PUBLIC RECORD

Dates: 05/06/2023 – 23/06/2023
30/06/2023

Medical Practitioner's name:	Dr Sekela MWAMBINGU
GMC reference number:	7014077
Primary medical qualification:	MB ChB 2008 The University of Warwick

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

Summary of outcome

Conditions, 12 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Miss Samantha Gray
Lay Tribunal Member:	Mr Inderjeet Gill
Medical Tribunal Member:	Dr Ann Smalldridge

Tribunal Clerk:	Ms Maria Khan - 05 June 2023, 08-23 June 2023 & 30 June 2023 Mr Andrew Ormsby - 06-07 June 2023

Attendance and Representation:

Medical Practitioner:	Present and not represented
Medical Practitioner's Representative:	N/A
GMC Representative:	Mr Thomas Coke-Smyth, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 19/06/2023

Background

1. Dr Mwambingu qualified in Medicine in 2008 from the University of Warwick. She qualified as a General Practitioner ('GP') in 2013 and started working as a GP at the Bromfield Medical Centre ('the Practice'), in Mold, Flintshire. The Practice had been opened in 1990 by [Mr T], who worked there as a GP. Shortly after Dr Mwambingu started at the Practice, [Mr T] had to step back due to ill-health and she was left as the sole practitioner. This case concerns allegations against Dr Mwambingu during her time as sole practitioner at the Practice between 2016 and 2020.

2. Concerns about Dr Mwambingu's practice were first raised and investigated by the Betsi Cadwaladr University Health Board ('the Board') in May 2019. The Board's direct involvement in the Practice began following it being told that Dr Mwambingu, the contract holder for the Practice, had a bankruptcy order made against her. The result was that a team from the Board was requested, by the Official Receiver, to take over management of the Practice to allow the Practice to continue to operate for the benefit of patients. The Board, and teams under its supervision, ran the Practice from 7th May 2019 pending the Practice's patients being redistributed elsewhere.

3. It was during this period that a number of issues were identified in relation to Dr Mwambingu's practice, and investigated. These form the basis of the allegation that has led to Dr Mwambingu's hearing and can be summarised as: inappropriate prescribing between July 2016 and February 2019; the use of pre-signed prescriptions between May 2017 and May 2019, allowing prescriptions to be used in Dr Mwambingu's absence by staff who were not authorised to do so; a large number of missed referrals and a lack of an appropriate system in place to follow up on patient concerns in respect of these; a lack of clinical records for a number of patients; and individual patients having been exposed to a risk of harm due to failure to refer them in the required time-frame.

4. The result of these concerns was that the Board commissioned a report addressing these matters which was written by Dr Bisola N, a practising GP and an Assistant Area Medical Director ('AAMD'). A referral was made to the GMC on 4 June 2019 by Dr Gareth Bowdler, the Area Medical Director of the Board.

5. From the 7th May 2019 Dr Mwambingu remained working under the supervision of Dr L and continued to see Practice patients at a neighbouring site. However, the Board took the decision to suspend Dr Mwambingu from its Medical Performers List on 4th June 2019. This allowed Dr Mwambingu to claim monies during her suspension. It was in this context that a further allegation was raised of making inappropriate claims for payment as a medical practitioner whilst suspended from the Medical Performers List.

Inappropriate Prescribing

6. A review of patient records by the Health Board included a search for any residents at the Practice address which found the names of Patients A, B, C and D, being relatives of Dr Mwambingu. It was then found that these patients had a number of prescriptions issued by Dr Mwambingu. The patients were not registered as permanent patients at the Practice, rather they were registered as *"immediately necessary treatment"*.

7. There was no documentation as to why the patients were seen in the Practice rather than by their usual GP. On several occasions there was no consultation or entry in the medical records, or any record of informing their usual GP of the prescriptions.

Prescription Forms

8. On taking over the Practice the Board team became aware of reports of staff at the Practice using prescription forms which had been pre-signed by Dr Mwambingu and that these were being used by the Practice Nurse to prescribe to patients. The Practice Nurse was not a qualified prescriber.

9. No pre-signed prescriptions were recovered during the investigation. However the Clinical Governance Team, being concerned by the allegations raised, undertook an analysis of the prescriptions issued during the time that Dr Mwambingu was on maternity leave and therefore unlikely to have been at the Practice.

Electronic Systems/Records

10. During the Board's initial management of the Practice, it experienced a number of patients phoning the Practice and chasing up referrals. This suggested to them that there was a larger problem with patient referrals and led the Board Clinical Governance Team to instruct one of its managers, Ms J, to undertake an initial review of medical records of patients who had consulted with Dr Mwambingu in the previous 12 months (up to 7 May 2019).

11. In carrying out this task Ms J used the Practice records system, EMIS, to first identify all appointments with Dr Mwambingu. She and her assistant then reviewed the record to see if there had been any plans for an onward referral recorded in the notes. They looked in the electronic records to see if a referral had been made. The initial review from May 2018 to May 2019 identified 326 missed referrals. In calculating these figures Ms J noted that some patients had more than one missed referral. If a referral had been completed, albeit delayed, this was not counted within the total number of missed referrals.

12. Following from this initial review a further exercise reviewing possible missed referrals between May 2017 and May 2018 was undertaken. This found a further 40 patients with missed referrals.

13. At the time of these reviews, although the Board had taken over management of the Practice, Dr Mwambingu was appointed as a locum at a neighbouring practice under the supervision of Dr L. The purpose of her appointment was to provide clinical cover and continuity for the Practice patients and to ensure that outstanding referrals could be actioned. During this period the Board observed that referrals allocated to Dr Mwambingu were not being completed.

14. In June 2019 Dr Mwambingu was suspended from the Medical Performers List. Ms J was then asked to carry out a further review of referrals not made by Dr Mwambingu in the period between the Board taking over the practice and her suspension. The purpose of this particular review was to cross-reference these against the previous review findings. This subsequent review found that for patients Dr Mwambingu had seen between 7th May 2019 and 5th June 2019, there were a total of 41 missed patient referrals. An additional review of missed referrals amongst transferred or deceased patients from May 2017 to May 2018 and May 2018 to May 2019 was carried out. This revealed a total of 19 and 12 missed referrals in those years respectively.

15. Therefore, in summary, in the period May 2017 to Dr Mwambingu's suspension from the Medical Performers List on 4th June 2019, the Board identified a total of over 400 missed patient referrals where there had been a written intention to refer in clinical records but no evidence of a subsequent referral.

16. The Board noted that patients were frequently calling the Practice to follow up on these. They were told by staff at the Practice that, initially, staff members used EMIS to document these calls in order to keep track of patient referrals and ensure that all staff knew where to look for information. However, staff told the Clinical Governance Team that they had been told by the Practice Nurse to stop using EMIS to document this and to use a written note in a shared message book.

17. Whilst reviewing EMIS in respect of patient referrals the Board team also identified that on 60 occasions the records showed that a patient had booked in and arrived at the Practice to see Dr Mwambingu, but there was no record of any consultation. In some cases

there had also been a referral logged from the appointment but nothing recorded by way of consultation notes.

Payment Claims

18. Following her suspension from the Medical Performers List on 6th June 2019, Dr Mwambingu was eligible to receive Suspension Payments from the Board. In order to receive these an application form was completed and submitted. Each application contained a declaration signed by the doctor confirming the details in the form, including a declaration of any other income received by the doctor.

19. Dr Mwambingu signed and submitted two applications following her suspension. These were dated 4th September 2019 and 4th October 2019 and both contained a declaration that she had not received any income whilst suspended or would receive any payment for work undertaken in the relevant period.

20. An investigation subsequently showed that during the relevant period, Dr Mwambingu had earned over £10,000 in locum income which had not been declared. This had been received between July and August 2019. It was also established that Dr Mwambingu had earned £170 from her private aesthetics business which was not declared. Dr Mwambingu was overpaid a total of £6,012.52 in respect of suspension payments.

21. The investigation undertaken by the Board showed that prior to the first declaration on 4th September 2019, Dr Mwambingu had carried out and invoiced for locum work undertaken throughout July and August 2019 at a number of different GP's surgeries. Payments for this work were received into the bank accounts of a company called Shida Limited and the accounts detail that in the period between 4th June and 4th September 2019 £10,675.00 was paid into this account. Companies House records show that Shida Limited was a company of which Dr Mwambingu was the sole director and had been since 4 September 2014. Bank account details for the company also show a number of payments to accounts associated with Dr Mwambingu.

Clinical Concerns

22. Within the missed referrals the Board identified a number of incidents which it considered to be a particular clinical concern due to the urgency of the referral required. These are reflected in paragraphs 14 to 18, each of which is alleged to represent a distinct and serious failing.

23. In the course of the Board investigation, Dr Mwambingu was invited to attend an interview on 29 November 2021 to address the matters raised but she emailed on that day to say that she could not attend due to ill health. An interview was rescheduled and she was invited to an interview on 6 December 2021 but no response was received from her and she did not attend.

The Outcome of Applications Made during the Facts Stage

24. On Day 1 of the hearing the Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that paragraph 19 of the Allegation be withdrawn. A further check of the clinical records for 17 May 2019 confirmed that rather than initially understood, it had not been Dr Mwambingu who saw Patient J that day but, in fact, somebody else at the Practice. Therefore, there was no failing on the part of Dr Mwambingu and there would be no injustice to her by withdrawing that paragraph. Dr Mwambingu did not object to the application. The Tribunal granted the application as it was satisfied that the proposed amendment would not result in injustice to either party.

25. Also on Day 1 of the hearing, the Tribunal granted Dr Mwambingu's application, made pursuant to Rule 34(1) of the Rules, to adduce two witness statements. One was Dr Mwambingu's own statement, the other was that of a witness of fact. Reasons for the Tribunal's decision are provided at Annex A.

26. On Day 5 of the hearing, the Tribunal granted the GMC's application, made pursuant to Rule 34(1) of the Rules, to introduce additional evidence. The evidence in question was a sample of Dr Mwambingu's signature that was used throughout the Board's relevant investigations. The GMC submitted it would demonstrate that it was distinct from the signature of [Mr T] who operated as a locum from time to time and thus it was unlikely that the investigators would confuse the same. Dr Mwambingu did not object to the application. Reasons for the Tribunal's decision are provided at Annex B.

The Allegation and the Doctor's Response

27. The Allegation made against Dr Mwambingu is as follows:

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

<u>Inappropriate Prescribing</u>

1. Between July and August 2016 you inappropriately issued the prescriptions set out in Schedule 1 to Patient A with whom you had a close personal relationship.
   Admitted and found proved

2. Between September 2017 and March 2019 you inappropriately issued the prescriptions set out in Schedule 1 to Patient B with whom you had a close personal relationship.
   Admitted and found proved

3. Between April 2018 and April 2019 you inappropriately issued the prescriptions set out in Schedule 1 to Patient C with whom you had a close personal relationship.
   Admitted and found proved

4. On 8 February 2019 you inappropriately issued the prescription set out in Schedule 1 to Patient D with whom you had a close personal relationship.
   Admitted and found proved

Prescription Forms

5. Between dates on and around 30 May 2017 to 7 May 2019 you pre-signed prescription forms allowing prescriptions to be issued in your absence by staff who were not authorised to issue prescriptions.
   To be determined

Electronic systems/records

6. On one or more occasion between May 2017 and 4 June 2019 you failed to ensure the timely referral of patients who were seen by you at the practice.
   Admitted and found proved

7. Between May 2017 and 4 June 2019 you failed to have an appropriate system in place to address patient concerns about missed and delayed referrals.
   Admitted and found proved

8. On one or more occasion between May 2018 and May 2019 you failed to generate a clinical record for a patient consultation.
   Admitted and found proved

Payment Claims

9. On 4 September 2019 you applied for payment as a medical practitioner suspended from the medical performers list and you:

   a. failed to provide details of any payments from alternative work;
      Admitted and found proved

   b. signed the declaration as set out in schedule 2.
      Admitted and found proved

10. On 4 October 2019 you applied for payment as a medical practitioner suspended from the medical performers list and you:

    a. failed to provide details of any payments from alternative work;
       Admitted and found proved

    b. signed the declaration as set out in schedule 2.
       Admitted and found proved

11. Between 4 June 2019 and 4 September 2019 you received payments:

    a. for locum work;
    Admitted and found proved

    b. from 'Shida Limited'.
    Admitted and found proved

12. You knew:

    a. you needed to declare the information referred to at paragraphs 9a and 10a;
    To be determined

    b. that you had received payments as at paragraphs 11a-b;
    To be determined

    c. that the declarations you signed at paragraphs 9b and 10b were false.
    To be determined

13. Your actions as at paragraphs 9a-b and 10a-b were dishonest by reason of paragraphs 12a-c.
    To be determined

<u>Clinical Concerns</u>

<u>Patient E</u>

14. Between 8 October 2018 and 30 November 2018 you consulted with Patient E and noted 'needs urgent referral back to gastroenterologists' following which you failed to make a referral under the 'two week wait' pathway for suspected malignancy.
    Admitted and found proved

<u>Patient F</u>

15. On 16 October 2018 you consulted with Patient F and you failed to make an urgent referral under the 'two week wait' pathway for suspected malignancy.
    To be determined

<u>Patient G</u>

16. On 26 October 2018 and/or 23 April 2019 you consulted with Patient G and you failed to refer Patient G to a:

a. chest pain service;
Admitted and found proved

b. cardiology service.
Admitted and found proved

Patient H

17. On 12 April 2019 you consulted with Patient H and recorded that they had a 'change in bowel habit' and were 'for fast track referral to colorectal team' and you failed to refer Patient H to gastroenterology within one working day.
Admitted and found proved

Patient I

18. On 3 May 2019 you consulted with Patient I and noted that she should be referred to dermatology and you failed to refer Patient I immediately on the 'two week wait' pathway for suspected malignancy.
Admitted and found proved

~~Patient J~~

19. ~~On 17 May 2019 you consulted with Patient J and you failed to make a referral under the 'two week wait' pathway for suspected malignancy.~~
Withdrawn

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

The Admitted Facts

28. At the outset of these proceedings, Dr Mwambingu made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

29. In light of Dr Mwambingu's response to the Allegation made against her, the Tribunal is required to determine whether Dr Mwambingu:

- pre-signed prescription forms between 30 May 2017 and 7 May 2019, allowing prescriptions to be issued in her absence by staff not authorised to do so;
- knew that she needed to provide details of any payments from alternative work on application forms for payment as a medical practitioner suspended from the medical

performers list, submitted on 2 September 2019 and 4 October 2019, and knew that the declarations she signed on both forms were false;

- knew that she had received payments for locum work and from 'Shida Limited' between 4 June 2019 and 4 September 2019;
- had acted dishonestly by not providing details of any payments from alternative work and signing declarations attesting to the veracity of information provided in the application forms;
- failed to make an urgent referral under the 'two week wait' pathway for suspected malignancy, for Patient F, after a consultation on 16 October 2018.

