PUBLIC RECORD

Dates: 12/10/2026 - 21/10/2026

Doctor:	Dr Peter COLLIN
GMC reference number:	3351060
Primary medical qualification:	MB ChB 1988 University of Liverpool

Type of case	Outcome on facts	Outcome on impairment
Misconduct	All facts found proved	Fitness to practise impaired

Summary of outcome

Suspension, 2 months

Tribunal:

Legally Qualified Chair	Ms Claire Lindley
Lay Tribunal Member:	Mr Amit Jinabhai
Registrant Tribunal Member:	Dr Matthew O'Meara

Tribunal Clerk:	Ms Hinna Safdar

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Stephen Brassington, instructed by MDDUS
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 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 Impairment - 19/10/2026

1. This determination will be handed down in private but as this case concerns Dr Collin's alleged misconduct, a redacted version will be published at the close of the hearing.

Background

2. Dr Collin graduated from the University of Liverpool in 1988. Initially, he worked in the field of Obstetrics and Gynaecology and then decided to become a GP. He completed his GP training in the Merseyside Area. For a period of time, from 1994 to 1995, Dr Collin worked in Australia and then returned. He became a Registrar in Mersey deanery until he resigned in 2001. He was appointed as a GP partner at Alyn Family Doctors, North Wales ('the Practice') in 2001.

3. In October 2023, the Practice interrogated their computer system, ('EMIS'), because of concerns about Dr Collin's behaviour and performance. Dr Collin was subsequently dismissed from the Practice because there was evidence of him both self - prescribing and prescribing to friends and family and attempting to conceal what he was doing.

4. After a referral by the Practice to the GMC, an investigation took place which resulted in the Allegation below and this Tribunal hearing.

The outcome of applications made during the facts stage

5. On Day 1 of the hearing, Mr Ian Brook, Counsel on behalf of the GMC, made an application pursuant to Rules 41XXX of the Rules for parts of the hearing to be held in private. Mr Stephen Brassington, Counsel on behalf of Dr Collin, asked the Tribunal to considering

sitting in private for the entirety of the hearing. The Tribunal decided that the first two stages of the hearing should be held entirely in private. Its full decision is set out in Annex A.

6. Mr Brook also made an application to amend the Allegation under Rule 17(6) of the Rules. Mr Brassington did not object to this application, and it was granted by the Tribunal on the basis that there would be no injustice to Dr Collin. There was also a confidential schedule which was also amended to correct the spelling of some of the drugs prescribed, and to align with the amendments made in the Allegation.

The Allegation and Dr Collin's response

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

1. Between 25 February 2021 and 26 October 2022, on one or more occasion you prescribed medication for yourself as set out in schedule 1. Admitted and found proved

2. On 25 February 2021 when you issued the prescription to yourself described at entry 1 of Schedule 1, you attempted to conceal the prescription as you:

    a. changed the prescription authoriser to Dr A; Admitted and found proved

    b. cancelled it after it had been printed; Admitted and found proved

    c. failed to document why the prescription had been cancelled in your medical records. Admitted and found proved

3. You knew that:

    a. by cancelling the prescription, it would give the false impression in the medical records that the prescription had not been issued;
    Admitted and found proved

    b. Dr A had not authorised the prescription; Admitted and found proved

    c. by changing the authoriser, it would give the false impression that Dr A had prescribed the medication to you. Admitted and found proved

4. Your actions at paragraph 2a were dishonest by reason of paragraphs 3b-c. Admitted and found proved

5. Your actions at paragraph 2b were dishonest by reason of paragraph 3a. Admitted and found proved

6. Between 29 May 2015 and 29 September 2023, on one or more occasion you prescribed medication, including controlled drugs, to Patient B as set out in schedule 2 when:

   a. you had a close personal relationship with Patient B; Admitted and found proved

   b. it was a non-emergency situation; Admitted and found proved

   c. you did not make a clear record of your relationship to Patient B and the reason why it was necessary for you to prescribe to them. Admitted and found proved

7. When you issued the prescriptions to Patient B as described in Schedule 2 at entries 17, 19a, 24a, 27b, 28 you attempted to conceal the prescriptions as you:

   a. cancelled them after they had been printed; Admitted and found proved

   b. failed to record a reason why the prescriptions had been cancelled in the patient's medical record; Admitted and found proved

   c. still issued one or more of the prescriptions to Patient B. Admitted and found proved

8. You knew that by cancelling the prescriptions, it would give the false impression in the patient's medical records that the prescriptions had not been issued. Admitted and found proved

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

10. When you issued the prescriptions to Patient B as described in Schedule 2 at entries 18, 19b to 19f, 27a, 30 - 32, you attempted to conceal the prescriptions as you:

    a. cancelled them after they had been printed; Admitted and found proved

    b. recorded a reason why the prescriptions had been cancelled in the patient's medical record; Admitted and found proved

c. still issued one or more of the prescriptions to Patient B. Admitted and found proved

11. You knew that by recording a reason for the cancellation, it would give the false impression that the prescriptions had been legitimately cancelled. Admitted and found proved

12. Your actions at paragraphs 10 were dishonest by reason of paragraph 11. Admitted and found proved

13. On 23 December 2021 when you issued the prescription to Patient B as described at entry 15 of Schedule 2, you attempted to conceal the prescription as you changed the prescription authoriser to Dr C. Admitted and found proved

14. You knew that:

a. Dr C had not authorised the prescription; Admitted and found proved

b. by changing the authoriser, it would give the false impression that Dr C had prescribed the medication. Admitted and found proved

15. Your actions at paragraph 13 were dishonest by reason of paragraph 14. Admitted and found proved

16. Between 25 January 2023 and 9 August 2023, on one or more occasion you prescribed medication, including controlled drugs, to Patient D as set out in Schedule 3 when:

a. you had a close personal relationship; Admitted and found proved

b. it was non-emergency situation; Admitted and found proved

c. you did not make a clear record of your relationship to Patient D and the reason why it was necessary for you to prescribe to them. Admitted and found proved

17. When you issued the prescriptions to Patient D as described in Schedule 3 at entries ~~1~~,5,6,8 and 9 you attempted to conceal the prescriptions as you: Amended under Rule 17(6)

a. cancelled them after they had been printed; **Admitted and found proved**

b. failed to record reasons why the prescriptions had been cancelled in the patient's medical records; **Admitted and found proved**

c. still issued one or more of the prescriptions to Patient D. **Admitted and found proved**

18. You knew that by cancelling the prescriptions, it would give the false impression on the patient's medical records that the prescriptions had not been issued. **Admitted and found proved**

19. Your actions at paragraph 17 were dishonest by reason of paragraph 18. **Admitted and found proved**

20. When you issued the prescriptions to Patient D as described in Schedule 3 at entries 2, 3 and 4, you attempted to conceal the prescriptions as you:

a. cancelled them after they had been printed; **Admitted and found proved**

b. recorded a reason why the prescriptions had been cancelled in the patient's medical records; **Admitted and found proved**

c. still issued one of more of the prescriptions to Patient D. **Admitted and found proved**

21. You knew that:

a. by cancelling the prescriptions, it would give the false impression on the patient's medical records that the prescriptions had not been issued; **Admitted and found proved**

b. by recording a reason for the cancellation, it would give the false impression that the prescription had been legitimately cancelled. **Admitted and found proved**

22. Your actions at paragraph 20 were dishonest by reason of paragraphs 21. **Admitted and found proved**

23. Between August 2023 and September 2023, on one or more occasion you prescribed medication to Patient E, including controlled medication as set out in Schedule 4 when:

a. you had a close personal relationship; Admitted and found proved

b. it was a non-emergency situation; Admitted and found proved

c. you did not make a clear record of your relationship to Patient E and the reason why it was necessary for you to prescribe to them. Admitted and found proved

24. When you issued the prescription to Patient E as described in entry 1 of Schedule 4, you attempted to conceal the prescription as you:

a. cancelled it after it had been printed; Admitted and found proved

b. failed to record a reason why the prescription had been cancelled in the patient's medical record; Admitted and found proved

c. still issued the prescription to Patient E. Admitted and found proved

25. You knew that by cancelling the prescription, it would give the false impression on the patient's medical records that the prescription had not been issued. Admitted and found proved

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

27. When you issued the prescriptions to Patient E as described in Schedule 4, at entries 2, 3 and 4, you attempted to conceal the prescriptions as you:

a. cancelled them after they had been printed; Admitted and found proved

b. recorded reasons why the medication had been cancelled in the patient's medical record; Admitted and found proved

c. still issued one or more of the prescriptions to Patient E. Admitted and found proved

28. You knew that:

a. by cancelling the prescriptions, it would give the false impression on the patient's medical records that the prescriptions had not been issued; Admitted and found proved

b. by recording a reason for the cancellation, it would give the false impression that the prescriptions had been legitimately cancelled. Admitted and found proved

29. Your actions as described at paragraph 27 were dishonest by reason of paragraph 28. Admitted and found proved

30. Between 30 July 2020 and 18 September 2023, on one or more occasion you prescribed medication, including controlled drugs, to Patient F as set out in Schedule 5 when you:

a. had a close personal relationship; Admitted and found proved

b. it was a non-emergency situation; Admitted and found proved

c. you did not make a clear record of your relationship to Patient F and the reason why it was necessary for you to prescribe to them. Admitted and found proved

31. ~~When you issued the prescription to Patient F on 2 August 2023, as described in Schedule 5, at entry 19 you attempted to conceal the prescription as you:~~

a. ~~cancelled it after it had been printed;~~ Withdrawn by the GMC

b. ~~recorded that the prescription had been cancelled on 'Clinical Grounds' in the patient's medical record.~~ Withdrawn by the GMC

32. ~~You knew that by:~~

a. ~~cancelling the prescription, it would give the false impression in Patient F's medical records that the prescription had not been issued;~~ Withdrawn by the GMC

b. ~~by recording a reason for the cancellation, it would give the false impression that the prescription had been legitimately cancelled.~~ Withdrawn by the GMC

33. ~~Your actions at paragraph 31 were dishonest by reason of paragraph 32~~. Withdrawn by the GMC

34. You failed to make any / adequate clinical notes in the medical records of: Amended under Rule 17(6)

a. Patient B in respect of your actions as set out at paragraphs 6; Admitted and found proved

b. Patient D in respect of your actions as set out at paragraph 16; Admitted and found proved

c. Patient E in respect of your actions as set out at paragraph 23; Admitted and found proved

d. Patient F in respect of your actions as set out at paragraph 30. 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

7. Dr Collin made admissions to the entirety of the Allegation, in accordance with Rule 17(2)(d) of the Rules.

8. Mr Brassington then pointed out that Dr Collin could not remember entering Dr C on EMIS as the authoriser for the prescription on 23 December 2021, as alleged at paragraph 13 of the Allegation, but said that he accepted that he must have done so.

