal also bore in mind that, at the time of the index events, Dr Wells had double the number of patients, as compared to the national average. He stated that the Surgery struggled to retain permanent staff, relying heavily on locums and ancillary health care professionals. Those circumstances limited the capacity for continuity of care for their patients. Such factors may have led to the temptation to try and save time.

26. In oral evidence Dr Wells identified the steps he had taken to ensure there will be no repetition of his dishonesty. These included sharing his role as clinical lead with the other salaried GP in the Surgery, holding regular meetings with the clinical lead of another GP

practice, attending a management training course which includes assertiveness training, and meeting regularly with the clinical director Dr K.

27. The Tribunal took into consideration Dr Wells' concerns about the consequences for the Surgery and his patients, should there be a prolonged absence by him. It would increase the instability of the Surgery and exaggerate the difficulties which arise from using locums such as poor continuity in patient care. Dr Wells explained the consequences for his own family would be significant as he is the sole earner, XXX.

28. The Tribunal considered each sanction in ascending order of seriousness starting with the least restrictive.

No Action

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

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

Conditions

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

32. The Tribunal also reminded itself that this was a case where it had considered it necessary to make a finding of impairment because of the need to uphold professional standards and public confidence in the profession.

33. The Tribunal considered that the imposition of conditions on Dr Wells' registration would be inappropriate as it would not send a sufficiently robust message to the public or the profession as to the inappropriateness and seriousness of his misconduct.

35. In the circumstances, the Tribunal determined that a period of conditional registration would not meet the public interest.

Suspension

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

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

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

> *'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention'*
>
> *'92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).'*
>
> *'93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions ...'*
>
> *'97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> > *a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*
> >
> > *...*
> >
> > *e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
> >
> > *f No evidence of repetition of similar behaviour since incident.*

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

'120 Good medical practice states that registered doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession.'

'125 Examples of dishonesty in professional practice could include:

…

e failing to take reasonable steps to make sure that statements made in formal documents are accurate.'

39. The Tribunal concluded in all the circumstances that, though serious, Dr Wells' misconduct was not fundamentally incompatible with continued registration. It considered that erasure would therefore be disproportionate and noted that it had already found that Dr Wells misconduct was capable of remediation. His misconduct had been remediated and he had insight into the consequences of his dishonesty. The risk of repetition of the misconduct was small. It also noted that erasure would deprive the public of an otherwise capable and committed GP.

40. The Tribunal determined that a period of suspension would be sufficient to uphold the overarching objective in respect of public confidence in the profession and the maintenance of professional standards. Further, it considered that a period of suspension was the appropriate and proportionate sanction in this case.

41. The Tribunal concluded that this suspension would send a clear signal to the medical profession and to the wider public that his misconduct relating to dishonest completion of MCCD was unacceptable.

42. It noted that by suspending Dr Wells from practice, this might adversely affect the running of the Surgery for a period of time, but nonetheless considered that to do so was in the public interest.

43. The Tribunal took into account the aggravating and mitigating factors identified and concluded that suspension for a period of three months would be sufficient to mark the seriousness of Dr Wells' misconduct.

44. The Tribunal determined that a reasonable and fully informed member of the public would regard a three-month suspension as a sufficient marker of the gravity of this particular case.

45. The Tribunal further determined that it was not necessary to direct a review of Dr Wells' case as it considered that he was unlikely to repeat his misconduct and did not consider there was any significant ongoing risk.

Determination on Immediate Order - 14/10/2022

1. Having determined that a three-month suspension is the appropriate sanction, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Wells registration should be subject to an immediate order.

Submissions

Submissions on behalf of the GMC

2. Mr Brook submitted that the GMC did not seek an immediate order.

Dr Wells' Submissions

3. Dr Wells submitted that he would prefer it, if an immediate order were not imposed on his registration.

The Tribunal's Determination

4. The Tribunal concluded that the imposition of an immediate order on Dr Wells' registration was not necessary to protect the public or to satisfy the public interest.

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

6. That concludes this case.