Witness Evidence

30. The Tribunal received evidence on behalf of the GMC from the following witnesses:

- Ms J, Clinical Governance Manager for the Board at the time of the events. Ms J provided a witness statement dated 3 January 2023 and gave oral evidence via video link; and
- Ms K, Practice Manager of the Practice from August 2017 – May 2019. Ms K provided a witness statement dated 2 June 2021 and gave oral evidence via video link.

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

- Dr L, GP, AAMD at the Board, and Cluster Lead until January 2019, who provided a statement dated 31 March 2021;
- Ms M, Clinical Governance Officer at the Board since 2010, who provided a statement dated 28 October 2022;
- Dr N, GP, AAMD for the Board since December 2017, and Primary Care Cluster Lead for the Board since 2016, who provided a statement date 31 October 2022; and
- Ms O, Deputy Head of NHS Counter Fraud Service Wales since 2017, who provided a statement dated 25 October 2022 and a supplemental statement dated 14 December 2022.

32. Dr Mwambingu provided her own witness statement dated 5 June 2023 and also gave oral evidence at the hearing. In addition, the Tribunal received evidence from the following witnesses on Dr Mwambingu's behalf:

- Ms P, retired Registered Nurse, Registered Osteopath, and Licenced Acupuncturist. Ms P worked at the Practice from 1990-2017 as a private Nurse and Osteopath. Ms P provided a witness statement dated 7 June 2023 and gave oral evidence via video link.

Expert Witness Evidence

33. The Tribunal received evidence from an expert witness, Dr Q, on behalf of the GMC. Dr Q is a practising GP with 23 years of experience, and is clinical governance lead for his practice. He has acted as an expert witness since 1998. Dr Q's reports assisted the Tribunal in understanding how Dr Mwambingu's alleged conduct compares with the standards expected of a reasonably competent GP. Dr Q also gave oral evidence at the hearing. The Tribunal had regard to the following reports produced by Dr Q:

- Expert report dated 27 February 2020;
- Supplemental reports dated 9 July 2021, 19 December 2022 and 1 May 2023.

Documentary Evidence

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

- Medical records of Patients A, B, C, D, E, F, G, H and I;
- Ms K's statement to the Board, dated 30 November 2020;
- Clinical Governance Report produced by Ms J, detailing initial findings of the Board investigations;
- Missed referrals spreadsheet covering May 2018 to May 2019;
- Missed referrals spreadsheet covering May 2019 to May 2020;
- Initial spreadsheet identifying where the Practice Nurse may have issued prescriptions;
- Spreadsheet identifying prescriptions signed by Dr Mwambingu during May, June and July 2017, while on maternity leave;
- Documents submitted by Dr Mwambingu at Interim Orders Tribunals (IOT) that were held on 26 June 2019, 21 August 2019 and 12 February 2020;
- Bundle of testimonials submitted to IOT;
- Dr Mwambingu's Rule 7 response, dated 27 May 2022;
- Practice Nurse's statement to the Board, dated 4 February 2021;
- Dr Mwambingu's signature sample.

Closing Submissions

On behalf of the GMC

35. On behalf of the GMC, Mr Thomas Coke-Smyth, Counsel, submitted that determining the matters of prescribing and inappropriate claiming depended on weighing up the evidence of the GMC against the credibility of Dr Mwambingu's evidence. Mr Coke-Smyth told the Tribunal there were good reasons to be sceptical of Dr Mwambingu's explanations, and to accept the GMC evidence on balance. Paragraph 15 of the Allegation was distinct in that it was a clinical failing and was more straightforward; the GMC's case was that what the Tribunal could see in the notes was what happened.

36. Mr Coke-Smyth submitted that the use of pre-signed prescriptions was a practice that had occurred not infrequently and did not require resolution of every single prescription on the spreadsheet. However, the GMC relied on the spreadsheet as it corroborated Ms K's evidence even though the Tribunal could find this allegation proved on Ms K's evidence alone.

37. Mr Coke-Smyth submitted there was no good reason why Ms K would be either mistaken or make up evidence in relation the prescriptions. It was a serious matter and Ms K had told the Board about it during its investigation, confirming and standing by her evidence in front of the Tribunal. Mr Coke-Smyth suggested that Ms K had not raised the matter with Dr Mwambingu as Dr Mwambingu was the Practice Principal at the centre of the wrongdoing and may not have challenged her.

38. In respect of Ms K's reliability, Mr Coke-Smyth reminded the Tribunal of the detail of her evidence. Mr Coke-Smyth then addressed Dr Mwambingu's suggestion that Ms K's evidence was not reliable as she had referred to a *'pad'* of prescriptions in her witness statement, then used the word *'batch'* in oral evidence. Mr Coke-Smyth drew the Tribunal's attention to Ms K's first statement to the Board in which she described there being a batch of pre-signed prescriptions. In her oral evidence, Ms K had explained clearly that it was not a prescription pad, but a *"stack"* of signed prescriptions.

39. Mr Coke-Smyth submitted this was consistent with the evidence on the spreadsheet, which showed prescriptions being entered by the Practice Nurse or a member of the Practice staff, and being printed, and somehow they ended up with Dr Mwambingu's signature on them. This fitted with the *"batch"* description, given by Ms K, and also the way the prescriptions would have to be printed. The content could be filled in electronically but the prescriptions would still need to be signed. This would explain why there were signatures already on those prescriptions and the Practice Nurse would simply add the details before printing.

40. Mr Coke-Smyth submitted there was no evidence that Ms K was lying. She had answered questions from the Board during its investigation, there was no obvious motivation for her to make this up, and no suggestion of her lying. No motive to lie had been explored when she was cross-examined. Ms K's evidence was consistent with the evidence on the spreadsheet, which showed there were times Dr Mwambingu was highly unlikely to be present to sign a prescription, let alone be available.

41. Mr Coke-Smyth drew the Tribunal's attention to occasions during Dr Mwambingu's maternity leave, and very close to her giving birth, when prescriptions signed by Dr Mwambingu had been issued. On these occasions there were no medical records entered by Dr Mwambingu or indeed any record of any other staff member suggesting they had consulted with her. Mr Coke-Smyth also set out that in one instance, Diazepam, a controlled drug, had been prescribed without any record of an assessment or discussion with the patient, a diagnosis, or anything that would indicate that Dr Mwambingu was in any way involved in that patient's care.

42. Mr Coke-Smyth reminded the Tribunal of another instance where prescriptions by Dr Mwambingu had been issued the day after she had given birth by caesarean section. He submitted that it was inherently improbable that Dr Mwambingu would have been at the Practice or available to sign prescriptions in the 24 hours after the birth. On this day, there had been two locums at the Practice and this raised the point of why the Practice Nurse would be going to Dr Mwambingu to sign the prescriptions rather than one of the two locums.

43. Mr Coke-Smyth submitted that the key evidence in this case was the report showing that no EMIS logins had been made or attempted by Dr Mwambingu between 26 June 2017 and January 2018. He stated that this was significant because if Dr Mwambingu had been involved in the issuing of these prescriptions, whether from home, the flat, or the surgery, she would have had to log in to the system to check a patient's current status, particularly if she was to assess a patient and prescribe a medication such as Diazepam.

44. Mr Coke-Smyth submitted that all of this evidence painted a compelling and coherent picture which was consistent with Ms K's evidence that there was a batch of pre-signed prescriptions. Mr Coke-Smyth suggested, by contrast, that Dr Mwambingu's evidence was not credible or reliable in the same way. The absence of any clinical records at all from Dr Mwambingu in this period was significant.

45. Mr Coke-Smyth submitted that Ms P's evidence in this matter could not be relied upon. She was not an impartial witness of fact and had been inconsistent during cross-examination about the dates she ceased working at the Practice. The important point was that just because Ms P had not seen something happen did not mean that it did not happen. Mr Coke-Smyth further submitted that, based on her evidence in cross-examination, Ms P was not at the Practice during the relevant period dealing with prescriptions.

46. In respect of the allegations relating to payment claims, Mr Coke-Smyth submitted that key allegation here was the knowledge Dr Mwambingu had in relation in respect of what she was required to declare about her alternative work. He directed the Tribunal to the specific wording of the forms that required declaration of any payments received from alternative work. Mr Coke-Smyth submitted that Dr Mwambingu's explanation that she had been confused because these payments were made to her limited company did not stand up to scrutiny. Dr Mwambingu was the only Director of the company and the only beneficiary of the money at the time in question. It could be seen from the evidence of the company's bank account that income was received relating to the locum work undertaken by Dr Mwambingu and thereafter, payments were made to Dr Mwambingu's sole and joint bank accounts.

47. Mr Coke-Smyth submitted that the idea that Dr Mwambingu would have been confused about or misunderstood what constituted declarable income, was not credible. He stated that when many thousands of pounds had been paid into a company account of which she had control and then payments authorised by her had been made to her personal accounts it was difficult to conceive that she would not understand this to be her income. At

all times, it was Dr Mwambingu who benefited from the payments received. He further submitted that it would have been abundantly obvious that receiving thousands of pounds in payment as a locum would affect any entitlement to be paid the suspension benefit payment.

48. Mr Coke-Smyth submitted that it was not unusual or difficult for an individual to understand that if they were billing through a company, that was still money that they had earned and were entitled to. Mr Coke-Smyth further submitted that if it was not Dr Mwambingu who was entitled to that money, then who was?

49. Mr Coke-Smyth told the Tribunal that he would not go on to deal with the dishonesty allegation because, in his submission, if the Tribunal found the particulars of paragraph 12 proved, it was simply an objective test for the Tribunal to apply.

50. In relation to paragraph 15 of the Allegation, Mr Coke-Smyth submitted that the only matter in issue here was the failure to make an urgent referral under the two week wait pathway for suspected malignancy. Dr Mwambingu had initially noted that a referral should be made. However, no subsequent referral was carried out and this point was not in dispute. However, Dr Mwambingu’s evidence was now that she had reviewed the patient and made a decision not to refer and it was unfortunate that there were no notes of her rationale or further consultations with the patient in this regard. Accordingly, the issue was whether Dr Mwambingu's actions were reasonable in the circumstances at the time.

51. Mr Coke-Smyth submitted that the Tribunal would need to consider carefully what would have been reasonable for a qualified and reasonably competent GP in Dr Mwambingu’s position. In this respect the Tribunal would be assisted by Dr Q’s evidence who, even though instructed by the GMC, was subject to an independent expert declaration and not a witness of fact. His evidence would assist the Tribunal by applying the standards of the profession objectively.

52. Mr Coke-Smyth submitted that it was a matter for the Tribunal whether it accepted Dr Q’s evidence. However, there would have to be good reason to disregard Dr Q’s assessment and prefer Dr Mwambingu’s explanation. The Tribunal may accept Dr Mwambingu’s explanation but whether or not it was reasonable was a matter for the Tribunal to judge, applying the proper standards of which Dr Mwambingu could not be an arbiter.

53. Mr Coke-Smyth told the Tribunal that this was a situation where Dr Mwambingu had initially done exactly what Dr Q said she should have done. Dr Mwambingu’s intention to refer was consistent with the report and the need to exclude malignancy within the differential diagnosis. Dr Mwambingu’s evidence was that having undertaken further reading after seeing the patient, she considered it unlikely that malignancy was the cause of the abnormalities identified on the scan, decided to screen for myeloma at the Practice and that a referral was no longer required. However, there were no records to corroborate this rationale or action. Mr Coke-Smyth suggested that the absence of such evidence rendered Dr Mwambingu's evidence in this regard unreliable.

54. Mr Coke-Smyth submitted that for these reasons the Tribunal could properly accept Dr Q's evidence and on that basis alone, the failures were made out. Additionally, Mr Coke-Smyth suggested that the explanation provided to the Tribunal by Dr Mwambingu was not what was going through her head at the time because if it was, it would be in the notes.

Dr Mwambingu

55. Representing herself, Dr Mwambingu submitted that large sections of the evidence presented by the GMC had been redacted and, in her opinion, this was because a lot of it was hearsay. She suggested that much of the information sent to the GMC was not relevant and this begged the question whether other information that had been submitted was relevant and accurate. Dr Mwambingu stated that evidence provided by the GMC was not consistent or accurate and stated that Ms J had said, in her witness statement, that she had not worked directly with Dr Mwambingu previously. However, when cross-examined by Dr Mwambingu, Ms J confirmed this was not correct and that they had worked together previously in 2014.

56. Dr Mwambingu submitted that the evidence presented to the Board by Ms J had been compiled by non-clinicians. Dr Mwambingu suggested that only a clinician would be able to properly understand the data being reviewed and questioned the validity of the evidence presented. Further Dr Mwambingu suggested that in relation to the EMIS searches it required someone with adequate up-to-date clinical knowledge to be able to assess referrals and determine whether a referral could be done by another method. Dr Mwambingu drew the Tribunal's attention to Ms J's evidence that no search had been done against hard copies of patient records in order to ascertain whether referrals had been made in paper format.

57. Dr Mwambingu drew the Tribunal's attention to inconsistencies in Ms J's evidence. Ms J had stated in her witness statement that she visited the surgery on numerous occasions regarding complaints. However, under cross-examination Ms J told the Tribunal she had not dealt with any complaints against Dr Mwambingu. There were also other matters relating to the Board team findings that Ms J was unable to explain.

58. Dr Mwambingu submitted that Ms K was a Practice Manager, not a clinician, and that she gave conflicting evidence regarding the pre-signed prescriptions. In her statements Ms K referred to a *"pad",* but had also called this a *"stack".* Ms K had given two different recollections of where she had seen the prescriptions; once she mentioned in the office and the other, the nurse's room. Dr Mwambingu submitted that as Practice Manager, Ms K had a responsibility for clinical governance as this was part of her contract. Dr Mwambingu accepted that Ms K may have not felt comfortable approaching her about the matter. However, Ms K had plenty of opportunities to raise the matter confidentially with the Board, which she chose not to do. Instead, the matter was only raised after some time had passed, during a meeting arranged by Ms J with old members of staff on 10 July 2019.