9. In accordance with Rule 17(2)(e) the Tribunal then announced the Allegation as admitted and found proved.

10. After Mr Brook had opened the case for the GMC, a query was raised by the Tribunal in relation to the prescription on 23 December 2021 and whether Dr Collin was right to admit it.

11. This is because the Tribunal had considered the computer printout from the EMIS system. It showed that Dr Collin had commenced a course of XXX tablets for Patient B on that date. This was also '*authorised by'* and *'entered by'* him on to the system at 11:23 and then printed off at the same time. One minute later, at 11:24 there is an entry which states;

Course reauthorised
Authorised by [Dr C]
Entered by Peter Gregory Collin (Dr)

12. The Tribunal noted that these entries were different to a similar instance listed at Paragraph 2 of the Allegation where Dr Collin entered Dr A as the authoriser for a prescription that he prescribed to himself on 25 February 2021. On this occasion there is not an entry on EMIS entitled '*Course reauthorised.*'

13. The Tribunal wanted to make sure that Dr C's name had not been entered in the EMIS system as a '*reauthoriser'* because he had previously authorised this medication to Patient B. It also wanted to know whether EMIS could have automatically populated Dr C's name because he was Patient B's registered GP.

14. Enquires were therefore made by the GMC. In response, the Practice Manager sent an email which was forwarded to the Tribunal. The Practice manager confirmed that he was a regular user of EMIS, and that he interpreted the entries to mean that Dr Collin had manually changed the authoriser as alleged. He said that no one else had accessed Patient B's account that day. He also said that he could see no reason why EMIS would change the name of an authoriser, and that he had not experienced this himself. The Tribunal was also made aware by the GMC that Dr C had confirmed that he had not previously prescribed any medication to Patient B.

15. Mr Brassington confirmed that Dr Collin was not seeking to reopen this issue and that the admission to paragraph 13, 14 and 15 could stand.

16. Having received the further material from the GMC, and sought the views of Dr Collin through his representative, the Tribunal accepted the admissions to the entirety of the Allegation.

Impairment

17. 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 Collin's fitness to practise is impaired by reason of misconduct.

The Evidence

Witness evidence

18. The Tribunal received written statements on behalf of the GMC from the following witnesses:

- Ms H, Head of Pharmacy, Primary care and Community services at East Betsi Cadwaladr University Health Board;
- Dr G, GP Partner at St George's Medical Centre, Wallasey;
- (Dr C), GP partner at the Practice;
- (Dr A), GP Partner at the Practice;
- Mr I, Practice Manager at the Practice.

19. Dr Collin provided a witness statement, dated 9 September 2026, two supplemental statements, and an Ethical Reflections Statement, which was undated. He also gave oral evidence at this impairment stage of the hearing.

20. The documentary evidence in this case included but was not limited to:

- Redacted patients' medical records and prescriptions
- Ms H prescribing audit report, dated 19 October 2023
- Alyn Family Doctor initial findings, dated 26 October 2023
- Clinical Investigation Report, dated 21 February 2024
- Notes from Dr Collin's interview, dated 30 January 2024
- Testimonials on behalf of Dr Collin
- Certificates of Dr Collin's Continuing Professional Development ('CPD')
- XXX
- XXX
- Letter for Dr L, Dr Collin's Responsible Officer ('RO'), dated 6 August 2026.

Context of the case

21. Dr Collin was appointed as a GP partner at the Practice in 2001. In 2019, Mr I joined the Practice as the Practice Manager. He found Dr Collin to be an efficient GP and they became close personal friends. However, in early 2022, Dr Collins had a period of absence from work, and, upon his return, Mr I thought that both his behaviour and performance had changed.

22. In October 2023, the partners of the Practice met, and decided to audit Dr Collin's clinical performance. Mr I was asked to extract and analyse data from EMIS.

23. In this Practice, the prescriptions at that time were typed out on EMIS and then printed off for the authorising GP to sign and stamp. Once signed, they were given to the patient who would take the printed prescription to a pharmacist to request their medication. When the pharmacist received the prescriptions, they gave the medication to the patient, then scanned the printed prescription and uploaded it onto another computer system ('the Primary Care Catalogue,') so that they could receive payment for the dispensing.

24. The initial interrogation of EMIS showed that Dr Collin had been recently prescribing medication to Patient B. XXX. There were no consultation records relating to the prescribing and Patient B was only a temporary patient in the practice. If a patient is registered as temporary, then Mr I asserted that they are not supposed to prescribe certain medications, especially controlled drugs, unless there is a genuine emergency. Also, the medication they are usually prescribed would be short term.

25. Further interrogation of the EMIS system showed that Dr Collin had also been prescribing medication to XXX, Patient D, and that he had been self-prescribing.

26. The Practice also noticed that some of the prescriptions were cancelled after they had been printed, which would ordinarily be an unusual occurrence when, for example, a genuine mistake had been made.

27. On 12 October 2023, the partners suspended Dr Collin from the practice and informed the relevant Health Board who initiated an independent audit.

28. Ms H, the Head of Pharmacy, Primary care and Community services at the Health Board conducted the audit. She was able to interrogate EMIS to see what had been prescribed and/or cancelled, and then the Primary Care Catalogue to see what had been dispensed at a pharmacy. She concluded that there were a number of prescribing issues, along with evidence of concealment. As a result, Dr Collin was dismissed from the practice on 24 October 2023.

29. On 25 October 2023, a further search of EMIS took place, and Mr I found that Dr Collin had been prescribing what appeared to be excessive amounts of medication to two other patients, (Patient E and Patient F) whose addresses were outside the Practice's

catchment area, and who appeared XXX to be friends of Dr Collin. Patient E had been registered as a temporary patient, who had not been seen by any of the other GPs, and Patient F had been registered by Dr Collin personally, something which is usually done by administrative staff.

30. One of the partners then referred the matter to the GMC and a formal investigation took place.

31. The investigations revealed that Dr Collin had been self-prescribing between 25 February 2021 and 26 October 2022. Ms H described this prescribing as *'sporadic.'* XXX. Notably, on 25 February 2021, Dr Collin had self-prescribed XXX, a drug known as XXX medication. On this occasion, Dr Collin had attempted to conceal what he had done by changing the prescription authoriser to Dr A, another GP in the practice.

32. For Patient B, the investigations revealed that Dr Collin had prescribed 36 different acute medications, between 29 May 2015 and 29 September 2023. XXX. On two occasions – 6 April 2022 and 20 February 2023 he had prescribed XXX, which is used to treat XXX and is a controlled drug. Between April 2022 and October 2022, there was also a high rate of repeat prescriptions for XXX, which is a drug used by XXX. On 23 December 2021, Dr Collin had named Dr C, another GP in the practice as the authoriser on the EMIS system when prescribing to Patient B.

33. For Patient D, the investigations revealed that Dr Collin prescribed the controlled drug XXX on four occasions, between March and August 2023, along with a number of prescriptions for other ailments.

34. For Patient E, the investigations revealed that Dr Collin also prescribed XXX on four occasions between 9 August 2023 and 25 September 2023, along with other medication.

35. For Patient F, the investigations revealed that Dr Collin prescribed XXX, as well as other medications, numerous times between 30 July 2020 and 18 September 2023. XXX. Dr Collin also prescribed a controlled drug, namely XXX on 18 September 2023.

36. On a number of occasions when self-prescribing and prescribing to Patient B, Patient D and Patient E Dr Collin cancelled the prescriptions after they had been printed. This meant that the EMIS system did not record that a printed prescription had been given to a patient, and it was only through the interrogation of the Primary Care Catalogue that Ms H was able

to see what had been dispensed. This was an attempt to conceal what Dr Collin was prescribing and was dishonest. Dr Collin made no or inadequate records.

37. Patient B, Patient D, Patient E and Patient F were all either family or friends of Dr Collin and the drugs had not been prescribed in an emergency situation.

Submissions

On behalf of the GMC

38. Mr Brook submitted that Dr Collin's conduct must amount to serious misconduct, and also there will be occasions where impairment of fitness to practise must be found as a matter of public policy, to uphold public confidence in the profession, where to make no such finding would have an adverse impact on public confidence in the profession and the regulator.

39. Mr Brook drew the Tribunal's attention to the several paragraphs of *Good Medical Practice 2013* ('GMP') and the relevant supplementary prescribing guidance. (These are referred to below when relied upon by the Tribunal.)

40. Mr Brook took the Tribunal through the steps set out in the *MPTS Guidance for Tribunals (Section three: MPT Hearings > Part B > Stage 2: Impairment > Steps 2(a) to (e) ('*Part B'*).* He submitted that Dr Collin's actions justified a finding of serious professional misconduct.

41. In relation to step 2(b) of Part B, Mr Brook pointed out that dishonesty would usually be at the higher end of the spectrum of seriousness. In this case, Dr Collin's conduct took place in his professional life, it was persistent and repeated, and showed a reckless disregard for patient safety and professional standards. He referred to the GMC guidance, *'Guidance on assessing the seriousness of concerns relating to self-prescribing or prescribing to those in close personal relationships with doctors.'* He said that a number of features set out in that Guidance applied in this case; some of the prescriptions were for controlled drugs, the prescribing was repeated, and on occasion there was an excessive dosage. Dr Collin had also prescribed in the name of other doctors. Mr Brook submitted therefore that the allegations are at the higher end of the spectrum of seriousness.

