PUBLIC RECORD

Dates: 10/11/2025 - 18/11/2025

Doctor:	Dr Charles WAYAWA MAFUTA KISOLOKELE
GMC reference number:	6100924
Primary medical qualification:	Lekarz 2002 Akademia Medyczna Im. Karola Marcinkowskiego W. Poznaniu Fac. I

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

Summary of outcome

Suspension – 9 months
Review hearing directed

Tribunal:

Legally Qualified Chair	Mr Paul Moulder
Lay Tribunal Member:	Mr George McLean
Registrant Tribunal Member:	Dr Joanne Topping

Tribunal Clerk:	Ms Fiona Johnston

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Stephen Brassington, Counsel, instructed by the MDDUS
GMC Representative:	Mr Carlo Breen, Counsel

Attendance of Press / Public

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

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 Impairment - 17/11/2025

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

Background

2. Dr Wayawa Mafuta Kisolokele ('Dr Wayawa') graduated with an MD from Karol Marcinkowskiego University of Medicine, Poland in 2001. Dr Wayawa worked in various roles and most recently as an emergency physician. At the time of the alleged incident, he was working as a Locum Middle Grade doctor in the Accident and Emergency, Urgent Care Centre ('UCC') of Royal Preston and Chorley Hospital (under GTD Health Care). He worked at the UCC from December 2018 until December 2023.

3. On 4 January 2024, the GMC received a referral from the NHS Counter Fraud Authority ('NHSCFA') ('the Referrer') regarding prescriptions that had been written by Dr Wayawa.

4. The allegation that has led to Dr Wayawa's hearing can be summarised that, between September 2022 and August 2023, whilst working at UCC, he inappropriately prescribed medication to Patient A when he knew that he should not. It is also alleged that, between

June 2022 and August 2023, Dr Wayawa inappropriately prescribed medications either for himself or in his own name intended for Patient B, who the GMC alleged had a close personal relationship with the doctor and was not a UK resident. It is further alleged that Dr Wayawa falsified records in an attempt to avoid detection and that his actions were dishonest.

Events leading up to the Allegations

5. A NHS Counter fraud Intelligence Report dated 4 January 2024 led to a Clinical Review Report dated 9 February 2024 ('the Review') which was conducted concerning the prescribing expenditure for the UCC and Out of Hours Service in Preston. This service provides care for patients outside of normal working hours of General Practice. From the Review, it was noticed that several high value prescriptions, in particular prescriptions for XXX and XXX, had been issued. As a result, further investigations were carried out into these prescriptions. A request was submitted to NHS Business Services Authority to recall the prescriptions, to identify the patient and prescriber information. The further investigations revealed that the prescription pads used to write the prescriptions for XXX and XXX were all booked out to 'C. WAYAWA'.

6. It was alleged that Dr Wayawa had written FP10 prescriptions for XXX that were later dispensed under the name of Patient A or his name, for a drug that was not required urgently, not appropriate to be prescribed within an UCC setting, and for quantities exceeding what would be reasonable to prescribe. Those prescriptions were dispensed at the same pharmacy and included:

- Prescription 1 dated 27/02/2023 for XXX, dispensed on the 19/05/2023.
- Prescription 2 dated 08/08/2023 for XXX, dispensed on the 30/09/2023.
- Prescription 3 dated 31/03/2023 for XXX and high quantities, on 30/09/2023.
- Prescription 4 dated 29/09/2022 for XXX prescribed alongside 3 courses of XXX; dispensed on 29/09/2022.

7. The date on prescriptions 1 and 3 appeared to have been backdated and did not correspond with the dates at the relevant prescription pad that had been issued to Dr Wayama. There was no record of the patient named in prescriptions 1 and 2 within the clinical records on the 'Adastra' or 'Quadramed' systems (the Patient Records systems for the UCC).

8. Further investigation also revealed a prescription signed on 11 June 2022 for XXX and three other medications made out to Dr Wayama.