59. Dr Mwambingu submitted that Ms K's non-reporting of her alleged observation of pre-signed prescriptions brought her integrity into question.

60. Dr Mwambingu reminded the Tribunal of her evidence in relation to the running of the surgery during her maternity leave. She stated that she was running the Practice single-handedly, and as this was her business she had continued to oversee the Practice when needed, including providing clinical advice. She also stated that when required, usually when no locum was available, prescriptions were brought out of the surgery to her home, or to the flat above the surgery, to be signed.

61. Dr Mwambingu submitted that on the day that there were two locums in the surgery, 18 July 2017, it was possible that the Practice could not afford to pay the locums to stay the whole day. The two prescriptions in question were issued at 17:41 and 17:44 hours, close to surgery closing time, and it was likely that the prescriptions were taken and signed by herself, to be picked up the next morning. This had happened before and although not ideal, this was how the surgery worked and there had been no complaints.

62. Dr Mwambingu told the Tribunal that she accepted that conversations were not documented and that there were no records of discussions, which was a grave error. However, this did not mean she was not still clinically supervising the Practice. Dr Mwambingu was someone who carried on in any situation. The Practice Nurse would visit her every day while she was on maternity leave and often the visit involved discussing a patient and signing a prescription. Dr Mwambingu stated that having a caesarean section had not disabled her from clinical practice and while there was no traceability, this was not succinct evidence that she was absent in providing clinical advice.

63. Dr Mwambingu submitted that evidence of the support for the surgery could be seen in her testimonial bundle, which spanned over 20 pages and contained testimonials from clinicians, non-clinicians and former patients.

64. Referring to the payment claims, Dr Mwambingu submitted that she did not initially have any additional work when first informed of the suspension payments. When she took on the additional work she was advised to do so through her limited company. She accepted responsibility for not putting all the information on the application forms however this was with no intent and she had not known how she was supposed to declare the income if it came through a limited company and believed that she only needed to declare income she had received directly.

65. Dr Mwambingu told the Tribunal that despite the Board having said it thought her behaviour was fraudulent, it had not taken matters further. Dr Mwambingu believed this was because the Board owed her a substantial amount of money, which contributed to her debt. The Board was not always timely with payments and this had contributed to the financial demise of the surgery. On closure of the Practice in May 2019, the Board used the Practice premises to run its investigation and stayed until 31 July 2019. No reimbursement was made to Dr Mwambingu for utility bills or any other running costs, and this further contributed to Dr Mwambingu's debts.

66. In respect of Patient F and a failure to make an urgent referral, Dr Mwambingu submitted that she had documented in the patient notes that her initial plan was to do a fast track referral to the spinal surgeons but unfortunately she did not at that time. Her record keeping was poor; she acknowledged this and had remedied this over the last four years. Dr Mwambingu told the Tribunal that after further clinical assessment and discussion with a colleague she decided to go with the National Institute for Health and Care Excellence ('NICE') guidelines relating to assessment of suspected multiple myeloma for people aged 60 and over.

67. Dr Mwambingu submitted that she found it discriminatory and insulting to suggest that as a mother she would not be able to continue running her business with having young babies. She had no choice but to carry on.

68. Dr Mwambingu submitted that it has been four years since the investigation started and the allegations were no longer appropriate in the current context of her being a part-time salaried GP in a surgery, under supervision. Dr Mwambingu told the Tribunal that she has received good reports in respect of this work and also from her two-year employment at a previous surgery. Dr Mwambingu submitted that a report of NHS England had attested to her remediation in relation to her clinical practice and record keeping.

69. Dr Mwambingu submitted she was no longer responsible for the running of a business, HR management of staff, or registration of patients. While she was currently not undertaking any locum work, should this change in the future she would seek guidance with regards to how to deal with any patients.

70. Dr Mwambingu submitted that had she been a risk to the public, as maintained by the GMC, she would not have been allowed to work without direct supervision for the last four years. She asked the Tribunal to consider all the evidence before it and submitted she wished to carry on working as a GP. Dr Mwambingu felt very supported and continued to want to improve on her clinical knowledge and care.

The Tribunal's Approach

71. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Mwambingu does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied.

72. In considering the evidence before it the Tribunal should have regard to the whole of the evidence and form its own judgement about the witnesses, and which evidence is reliable and which is not. Dr Mwambingu has given evidence in this matter and the Tribunal must judge her evidence by precisely the same fair standards as it applies to any other evidence in

the case. It is for the Tribunal to decide what weight it attaches to evidence before it. The fact that a doctor has denied a number of the allegations cannot be a factor to be held against them when assessing their evidence. The role of the Tribunal is to determine if the denial is supported or undermined by the evidence.

73. The High Court decisions of *Dutta v GMC* [2020] EWHC 1974 (Admin) and *Khan v GMC* [2021] EWHC 374 (Admin) make it clear that assessing the credibility of a witness should not be based exclusively on a witnesses' demeanour but their veracity should be tested by reference to objective facts proved independently in their evidence, in particular by reference to the documents in the case. The Tribunal should make a rounded assessment of a witness's reliability and consider all of the evidence before it before coming to a conclusion about a witness's credibility. This could include conflicts in evidence with another witness, denials of the allegations and reasons why they could not be true. The Legally Qualified Chair ('LQC') reminded the Tribunal that in the case of *Khan* it was also said that it is open to tribunals not to rule out the whole of a witness's evidence based on credibility; credibility can be divisible.

74. The LQC advised the Tribunal that it should consider how the passage of time may have affected a witness's memory. Memories can fade with the passage of time, and recollections may change, or may become confused, as to what did or did not happen at a particular time. An honest witness can be mistaken, and a mistaken witness is not necessarily wrong about every fact. The Tribunal should make due allowance for the way in which the passage of time may have affected the recollections of any of the witnesses, including Dr Mwambingu.

75. In this matter there is an allegation of dishonesty. When considering matters of dishonesty, the Tribunal should take into account the principles set out in *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords Club)* [2017] UKSC 67. The Tribunal must first ascertain, subjectively, the actual state of Dr Mwambingu's knowledge or belief as to the facts and should then decide whether her conduct was honest or dishonest by applying the objective standards of ordinary decent people. There is no requirement that the individual must appreciate that what they have done was, by those standards, dishonest.

76. The Tribunal reminded itself that it must reach its decision on the facts only on the evidence before it. While the Tribunal is entitled to draw inferences from the evidence it has heard, it should not speculate on what other evidence there might have been. It should only draw an inference if it can safely exclude other possibilities.

77. The Tribunal has before it a number of character references provided on behalf of Dr Mwambingu. It should consider these and attach such weight to them as it considers appropriate. It is not evidence that goes directly to the Allegation though it is a matter to be put into the balance when the Tribunal is evaluating all of the evidence in the case.

78. The Tribunal should give reasons for its decisions and findings. These reasons do not need to be lengthy or complex, and do not need to summarise all the evidence and submissions. The Tribunal is not required to decide every point which has been raised during

the hearing; only such matters as will enable it to say whether the matters alleged against Dr Mwambingu have been proved.

The Tribunal's Analysis of the Evidence and Findings

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

Prescription Forms

Paragraph 5

80. When determining paragraph 5 of the Allegation the Tribunal first discounted the submission that Ms K's evidence could not be relied upon as she had used the words *"pad"* and *"stack"* when referring to the prescriptions, and that her description of the flat was incorrect. Ms K had, in questions from the Tribunal, clarified that the documents to which she was referring to were a stack of prescription forms that were pre-signed and were the type to be fed through a printer where the prescription would electronically be added. Further, the description of the flat to the surgery was a matter of semantics, both Ms K and Dr Mwambingu agreed that there was a living room, kitchen and two other rooms. Ms K had described the two other rooms and a bedroom and an office, whereas Dr Mwambingu described both additional rooms as bedrooms.

81. The Tribunal considered Ms K to be an honest and credible witness. Her evidence was clear and she took time to recollect events as best she could, stating when she could not recall something specifically. The Tribunal noted that Ms K made the initial statement in August 2019 and her evidence was consistent throughout. The Tribunal took into account that Ms K was clear on what she had seen, namely pre-signed prescription forms, and was able to describe to the Tribunal the format of these documents. The Tribunal could find no reason as to why Ms K would fabricate this detail. It acknowledged Dr Mwambingu's argument that Ms K could have reported the matter to her or the Board. However, the Tribunal noted that ultimately the clinical governance of the Practice sat with the contract holder, Dr Mwambingu.

82. The Tribunal also considered Ms J to be an honest and reliable witness. She was able to explain to the Tribunal the rationale and methodology applied throughout the Board's investigation. She was also clear that any recollections were that of her own experiences and confirmed that she was not able to comment outside of her direct knowledge of the investigations. In respect of the discrepancy identified by Dr Mwambingu in Ms J's evidence in relation to having previously worked with Dr Mwambingu, the Tribunal were satisfied with Ms J's explanation in this regard in that she had not previously directly worked with Dr Mwambingu but had been an assistant to the individual who worked directly with the Doctor during a 2014 coroners inquiry.

83. The Tribunal next examined the account of Dr Mwambingu. It accepted that it was plausible that she had been working during her maternity leave both from home and the flat above the surgery, and would make herself available when required. Further, the Tribunal considered that it was conceivable that the Practice Nurse would visit her at home, whilst on maternity leave, to discuss clinical matters and, on occasion ask Dr Mwambingu to sign prescriptions. The Tribunal balanced this with the fact that between 26 June 2017 and January 2018 Dr Mwambingu had not appeared to log in to EMIS to check patient records when signing prescriptions. Dr Mwambingu had confirmed during her evidence that she did have access to EMIS at her home address via a laptop. The login evidence contained in Dr N's undisputed evidence showed no logins or attempted and failed logins during this period. The Tribunal noted Dr Mwambingu's evidence that sometimes there were issues logging into EMIS on her laptop but were mindful that her evidence suggested that many of those problems related to EMIS *"bolt-ons"* which allowed referrals to be made, but on occasion she may have been given temporary log-in details. In spite of this the Tribunal considered it more likely than not that had Dr Mwambingu logged into EMIS between 26 June 2017 and January 2018, she would have on at least one occasion used her own login details. The evidence suggested that it was more likely than not that Dr Mwambingu had not logged into EMIS at all between 26 June 2017 and January 2018 whilst on maternity leave.

84. The Tribunal considered that the two prescriptions issued with Dr Mwambingu's signature on 18 July 2017 were of particular concern. The Tribunal noted that 18th July 2017 was the day after Dr Mwambingu had given birth to twins by a planned caesarean section. Whilst the Tribunal acknowledged that giving birth would certainly not render Dr Mwambingu incapable of considering clinical matters, it considered it unlikely that practice staff would take prescriptions to her home for her signature the day she left hospital following surgery with two new-born babies. The Tribunal was particularly mindful that there were two other locums present at the practice on this particular day and Dr Mwambingu had stated in her evidence that these locums were competent in administrative matters and very obliging. The Tribunal considered why, under these circumstances, the Practice Nurse would need to visit Dr Mwambingu to sign prescriptions when she could have asked one of the locums to do so.

85. The Tribunal were also cognisant that in the relevant period there was no note of any practitioner, or indeed other staff member, consulting or discussing any patients or prescription requirements with Dr Mwambingu. The Tribunal noted that some 30 prescriptions were deemed to be signed by Dr Mwambingu but no notes of any of these prescriptions, or any consultation relating to the patient being prescribed, were made by any party. The Tribunal noted that Dr Mwambingu's explanation for this was that she was poor at record keeping and realised this was a failure on her part. However, it also noted that there was no note made by the Practice Nurse or indeed any other staff member, that a discussion had been held with Dr Mwambingu, or indeed any other authorised prescriber regarding these particular patients and/or prescriptions. The Tribunal considered that it was more likely than not that notes were not made on these 30 occasions because no such conversations were had with Dr Mwambingu when the prescription was issued. The Tribunal further

determined that Dr Mwambingu did not log in to the EMIS system to check a patient's status because she was not made aware of the medicines being issued at the relevant time as they were issued on pre-signed prescription forms.

86. The Tribunal acknowledged the GMC stance that it did not have to prove all the prescriptions were issued in this way and that one was bad enough. In making its decision on the facts, the Tribunal took into account that there had been no attempts made by Dr Mwambingu to log in to EMIS on any of the occasions a prescription had been issued, and the lack of documentation relating to any discussions, assessments or diagnoses about the patients. The Tribunal determined that on the balance of probabilities, between dates on and around 30 May 2017 to 7 May 2019 Dr Mwambingu pre-signed prescription forms allowing prescriptions to be issued in her absence by staff who were not authorised to issue prescriptions.

87. Accordingly, the Tribunal found paragraph 5 of the Allegation proved.

Paragraph 12

88. When determining paragraph 12 of the Allegation, the Tribunal first considered the wording on the application form *'APPLICATION FOR PAYMENTS TO MEDICAL PRACTITIONERS SUSPENDED FROM MEDICAL PERFORMERS LISTS'.* The Tribunal had particular regard to the question asked in the form:

> *'PLEASE GIVE THE FOLLOWING INFORMATION: -*
>
> - *Details of any payments that have been received or will be received from alternative work taken on following the date of your suspension'*

89. The Tribunal was satisfied that the wording was clear in the information required and that it did not specify a category of work, or the recipient of any payment, just that any payments from any type of work needed to be documented.

90. The Tribunal then went on to examine the account of Dr Mwambingu. Dr Mwambingu told the Tribunal that it was not clear to her that she had to declare her locum income as payment if the payment was going into Shida Ltd, the company she was sole director of, and completed the form as she thought she had to. She had assumed that as the income was not being paid directly to her, it did not count as income.

91. Dr Mwambingu clarified to the Tribunal under cross-examination that at that time of her filling in the forms she had an accountant but did not seek advice from them on whether she needed to declare her income as a locum on the forms. She also confirmed that she had not attempted to seek clarity from the Board on this matter. Instead, Dr Mwambingu asked [Mr R] what she should do, and he advised her that as the payments were going through the limited company, she did not need to declare them. Dr Mwambingu also told the Tribunal

that at the time she had filled out both forms she was under a great deal of stress, leading to her filling out the forms in a rush.

92. Dr Mwambingu acknowledged in oral evidence that the request for additional information on the form was very clear and that she should have been more diligent.