42. In relation to step 2(c), Mr Brook said that there was no work context that the Tribunal should take into account, and that Dr Collin was an experienced GP at the time of the

conduct. However, Mr Brook accepted that Dr Collin had put forward a number of issues about his personal life, XXX, which was corroborated in part by some of the testimonial evidence. Mr Brook also noted XXX and pointed out that the testimonial makers speak of him in '*glowing terms*' and that the behaviour had not been repeated. Mr Brook stated that the GMC's view was that the personal context in this case reduced the risk to public protection from high to medium.

43. In relation to step 2(d), Mr Brook accepted that Dr Collin had admitted the Allegation and said that Dr Collin had shown '*considerable insight*' into his behaviour. He submitted that Dr Collin had been found to be open and honest when the investigations took place, and that Dr Collin is now working as a salaried GP. He said that Dr Collin had XXX and that he had also undertaken courses in Professionalism and Remedial Medical Ethics. He said that the statement from Dr Collin's RO clearly demonstrates how the doctor has kept his knowledge and skills up to date. He submitted that the risk of repetition is low, and the doctor does appear to have shown significant insight into his actions. He concluded that the risk to public protection remains medium.

44. In relation to step (e) and based on his submissions in relation to steps 2(b), (c) and (d), Mr Brook submitted that there remained an ongoing risk to all three limbs of public protection and that a finding of current impairment was required. In particular, he argued that such a finding was necessary to maintain public confidence in the medical profession and to uphold proper professional standards and conduct.

45. Overall, Mr Brook invited the Tribunal to conclude that Dr Collin's fitness to practise remained impaired and the '*risk level posed is medium*'.

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

46. Mr Brassington confirmed firstly that Dr Collin was not opposed to a finding of impairment. He accepted that there is misconduct in this case. He highlighted that dishonesty is serious, unless an isolated or one-off incident, and that the public interest calls for a finding of misconduct and subsequent impairment. He accepted that inappropriate prescribing, which is concealed, would be regarded as something which the profession might regard as deplorable.

47. Mr Brassington highlighted that Dr Collin did not seek to avoid responsibility for any of the misconduct in this case.

48. However, Mr Brassington did not concede that there was a current risk of repetition in Dr Collin's case. He said that it was hugely disappointing that the GMC had not treated this case as XXX as the Health Board had done. He said that Dr Collin had given so many years of service, but XXX, and this had impacted on and eroded his judgment. XXX. Mr Brassington said that he did not seek to persuade the Tribunal that Dr Collin's conduct was purely a consequence of XXX.

49. Mr Brassington reminded the Tribunal that it should look forward as to Dr Collin's risk to public protection now and in the future. He submitted that Dr Collin is not a risk today, because of multi-factorial reasons. He said that Dr Collin had been open and frank '*from day one'* and cooperative, even when the Allegation was amended. He said that Dr Collin had attended the '*gold standard' Ethical Reflections* course, which is personally tailored, and is both challenging and exhausting. (Mr Brook, likewise, accepted that this course is considered the '*gold standard'*). He explained that Dr Collin had reflected on his conduct and had conducted an honest analysis of himself – describing it as *'searingly honest.'* He also pointed to the testimonial of Dr Collin's current clinical supervisor, Dr N, and how much Dr Collin had appreciated this support and that it provided a protective mechanism.

50. Mr Brassington then responded to the GMC submissions. He said that it was surprising that the GMC did not accept that there is a working environment context in this case. He said that Dr Collin had been running a vaccination clinic during the COVID-19 pandemic and that it had vaccinated over 100,000 patients. He said that Dr Collin should be proud and that this was not without personal cost XXX. He said that the pandemic affected Dr Collin's boundaries and clear judgment, and that this was important context but not an excuse.

51. Mr Brassington said that the risk of repetition in this case was *'vanishingly small.'* He said that Dr Collin had a support mechanism in place now and XXX. He pointed to the RO statement which showed that Dr Collin had a willingness to engage, and that the reaction to his return to practice had been universally positive.

52. Mr Brassington conceded that dishonesty was always serious, but that Dr Collin's conduct was at the mid-range rather than the top end of seriousness. He also explained that the motivation behind the prescribing was to help patients and not for Dr Collin's personal or financial gain. While not minimising what Dr Collin had done, he explained that his actions were '*misguided and stupid.'*

53. The Tribunal asked Mr Brassington where on the spectrum of seriousness he felt that the conduct lay. He said that the controlled drugs were only prescribed in 2022 and 2023, which is a shorter span of time than the period of the whole Allegation. He also explained that Dr Collin only began to conceal his prescribing laterally.

The Relevant Legal Principles

54. The LQC gave the Tribunal legal advice, which is summarised below:

55. The Tribunal must assess whether Dr Collin poses any current and ongoing risk to public protection. This assessment must be made with reference to the facts that were admitted at the first stage of the hearing and the further evidence presented to the Tribunal.

56. The Tribunal was advised to take into account Part B of the Guidance.

57. Step 2(a) of that Guidance advises the Tribunal to decide whether there is a legal basis for considering impairment. Firstly, therefore, the Tribunal must decide whether the facts as found proved amount to misconduct.

58. 'Misconduct' has no statutory definition. It is a matter for the judgement and experience of the tribunal. However, the misconduct should be 'serious misconduct' before the Tribunal should move to consider fitness to practise. The word 'serious' should be given its ordinary meaning, and the Tribunal should look for an act or omission which falls short of what would be proper in the circumstances.

59. The Tribunal should therefore take into account whether Dr Collin has departed from the standards set out in GMP 2013 and any associated guidance.

60. The Tribunal was reminded that misconduct is conduct which would be regarded as 'deplorable' by fellow practitioners, and that dishonest conduct can very easily be regarded as serious professional misconduct.

61. If, having decided that there is a legal basis to consider impairment, then the Tribunal should go onto to consider the other steps in the Guidance set out in 2(b), (c), and (d). This involves considering the seriousness of the conduct, any relevant context, and how Dr Collin has responded to the Allegation.

62. The Tribunal was informed that it can take into account the fact that Dr Collin does not have any relevant fitness to practise history, and the testimonial evidence that has been received.

63. However, the Tribunal was reminded that Dr Collin has admitted dishonesty, and that caselaw confirms that it is unusual for matters involving dishonesty not to result in impairment.

64. The Tribunal should also recognise that dishonesty is generally held to be difficult to remediate. This is because, unlike with clinical errors, where further practice and/or teaching would likely show a practitioner the correct method of practice, the nature of dishonest behaviour goes more to the practitioner's character than learning. Mitigation therefore holds less weight in such cases.

65. Once the steps have been considered as above, the Tribunal should decide what risk, if any, Dr Collin poses to public protection and therefore whether he is currently impaired.

66. Whilst there is no statutory definition of impairment, the Tribunal is reminded of the guidance provided by Dame Janet Smith in the *Fifth Shipman Report,* as adopted by the case of *'Grant.'* Dame Smith sets out some features that are likely to be present when impairment is found. These are where a doctor has in the past or is liable in the future to

a) act so as to put a patient or patients at unwarranted risk of harm.
b) bring the medical profession into disrepute.
c) breach one of the fundamental tenets of the medical profession; and/or
d) have acted dishonestly and or is liable to do so in the future.

67. The Tribunal was informed that there will be occasions where impairment of fitness to practise must be found as a matter of public policy if to make no such finding would have an adverse impact on public confidence in the profession and the regulator.

<u>The Tribunal's determination on impairment</u>

68. The Tribunal took into account the submissions made by both Mr Brook and Mr Brassington. It accepted the LQC advice, along with the caselaw that had been referred to. At all times, it has had regard to Part B of the Guidance as advised.

Step 2a: legal basis for considering impairment

69. The Tribunal firstly had to decide whether there is a legal basis for considering impairment. It therefore considered whether the paragraphs of the Allegation amounted to misconduct. The Tribunal was aware that the misconduct had to be serious professional misconduct before it could move to impairment.

70. The Tribunal reminded itself of the facts of the case as set out above. Dr Collin while working as a GP partner had self-prescribed medication and prescribed to four patients over a number of years. Laterally, this included the prescribing of controlled drugs. The four patients were close friends or family, and all the prescribing was done in a non-emergency situation. Sometimes Dr Collin made no medical records, and if he did, they were inadequate. Dr Collin attempted to conceal his actions by cancelling prescriptions after they had been printed and he twice entered another GP as the authoriser on the EMIS system. These amounted to numerous acts of dishonesty.

71. The Tribunal decided that fellow practitioners would find Dr Collin's overall conduct deplorable. The inappropriate prescribing put patients at risk of harm, and the dishonest acts breached a fundamental tenet of the profession, namely to act with honesty and integrity.

72. The Tribunal had regard to paragraphs 77 and 80 of the MPTS Introduction Guidance. It states;

> *Case type 2: dishonesty*
>
> *77. Honesty is a basic quality that is expected of all, based on shared moral values. It involves being truthful about important matters and respecting the property rights of others. Dishonesty is a disregard for this shared moral value and can be used to describe a lack of probity, cheating, lying or deliberately withholding information.'*
> *…*
> *'The professional standards doctors are expected to meet*
> *80 Honesty is at the heart of medical professionalism and is essential for the public to have trust in doctors and the systems they work in. Doctors must make sure their conduct justifies their patients' trust in them and the public's trust in the profession...'*

73. The Tribunal understood that dishonesty is inherently serious. When committed as part of a doctor's professional working life, it is clearly capable of undermining public confidence in the profession.

74. The Tribunal also took the view that Dr Collin had departed from the standards set out in GMP, and the associated Prescribing Guidance.