93. The Tribunal took into consideration that the only payments going into the limited company account, Shida Ltd, during that time were the incomes from the locum work, and the majority of payments, and particularly those of any substantial amount, going out were into Dr Mwambingu's sole and joint bank accounts. The Tribunal had regard to Dr Mwambingu's evidence that the money was being drawn by her and she accepted she was receiving money from the company account.

94. The Tribunal acknowledged Dr Mwambingu's evidence that she had not sought advice from at least two cogent sources, on whether she should declare the income and that she recognised now that she should have. However, the Tribunal noted that Dr Mwambingu had had a further opportunity to check when she filled in the second form.

95. The Tribunal concluded that Dr Mwambingu's evidence that she asked [Mr R] for advice was not a plausible explanation for someone who was a director of a limited company. The wording on the form was simple and related to *"any payments"* and not "income". Dr Mwambingu would have known what she needed to declare.

96. The Tribunal discounted Dr Mwambingu's evidence that, as the locum payments were not going directly to her, she believed it would not be classed as her income and her accountant would advise her as to how it was to be treated. She knew she was receiving payments from alternative NHS work and that the payments into the limited company were her only earnings at that time. The Tribunal concluded that Dr Mwambingu knew that the money was coming into the account, she knew it was payment received from alternative work, and that she was drawing money from the company account into her personal accounts. The Tribunal determined that Dr Mwambingu knew that the declarations she signed on the forms were false.

97. Accordingly, the Tribunal found paragraph 12 of the Allegation proved in its entirety.

Paragraph 13

98. In considering the findings set out in relation to paragraph 12, set out above, the Tribunal applied the test as set out in *Ivey.* In particular, the Tribunal considered that as it had determined that Dr Mwambingu must have known she was required to declare the payments she received for her locum work, she had received such payments and she knew that the declarations were false, any person looking objectively at the facts would consider her actions to be dishonest.

99. Accordingly, the Tribunal found paragraph 13 of the Allegation proved.

Paragraph 15

100. When determining paragraph 15, the Tribunal had regard to Dr Mwambingu's evidence and the evidence of the expert witness, Dr Q.

101. The Tribunal accepted the opinion of Dr Q in this regard, in particular, that having received a report from the radiologist suggesting further investigation, it would be appropriate for a GP to refer the patient for an urgent (two week wait pathway) specialist opinion. It further noted that Dr Q had confirmed that that Dr Mwambingu's initial action to make such referral, as identified in the patient notes, was the appropriate action and she had recorded this in the patient's notes.

102. However, the Tribunal noted that following the initial consultation with Patient F on 16 October 2018 when a note that a referral to a spinal surgeon was going to be made, there was no further entry by Dr Mwambingu in the notes. Dr Mwambingu stated in evidence that the reason the referral was not made was that she had reflected on the patient's status after the appointment and changed her rationale for treatment.

103. The Tribunal did not accept Dr Mwambingu's explanation as to the reasons she did not ultimately refer Patient F as set out in the medical notes. In particular the Tribunal noted that, if Dr Mwambingu's evidence was to be accepted there were five distinct actions and/or inactions which would have prompted an entry in the Patient F's records.

104. First, The Tribunal noted that it was Dr Mwambingu's evidence that after the consultation she considered the report and undertook some reading of medical reports relating to the results received. Second, she discussed the matter with a colleague. Third, she referred to the NICE guidelines and decided to test for myeloma with an in-house blood test. Fourth, she told the Tribunal that she would have called Patient F to arrange a blood test and explain her change in rationale; and fifth Dr Mwambingu told the Tribunal that Patient F failed to turn up for the blood tests on three separate occasions. The Tribunal was of the view that overriding a decision to refer would have required thorough notes as to the reasons why. The Tribunal considered it especially inconceivable that a conversation with a patient about such a potential serious condition would not be recorded. It also considered that if the blood test was necessary, Dr Mwambingu had made no notes on whether, after three occasions of Patient F not attending for a blood test, there was any follow-up.

105. The Tribunal also acknowledged Dr Mwambingu's evidence that she followed the NICE guidelines and had ruled out myeloma. On questioning, Dr Mwambingu stated that she ruled out potential metastases as she thought that Patient F's smoking, and other history, could explain the MRI findings and that Patient F had not previously had cancer. The Tribunal had regard to Dr Q's evidence that metastases could be present without knowledge of a primary cancer and no GP could discount this without the relevant tests. A blood test would not exclude the possibility of bony metastases.

106. The Tribunal did not accept Dr Mwambingu's explanation that she was poor at record keeping and realised it was a failure on her part. Dr Mwambingu had had multiple opportunities to make notes yet had not done so.

107. The Tribunal was cognisant that it appeared to it that on each occasion throughout these proceedings when Dr Mwambingu proffered an alternative version of events there appeared to be a distinct absence of medical notes in each situation. It further noted that Dr Mwambingu's response to explain each situation was that she had been poor at record keeping. The Tribunal considered it more likely than not that the records did not exist because the conversations and/or actions did not occur as suggested by Dr Mwambingu.

108. The Tribunal found it more plausible that Dr Mwambingu simply did not make the referral as set out in the medical records and no further action was taken in respect of Patient F until the Board took over the running of the Practice in June 2019.

109. The Tribunal accepted the evidence of Dr Q who stated that in these circumstances Dr Mwambingu had a clear duty to make an urgent referral under the *'two week wait'* pathway for suspected malignancy. As she had not done so, this was a failure on her part.

110. Accordingly, the Tribunal found paragraph 15 of the Allegation proved.

The Tribunal's Overall Determination on the Facts

111. The Tribunal has determined the facts as follows:

Inappropriate Prescribing

1. Between July and August 2016 you inappropriately issued the prescriptions set out in Schedule 1 to Patient A with whom you had a close personal relationship.
   Admitted and found proved

2. Between September 2017 and March 2019 you inappropriately issued the prescriptions set out in Schedule 1 to Patient B with whom you had a close personal relationship.
   Admitted and found proved

3. Between April 2018 and April 2019 you inappropriately issued the prescriptions set out in Schedule 1 to Patient C with whom you had a close personal relationship.
   Admitted and found proved

4. On 8 February 2019 you inappropriately issued the prescription set out in Schedule 1 to Patient D with whom you had a close personal relationship.
   Admitted and found proved

Prescription Forms

5. Between dates on and around 30 May 2017 to 7 May 2019 you pre-signed prescription forms allowing prescriptions to be issued in your absence by staff who were not authorised to issue prescriptions.
   Determined and found proved

Electronic systems/records

6. On one or more occasion between May 2017 and 4 June 2019 you failed to ensure the timely referral of patients who were seen by you at the practice.
   Admitted and found proved

7. Between May 2017 and 4 June 2019 you failed to have an appropriate system in place to address patient concerns about missed and delayed referrals.
   Admitted and found proved

8. On one or more occasion between May 2018 and May 2019 you failed to generate a clinical record for a patient consultation.
   Admitted and found proved

Payment Claims

9. On 4 September 2019 you applied for payment as a medical practitioner suspended from the medical performers list and you:

   c. failed to provide details of any payments from alternative work;
      Admitted and found proved

   d. signed the declaration as set out in schedule 2.
      Admitted and found proved

10. On 4 October 2019 you applied for payment as a medical practitioner suspended from the medical performers list and you:

    c. failed to provide details of any payments from alternative work;
       Admitted and found proved

    d. signed the declaration as set out in schedule 2.
       Admitted and found proved

11. Between 4 June 2019 and 4 September 2019 you received payments:

    c. for locum work;
       Admitted and found proved

d. from 'Shida Limited'.
Admitted and found proved

12. You knew:

a. you needed to declare the information referred to at paragraphs 9a and 10a;
Determined and found proved

b. that you had received payments as at paragraphs 11a-b;
Determined and found proved

c. that the declarations you signed at paragraphs 9b and 10b were false.
Determined and found proved

13. Your actions as at paragraphs 9a-b and 10a-b were dishonest by reason of paragraphs 12a-c.
Determined and found proved

<u>Clinical Concerns</u>

<u>Patient E</u>

14. Between 8 October 2018 and 30 November 2018 you consulted with Patient E and noted 'needs urgent referral back to gastroenterologists' following which you failed to make a referral under the 'two week wait' pathway for suspected malignancy.
Admitted and found proved

<u>Patient F</u>

15. On 16 October 2018 you consulted with Patient F and you failed to make an urgent referral under the 'two week wait' pathway for suspected malignancy.
Determined and found proved

<u>Patient G</u>

16. On 26 October 2018 and/or 23 April 2019 you consulted with Patient G and you failed to refer Patient G to a:

a. chest pain service;
Admitted and found proved

b. cardiology service.
Admitted and found proved

<u>Patient H</u>

17. On 12 April 2019 you consulted with Patient H and recorded that they had a 'change in bowel habit' and were 'for fast track referral to colorectal team' and you failed to refer Patient H to gastroenterology within one working day.
Admitted and found proved

Patient I

18. On 3 May 2019 you consulted with Patient I and noted that she should be referred to dermatology and you failed to refer Patient I immediately on the 'two week wait' pathway for suspected malignancy.
Admitted and found proved

~~Patient J~~

19. ~~On 17 May 2019 you consulted with Patient J and you failed to make a referral under the 'two week wait' pathway for suspected malignancy.~~
Withdrawn

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

Determination on Impairment - 23/06/2023

112. 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 Mwambingu's fitness to practise is impaired by reason of misconduct.

The Evidence

113. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

114. The Tribunal also received a further bundle of documentation from Dr Mwambingu which included, but was not limited to:

- Appraisal summary, dated 31 July 2019;
- 3 x Clinical Supervisor reports covering 2020, 2021 and 2022;
- 'Clinical record keeping course' certificate, dated 18 January 2020;
- 'Equality and Diversity and Human Rights – Level 1' certificate of completion, dated 4 August 2020;
- 'Dealing with an angry patient' CPD certificate, dated 16 June 2021;
- 'Protected Learning Time Presentation about Patient Feedback Online' CPD certificate, dated 1 July 2021;
- 'Salaried GP Forum Meeting' CPD certificate, dated 2 July 2021;

- ‘Safeguarding of Vulnerable Adults’ CPD certificate, dated 5 July 2021;
- ‘Telephone Triage’ certificate of completion, dated 6 July 2021;
- ‘Antibiotics’ certificate of completion, dated 8 July 2021;
- ‘Referral of suspected BCC lesions’ CPD, dated 8 July 2021;
- Email from Dr R, Associate Medical Director and Responsible Officer (‘RO’) at the Board, to Dr Mwambingu, confirming the lifting of Dr Mwambingu’s suspension from the Medical Performers List, dated 12 December 2019; and
- RO statement from Dr S, dated 31 March 2023.

Submissions

On behalf of the GMC

115. On behalf of the GMC, Mr Coke-Smyth submitted that the facts found proved were serious enough to reach the threshold for misconduct. In terms of impairment, Mr Coke-Smyth submitted that whether or not the Tribunal concluded that Dr Mwambingu had remediated any misconduct, its findings were sufficiently serious to require a finding of impairment. Mr Coke-Smyth stated that such finding was required to uphold public confidence in the profession and to maintain and uphold standards.

116. Mr Coke-Smyth drew the Tribunal’s attention to the definition of the word, *‘misconduct’,* as set out in the case of *Roylance v. GMC* (No 2) [2000] 1 AC 311, in which it was described as “*a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances”.* He submitted the key threshold the Tribunal must apply is to identify whether there had been any omissions or failings against relevant standards, contained in Good Medical Practice (2013) (‘GMP’), and then ask whether these were serious.

117. Mr Coke-Smyth directed the Tribunal to the relevant paragraphs of GMP which, he submitted, were the relevant standards engaged in this case.

118. With regard to the allegations set out at paragraphs 1 to 4 of the Allegation which related to Dr Mwambingu issuing prescriptions to individuals with whom she had a close personal relationship, Mr Coke-Smyth submitted the relevant standard was set out at paragraph 16(g) of GMP, and he also referred the Tribunal to GMC guidance, *Good practice in prescribing and managing medicines and devices* (‘the GMC prescribing guidance’)

119. Mr Coke-Smyth also drew the Tribunal’s attention to the evidence of the expert witness, Dr Q. Mr Coke-Smyth accepted that Dr Q’s opinion in respect of the allegations at paragraphs 1 to 4 was that Dr Mwambingu’s actions had fallen below the standards expected but not seriously below as she had not prescribed controlled drugs in these cases. However, Mr Coke-Smyth stated that whilst Dr Q was entitled to hold that opinion, the GMC position was that they were explicit breaches of clear standards and accordingly fell seriously below the required standard.

120. Mr Coke-Smyth submitted that in relation to paragraphs 1 to 4 of the Allegation, the Tribunal would need to consider the fact that there were four separate patients, the prescribing took place over three years and was repeated on a number of occasions. It would be open to the Tribunal to consider whether a repeated breach of explicit written standards from GMP, even if not posing a high risk to patients, would still be capable of falling seriously below the relevant standards.

121. In relation to paragraph 5 of the Allegation, Mr Coke-Smyth reminded the Tribunal of Dr Q's evidence that leaving pre-signed blank prescription forms and abdicating the responsibility of prescribing to someone not qualified to do so could not be justified by any sort of emergency. It would be unsafe, as patients would be exposed to the unsupervised opinion of an untrained, unqualified member of staff. Dr Q concluded in his evidence that Dr Mwambingu's actions demonstrated a reckless disregard for the safety of patients and integrity of drug supply, and fell seriously below the expected standards.

122. Mr Coke-Smyth submitted that in relation to the missed referrals as set out in paragraph 6 of the Allegation, Dr Q described that the number of failures to action those referrals demonstrated an egregious lack of application to basic principles of safe practice by Dr Mwambingu.

123. Mr Coke-Smyth next addressed paragraph 7 of the Allegation which dealt with the system used for dealing with patient complaints. He submitted that the key issue was the use of a message book, and this was an inadequate system particularly as there was no electronic record to confirm any action had been taken. He further stated that when the Board took over the Practice there was evidence of patients frequently calling the Practice to complain about a lack of referral. Mr Coke-Smyth submitted that this was not a *"one-off"* occurrence and was in circumstances where there clearly was a problem with referrals and, therefore, fell seriously below the relevant standards

124. In relation to paragraph 8 of the Allegation, dealing with the lack of patient records relating to some 60 separate patient consultations, Mr Coke-Smyth submitted that Dr Q's opinion was that Dr Mwambingu's actions fell seriously below the relevant standards. In particular, Dr Q had stated that the failure to keep records jeopardised the safe treatment of patients as it did not allow other colleagues to ascertain what opinions, investigations or referrals had been carried out.

125. With regard to paragraphs 9 to 13 of the Allegation relating to payment claims, Mr Coke-Smyth reminded the Tribunal that Dr Mwambingu was overpaid in the region of £6000 as a result of those claims. This was payment that Dr Mwambingu would not have been entitled to, in view of the locum income she was receiving, and was directly attributed to her dishonest failure to declare over £10,000 worth of income.

126. Mr Coke-Smyth submitted there had been a significant financial benefit to Dr Mwambingu as a result of these dishonest declarations. Furthermore, he submitted that Dr

Mwambingu's failure to declare payments was not a single incident but occurred on two separate occasions. Mr Coke-Smyth submitted that given the very clear standards on honesty and integrity as set out in GMP, this was an obvious and serious breach of those standards sufficient to amount to misconduct.

127. Addressing paragraphs 14 to 18 of the Allegation, Mr Coke-Smyth submitted that Dr Q's opinion was that each one of these would have fallen seriously below relevant standards. However, Mr Coke-Smyth told the Tribunal he would deal with them collectively as the themes and points in all five instances were the same, in respect of patients where Dr Mwambingu failed to make an urgent referral, despite noting referral was necessary.

128. Mr Coke-Smyth submitted that for four of these patients there was a failure to urgently refer potential malignancies. The fifth patient referral was also urgent as there was a possibility of angina due to coronary insufficiency. In all of these cases the patients faced a delay of potentially life-saving treatment. It was fortunate that there was no evidence of any of these patients coming to harm as a result of the failure to refer but the risk in itself was serious enough to meet the threshold for misconduct.

129. Mr Coke-Smyth then addressed the Tribunal on impairment and submitted that there was more than one basis on which to find impairment. It was right for the Tribunal to have regard to remediation and whether the failings that led to the misconduct had been remedied. However, the Tribunal would also need to have regard to all three limbs of the statutory overarching objective which requires the Tribunal to:

> *'a. Protect, promote and maintain the health, safety and well-being of the public,*
>
> *b. Promote and maintain public confidence in the medical profession, and*
>
> *c. Promote and maintain proper professional standards and conduct for members of that profession.'*

130. Mr Coke-Smyth submitted that even if the Tribunal was to conclude there had been remediation of clinical failings, it would still be appropriate to make a finding of impairment on the basis that public confidence and standards would require a finding of impairment.

131. Mr Coke-Smyth submitted that the Tribunal may be satisfied by evidence put forward by Dr Mwambingu that she had remediated the matters which led to a finding of misconduct and that any failures were highly unlikely to be repeated. However, when considering the extent of failings across different parts of Dr Mwambingu's practice, the evidence fell short of showing full remediation and in addition to clinical failings, there had been dishonesty. He also submitted that Dr Mwambingu's actions in allowing the Practice Nurse to use pre-signed prescriptions was not misconduct relating to a clinical deficiency and was not conduct that could happen through a lack of training. Instead, he submitted that Dr Mwambingu had made an active decision to allow the pre-signed prescriptions to be used. Furthermore, he

submitted that she had also made active decisions to not declare her payment information on the form to the Board.

132. Mr Coke-Smyth submitted the only way to remediate these issues would be to reflect and to provide assurance that the conduct would not be repeated. Even then, there was the issue of public confidence. He stated that there was no real evidence of remediation for the serious misconduct.

133. Mr Coke-Smyth acknowledged the statement from Dr Mwambingu's RO and placement reports from her clinical supervisor and he accepted, on the face of those, that there were no current clinical concerns. Therefore, Mr Coke-Smyth stated that he was not making submissions on the basis of any current clinical concerns, instead he was making his submissions based on Dr Mwambingu's lack of insight and reflection. He suggested that the Tribunal had not seen any evidence of real reflection.

134. Mr Coke-Smyth submitted that in the case of the five patients where urgent referrals were missed, there was no reflection from Dr Mwambingu on how her failures might have affected those patients, or how that might have affected public confidence in GPs, given the key role they play as gatekeepers. He stated that Dr Mwambingu had placed reliance on the fact that no patient had made a complaint about her or come to any harm. However, he stated that she had failed to recognise the very real risk of harm to patients through lack of keeping clinical records. Just because a patient did not complain did not mean there was no concern.

135. Mr Coke-Smyth submitted that, at times, Dr Mwambingu had sought to blame the Board and focus on its failings in terms of how it had dealt with her, rather than focus on what she was responsible for.

136. Mr Coke-Smyth told the Tribunal that while there may well be evidence of attempts at remediation and that Dr Mwambingu may no longer pose a risk, this did not mean the failings that led to the misconduct had been fully remediated.

137. Mr Coke-Smyth submitted that there had been a number of serious breaches of standards which would inevitably have damaged the reputation of the profession, and it was on the basis of public confidence in the profession and declaring standards that there should be a finding of impairment, irrespective of remediation. Mr Coke-Smyth drew the Tribunal's attention to the dishonest claims and submitted that honesty and integrity are fundamental tenets of any profession.

138. Mr Coke-Smyth submitted that while the Tribunal would have to consider, and give due weight to, the context and circumstances of Dr Mwambingu's misconduct, including her struggle to run the Practice singlehandedly and to recruit another full-time GP, it should also have close regard to the impact of Dr Mwambingu's conduct on an informed member of the public and whether or not their confidence in the profession would be undermined as a result. Where actions had been sufficiently serious to damage that confidence and bring the

reputation of the profession into disrepute, a finding of impairment was necessary to make it clear that that conduct was not acceptable, and to uphold proper standards in the profession.

Dr Mwambingu

139. Dr Mwambingu, representing herself, submitted that despite the allegations being determined as proven at the previous stage, they dated back to three or four years ago. Although the GMC felt there was a level of impairment, Dr Mwambingu felt that the document provided by the RO, who held a high position and was held in high regard, along with the clinical supervisor reports, demonstrated that she had taken the necessary steps to remediate.

140. Dr Mwambingu submitted that her remediation was demonstrated in the work she had been doing over the last four years. She stated that she had been keeping in regular contact with her supervisor, overseen by NHS England, and they were satisfied with her work. She suggested that if there had been any patient concern in relation to her work it was unlikely that her contracts would have been extended as they had. Furthermore, in relation to the issue of public confidence and the maintaining of standards, she stated that had she been seen to be affecting the reputation of the surgeries she was working at, this would have been highlighted as an issue and her contract not extended. Dr Mwambingu's stated that her placement in Stoke-on-Trent had been for an initial three-month period, and this was subsequently extended. Dr Mwambingu stated that the only reason she left this position was because of commuting issues.

141. Dr Mwambingu told the Tribunal she had been in her current position for a year. She stated that she continued to be overseen by NHS England and submitted that because of this she did not feel she was currently impaired. Furthermore, she stated that NHS England was satisfied with her attendance on a NHS approved remediation course, and they had expressed satisfaction when reviewing the conditions placed on her practice. Dr Mwambingu also informed the Tribunal that, as a result of her development, BCHB had reviewed her position and had revoked the suspension previously imposed by the Board. Dr Mwambingu informed the Tribunal that she was asked if she wanted to return to work for the Board but had declined this, preferring to work in England.

142. In relation to the misconduct involving finances, Dr Mwambingu submitted that she had admitted to this and that she had not been aware of any wrongdoing. She submitted that, on reflection, this was a position she should not have been in. She did not think she had the adequate experience to run and manage a business at the time and she should have taken advice from people with the relevant experience. She stated that she accepted that she needed to take responsibility for this conduct.

143. Dr Mwambingu told the Tribunal she wanted to be completely honest with all of her dealings relating to finances. She stated that she now had a solicitor with whom she liaised regarding her financial affairs. Furthermore, she stated that she was a salaried GP, not in

charge of any finances of a business. She had not done any locum work for a while and if she chose to do so, she would seek advice from an accountant.

144. Dr Mwambingu then addressed the matters of public interest and bringing the profession into disrepute and submitted that she understood this may be an area of concern. However, in the four years since the index events she had received a lot of support from patients, other doctors, and members of the public and she felt like they had empathised with her, rather than feeling like a doctor who had been given a bad reputation.

145. Dr Mwambingu submitted that had she brought the profession into disrepute, she would not have been given job opportunities by employers who, despite being aware of the GMC allegations and the nature of them, remained happy to employ her.

146. Dr Mwambingu submitted that she felt the public interest would be satisfied that the allegations were from some time ago and that she had been working under restrictions since then. She stated that the public would be satisfied that during the period of time since the index incidents and whilst she has practised under restrictions, she would have had time to reflect and improve her practice. Dr Mwambingu stated that she was trying hard in a career that she was passionate about, wanting to work hard for patients and the public. Furthermore, she submitted that if the GMC felt she was currently impaired, it raised questions as to why the restrictions on her practice had not been tightened.

147. In relation to prescribing to those she had a close personal relationship to, Dr Mwambingu submitted that her practice was now overseen and there was no evidence that she had prescribed for friends or relatives since the last incident. She stated that she was not in a position where she could now do this. Accordingly, she did not consider herself to be currently impaired. Dr Mwambingu stated that she respected Dr Q's evidence and submitted that he had highlighted no controlled drugs were prescribed and this was below, but not seriously below, expected standards. She submitted that the GMC that was making this out to be more serious than it was. Dr Mwambingu agreed that her conduct went against GMP and this was something that would not happen again. Dr Mwambingu stated that in relation to these incidents, the drugs were not controlled, and she knew the patients well. She therefore submitted that this was not serious misconduct, and she was not currently impaired.

148. With regards to the pre-signed prescriptions, Dr Mwambingu submitted that she was no longer in the situation where she was running a practice singlehandedly and, as such, it was unlikely that this risk would arise again. She stated that she did not plan to enter another practice as the sole GP, therefore, felt that she was not currently impaired.

149. Dr Mwambingu submitted that she had reflected and was trying her best to do what she could. She stated that she had, unfortunately, had to defer her appraisal for a number of personal reasons. Despite this, Dr Mwambingu stated that she had learnt from her mistakes.

150. Dr Mwambingu told the Tribunal that she felt sad such a situation had arisen and she wished to learn from the experience and move on. She submitted that she could have walked away from the profession and find alternative work, which might have been easier than finding supervised placements. However, she stated that she chose to continue with practising as a doctor as this was her passion.

151. In closing, Dr Mwambingu submitted that the Tribunal should take into consideration that although she lost a business, she was no longer under the same risks regarding finances. She also asked the Tribunal to take into consideration the testimonials provided and the very positive report from the RO.

The Relevant Legal Principles

152. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone, taking into account the statutory overriding objectives.

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

154. The Tribunal should have regard to the comments of Lord Justice Beatson in the case of *Schodlok v GMC* [2015] EWCA where he suggested that in relation where there are accumulated findings of non-serious misconduct the Tribunal should consider both the volume and similarity of the finding of non-serious misconduct before deciding whether a series of non-serious misconduct could amount to a finding of serious misconduct.

155. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in the case of *CHRE v NMC and P Grant* [2011] EWHC 927 (Admin). In particular, the Tribunal considered whether its findings of fact showed that Dr Mwambingu's fitness to practise is impaired in the sense that she:

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

156. The Tribunal should have regard to paragraph 74 of *Grant* which states

> *'74 In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

158. Furthermore the Tribunal should consider whether Dr Mwambingu has demonstrated any insight in respect of her conduct.

159. When considering insight the Tribunal should consider the case of *Sayer v GOC* [2021] EWHC 370 Admin, where it was held that it is proper to take into account, when weighing up insight, the registrant's understanding of and attitude towards the underlying allegation.

160. The attitude of Dr Mwambingu to the events which gave rise to the specific allegations against her, is something which the Tribunal can take into account either in her favour or against her when it considers whether her fitness to practise is impaired.

161. In coming to a conclusion on impairment, the authorities make clear that the Tribunal must look forward. It must consider whether, in the light of what happened, and of evidence as to the registrant's conduct and ability demonstrated both before and after the misconduct, fitness to practise is impaired by the particular event.

162. In setting out its determination the Tribunal should ensure that its decision is clear, and should demonstrate how it has reached its decision.

The Tribunal's Determination on Impairment

Misconduct

163. In determining whether Dr Mwambingu's fitness to practise is impaired by reason of misconduct, the Tribunal first considered whether the facts found proved amount to misconduct.

164. Throughout its deliberations, the Tribunal took account of the statutory overarching objective of protecting the public, which includes protecting the health, safety, and wellbeing of the public, maintaining public confidence in the profession, and promoting and maintaining proper professional standards and conduct for the members of the profession.

Paragraphs 1- 4

165. The Tribunal considered that paragraph 16(g) of GMP was engaged:

> ***16*** *In providing clinical care you must:*
> …
> ***g*** *wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.*

166. The Tribunal also had regard to paragraphs 67, 68 and 69 of the GMC prescribing guidance which state:

> ***67*** *Wherever possible, you must avoid prescribing for yourself or anyone you have a close personal relationship with.*
>
> ***68*** *If you prescribe any medicine for yourself or someone close to you, you must:*
>
> ***a*** *make a clear record at the same time or as soon as possible afterwards; the record should include your relationship to the patient, where relevant, and the reason it was necessary for you to prescribe*
>
> ***b*** *follow the advice on information sharing safe prescribing* (reference given)
>
> 69 *You must not prescribe controlled drugs for yourself or someone close to you unless:*
>
> ***a*** *no other person with the legal right to prescribe is available to assess and prescribe without a delay*
>
> ***b*** *emergency treatment is immediately necessary to avoid serious deterioration in health or serious harm.*

167. The Tribunal took into account Dr Q's expert opinion that issuing prescriptions that were not for controlled drugs and failing to document the reason for such prescriptions on an urgent basis to people who had a close personal relationship to Dr Mwambingu was below, but not seriously below, the standards expected of a reasonably competent GP.

168. The Tribunal determined that although no controlled drugs had been prescribed, Dr Mwambingu had repeated the prescribing on a number of occasions. In particular, the prescriptions related to four different people and the action of writing such prescriptions had occurred several times, over a number of years. In addition, it was noted that there were no notes or records of any consultations or assessments on several occasions. The Tribunal considered that these actions constituted a marked departure from the principles set out within GMP and the GMC prescribing guidance on a number of occasions. Accordingly, the

Tribunal considered that the repeated pattern of behaviour, and long timespan involved, tipped the conduct into the sphere of seriousness.