75. The Tribunal firstly considered the paragraphs of GMP relating to dishonesty. In particular it took the view that paragraph 1 and paragraph 65 were engaged. These paragraphs highlight the importance of honesty in the medical profession and the effect that dishonesty could have on public trust. They read:

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

76. The Tribunal also noted the paragraphs that specifically relate to prescribing. When Dr Collin was prescribing to the four patients, he did not necessarily have their full medical history and clinical records. They each had a close relationship with him, so prescribing to them should have been avoided, especially in non-emergency situations. The Tribunal decided therefore that paragraph 16 (a) and paragraph 16 (g) of GMP both applied. They read:

> *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*
> *…*
> *g wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.*

77. Dr Collin admitted that sometimes he did not enter any medical records onto the EMIS system for the four patients, and those he did make were inadequate. The Tribunal

decided that Dr Collin's conduct in this respect engaged paragraph 19 and paragraphs 21(d) and 21(e) which read:

> *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:*
>
> ***…***
>
> *d any drugs prescribed or other investigation or treatment*
>
> *e who is making the record and when.*

78. The Tribunal noted that Dr Collin had explained in both his statements and his oral evidence that when he first started prescribing in this way, he was not fully up to date with the relevant GMC Guidance about prescribing, and that he relied on the custom and practice in the Practice. He said in his witness statement; *'I was not fully aware of the changes in GMC guidance prohibiting the practise of prescribing to friends or family.'* The Tribunal decided therefore that paragraph 12 of GMP applied because it emphasises that a doctor must keep his knowledge up to date. It reads:

> *12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.*

79. Lastly, the Tribunal noted that Dr Collin, on two occasions had named other GPs as the authoriser on the EMIS system which was not correct. In relation to Dr A, Dr Collin stated in his Ethical Reflection statement that he had prescribed medication for himself by using Dr A's computer, which he recognised was an act of dishonesty. The Tribunal decided that this conduct engaged paragraph 36 which reads:

> *36 You must treat colleagues fairly and with respect.*

80. The Tribunal concluded therefore that Dr Collin's actions fell far below the standards expected of him, and that he had departed from the professional standards set out in GMP in a number of respects. It decided that fellow practitioners would be extremely concerned about this type of conduct.

81. The Tribunal found therefore that Dr Collin's actions amounted to serious professional misconduct, both in terms of the inappropriate prescribing and the associated acts of dishonesty. It concluded therefore that there was a legal basis for it to consider impairment.

Step 2b deciding where on the spectrum of seriousness the Allegation lies

82. The Tribunal then went on to consider where on the spectrum of seriousness the allegation lies. The Tribunal again considered Part B and the Guidance Introduction.

83. The Tribunal reminded itself again of the facts of this case. It considered the Allegation and recognised that there were a number of features that could increase the seriousness of it. In particular, the Tribunal noted Paragraph 31 of Part B- which confirms that allegations that are likely to fall at the higher end of the spectrum of seriousness, in relation to acts of dishonesty could be:

> *'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.'*

84. The Tribunal considered, therefore, as its starting point, that Dr Collin's dishonest conduct was at the higher end of the spectrum of seriousness, but it also decided that there were a number of other features of concern. Dr Collin had put patients at unwarranted risk of harm in a number of respects; for example, by prescribing controlled drugs, not making any/adequate records, and being unaware of the patients' medical history before prescribing. Also, by his own admission, Dr Collin had on two occasions written out a prescription for a controlled drug, for Patient E, which was given to Patient D for dispensing; which was another attempt by Dr Collin to conceal what he was really doing.

85. The Tribunal then considered paragraph 36 of Part B which sets out some of the features that may increase seriousness. It decided that the following features applied in this case:

86. The Tribunal decided that Dr Collin's conduct was both '*persistent'* and *'repeated.'* Dr Collin had prescribed for himself and others and concealed what he was doing over a number of years, with the Allegation demonstrating a span of time between May 2015 and September 2023. The Tribunal accepted that the prescribing of controlled drugs took place over a shorter span of time (from April 2022 to September 2023). Nevertheless, it felt that prescribing and

being dishonest over such a prolonged period was a significant feature which increased the seriousness in this case.

87. The Tribunal decided that Dr Collin's conduct was '*premediated.'* On his own admission he knew what he was doing was wrong. He recognised in his witness statement, for example, that when he changed the prescription authoriser to Dr A in February 2021'*…that this behaviour was unacceptable and dishonest and a betrayal of my colleague [Dr A] and therefore I did not get the prescription dispensed and I destroyed it*.' He had clearly acted with intention and planning, as evidenced by the fact that he concealed his actions by cancelling several prescriptions on the EMIS system after they had been printed.

88. The Tribunal decided that, by his actions, Dr Collin had demonstrated a *'reckless disregard for patient safety or professional standards.'* He knew what he was doing was wrong, and ought to have known that prescribing in this manner put those patients at risk of harm. When considering Patient E, in his witness statement Dr Collin said that 'the *inappropriateness of this* [i.e. prescribing in this manner] *only became apparent to me when I was subsequently made aware of [XXX].'*

89. The Tribunal decided that Dr Collin had acted in a way that *'undermined a system designed to protect the public.'* The system in the Practice of medical consultations, recording of decisions, and authorising prescriptions was in place to ensure that the public is not harmed. Dr Collin undermined the integrity of the system when he acted in the way he did.

90. The Tribunal considered carefully whether Dr Collin had *'attempted to hide and/or avoid taking responsibility for his behaviour...'*. It decided that by cancelling the prescriptions and naming other doctors as the authoriser on the EMIS system he was attempting to hide what he was doing. It accepted, though, that when the investigations took place, he was fully cooperative, open and honest, and did not attempt to hide his actions from the Practice or the regulator.

91. The Tribunal concluded that there were a number of concerning features in this case, and that its start point was that Dr Collin's conduct was at the higher end of the spectrum of seriousness. This in turn meant that the Tribunal's starting point for assessing current and ongoing risk to public protection is high.

Step 2c- What is the impact of any relevant context known about Dr Collin and his working environment?

92. The Tribunal considered whether there was any work environment context, role and experience, or personal context which might have an impact on the assessment of whether Dr Collin poses a current and ongoing risk to public protection.

93. The Tribunal firstly considered whether there was any relevant work environment context.

94. The Tribunal noted that, in both his written statement and his Ethical Reflections document, Dr Collin described a very busy time during the COVID-19 pandemic, when he was setting up and leading the vaccination clinic, which involved 'a *high volume of work',* and he said that, as a consequence, he XXX. The Tribunal also took into account the submissions made by Mr Brassington. It accepted that Dr Collin had been at the forefront of the local vaccine roll out programme, and that the clinic he led vaccinated over 100,000 patients. It was mindful therefore of paragraph 53 of Part B and accepted that Dr Collin would have had *workload issues* during the pandemic time, and that he would have been working in an *unfamiliar role.*

95. The Tribunal acknowledged that COVID-19 had an impact on the medical profession and the individuals working within it. It accepted that Dr Collin felt under stress during this period of time. It also noted Dr Collin's contention that working remotely and during the pandemic resulted in a loss of boundaries for him. However, the Tribunal was troubled that the span of the Allegation started from before the pandemic (May 2015) to after it had ended (September 2023) and only stopped because of the audit that took place at the practice. In those circumstances, it could not conclude that COVID-19 was the reason for Dr Collin's conduct, but it did acknowledge that it could have exacerbated or accelerated it.

96. The Tribunal next considered whether Dr Collin's role and experience impacted on its decision making in any way and concluded that it did not. Dr Collin was an experienced doctor working as a partner in a GP practice at the time. The Tribunal noted the evidence of Ms H that there was a custom within the practice for colleagues to prescribe for each other. While the Tribunal considered that this may have affected Dr Collin's own judgment on this, the Tribunal gave it limited weight. It was of the view that Dr Collin should have made himself aware of the GMC Guidance on prescribing, and in any event, he acknowledged that he knew that what he was doing was wrong, as early as February 2021.

97. Lastly, the Tribunal considered the personal circumstances in Dr Collin's case. XXX.

98. XXX. Dr Collin said that he was prescribing for Patient B generally, XXX. He accepted that he also prescribed the controlled drug XXX. Prescribing for Patient B was sporadic up until the period of the pandemic XXX. Dr Collin's explained in his evidence that he misguidedly prescribed medications to Patient B in an attempt to help to treat him XXX.

99. Dr Collin described that Patient D XXX.' He said in his statement that:

'On several occasions, I did prescribe for Patient [D] XXX.'

100. Dr Collin described that Patient E XXX. Therefore, Dr Collin prescribed for XXX, but also '*reluctantly*' prescribed XXX. He explained that two further prescriptions written out to Patient E for XXX were in reality for Patient D and were given to him.

101. Dr Collin described that Patient F was XXX. Because she would not register with a local GP, he registered her at the Practice and then prescribed for her. He said that she responded well and her health improved.

102. The Tribunal accepted Dr Collin's description of his relationship with the four patients.

Some of the testimonial evidence received corroborated his account, for example:

> *'During our friendship, I was aware that Peter experienced a particularly difficult period XXX. It was clear that this was an extremely challenging time for him'*

> *'XXX We could see Pete was struggling, he was XXX and making poor judgements*

103. The Tribunal also noted that Mr I, the Practice manager, was aware of the personal difficulties that Dr Collin was experiencing. XXX.

104. The Tribunal concluded that the relationships Dr Collin described with Patient B and Patient D could have directly affected his conduct. It also accepted that Dr Collin was acting with the 'benign motivation' of trying to help people, especially Patient F.

105. XXX

106. XXX

107. XXX

108. The Tribunal decided therefore that Dr Collin's personal context both in terms of his personal relationships and XXX, directly affected his behaviour. In particular, those allegations relating to his dishonest conduct occurred in the time following a turbulent period in his professional and personal life, which had led to a maelstrom of difficulties, as identified by Dr Collin and his colleagues in the Practice.