169. In all the circumstances, the Tribunal concluded that Dr Mwambingu's conduct fell sufficiently far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct which was serious.

Paragraph 5

170. The Tribunal had regard to paragraph 16(a) of GMP,

> ***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.*
> *…*

and paragraph 3 of the GMC prescribing guidance which states*:*

> ***3*** *You are responsible for the prescriptions you sign. You are also accountable for your decisions and actions when supplying or administering medicines and devices, and when authorising or instructing others to do so.*

171. The Tribunal took into account the evidence of Dr Q, who stated, *"Dr Mwambingu has put her name to prescriptions, and therefore assumed responsibility for their content, and then promptly abdicated that responsibility to a colleague who is not authorized as a prescriber.", "There are no 'emergency situations' where a prescription needs to be issued before a prescriber can be located, unless it is in the context of a practice that is so poorly staffed that there is no GP presence for hours on end, which of itself would be a concern that there were other aspects of patient care that may be below the standard of a reasonably competent General Practitioner."*

172. The Tribunal had regard to its findings in the previous stage relating to the lack of any notes on the patients' medical records, indicating that no check had been made of the records before they were issued with a prescription. This meant that unqualified and untrained members of staff were allowed to issue prescriptions, which had the potential to jeopardize patient safety. The Tribunal also noted that in one instance Diazepam, a controlled drug, had been prescribed with a pre-signed prescription and there was no evidence that a qualified prescriber had assessed the patient or indeed checked their patient record prior to prescribing.

173. Furthermore, the Tribunal noted that Dr Q stated, in his report, *"Dr Mwambingu's actions are unsafe because … they allow the possibility of misappropriation of drugs should the signed prescriptions be misplaced or stolen. This is seriously below the expected standard*

because it demonstrates a reckless disregard for … the integrity of the drug supply. Such practice could easily lead to misappropriation by dishonest or criminal concerns with subsequent impact on the community."

174. The Tribunal took into account that some 30 prescriptions issued were pre-signed over the course of nearly two years, constituting a serious departure from the principles set out within GMP and the GMC prescribing guidance. It determined the potential risk to patient safety by Dr Mwambingu relinquishing her prescribing duties to members of staff not authorised to issue prescriptions could not be mitigated.

175. The Tribunal concluded that Dr Mwambingu's conduct fell far short of the standards of conduct reasonably to be expected of a doctor. Accordingly, her conduct amounted to misconduct which was serious.

Paragraph 6

176. The Tribunal first had regard to the paragraphs of GMP it considered to be engaged, these being paragraphs 13, 15(b), 18 and 22:

> ***13*** *You must take steps to monitor and improve the quality of your work.*
>
> ***15*** *You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> …
>
> ***b*** promptly provide or arrange suitable advice, investigations or treatment where necessary
>
> …
>
> ***18*** *You must make good use of the resources available to you.*
>
> ***22*** *You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:*
>
> ***a*** *taking part in regular reviews and audits of your own work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary*
>
> ***b*** *regularly reflecting on your standards of practice and the care you provide*
>
> ***c*** *reviewing patient feedback where it is available.*

177. The Tribunal also had regard to Dr Q's opinion as set out in his expert report. He accepted that that there may be an occasion where a GP had failed to action a referral when the decision to refer had been made, citing the pressure of work could sometimes be a distraction. However, the Tribunal noted that Dr Q had also stated that the risk of this could be mitigated by failsafe mechanisms.

178. The Tribunal had no evidence before it that Dr Mwambingu was an incompetent doctor and determined, therefore, that each referral was warranted and necessary to deal with a patient's health. The Tribunal also took into account that among these missed referrals there would have been some patients who needed to be referred as a matter of urgency. The Tribunal noted that, in failing to refer in a timely manner, Dr Mwambingu was potentially prolonging the ill-health of some of her patients. There was also a wider potential impact on their personal lives and employment.

179. The Tribunal also took into account Dr Q's opinion that the *"sheer number of failures to action referrals demonstrates an egregious lack of application to basic principals of safe practice by Dr Mwambingu, and the failure to mitigate the risk of this happening in any way",* and that the overall standard demonstrated by Dr Mwambingu was seriously below the standard of a reasonably competent GP.

180. Based on the above, the Tribunal concluded that Dr Mwambingu's failure to ensure patients were referred in a timely manner amounted to misconduct which was serious.

Paragraph 7

181. The Tribunal had regard to paragraphs 13, 15(b), 18 and 22 of GMP when determining paragraph 7.

182. The Tribunal took into account that whilst it appeared that there was an appropriate complaints procedure in place at the Practice to deal with formal complaints, there was no adequate system in place to address day to day patient concerns and enquiries about the status of their referrals.

183. The Tribunal also took into account Dr Q's opinion that any kind of system would have been adequate had it worked. Even though the patient concerns were no longer being logged on EMIS, providing action was being taken to address the concerns being logged in the message book, this would have been satisfactory. However, as evidenced by the number of calls received by the Board from patients who had not been referred, the book system had not worked.

184. The Tribunal had regard to the impact on the health of the patients and the risks to their safety incurred by not having an appropriate system in place to address their concerns. For some patients the risk was potentially heightened if they missed, for example, a cancer referral.

185. The Tribunal took into consideration that to log the concerns in a book was not, in itself, misconduct, and that either of two systems were in place at the Practice would have been appropriate if they worked. However neither worked and this was therefore serious.

186. The Tribunal determined that as Dr Mwambingu was in charge of the Practice it was her responsibility to ensure the safety of her patients and ensure a general system was in place to address patient concerns and enquiries.

187. The Tribunal concluded that not having the appropriate system in place to address these concerns amounted to misconduct which was serious.

Paragraph 8

188. The Tribunal had regard to paragraphs 19, 21, 22 and 44(a) of GMP, which it considered engaged in this case:

> ***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:*
>
> ***a*** *relevant clinical findings*
>
> ***b*** *the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
>
> ***c*** *the information given to patients*
>
> ***d*** *any drugs prescribed or other investigation or treatment*
>
> ***e*** *who is making the record and when.*
>
> ***44*** *You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:*
>
> ***a*** *share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers.*

189. The Tribunal had regard to Dr Q's report that a failure to generate clinical records for patient consultations jeopardized the safe treatment of patients because it did not allow another colleague to understand what opinions, investigations or referrals had been carried out for that patient, should that need arise. It was also Dr Q's opinion that Dr Mwambingu's failure to generate clinical records was seriously below the standard expected of a reasonably competent GP.

190. The Tribunal took into account the number of clinical records not generated and that this was a pattern of events repeated over a number of years.

191. The Tribunal also took into account Dr Mwambingu's evidence that there was no real reason for this failure other than she was busy and stressed. While the Tribunal understood that Dr Mwambingu faced challenges in her work and personal life at that time, and was sympathetic to this, patient safety was at risk by there being no clinical records generated. This is a fundamental part of GMP which all doctors must comply with.

192. The Tribunal concluded that Dr Mwambingu's failure to generate clinical records for patient consultations amounted to misconduct which was serious.

Paragraphs 9-13

193. The Tribunal had regard to the paragraphs of GMP relating to integrity and dishonesty, that it considered to be engaged in this case:

> *71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.*[16] *You must make sure that any documents you write or sign are not false or misleading.*
>
> *a You must take reasonable steps to check the information is correct.*
>
> *b You must not deliberately leave out relevant information.*
>
> *77 You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals.*

194. The Tribunal took into account that there had been two occasions of dishonest behaviour. Given both Dr Mwambingu's responsibilities as director of a company and a member of the medical profession, the Tribunal considered that the form was very clear and there could be no misunderstanding of the requirement to disclose relevant information relating to finances.

195. The Tribunal acknowledged Dr Mwambingu's previous submissions and evidence that the Board had not taken this matter further but was of the view that this did not mitigate Dr Mwambingu's dishonest behaviour.

196. The Tribunal had regard to the fact that there were two clear breaches of principles as set out in GMP and that any dishonesty could be nothing other than serious.

197. The Tribunal concluded that Dr Mwambingu's failure to declare payments she was receiving from alternative work, in the knowledge that she should be doing so, amounted to misconduct which was serious.

Paragraphs 14-18

198. The Tribunal first had regard to paragraphs 15(b) and 44(a) of GMP, which it considered were engaged in this case.

199. The Tribunal took into account Dr Q's opinion that each of the failures to make a referral breached the relevant standards as set out in GMP.

200. The Tribunal took into consideration that these failures could have had serious consequences for the patients and that this had happened five times. Four of these were for suspected malignancies and one for angina. One instance of such failure was serious but five instances was unacceptable. Any delay could have been catastrophic.

201. The Tribunal concluded that Dr Mwambingu's failure to make urgent referrals amounted to misconduct which was serious.

Impairment

202. The Tribunal having found that the facts found proved amounted to misconduct went on to consider whether, as a result of that misconduct which was serious, Dr Mwambingu's fitness to practise is currently impaired.

203. The Tribunal was of the view that remediation of some of the misconduct was possible and considered what steps Dr Mwambingu had taken to remedy it. The Tribunal had regard to the appraisal documentation, clinical supervisor reports, courses undertaken, as well as the positive testimonials provided for the Facts stage and other documents provided at this stage.

204. The Tribunal looked for evidence of the level of Dr Mwambingu's insight into her actions and the wider reaching impact, as well as any expressions of remorse.

205. The Tribunal accepted the steps Dr Mwambingu has so far taken to remediate her behaviours and took into account that there had been no repetition of any of her misconduct. However, the role of the Tribunal is to ensure patient safety and to fulfil the statutory overarching objective. One of the ways it must do this is to assess the level of insight into any serious misconduct. A number of elements are required to demonstrate full insight, including reflecting on the impact the misconduct had on patients or those involved, identifying the potential risk to patient safety flowing from the misconduct, and demonstrating any appropriate remorse.

206. The Tribunal also had regard to the test in the case of *Grant.*

<u>Paragraphs 1-4</u>

207. The Tribunal took into account Dr Mwambingu's evidence that there had been no repetition of prescribing to friends or family members since the last incident in April 2019. The Tribunal gave credit for this and accepted that while there had been no further incidents of this type over the last four years. The Tribunal considered that because Dr Mwambingu had been working under supervision and had no opportunity to issue prescriptions for those close to her, this had minimised the risk.

208. The Tribunal also had regard to Dr Mwambingu's submission that she XXX and that she felt this mitigated her actions.

209. The Tribunal considered this disclaimer highlighted Dr Mwambingu's lack of insight into her behaviour and the potential risks of prescribing for close friends or family members. Dr Mwambingu had made no notes in the patient records as to the medication she had prescribed, and this had the potential to put the patients' safety at risk if they had to be treated and the treating clinician was unaware of previous medication.

210. The Tribunal had regard to the fact that Dr Mwambingu did not address the fact that she did not tell the patients' GP that she had prescribed medication for them. The Tribunal

was of the view that being busy or stressed was not a reasonable excuse to not inform the GP.

211. The Tribunal had no evidence before it of how Dr Mwambingu would behave if placed in a similar situation in the future, nor of her understanding of the risks of prescribing for XXX, nor the potential risk if a situation arose where emergency treatment was needed by any of the patients.

212. The Tribunal concluded that Dr Mwambingu's failure to address the potential risks demonstrated that she had not yet shown full insight into why prescribing for family members and not recording this information was wrong. Accordingly, it considered that there was an ongoing risk of repetition of the misconduct if Dr Mwambingu was in unrestricted practice and/or the nature of her practice changed.

213. The Tribunal has therefore determined that Dr Mwambingu's fitness to practise is currently impaired by reason of misconduct in relation to paragraphs 1-4.

Paragraph 5

214. The Tribunal took into account that Dr Mwambingu did not appear to accept the findings of fact in relation to this allegation, having stated to the Tribunal that she had explained her situation giving rise to the index incidents. Dr Mwambingu submitted that she was not planning to be in that situation again and therefore her fitness to practise was not currently impaired. The Tribunal found that this demonstrated a lack of insight as to the seriousness of the incidents and the risk such actions had with regard to patient safety.

215. The Tribunal noted that whilst there had been no repetition of the misconduct, Dr Mwambingu's practice was restricted and supervised and the opportunity to pre-sign prescriptions had not presented itself. The Tribunal concluded that due to the lack of insight, there was the potential for Dr Mwambingu to behave in this way again in a different practice setting.

216. The Tribunal has therefore determined that Dr Mwambingu's fitness to practise is currently impaired by reason of misconduct in relation to paragraph 5.

Paragraphs 6-8

217. The Tribunal was of the view that once a practitioner shows an understanding of why they acted in a particular way, that is the beginning of the insight journey. It took into account Dr Mwambingu's evidence about the pressures and stresses of singlehandedly running a practice and that she was now a salaried GP, and that this went some way to showing how she has now changed the way she works. However, the Tribunal did not hear anything from Dr Mwambingu relating to the impact of her failures on her patients and the potential risks they were exposed to. This is a fundamental element of insight which helps the Tribunal to assess any future risk to patient safety.

218. The Tribunal took into account that Dr Mwambingu cited her personal life and XXX as reasons for her failures but that she did not address the fact that her obligation was to seek help from others to maintain patient safety.

219. The Tribunal also took into account Dr Mwambingu's evidence that there had been no similar instances of not complying with systems since the last incident and that she was learning new systems. The Tribunal saw some evidence of how Dr Mwambingu's clinical practice had changed as a salaried GP. However, Dr Mwambingu did not address what plans she had in place if she was in unrestricted practice. The Tribunal had neither seen nor heard any reflection on plans she had to develop a system to keep up with her referrals, nor what she would have in place to guarantee there would be no failures to address patient concerns in the future.

220. The Tribunal has therefore determined that Dr Mwambingu's fitness to practise is currently impaired by reason of misconduct in relation to paragraphs 6-8.

Paragraphs 9-13

221. The Tribunal took into account Dr Mwambingu's evidence that she now meets with a solicitor regularly, and that she showed an understanding of the reasons behind her behaviour. Dr Mwambingu also displayed that she had taken steps to avoid anything similar from happening in the future. However, the Tribunal found that there was a lack of remorse.

222. In determining whether a finding of impairment was necessary, the Tribunal considered whether the misconduct could be remedied while bearing in mind that matters of dishonesty are difficult to remediate. It considered the evidence in respect of Dr Mwambingu's insight and remediation and balanced that against the three limbs of the statutory overarching objective.

223. In considering the public interest, the Tribunal noted that Dr Mwambingu's dishonesty was repeated twice, over a short period of time. The Tribunal was satisfied that a member of the public, knowing the facts of this case would be concerned to learn of a doctor acting in this way. The Tribunal was also satisfied that public confidence in the profession, the regulator and the disciplinary process would be undermined if a finding of impairment were not made. Further, in light of its findings of serious misconduct, the Tribunal was satisfied that the need to promote and maintain proper professional standards and conduct for members of the profession would be undermined if a finding of impairment were not made.

224. The Tribunal has therefore determined that Dr Mwambingu's fitness to practise is currently impaired by reason of misconduct in relation to paragraphs 9-13.

Paragraphs 14-18

225. The Tribunal took into account the clinical supervisor reports. The Tribunal also had regard to the fact that Dr Mwambingu had made advances in her clinical work and that she was no longer running a business. It acknowledged the steps she had taken in relation to personal development and clinical practice, and that there were no current concerns in this area.

226. The Tribunal also acknowledged that Dr Mwambingu had shown she was capable of remediation by attending relevant courses and that there had been no repetition of this misconduct in the last four years.

227. The Tribunal found, however, that Dr Mwambingu's attitude to the allegations showed a lack of understanding about the wider impact of her actions and the risks she subjected the public to, and was concerned about Dr Mwambingu's lack of reflection and any insight into how her failures to make these referrals could have had an impact on the patients. The Tribunal also had regard to the fact that there had been no expression of remorse from Dr Mwambingu. This did not satisfy the Tribunal that she would not behave this way again in the future if a similar situation arose.

228. The Tribunal also considered that a reasonable and ordinary member of the public would be concerned about a doctor who missed urgent referrals.

229. Taking all the above factors and circumstances into account, the Tribunal was satisfied that Dr Mwambingu's fitness to practise is currently impaired, notwithstanding the passage of time since the events in question and that the misconduct had not been repeated. Further, the Tribunal was of the view that given its finding of serious misconduct and the lack of insight, a reasonably informed observer would be concerned if a finding of impairment were not made.

230. The Tribunal has therefore determined that Dr Mwambingu's fitness to practise is currently impaired by reason of misconduct in relation to these paragraphs.

Determination on Sanction - 30/06/2023

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

The Evidence

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

Submissions

On behalf of the GMC

233. On behalf of the GMC, Mr Coke-Smyth submitted that the minimum appropriate sanction in this case would be one of suspension. He referred the Tribunal to paragraph 17 of the Sanctions Guidance (November 2020 edition) ('the SG'), which set outs the reasons for imposing sanctions:

> ***14*** *The main reason for imposing sanctions is to protect the public. This is the statutory overarching objective, which includes to:*
>
> ***a*** *protect and promote the health, safety and wellbeing of the public*
>
> ***b*** *promote and maintain public confidence in the medical profession*
>
> ***c*** *promote and maintain proper professional standards and conduct for the members of the profession.*

234. Mr Coke-Smyth submitted that although any sanction must be proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.

235. Mr Coke-Smyth then drew the Tribunal's attention to paragraph 124 of the SG, which relates to dishonesty:

> ***124*** *Although it may not result in direct harm to patients, dishonesty related to matters outside the doctor's clinical responsibility (eg providing false statements or fraudulent claims for monies) is particularly serious. This is because it can undermine the trust the public place in the medical profession. Health authorities should be able to trust the integrity of doctors, and where a doctor undermines that trust there is a risk to public confidence in the profession. Evidence of clinical competence cannot mitigate serious and/or persistent dishonesty.*

236. Mr Coke-Smyth submitted that in view of the findings of dishonesty and the seriousness of other aspects found proved, any sanction below suspension would not be sufficient to address the damage caused to the reputation of the medical profession and to uphold standards. Mr Coke-Smyth referred the Tribunal to paragraphs 93 and 97(a) and (f) of the SG, which supported his submission that a period of suspension showed that would be the most appropriate sanction in this case:

> ***93*** *Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate*
> *their actions.*

> ***97*** *Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> ***a*** *A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*
> *…*
>
> ***f*** *No evidence of repetition of similar behaviour since incident.*
> *…*

237. Mr Coke-Smyth submitted that the two occasions when Dr Mwambingu claimed money dishonestly while she was already suspended and under investigation, represented particularly serious breaches of GMP.

238. Mr Coke-Smyth reminded the Tribunal of Dr Q's evidence in relation to the use of pre-signed prescriptions; that Dr Mwambingu's actions demonstrated a reckless disregard for the safety of patients and integrity of drug supply. It had not been a one-off instance, and this misconduct in itself was enough to merit suspension. Dr Mwambingu's failure to make referrals, including urgent referrals, and her failures to prioritise urgent clinical cases could have had catastrophic consequences, posed a significant risk of harm to patients and was a serious breach of GMP.

239. Mr Coke-Smyth submitted that the key here was paragraph 97(f) of the SG; there had been no evidence of repetition of the misconduct and this mitigated against a more serious sanction.

240. Mr Coke-Smyth reminded the Tribunal of its findings in the earlier stages in relation to Dr Mwambingu not yet showing full insight. However, the Tribunal had not found her incapable of doing so and, Mr Coke-Smyth submitted, there was still an opportunity for Dr Mwambingu's insight to develop further. This was the main reason for suspension being the most appropriate sanction.

241. Mr Coke-Smyth then went on to submit that if a period of suspension were to be imposed, there should be a review hearing prior to its expiry. This would allow the reviewing tribunal to consider whether Dr Mwambingu has fully realised the gravity of the impact of her misconduct and whether she has developed sufficient insight to return to unrestricted practice.

242. In relation to the length of suspension, Mr Coke-Smyth referred the Tribunal to the relevant factors as set out in the SG. The length would need to ensure adequate time for Dr Mwambingu to remediate and this would weigh in favour of a longer suspension, and she clearly had some way to go before her insight could be considered as full.

243. Mr Coke-Smyth submitted that the length of suspension would also have to take into account the seriousness of the Tribunal's findings. The Tribunal would need to look at aggravating and mitigating factors and take into account the risk to public safety and the public's confidence in the profession. Factors to take into account were the potential catastrophic results of Dr Mwambingu's misconduct, the risk to patients, and her dishonesty related to claiming payments which were for her personal benefit.

244. Mr Coke-Smyth submitted that another factor to take into account when determining the length of suspension was the extent of the significant and sustained acts of misconduct. The allegation spanned from May 2017 to October 2019, during which there were multiple occasions of misconduct, including two instances of dishonesty. The Tribunal should also consider whether Dr Mwambingu's conduct demonstrated a deliberate or reckless disregard for the requirements of a doctor's practice. Mr Coke-Smuth submitted that this could be the case in respect of the pre-signed prescriptions.

245. In closing, Mr Coke-Smyth submitted that in cases where there is dishonesty, accompanied by other serious breaches and a risk of harm to patients, the minimum sanction to maintain public confidence and maintain proper standards would be a period of suspension with a review prior to its expiry.

Dr Mwambingu

246. Representing herself, Dr Mwambingu submitted that she was deeply regretful that such a situation had arisen and it was unfortunate that certain circumstances and the conditions under which she had been working, led to a finding of impairment of her practice.

247. Dr Mwambingu submitted that a period of suspension would make it difficult for her to remediate fully and would not allow her to continue developing her clinical skills to demonstrate she was not a risk to patients. Additionally, Dr Mwambingu submitted that if she was not in a practice setting it would not be possible for a practice manager to comment on her honesty with regards to finances should she have reason to be involved in matters where payments might be involved.

248. Dr Mwambingu told the Tribunal that it would be detrimental to have a gap in her clinical practice after having carried on for four years during the investigation and would also be detrimental to XXX. Dr Mwambingu submitted that the NHS was struggling with a shortage of GPs and even though this should not be the reason for her not to be suspended, it would put a strain on the service if she was.

249. Dr Mwambingu submitted that during the four years of the investigation at no point was it felt that suspension would be appropriate. She stated that it was her opinion that were the allegations as serious as they had now found to have been, surely it would have been appropriate to impose a period of suspension earlier to protect the public interest. Dr Mwambingu stated that she had worked safely under supervision since August 2019 with no

concerns being raised by any supervisors in relation to prescriptions, clinical practice, public interest or finances.

250. Dr Mwambingu referred the Tribunal to paragraph 82 of the SG which states:

> *82 Conditions are likely to be workable where:*
>
> ***a** the doctor has insight*
>
> ***b** a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings*
>
> ***c** the tribunal is satisfied the doctor will comply with them*
>
> ***d** the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.*

251. Dr Mwambingu submitted that having conditions placed on her practice would be sufficient to protect the public and to show something was being done to allow her to improve on her practice, remediate, and move on from the impairment.

252. Dr Mwambingu submitted that employers may question why she was not suspended by the GMC earlier. She stated that she was of the opinion that she had demonstrated to them that she was not impaired during the investigation period. Dr Mwambingu further submitted that it was a strong statement that the Board trusted her enough to be employed again. It had revoked her suspension and asked her to return to work during its investigation, when it already had raised allegations of financial issues. Dr Mwambingu's current employer, NHS England, Cheshire West, had placed trust in her with in full knowledge of the allegations, including probity issues. The issue of probity was not ongoing or current.

253. Dr Mwambingu reminded the Tribunal that there had been no repetition of any of the allegations during her four years under interim orders conditions, and there was no reason why they would reoccur. Dr Mwambingu submitted she was no longer in the situations that led to certain things arising and she was working closely in large practices with doctors and other members and staff, who could observe her, work closely with her and supervise her.

254. In closing, Dr Mwambingu submitted that a period of conditions would allow her to continue practicing safely while, amongst other things, getting support with CPD work, attending courses and meetings, and gaining feedback. Working under conditions would prevent Dr Mwambingu from losing the passion that had continued to drive her through this four year investigation.

The Relevant Legal Principles

255. The decision as to the appropriate sanction to impose, if any, is a matter for the Tribunal exercising its own judgement.

256. The Tribunal should consider the least restrictive sanction first before moving on to consider the other available sanctions in ascending order of severity.

257. The Tribunal must bear in mind that the main reason for imposing a sanctions is to protect the public and its purpose is not to punish, although it may have a punitive effect. The Tribunal should consider proportionality, by weighing the public interest against the interests of Dr Mwambingu but bear in mind that the reputation of the profession as a whole is more important than the interests of any individual doctor, as explained in *Bolton v Law Society* [1994] 1 WLR 512.

258. The Tribunal should take into account any aggravating and mitigating features and weigh them up accordingly, considering these in conjunction with the statutory overarching objective.

The Tribunal's Determination on Sanction

259. Before considering what action, if any, to take in respect of Dr Mwambingu's registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case.

Aggravating Factors

260. The Tribunal identified Dr Mwambingu's failure to demonstrate timely development of full insight to be an aggravating factor in this case, particularly in relation to the impact of her misconduct in relation to the risk to patient safety and impact on patients and the wider community. One example was the lack of understanding regarding the pre-signed prescriptions and how they could have been misappropriated.

261. The Tribunal also considered multiple occasions of misconduct, including dishonesty, over a protracted period of time to be an aggravating factor.

262. Furthermore, the Tribunal also noted the extent of Dr Mwambingu's failure in relation to the number of missed referrals and that these involved hundreds of patients over a long period of time. They, again, considered this to be an aggravating factor.

Mitigating Factors

263. The Tribunal identified that Dr Mwambingu's personal circumstances had led to some of the misconduct taking place. She had been running the Practice singlehandedly after XXX. It acknowledged that Dr Mwambingu accepted that she was inexperienced in running a practice and indeed a business. Dr Mwambingu had tried to recruit a GP partner but had been unable to. During this time she XXX, and was experiencing XXX.

264. The Tribunal also identified the following mitigating factors:

- Lapse of time since the last incident (four years);
- Some evidence that Dr Mwambingu understands the concerns and has taken some steps towards remediation;
- Lack of previous regulatory findings and no evidence of repetition since these events;
- Dr Mwambingu's engagement with this process and that she made some admissions from the start;
- Four years of good clinical practice with positive testimonials from other practitioners.

No action

265. The Tribunal first considered whether to conclude the case by taking no action. It noted from the SG that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

266. The Tribunal took into consideration that in Dr Mwambingu's case there were unusual circumstances that had led to some of the misconduct. However, the Tribunal determined that these could not be classed as exceptional enough to justify taking no action. Additionally, Dr Mwambingu had not yet developed full insight into her misconduct or completed sufficient remediation.

267. The Tribunal found that given the serious nature of Dr Mwambingu's misconduct and its finding of impairment, taking no action would not be sufficient, proportionate or meet the statutory overarching objective.

Conditions

268. The Tribunal took into account that there would need to be a marking of the breadth and gravity of Dr Mwambingu's misconduct and next considered whether the statutory overarching objective could be met by imposing a period of conditions on Dr Mwambingu's practice.

269. The Tribunal reminded itself of its findings in relation to Dr Mwambingu's current levels of insight and remediation, and that while there was some understanding of the risks she had taken and the mistakes she had made, she still did not fully understand the impact. The Tribunal also bore in mind that there were two occasions of dishonesty that needed to be marked.

270. The Tribunal had regard to the length of time Dr Mwambingu had been working under restrictions already and that NHS England were happy for her to keep working. The fact that Dr Mwambingu is a good doctor was echoed by the fact of the Board lifting her suspension and asking her to return to work.

271. The Tribunal considered that working under a period of conditions would not only allow Dr Mwambingu the opportunity to reflect, remediate, and develop full insight but that it would also allow her to demonstrate her progress in these areas while improving her clinical skills and knowledge. The Tribunal further considered that conditions would allow Dr Mwambingu to continue to practise in a monitored situation in which the risk of repetition is both minimised and supervised. Conditions would also ensure no risk to patient safety.

272. The Tribunal considered whether conditions would be adequate to maintain public confidence in the profession in light of the seriousness of its findings, particularly the dishonesty and risks to patient safety. The Tribunal took into account that Dr Mwambingu has had adverse findings against her and that this blemish on her career is public knowledge. The Tribunal considered that this, along with a period of restricted practice and less opportunity for her to work in the way she pleases, was enough to mark the misconduct. A period of conditions would ensure that Dr Mwambingu carried on working in a supportive environment while developing insight in a professional, hands-on situation. This would allow her to reflect while working with patients. The Tribunal was of the view that in the particular circumstances of this case, this would be more useful than to suspend Dr Mwambingu and leave her unsupported to reflect in isolation.