109. The Tribunal was therefore able to attach weight to the overall context in this case, owing to the constellation of his working environment and personal context at the time. Accordingly, the Tribunal determined that, at this stage, the current and ongoing risk posed by Dr Collin sits at the medium level. It noted that steps have been put in place to avoid circumstances such as these happening again and therefore concluded that the current and ongoing risk to public protection could decrease, because of the reduced likelihood of repetition.

110. Nonetheless, the Tribunal was concerned about the level of seriousness in this case, which it determined remained at the higher level of the spectrum. However, it concluded, that because of the personal context as described above, the level of current and ongoing risk to public protection posed by Dr Collin at this stage could be described as medium.

Step 2d- How has Dr Collin responded to the allegations?

111. The Tribunal then considered carefully the way in which Dr Collin has responded to these allegations. It considered his insight, remediation, and the risk of repetition.

Insight

112. The Tribunal firstly looked to see if there was any evidence of insight. It wanted to see if Dr Collin understood what had happened and how he could act differently in the future.

113. The Tribunal noted that Dr Collin cooperated as soon as the investigation at the Practice began. Dr G carried out the formal investigation, and he interviewed Dr Collin on 30 January 2024. It was clear that Dr Collin accepted his wrongdoing. He said:

> '*…Dr Collin also accepted that he did attempt to conceal his prescribing when interviewed. He explained that he had not used any of the prescriptions found to be concealed for his own use. When asked why he had concealed the prescriptions Dr Collins said it was because he knew it was wrong. … Dr Collin was co-operative and open with me from the outset of the investigation. He was facing [XXX]. He was also working very long hours during the pandemic including weekends in the vaccination centre.'*

114. The Tribunal also noted that Dr Collin fully cooperated during the GMC investigation, and throughout this Tribunal hearing. In his written statement dated 9 September 2026, Dr Collin made admissions to the then Allegation, and he admitted them again at the start of the hearing, after they had been amended by the GMC.

115. The Tribunal noted from the witness statement that Dr Collin expressed regret for his behaviour, and he recognised that his actions were inappropriate. He said that they were '*abhorrent and unrecognisable to my usual standards.'* He said that he was '*confused and had muddled thinking'* at the time. Dr Collin described himself as '*ashamed',* and *'embarrassed.'* He did not excuse his behaviour.

116. The Tribunal had regard to Dr Collin's Ethical Reflection's statement. He accepted his self-prescribing was '*unacceptable*.' He said he knew that using his colleague's computer to prescribe XXX was '*entirely wrong.*' He accepted that it was a serious error of his professional judgment. He accepted that his behaviour fell far below that what was expected of him. He stated:

> '*I appreciate now that my actions compromised the integrity of the clinical record, obscured my own responsibility for the prescribing decision and, importantly, risked implicating an innocent colleague in an action for which they were not responsible.'*

117. The Tribunal considered what insight Dr Collin was now demonstrating. He was clearly remorseful, which was noted from his two statements and from the oral evidence that he gave at this hearing. It noted that Dr Collin did not seek to excuse his behaviour, but that he had reflected on the relationships at the time and how they '*blurred'* both his boundaries and his judgment.

118. In his oral evidence, Dr Collin said that he had reflected on his behaviour over a period of two years and that the reflections in his statements were very personal to him.

119. The Tribunal accepted that Dr Collin now recognises his behaviour was wrong and that it fell far below the professional standards expected of him. It also noted that Dr Collin fully understood the impact of this sort of conduct on the trust and confidence that the public holds in the medical profession.

120. The Tribunal was initially concerned that Dr Collin had not fully reflected in his written statements on the fact that his actions carried a very real risk of harm to the four patients to whom he was prescribing. However, during his oral evidence Dr Collin responded well and with meaningful insight to specific questions from the Tribunal about the risk of harm that he had exposed patients to. After hearing his evidence, the Tribunal was assured that Dr Collin had fully understood the serious impact of his conduct on patient safety.

121. The Tribunal noted that it had no evidence that Dr Collin had apologised to the patients, nor to his work colleagues Dr A and Dr C. It accepted that this may be difficult in relation to the patients, and it also accepted that the motivation behind his prescribing was benign.

122. The Tribunal concluded that Dr Collin had demonstrated good evidence of insight into his behaviour.

Remediation

123. The Tribunal firstly considered whether Dr Collin's actions were remediable, and it recognised that dishonesty is generally held to be difficult to remediate

124. The Tribunal decided that Dr Collin's actions were difficult to remediate but considered that it was possible. It then moved on to consider what steps he had taken to remediate.

125. The Tribunal noted Dr Collin's efforts to remediate his dishonesty and had regard to the two courses that he has undertaken. He attended a course entitled '*Professionalism: fulfilling your duty as a doctor,*' on 26 June 2025, which consisted of 5 CPD hours. In his oral evidence, Dr Collin described that there were five/six other participants on the course, and that it was practical in nature. He said that from it, he recognised that dishonesty erodes the trust and confidence of the public in the profession.

126. The Tribunal also saw that Dr Collin had attended a '*short course on medical ethics'* on 3 September 2026. He described this as a one-to-one course in London from 10am to 5pm with a highly regarded instructor in Medical Ethics. He said that it was both challenging and confronting.

127. The Tribunal noted that Dr Collin said in his statements that he was now up to date with GMP, and its associated prescribing guidance, and recognised its importance. In his oral evidence he reiterated this and confirmed that he would be keeping up to date going forward.

128. XXX

129. XXX

130. XXX

131. The Tribunal went onto consider whether there was a risk of repetition in Dr Collin's case. The Tribunal concluded that Dr Collin had gone a long way to remediate his actions and prevent them recurring. It noted that he was presently supported in his new workplace and had a stable personal life. However, it did not accept that the risk of repetition was '*vanishingly small'* as submitted by Mr Brassington. It noted that Dr Collin was beholden to a supportive work environment, and a stable personal life.

132. The Tribunal therefore decided that the risk of repetition remained but was low.

Knowledge and skills

133. The Tribunal was aware that Dr Collin was an experienced GP with no relevant fitness to practise history. The testimonial evidence from colleagues and friends describe him as a considerate and empathetic GP.

134. The Tribunal asked itself whether Dr Collin had kept his knowledge and skills up to date since September 2023. After he XXX, Dr Collin started working at another Practice. Since August 2024, he has been working there for three days a week with conditions on his licence that he does not prescribe controlled drugs. The Tribunal saw that there were a number of testimonial statements from that new Practice which were all very positive. Dr Collin himself described a very positive and supportive environment.

135. The Tribunal noted in particular the testimonial from Dr N, his current clinical supervisor, where he said that Dr Collin's *'clinical management was always of high quality.'*

136. The Tribunal also noted the statement of Dr Collin's present RO, which was again very positive. They gave an update in relation to doctor's current practice and said:

> *'Dr Collin provides locum sessions at one of our health board managed practices with clinical supervision, as per the GMC conditions, provided by the Clinical Lead in the surgery. According to his clinical supervisor in practice: "Feedback from staff working at the practice continues to be universally positive with comments that Peter is friendly, approachable, and will often go out of his way to help or assist. This has also been my opinion of Peter who I consider a positive and valuable addition to the practice team".*
>
> *There have been no concerns raised about Peter while working at the practice and his clinical management and diagnostic skills are always of high quality.*
> *I have also received verbal feedback from the practice manager that he is well respected and liked by the surgery staff and they have no clinical concerns about him.*
> *He successfully applied to become a salaried GP based in two of our health board managed practices (where he currently provides locum sessions and at a neighbouring practice). He was open and transparent within his application and at interview about the challenges he's had and the ongoing GMC investigation.*
> *He is due to start on the 1st of September, and we will continue to support him with clinical supervision and as per the rest of his GMC conditions.'*

137. The Tribunal concluded from the evidence that Dr Collin was highly respected at the new Practice. It noted that practice staff, in particular the receptionists, commented that many patients have thought highly of him and specifically sought to see him. He was clearly keeping his skills and knowledge up to date and was deemed by Dr N to be practising safely in accordance with the GMC conditions.

Step 2e- Tribunal's decision as to whether Dr Collin poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

138. The Tribunal next had to consider, overall, whether Dr Collin poses any current and ongoing risk to public protection. It therefore reviewed its conclusions at Steps 2(a) to (d) above.

139. At step 2(a) the Tribunal found that Dr Collin's actions amounted to serious misconduct, and at step 2(b) it decided that his misconduct was at the higher end of the spectrum of seriousness.

140. At step 2(c), the Tribunal concluded that, although the conduct remained at the higher end of the spectrum of seriousness, the risk to public protection was medium because of the context in which the misconduct took place, and the steps Dr Collin has taken in order to cope with these circumstances should they occur again. When considering step 2(d), it concluded that there was a risk of repetition albeit low.

141. The Tribunal reminded itself of the seriousness of this case. Dr Collin put patients at risk of harm, and his actions were far below proper professional standards, breaching GMP in a number of respects. The misconduct, especially the dishonesty, would undermine the confidence that the public holds in the profession.

142. The Tribunal then considered the features set out in the case of *Grant.* It concluded that Dr Collin's actions put four patients at risk of harm, and that he had both brought the medical profession into disrepute and breached one of the fundamental tenets of the medical profession. He had also acted dishonestly.

143. Considering the above findings, the Tribunal was satisfied that Dr Collin's misconduct remained at the higher end of the spectrum of seriousness and that he still poses a current and ongoing risk to public protection, albeit low.

144. The Tribunal recognised that the risk of repetition is low but remained concerned about the seriousness of the misconduct, which included persistent dishonesty. It concluded overall that Dr Collin represented a low risk to all parts of public protection.

145. The Tribunal was also of the view, as a matter of public policy, that given the misconduct found, public confidence in both the profession and the regulator would be undermined if a finding of impairment were not made.

146. The Tribunal concluded that Dr Collin's fitness to practice was therefore impaired.

Determination on Sanction - 21/10/2026

147. This determination will be handed down in private but as this case concerns Dr Collin's alleged misconduct, a redacted version will be published at the close of the hearing.