273. The Tribunal was of the view the public would understand that there were a number of mitigating circumstances around the time of the incidents and that over the last four years, including during the COVID-19 pandemic, Dr Mwambingu had been working with no issues. The Tribunal determined that there was no reason that her insight could not develop fully if she were allowed to carry on working in this way.

274. The Tribunal then considered whether conditions were adequate to promote and maintain proper professional standards and conduct for members of the profession. The Tribunal took the view that the finding of impairment, and placement of restrictions on Dr Mwambingu's practice sends a clear message that serious breaches of professional standards and dishonest misconduct leads to sanctions and restrictions on practice, even in the face of good clinical performance and strong mitigating factors.

275. The Tribunal concluded that a lengthy period of restrictions on Dr Mwambingu's practice would be sufficient to mark the seriousness of the misconduct. This would ensure a clear message is sent out to the profession, and the public, of the considerable consequences of dishonesty within the profession. The Tribunal was satisfied that conditions would uphold the overarching objective, ensuring the public interest was served by marking the misconduct while still allowing a competent and well-regarded physician to assist the public.

Suspension

276. The Tribunal was mindful that it should impose the least restrictive sanction that appropriately and proportionately addressed the misconduct identified. It carefully considered imposing the more serious sanction of suspension, which would have a clear deterrent effect and may be necessary in order to send a signal to Dr Mwambingu, the

profession, and the public about what is regarded as behaviour unbefitting a registered doctor.

277. After taking into account all the circumstances of this case in the round, the Tribunal was satisfied that a period of suspension would not be proportionate, and that the lesser restrictive sanction of conditions would adequately uphold the overarching objective. It considered that a period of suspension would be unduly punitive. The Tribunal was also mindful that Dr Mwambingu could become de-skilled if a period of suspension was put in place.

278. The Tribunal therefore determined to impose the following public conditions upon Dr Mwambingu's registration:

1. She must personally ensure that the GMC is notified of the following information within seven calendar days of the date these conditions become effective:

    a. the details of her current post, including:

        i. her job title

        ii. her job location

        iii. her responsible officer (or their nominated deputy)

    b. the contact details of her employer and any contracting body including her direct line manager

    c. any organisation where she has practising privileges and/or admitting rights

    d. any training programmes she is in

    e. the organisation on whose medical performers list she is included.

2. She must personally ensure the GMC is notified:

    a. of any post she accepts, before starting it

    b. that all relevant people have been notified of her conditions, in accordance with condition 10

    c. if any formal disciplinary proceedings against her are started by her employer and/or contracting body, within seven calendar days of being formally notified of such proceedings

d. if any of her posts, practising privileges or admitting rights have been suspended or terminated by her employer before the agreed date within seven calendar days of being notified of the termination

e. if she applies for a post outside the UK.

3. She must allow the GMC to exchange information with her employer and/or any contracting body for which she provides medical services.

4. a She must have a workplace reporter appointed by her responsible officer (or their nominated deputy).

b She must not work until:

i her responsible officer (or their nominated deputy) has appointed her workplace reporter

ii She has personally ensured that the GMC has been notified of the name and contact details of her workplace reporter.

5. She must get the approval of the GMC before working in a non-NHS post or setting.

6. She must only work in a group practice setting where there is a minimum of two GP partners or employed GPs (excluding herself). The GPs must be partners or permanently employed GPs who are on the GP register (this excludes locum staff).

7. She must only work as a salaried GP.

8. a. She must be supervised in all of her posts by a clinical supervisor, as defined in the *Glossary for undertakings and conditions*. Her clinical supervisor must be appointed by her responsible officer (or their nominated deputy).

b. She must not work until:

i. her responsible officer (or their nominated deputy) has appointed her clinical supervisor and approved her supervision arrangements

ii. she has personally ensured that the GMC has been notified of these arrangements

c. She must provide a report from her clinical supervisor in advance of or at her next review hearing.

9. She must have a mentor who is approved by her responsible officer (or their nominated deputy).

10. She must personally ensure the following persons are notified of the conditions listed at 1 to 9:

a her responsible officer (or their nominated deputy)

b the responsible officer of the following organisations:

i her place(s) of work, and any prospective place of work (at the time of application)

ii all her contracting bodies and any prospective contracting body (prior to entering a contract)

iii any organisation where she has, or has applied for, practising privileges and/or admitting rights (at the time of application)

iv If any of the organisations listed at i to iii does not have a responsible officer, she must notify the person with responsibility for overall clinical governance within that organisation. If she is unable to identify this person, she must contact the GMC for advice before working for that organisation.

c the responsible officer for the medical performers list on which she is included or seeking inclusion (at the time of application)

d her immediate line manager and senior clinician (where there is one) at her place of work, at least 24 hours before starting work (for current and new posts).

279. Having determined it appropriate to impose conditions, the Tribunal considered the length of the order of conditional registration. The Tribunal was of the view that Dr Mwambingu's misconduct was serious enough so as to be on the cusp of suspension, and a short period of conditional registration would not mark the gravity or seriousness of the misconduct. It would also be insufficient time for Dr Mwambingu to demonstrate sufficient insight and ensure adequate reflection and remediation. The Tribunal determined that a period of conditional registration for 12 months was the appropriate and proportionate length in this case. Dr Mwambingu would have sufficient time to address the issues identified, whilst also adequately addressing the seriousness of the misconduct.

280. The Tribunal determined to direct a review of Dr Mwambingu's case. A review hearing will convene shortly before the end of the period of conditional registration. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Mwambingu to demonstrate her compliance with the conditions imposed, and how she has remediated her

misconduct and developed her insight. It therefore may assist the reviewing Tribunal if Dr Mwambingu provides:

- A reflective statement;
- An up-to-date report from her mentor and/or supervisor;
- A Personal Development Plan;
- Evidence of her insight;
- Evidence of how she has kept her knowledge and skills up to date.

Dr Mwambingu will also be able to provide any other information that she considers will assist.

Determination on Immediate Order - 30/06/2023

281. Having determined to impose conditions on Dr Mwambingu's registration for a period of 12 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Mwambingu's registration should be subject to an immediate order.

Submissions

282. Mr Coke-Smyth confirmed that the GMC had no submissions on the issue of an immediate order.

283. Representing herself, Dr Mwambingu submitted that the Tribunal should consider that she required time to implement the requirements of the Conditions. She further submitted that that she had no intention of making any changes to her practice during the next 28 days.

The Tribunal's Determination

284. In reaching its decision, the Tribunal exercised its own discretion. It took into account the submissions from both parties as well as the facts of this case and its findings at the previous stages of this hearing.

285. The Tribunal had regard to paragraphs 172-178 of the SG and bore in mind that it may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest or is in the best interests of the doctor. It also considered that an immediate order may be particularly appropriate where there was a risk to patient safety or a need to protect public confidence in the profession.

286. The Tribunal took into account both the seriousness and rationale of its earlier findings, in which it identified patient safety concerns if Dr Mwambingu were allowed to return to unrestricted practice. The Tribunal determined, therefore, it was proportionate and in the public interest, to impose an immediate order to ensure patient safety. Such action

would also maintain public confidence in the profession during the period before the substantive sanction takes effect.

287. This means that Dr Mwambingu's registration will be made subject to the immediate conditions from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

288. The interim order is hereby revoked.

289. That concludes this case.

ANNEX A – 19/06/2023

Application under Rule 34(1) to admit evidence

290. On 5 June 2023, Day 1 of the hearing, Dr Mwambingu made an application under Rule 34(1) of the Rules to adduce two witness statements. One was her own witness statement dated 5 June 2023, and the other, that of Ms P, dated 2 January 2023.

Submissions

Dr Mwambingu

291. Dr Mwambingu told the Tribunal that her own witness statement was being submitted at this late stage, past the deadline of 17 March 2023 given by the MPTS Case Management Team ('CMT'), due to personal issues and XXX. Dr Mwambingu had made the GMC aware that over the last few months it had been difficult for her to meet particular deadlines. The delay came with the fact that Dr Mwambingu had wanted to provide an up-to-date statement bringing her up to this day.

292. In relation to the late submission of Ms P's statement, Dr Mwambingu told the Tribunal that she was not aware of why Ms P had not provided this to her earlier. However, there had been a point where Dr Mwambingu was going to use Ms P as her representative during these proceedings as Ms P had represented her previously in NHS proceedings. Under those circumstances, Ms P would have been unable to provide evidence. Dr Mwambingu said that Ms P was now no longer representing her and wanted to provide a statement in order to support the information that Dr Mwambingu had put forward. Dr Mwambingu confirmed that Ms P would be available to give evidence to the Tribunal.

On behalf of the GMC

293. Mr Coke-Smyth submitted that in terms of providing witness statements, it had been initially directed that these be provided some months prior to the hearing. Mr Coke-Smyth had reviewed Dr Mwambingu's statement and submitted it was a matter for the Tribunal as to whether it should be admitted. He added that the statement seemed to set out in a bit more detail what had already been provided to the GMC, and Dr Mwambingu would be entitled to say what was in her statement were she to give evidence. Mr Coke-Smyth confirmed that there were no further enquiries this statement would prompt and therefore, as a result, no difficulty would be caused to the GMC if it was admitted.

294. In relation to the statement of Ms P, Mr Coke-Smyth submitted this was problematic in that the document was dated 2 January 2023 and raised the question of why it had not been submitted until now. In addition, it did not conform to the usual format of a witness statement, being an unsigned Word document. Mr Coke-Smyth submitted that even assuming this could be remedied, some of the content did not appear relevant to the allegations before the Tribunal and other parts did not make it clear whether Ms P was at the GP practice at the times referred to in the pertinent particulars of the Allegation.

295. Mr Coke-Smyth submitted that as Ms P's statement was a matter of fact, unless she was available to have her evidence tested the GMC would be unable to agree to her statement being admitted as evidence.

The Relevant Legal Principles

296. The Tribunal had regard to the principles of fairness and relevance, in accordance with Rule 34(1) of the Rules, which states:

> *'The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'*

297. The Tribunal must ensure that it assesses the impact of admitting the evidence upon the public interest, as well as any prejudice caused to the practitioner or other parties, and it should have regard to the interest of fairness to each party whilst holding the statutory overarching objective as the Tribunal's predominant purpose.

The Tribunal's Decision

298. The Tribunal took into account the submissions made by both parties.

299. The Tribunal considered the witness statement of Dr Mwambingu and that it was a matter for the Tribunal as to what weight to attach to it. It noted that the GMC had no objection to the doctor's statement being admitted and determined that the points addressed in the statement were relevant to the matters before it.

300. The Tribunal concluded that there was no prejudice caused to either party and the evidence was likely to be relevant to the matters to be determined. Accordingly, the Tribunal concluded that it was fair to admit the statement into evidence.

301. The Tribunal next considered whether it was fair to admit the witness statement of Ms P into evidence. It took into account that that the current statement was not in the correct format and was not signed. However, the Tribunal was cognisant to the fact that this evidence could be relevant and that the GMC, providing Ms P was available to attend the Tribunal, would have an opportunity to test it. The Tribunal concluded, therefore, that there would be no prejudice to either party in admitting Ms P's statement on the conditions that:

- The document be resubmitted by 16:00 on the following day to include a Statement of Truth; and
- Ms P be available to give evidence to the Tribunal at 09:30 on Monday 12 June 2023.

ANNEX B – 19/06/2023

Application under Rule 34(1) to admit evidence

302. On 9 June 2023, Day 3 of the hearing, Mr Coke-Smyth made an application on behalf of the GMC, under Rule 34(1) of the Rules, to adduce further evidence.

303. Mr Coke-Smyth told the Tribunal that questions had been asked about signatures on prescriptions and that Ms J, when giving oral evidence, had told the Tribunal the signatures had been checked by another member of the Board team, and recorded in the spreadsheet.

304. Mr Coke-Smyth submitted that all the GMC had by way of response was Dr Mwambingu's Rule 7 reply, which suggested it was accepted that she had signed the relevant prescriptions. The issue that had been identified was whether or not Dr Mwambingu had been present on each and every occasion a prescription had been signed, and that the GMC understood her response to say she had been in the flat, and therefore present.

305. Mr Coke-Smyth reminded the Tribunal that the matter of signatures had been dealt with in the report of Dr N, who was the clinician who drew together all of the Board statements and reviewed all the evidence. Dr N had a sample signature from Dr Mwambingu and was familiar with the signature.

306. Mr Coke-Smyth told the Tribunal he was raising this matter of signatures as it would be a concern on behalf of the GMC if it were to be suggested that the signatures always understood to be Dr Mwambingu's, were not hers. The only way to properly resolve the issue would be to call Dr N to give evidence as she had produced the final report

307. Dr Mwambingu pointed out that whoever had collated the information on the spreadsheet had included a signature that was not hers, but that belonged to Dr FM, and she did not object to the sample of her signature to be introduced as evidence.

The Relevant Legal Principles

308. The Tribunal had regard to the principles of fairness and relevance, in accordance with Rule 34(1) of the Rules, which states:

> *'The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'*

309. The Tribunal must ensure that it assesses the impact of admitting the evidence upon the public interest, as well as any prejudice caused to the practitioner or other parties, and it should have regard to the interest of fairness to each party whilst holding the statutory overarching objective as the Tribunal's predominant purpose.

The Tribunal's Decision

310. The Tribunal considered the purpose of introducing the signature, which was to avoid any confusion with the signature of Dr FM if they were both similar. Introducing Dr Mwambingu's signature as evidence would remove any doubt in Dr Mwambingu's mind whether adequate checks had been made. Additionally, it could put more weight on the evidence if the signatures were distinct.

311. The Tribunal considered it fair to introduce the evidence as it would give Dr Mwambingu the opportunity to confirm her signature and it would allow the Tribunal to confirm the evidence presented to it that contained her signature. It would also satisfy the Tribunal that it was unlikely there were any errors in attributing signatures to Dr Mwambingu.

312. The Tribunal concluded that there was no prejudice caused to either party and the evidence was likely to be relevant to the matters to be determined. Accordingly, the Tribunal concluded that it was fair to admit Dr Mwambingu’s sample signature into evidence.

Confidential Schedule

Schedule 1

XXX

Non-Confidential Schedule

Schedule 2

'I declare that the above information is correct and I agree to notify the LHB immediately should I take up any work and/or if there is any other change to my circumstances that might affect my entitlement to payments under this Determination'.