148. Having determined that Dr Collin's fitness to practise was impaired by reason of his misconduct, the Tribunal was then required to decide, in accordance with Rule 17(2)(n) of the Rules, what action, if any, it should take with regard to Dr Collin's registration.

The outcome of applications made during the sanction stage

149. Mr Brassington made an application for this stage of the hearing to be held entirely in private, pursuant to Rules 41XXX of the General Medical Council (Fitness to Practise Rules) 2004. The Tribunal decided to partly grant this application, so that parts of the hearing could be held in private. Its full decision is set out in Annex B.

150. Mr Brassington made an application under Rules 34(13) and (14) for the testimonial maker, Dr N to give his evidence by video link. This was not opposed by the GMC and was granted by the Tribunal.

The Evidence

151. The Tribunal reviewed its findings at the impairment stage and took into account all the evidence it had received during the earlier stages of the hearing where relevant to reaching the decision on sanction.

152. The Tribunal received further evidence on behalf of Dr Collin. It heard testimonial evidence from Dr Collin's present clinical supervisor Dr N.

Submissions

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

153. Mr Brook referred the Tribunal to the Guidance at Part C. He stated that the decision on sanction is a matter for the Tribunal. He directed it to the sanctions bandings and said that

because this case involves dishonesty, the Tribunal should be considering a sanction of suspension in the region or three to nine months.

154. Mr Brook submitted that this was not a 'no action' case and also that a sanction of conditions would not be appropriate, despite Dr Collin presently working under interim conditions. He outlined that interim orders serve a different purpose to sanctions. He explained that the Interim Orders Tribunal (IOT) conditions were '*pastoral and supervisory,'* and provided prescribing restrictions of what and to whom. He said that the present conditions were, albeit not exclusively, mainly there to protect the public from inappropriate prescribing.

155. Mr Brook submitted that this is not a case that conditions as a sanction would address the public interest and the need to uphold proper professional standards. He added that conditions are not appropriate, measurable and/or workable, due to the level of current and ongoing risk to public protection and this cannot be safely managed with conditions.

156. Mr Brook anticipated that Dr Collin's case may well be that conditions will continue to suffice and he accepted that Dr Collin has been working under the IOT conditions for the last two years without issues. He noted the oral evidence given by Dr N and the testimonials that the Tribunal had received. He accepted that Dr Collin *'is clearly a good doctor and is highly regarded.'* He said that Mr Brassington might argue that suspending Dr Collin would deprive the public of such a doctor when the NHS is struggling to recruit GPs.

157. Mr Brook, however, submitted that Dr Collin is a locum doctor and another locum doctor could '*fill his slot'*, should he be suspended. He said that the Tribunal should conduct a balancing exercise. He submitted that upholding public confidence in the profession and upholding high professional standards outweigh the public interest in allowing Dr Collin to continue to practise.

158. Mr Brook addressed the Tribunal in relation to suspension. He referred it to Paragraph 41 of Part C, and submitted that suspension is for those cases where the doctor's behaviour, performance or the impact that a health condition is having on their ability to practice safely and effectively is currently incompatible with unrestricted registration. This means that the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting his registration for a period, with the aim that they should be able to return safely to unrestricted practice in the future.

159. Mr Brook also referred to paragraphs 44, 45 and 47 of Part C. He stated that the restrictive action of suspension is not intended to be punitive, but can have a deterrent effect. He said that some, if not all, of the factors set out in those paragraphs apply in Dr Collin's case. He said that conditions are not appropriate, there remains a level of risk, and suspension is needed to maintain public confidence and professional standards.

160. Mr Brook highlighted that the Tribunal had found that Dr Collin's misconduct fell at the higher end of the spectrum of seriousness. It had then found that there was evidence of relevant context, and of insight and remediation and concluded that these factors decreased the level of current and ongoing risk to public protection. However, it had concluded that a risk of repetition remained, albeit low.

161. Mr Brook emphasised that this is not just a case of self-prescribing over-the-counter medication in an odd emergency or similarly to family and friends. It included controlled drugs, and dishonest concealment, and was not *'a one-off.'* Mr Brook submitted that it cannot be said that there are no outstanding patient safety considerations, and therefore a standard suspension would be needed. He reiterated that suspension would also be needed to maintain public confidence in the profession and to maintain professional standards.

162. Mr Brook submitted that after a period of suspension, a review should be directed. He noted that, whilst Dr Collin has shown good insight and remediation, a review would allow him an opportunity to reflect further and to provide an update on XXX. It would also allow him to demonstrate how he has kept his knowledge and skills up to date during any period of suspension that the Tribunal might impose.

163. Mr Brook was asked by the Tribunal about the relevant sanction banding in this case, bearing in mind that it had found the risk of repetition to be low. It pointed out that the sanction banding for a lower level of risk to public protection would be *'suspension of up to three months.'* Mr Brook however maintained that the GMC sought a sanction of between three to nine months.

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

164. Mr Brassington reminded the Tribunal that the purpose of sanctions was not to punish doctors, but to protect patients, and the public interest. He said that proportionality requires no more than that which is necessary to advance the Tribunal's statutory purpose.

He stated that the Tribunal should consider the least restrictive sanction first, before considering others.

165. Mr Brassington stated that the Guidance was '*only guidance'* and that it was not directive. Each case should be considered on its own facts, and this should not be a *'tick box'* exercise. The Tribunal should use its own judgment.

166. Mr Brassington submitted that the Tribunal should consider whether conditions are appropriate and proportionate, and that it would be wrong to '*gloss over it'* as suggested by the GMC. He drew the Tribunal's attention to the relevant paragraph of Part C and outlined that conditions can be imposed for up to three years. He submitted that they must not be thought of as '*a soft option'.* He submitted that it is '*a draconian measure'* for any doctor to have their practice restricted in any way. Mr Brassington submitted that conditions have significant implications for any clinician and that this does '*relay a message,'* not only to the doctor, but to the wider profession.

167. Mr Brassington submitted that any conditions imposed must address the specific findings about the current and ongoing risk to public protection posed by a doctor. He highlighted that the Tribunal had found that the risk posed by Dr Collin is low, and he submitted that conditions would therefore meet that risk. Mr Brassington rhetorically challenged the Tribunal to find someone more willing to remediate their previous failures than Dr Collin. He said that Dr Collin has shown significant insight and has demonstrated through two years of unblemished practice that he is more than competent to comply with any conditions that are imposed upon him.

168. Mr Brassington referred the Tribunal to paragraphs 21 and 23 of Part C. He submitted therefore that all of the factors pointing to the imposition of conditions are met. He submitted that they would be an appropriate and proportionate sanction. He said that they are workable and that there are identifiable areas of Dr Collin's practice which need prohibiting. He reminded the Tribunal that Dr Collin is presently restricted from prescribing controlled drugs. He said that the imposition of conditions would give Dr Collin further time to demonstrate that he is no longer a risk to public protection.

169. Mr Brassington referred the Tribunal to paragraph 28 of Part C. He pointed out that Dr Collin has demonstrated that he is willing to be open and honest with patients and others he works with. He has been open and frank with the investigation and acknowledged all of his wrongdoing. He provided information that would not have been available to the investigators

or the GMC. Mr Brassington submitted that Dr Collin is not a dishonest man, rather he has behaved in a dishonest fashion at various points. He confirmed that Dr Collin has not put patients at risk of harm during the last two years that he has been working.

170. Mr Brassington addressed paragraph 30 of Part C, which states that conditions are unlikely to be a proportionate response in cases which are at the higher end of the spectrum of seriousness. He submitted that that was beginning to sound like punishment, and that the Tribunal should concentrate on current and future risk which it had found in its Determination on impairment to be low. He reiterated that this is not a '*tick box*' exercise, otherwise there would be no point in having hearings such as this. He said that it cannot be right that suspension is always necessary in cases such as this.

171. In terms of the sanction banding, Mr Brassington submitted that, as the level of risk to public protection is low, the guidance suggests that the sanction should be suspension up to three months as a maximum. It does not preclude conditions being imposed beneath it. He invited the Tribunal to consider that there is no basis within the Tribunal's findings in relation to impairment for it to put Dr Collin's misconduct within the sanctions banding of a suspension of three to nine months.

172. Mr Brassington stated that he did not propose to address the Tribunal on the possibility of Dr Collin's name being erased from the medical register. He said the misconduct was not incompatible with continued registration. He said that Dr Collin had demonstrated insight and that he does not pose a risk of significant harm to patients, having worked for the last two years without incident.

173. Mr Brassington referred to the Tribunal's Determination on impairment in which it noted that Dr Collin had not apologised to the patients or the two work colleagues. Mr Brassington told the Tribunal that it was difficult in relation to the patients because of the personal circumstances and that he had not been allowed to contact the work colleagues during the course of these proceedings. He said that Dr Collin has expressed a sincere wish that they understand how sorry he is for the trouble he caused them, for the concealment, for the time and energy that they had to expend in relation to this, and the subsequent loss of him as a GP at that practice. Mr Brassington suggested that, perhaps at the conclusion of this case, he would be permitted to express that apology to them.

174. Mr Brassington pointed out Dr Collin's personal circumstances. XXX. He explained that this could not, however, be '*the meat*' of any submissions. He reminded the Tribunal,

therefore, of Dr N's evidence and the good work that Dr Collin is doing at the surgery in relation to minor procedures that he can carry out because of his previous Obstetrics and Gynaecology experience. In some case, Dr N confirmed that Dr Collin undertook as many as 90% of these procedures and his absence would cause difficulties for a number of patients who would have to join lengthy waiting lists outside of the practice. He said that in this regard, the public interest is *'a two-way street.'*

175. Mr Brassington took the Tribunal through the testimonial evidence. He quoted from a number of them, especially those who work with him in his present practice. He described, for example, the reference from the senior receptionist at the present practice as *'a wonderful reference.'*

176. Mr Brassington concluded by submitting that the level of current and ongoing risk to public protection can be safely managed with conditions. He said that a reasonable member of the public would not demand a suspension in this case, but rather that a good doctor is put back to work. He submitted that conditions would send out a message to the doctor and the profession and that a period of suspension in this case would be unnecessary and disproportionate.

177. Mr Brassington submitted that if the Tribunal was against him on this, it should be minded to impose a suspension of no longer than three months.

The Relevant Legal Principles

178. The LQC gave the Tribunal legal advice, which is summarised below.

179. The Tribunal is reminded that the decision as to the appropriate sanction, if any, is a matter for its own judgement, which must be made independently.

180. The Tribunal should have regard to Part C, of the Guidance which, although not statutory, gives it an authoritative steer.

181. The Tribunal is reminded that it must consider the level of current and ongoing risk that the doctor poses to public protection and refer to any relevant sanction bandings in the Guidance. The sanction it imposes must be proportionate, transparent and fair.

182. The Tribunal can take into account the fact that Dr Collin's had no previous relevant fitness to practise history along with the testimonial evidence that he has put forward.

183. The Tribunal is reminded that Dr Collin is facing a matter of dishonesty, and that this is very serious, especially if it occurs in the context of a doctor's professional duties. Caselaw would suggest that the balance the Tribunal needs to exercise can ordinarily be expected to fall down on the side of maintaining public confidence in the profession by a severe sanction against the practitioner concerned.

184. The Tribunal must bear in mind however that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest. The Tribunal should be mindful that this is a balancing exercise - weighing up what is in the public interest.

185. In the case of *Bolton v Law Society* [1994] 1 WLR 512 it was made clear that the reputation of the profession as a whole is more important than the fortunes of any individual member, even if the consequences may be deeply unfortunate for them.

186. The Tribunal is reminded of the three limbs of public protection which are, namely, the need to:

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

The Tribunal's determination on sanction

187. The Tribunal took into account the submissions made by both Mr Brook and Mr Brassington. It accepted the LQC advice, along with the caselaw that had been referred to.

188. The Tribunal reminded itself of its earlier findings. Dr Collin had self-prescribed medication and prescribed to four patients over a number of years, which included prescribing controlled drugs. The four patients were close friends or family, and all the prescribing was undertaken in a non-emergency situation. Sometimes Dr Collin made no medical records, and if he did, they were inadequate. Dr Collin attempted to conceal his actions by cancelling prescriptions after they had been printed and he twice entered another GP as the authoriser on the EMIS system.

189. The Tribunal had noted that there were several concerning features of this case and concluded that Dr Collin's actions were at the higher level of the spectrum of seriousness. It noted that Dr Collin's misconduct related to both clinical concerns about the inappropriate prescribing and dishonesty of concealing what he was doing.

190. Due to the personal contextual factors of this case, and the good evidence of insight and remediation demonstrated by Dr Collin, the Tribunal at the impairment stage determined that Dr Collin posed a risk to all three limbs of public protection, albeit low. Having heard the evidence of Dr N and further submissions, it was satisfied that Dr Collin posed no risk to patient safety, insofar as the clinical concerns raised in this case.

191. The Tribunal was, therefore, mindful of the sanction bandings set out at paragraph 62 of Part C, which state:

Case type	Lower level of risk to public protection	Medium level of risk to public protection
Dishonesty	Suspension up to 3 months	Suspension 3 to 9 months
Clinical concerns	conditions 6 to 12 months	conditions 24 to 36 months to suspension 6 months

192. The Tribunal acknowledged that the sanctions bandings are indicative rather than binding, and any decision on sanction is one for the Tribunal and its own independent judgment.

193. Accordingly, the Tribunal considered all possible sanctions open to it, starting with the least restrictive first.

No action

194. The Tribunal first considered whether to conclude the case by taking no action. It noted that it is usually necessary for a Tribunal to restrict a doctor's registration unless there are exceptional circumstances to justify it taking no action. The Tribunal noted from paragraph 13 of Part C that *'exceptional circumstances are unusual, special, or uncommon, so such cases are likely to be very rare.'*

195. The Tribunal decided that there were no exceptional circumstances which would justify it taking no action. Given the serious nature of the Allegation, and its findings at the impairment stage, it concluded that taking no action would not be appropriate in this case.

Conditions

196. The Tribunal next considered whether to impose conditions on Dr Collin's registration. It had regard to paragraph 21- 30 of Part C. It bore in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

197. The Tribunal concluded at the impairment stage that Dr Collin had demonstrated good evidence of insight into his behaviour and that he had gone a long way to remediate his actions and prevent them recurring. It accepted that there had been no repetition, and that he had worked well under the conditions that were imposed on him by the IOT. The Tribunal accepted, however, that the IOT conditions were imposed to serve a very different purpose to that of a sanction. The IOT had not received the admissions to the Allegation as this Tribunal has and was applying different criteria at the time.

198. The Tribunal noted that Dr Collin had made a very positive contribution in his present practice, and it accepted the evidence of Dr N. XXX. It was satisfied that Dr Collin's skills and knowledge remained up to date.

199. The Tribunal considered carefully therefore whether the imposition of conditions would be workable and measurable. It concluded that, had Dr Collin's misconduct related solely to the clinical failings of inappropriate prescribing then it might have been. The relevant sanctions banding states that conditions in such circumstances should be considered. Clinical inadequacies could be remedied in this way, and skills and knowledge could be kept up to date. The Tribunal felt that conditions such as the present ones that Dr Collin was working under might have sufficed and would have been both workable and measurable.

200. However, the Tribunal was concerned about the repeated acts of dishonesty in this case. It was of the view that it would not be possible for any conditions to be formulated that address dishonesty and that conditions to address this issue would not therefore be workable or measurable.

201. The Tribunal went on to consider whether conditions would be an appropriate and proportionate response in Dr Collin's case. It reminded itself of the serious nature of the Allegation. The misconduct was both persistent and repeated. Dr Collin concealed what he was doing over a number of years using different methods. His actions were premeditated and demonstrated a reckless disregard for patient safety or professional standards. He had undermined a system designed to protect the public.

202. The Tribunal noted paragraph 30 of Part C which states:

> *'conditions are unlikely to be a proportionate response in cases where the nature of the allegations about the doctor's behaviour fall at the higher end of the spectrum or seriousness… '*

203. The Tribunal had decided at the impairment stage that Dr Collin's misconduct fell at the higher end of the spectrum of seriousness. The Tribunal acknowledged the submissions of Mr Brassington and accepted that Dr Collin had complied with the conditions to date, has demonstrated sufficient insight and remediation. However, notwithstanding the finding that the overall risk to public protection was low, the Tribunal concluded that the imposition of conditions would not be either an appropriate or proportionate response in all the circumstances of this case.

204. The Tribunal concluded therefore, that conditions would not mark the seriousness of the misconduct, nor uphold the public confidence or maintain proper professional standards and conduct for the profession.

Suspension

205. The Tribunal went on to consider whether a period of suspension would be appropriate. It took into account paragraphs 41-54 of Part C.

206. The Tribunal noted that suspension can have a deterrent effect on practitioners and can be used to send out a signal to the doctor, the profession and the public about behaviour that is considered to be unbefitting of a registered doctor.

207. The Tribunal was mindful that suspension is an appropriate response to misconduct that is so serious that action must be taken to maintain public confidence in the profession. It was aware that a period of suspension might be appropriate for conduct that is serious but

falls short of being fundamentally incompatible with continued registration. It noted that 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.

208. When considering whether suspension was the appropriate sanction in this case, the Tribunal had regard to all of the circumstances. It acknowledged again that the misconduct was at the higher end of the spectrum of seriousness. It had accepted that Dr Collin had demonstrated good evidence of insight into his behaviour and that he had remediated his clinical failings in order to prevent them recurring.

209. The Tribunal considered paragraph 45 of Part C which sets out when Suspension may be proportionate. It states that some, or all, of the following factors may be 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.*

210. The Tribunal concluded that paragraph 45 applied in Dr Collin's case. The Tribunal decided not to impose conditions and that suspension is needed to maintain public confidence and to uphold proper professional standards and conduct.

Erasure

211. The Tribunal considered, however, whether erasure would be an appropriate sanction in this case. It was aware of the seriousness of the Allegation and that it involved numerous repeated acts of dishonesty. The Tribunal took into account the contextual features in this case, the direct link between Dr Collin's personal circumstances and his misconduct, and his subsequent evidence relating to insight and remediation. It concluded therefore that the misconduct was not fundamentally incompatible with continued registration and did not therefore necessitate a consideration of erasure.

212. The Tribunal was satisfied, weighing all the factors, including the interests of Dr Collin against the need to meet the limbs of public protection, that a period of suspension was the appropriate and proportionate response in this case.

Length of Suspension

213. Having decided that a period of suspension was appropriate in this case, the Tribunal went onto consider the appropriate length of time to impose. It noted that it could impose a maximum of up to 12 months. It noted that the sanction banding for dishonesty where the risk to public protection is low stated that the Tribunal should consider *'up to 3 months suspension.'*

214. The Tribunal was aware of paragraph 47 of Part C which sets out where a Tribunal may find that a short suspension is appropriate. It states:

> *47 A short suspension may be appropriate in cases where: the doctor's behaviour fell at the higher end of the spectrum of seriousness; there was evidence of relevant context and/or evidence of insight and remediation that decreased the level of current and ongoing risk to public protection such that there are no outstanding patient safety considerations; and suspension is being imposed on public confidence grounds and/or to maintain professional standards. It might also be appropriate in relation to a very small number of clinical cases where a doctor's performance was such that although unlikely to recur, the nature of the allegation was so serious as to undermine the public's trust in the profession.'*

215. The Tribunal accepted the testimonial evidence that Dr Collin is a highly respected, compassionate and exceptional GP and that his actions had been out of character. It accepted the evidence of Dr N in relation to the services Dr Collin provides and also accepted Dr Collin's wish to stay in the area, remain in the present practice and start work at a nearby practice. It rejected the submission of Mr Brook that Dr Collin was simply a locum.

216. The Tribunal decided that in this case, the nature of the behaviour was at the higher end of the spectrum of seriousness, but that Dr Collin's insight and remediation so far had decreased the ongoing risk to public protection. Notwithstanding this, it determined that a brief period of suspension should be imposed to ensure that public confidence and professional standards are upheld and maintained.

217. The Tribunal considered the imposition of a three-month suspension to mark the seriousness of Dr Collin's behaviour. However, it then considered the oral evidence given by Dr N, and the glowing testimonials that it had received from the present practice. It was aware that Dr Collin had been working well at the practice and was highly regarded. It noted that he was about to start at another practice in the same Health Board area, whilst also remaining at the current practice. The Tribunal was aware of the service that Dr Collin had been providing to patients and the specialist procedures he was carrying out. It considered that this was additional evidence that was relevant to the decision on what sanction is appropriate. It noted paragraph 66 of Part C which states:

> *'66 The following matters are not relevant to the assessment of current and ongoing risk to public protection which will have informed the MPT's decision on impairment, but can be considered at this stage when deciding what sanction is proportionate:*
> *a) evidence about the impact that taking a specific type of action may have on patients or members of the public, or the doctor themselves, and/or*
> *b) references and testimonials about the doctor's character.'*

218. The Tribunal noted therefore that the impact on patients can be taken into consideration at this stage, as well as references and testimonials. The Tribunal therefore took these into account and decided that an appropriate length of suspension would be two months.

Review hearing

219. The Tribunal then considered whether to order a review hearing. It had regard to Part C of the Guidance, namely, paragraph 52, which states:

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

220. The Tribunal acknowledged that no doctor should be allowed to resume unrestricted practise following a period of suspension unless the Tribunal considers that they are safe to do so. It also bore in mind that, in some cases, it may be evident that, following a short

suspension, there will be no value in a review hearing but that in most cases the Tribunal will need to be reassured that the doctor is fit to resume unrestricted practise.

221. The Tribunal decided that a review hearing was not necessary in this case given the low risk of repetition and the length of the suspension. The Tribunal was not persuaded that there was a need for Dr Collin to provide an update on XXX. It was also satisfied that Dr Collin's knowledge and skills were up to date, and that this would not be affected by a two-month period of suspension. It determined therefore that a review hearing would serve no purpose.

Summary

222. The Tribunal decided to suspend Dr Collin's registration from the medical register for a period of two months and did not direct a subsequent review. It was satisfied that a period of suspension was necessary to mark the seriousness of Dr Collin's misconduct by upholding the need to maintain public confidence in the profession and upholding proper professional standards and conduct. The Tribunal considered that a longer period of suspension would be disproportionate given the circumstances surrounding the occurrence of the misconduct, Dr Collin's insight and remediation, and the Tribunal's finding that it was unlikely that he would repeat his misconduct.

Determination on Immediate Order - 21/10/2026

223. Having determined that Dr Collin's registration should be suspended for a period of two months without a review, the Tribunal considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Collin's registration should be subject to an immediate order.

Submissions

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

224. Mr Brook submitted that the GMC did not believe it is appropriate to make an application for an immediate order and it did not do so.

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

225. Mr Brassington reminded the Tribunal this was a matter for its own judgement. He submitted that, according to the findings of the Tribunal in its determination on sanction, there is no risk to patient safety currently from Dr Collin, so no immediate order is required to protect against a risk to patients. He drew the Tribunal's attention to Part C paragraph 84 and submitted that the public interest was a '*two-way street*'.

226. Mr Brassington submitted that the public interest in this case and the declaration of standards is maintained by the sanction of suspension that the Tribunal has imposed. He submitted therefore that an immediate order is neither necessary nor desirable.

227. In relation to practising following a revocation of his interim order, Mr Brassington submitted that Dr Collin has no desire, until he has concluded the period of suspension, to return to prescribing control drugs without supervision. He will continue in his supervisory meetings with Dr N in any event, because he finds them useful. XXX.

The Tribunal's determination

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

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

> *'79 The MPT may impose an immediate order where it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. Where the MPT has imposed a sanction of conditions, it may impose an immediate order of conditions. Where the MPT has imposed a sanction of suspension or erasure, it may impose an immediate order of suspension.*
>
> *…*
>
> *84 It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:*
>
> *a. the doctor poses a risk to patient safety*
> *b. the risk to one or more parts of public protection is high, and/or*

c. immediate action is needed to maintain public confidence in the medical profession.'

230. Given its findings at the previous stages, the Tribunal considered that an immediate order is not necessary in this case. It determined that the substantive suspension met the necessity to uphold public confidence and professional standard and, in itself was sufficient.

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

232. The interim order currently in place on Dr Collin's registration is hereby revoked.

233. That concludes the case.

ANNEX A – 12/10/2026

Application for parts or entirety of the hearing to be in private

234. 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 Collin's alleged misconduct a redacted version will be published at the close of the hearing.

235. On Day 1 of the hearing, Mr Ian Brook, Counsel on behalf of the GMC, made an application pursuant to Rules 41XXX of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules) for parts of the hearing to be heard in private where confidential matters are discussed. He submitted that this was necessary due to the risk of jigsaw identification of the individuals considered within the case.

236. Mr Stephen Brassington, Counsel on behalf of Dr Collin, made an application, pursuant to Rules 41XXX of the Rules for the entirety of the hearing to be in private, albeit he was content to make a fresh application at each stage as necessary.

Submissions

237. Mr Brook submitted that the GMC was keen to prevent jigsaw identification of people who feature in the case quite significantly but were not witnesses. He highlighted that normally these individuals would be anonymised however as they were not witnesses, this would be difficult, despite their anonymisation within the Allegation. Mr Brook submitted it would be proper for any mention of these individuals to be heard in private.

238. Mr Brassington submitted that it was the Tribunal's discretion to hold the whole hearing in private. He highlighted that having any discussion relating to these individuals would require the Tribunal to sit in private. Mr Brassington submitted that it would be impossible to not identify the patients through jigsaw identification. He also submitted it would logistically be more appropriate in this case for the whole hearing to be heard in private.

The Tribunal's Decision

239. In considering this application, the Tribunal had regard to Rule 41 of the Rules. Rule 41XXX 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 Medial 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.*
>
> *XXX'*

240. The Tribunal has been invited to consider whether it ought to sit in private for parts of or the entirety of the hearing versus moving between public and private session dealing with the two separate issues.

241. Ordinarily, MPT hearings would sit in public for misconduct matters and move into private for the XXX issues. However, it has been submitted in this case that there is a link in the evidence for the misconduct matters to XXX. In addition, the Tribunal was aware that the XXX and personal details of individuals who were not witnesses in this case also needed to be considered.

242. It has been submitted that the practical difficulties of moving in and out of public session could interrupt the flow of evidence and increase the risk that personal information is disclosed before a decision to move into private session is made, and make the hearing more difficult to manage.

243. Under Rule 41(2) of the Fitness to Practise Rules, the 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.

244. The Tribunal further considered whether any other measures could be granted that would ensure the confidentiality of patients concerned. It decided that anonymity would not address the issues raised because of the high risk of jigsaw identification. No other special measures were appropriate.

245. The Tribunal was satisfied that, due to the personal relations involved in this case, the risk of individuals' health which may arise and the risk for jigsaw identification that it would be more practical for the first two stages of the hearing to be held entirely in private.

246. Having considered the submissions from both parties, the Tribunal considered that, on balance, the matters to be considered in this hearing should be heard in private for the first two stages of the hearing. It determined that, should the hearing proceed to sanction, it would hear another application at that stage for whether to proceed in private.

247. The Tribunal therefore determined to grant the application for the first two stages of the hearing to be entirely in private.

ANNEX B – 20/10/2026

Application for hearing to continue in private

248. 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 Collin's alleged misconduct a redacted version will be published at the close of the hearing.

249. On Day 6 of the hearing, Mr Brassington made an application pursuant to Rules 41XXX of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules) for the hearing to continue in private.

Submissions

250. Mr Brassington submitted that his application at this stage is stronger than it was previously. He referred the Tribunal to Annex A namely that in this case there is a link in the evidence for the misconduct matters to XXX and personal details of individuals who were not witnesses in the case also needed to be considered. He also referred to paragraphs 108 and 109 of the Tribunals Determination on impairment, where it found there was a link between XXX and misconduct.

251. Mr Brassington submitted that he was surprised by the GMC's stance on this matter and, as far as he could discern, there was no change in the position in relation to the jigsaw identification of the patients, who remain entitled to their confidentiality in relation to both

their medical conditions suffered and medication and treatment prescribed and taken, whether inappropriately or otherwise. Further, he submitted that XXX.

252. Mr Brook submitted that this stage of the hearing can be conducted publicly. He stated that he did not know what would emerge in Dr Collin's case however, XXX, and the hearing could move into private '*in the normal way*' when necessary. He submitted that there would be no matter relating to XXX and jigsaw identification within the GMC's submissions.

The Tribunal's Decision

253. In considering this application, the Tribunal had regard to Rule 41 of the Rules. Rule 41XXX 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 Medial 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.*
> *XXX'*

254. The Tribunal was mindful that hearings should be held in public where possible.

255. The Tribunal recognised that there is a link between XXX and the misconduct. It accepted therefore matters of XXX may arise during stage 3 however, decided that these matters could be dealt with XXX, without the entirety of the hearing being held in private.

256. The Tribunal considered Rule 41(2) and whether there were any particular circumstances of this case which would outweigh the public interest of holding the hearing in public. It took the view that confidential matters relating to the four patients had been rehearsed in some detail at stage 1 and stage 2 of the hearing. The Tribunal decided that any submissions from parties were unlikely to need to describe this detail again.

257. Therefore the Tribunal determined that the hearing should be held partly in private under Rule 41XXX.

258. The Tribunal heard from Mr Brook that he did not anticipate raising matters relating to the four patients in his submissions. Should Mr Brassington wish to raise any detailed issues relating to the patients at this stage, the Tribunal determined that he could address it accordingly.