The Outcome of Applications

9. The GMC provided the Tribunal with a Hearing Bundle in advance of the hearing. Shortly before the start of the hearing, Dr Wayawa provided two bundles: a 'Defence bundle' and a 'Remediation bundle', including statements of Dr Wayawa, reflections, testimonials and other documents.

10. On day four of the hearing, Mr Stephen Brassington, counsel on behalf of the doctor, applied to adduce a medical report and a death certificate relating to Patient B. Mr Carlo Breen, counsel on behalf of the GMC did not oppose the application. The Tribunal, having considered the provisions of Rule 34(1) determined it was fair and relevant to allow them into evidence and granted Mr Brassington's application.

The Allegation and the Doctor's Response

11. The Allegation made against Dr Wayawa is as follows:

1. Between 29 September 2022 and 8 August 2023, on one or more occasion, you inappropriately prescribed medication to Patient A as set out in Schedule 1, in that:

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

b. she had not been formally booked into the Urgent Care Centre ('UCC');
Admitted and found proved

c. the quantities of items 1, 2a, 2b, and 3 were excessive.
Admitted and found proved

2. On or around 17 May 2023 when you issued the prescription to Patient A as described at Item 2 of Schedule 1 you:

a. backdated the prescription to 27 February 2023;
Admitted and found proved

b. deliberately failed to record any information on the Prescribing Record for Pre-printed prescriptions ('prescribing record').

Admitted and found proved

3. Your actions as described at paragraph 2 were an attempt to conceal that the prescription was for Patient A and/or avoid detection of the prescription as you knew:

a. you should not have been prescribing to Patient A:

i. as it was not an emergency situation;

Admitted and found proved

ii. as she had not been formally booked into the UCC;

Admitted and found proved

b. the prescription was not issued by you on 27 February 2023;

Admitted and found proved

c. you needed to keep accurate records.

Admitted and found proved

4. Your actions as described at paragraph 2 were dishonest by reason of paragraph 3.

Admitted and found proved

5. On or around 8 August 2023 when you issued the prescription to Patient A as described at Item 3 of Schedule 1, you inputted a false Quadramed/Adastra number on the prescribing record.

Admitted and found proved

6. Your actions as described at paragraph 5 were an attempt to conceal that the prescription was for Patient A and/or to avoid detection of the prescription as you knew:

a. you should not have been prescribing to Patient A;

i. as it was not an emergency situation;

Admitted and found proved

ii. as she had not been formally booked into the UCC;

Admitted and found proved

b. by inputting a false Quadramed/Adastra number it would give the false impression that the prescription had been issued to another patient that had been booked into the UCC;

Admitted and found proved

c. you needed to keep accurate records.

Admitted and found proved

7. Your actions as described at paragraph 5 were dishonest by reason of paragraph 6.

Admitted and found proved

8. You failed to inform Patient A's GP of the prescriptions as set out in Schedule 1.

Admitted and found proved

9. Between 10 June 2022 and 10 August 2023, you inappropriately prescribed the medications as set out in Schedule 2 as:

a. they were intended for yourself;

Admitted and found proved

b. it was not an emergency situation;

Admitted and found proved

c. the dosage of Items 1, 2a and 2b were excessive.

Admitted and found proved

10. On or around 10 August 2023 when you issued the prescription at Item 2 of Schedule 2 you:

a. inputted a false Quadramed/Adastra number on the prescribing record;

Admitted and found proved

b. backdated the prescription to 31 March 2023.

Admitted and found proved

11. Your actions as described at paragraph 10 were an attempt to avoid detection of the prescription as you knew:

a. you should not be prescribing to yourself;
Admitted and found proved

b. by inputting a false Quadramed/Adastra number it would give the false impression that the prescription had been issued to another patient that had been booked into the UCC;
Admitted and found proved

c. the prescription was not issued by you on 31 March 2023;
Admitted and found proved

d. you needed to keep accurate records. Admitted and found proved

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

13. In the alternative to paragraph 9, between 10 June 2022 and 10 August 2023, you inappropriately prescribed the medication set out in Schedule 2 to yourself, when it was in fact intended for the use of Patient B and:

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

b. Patient B was not a UK resident as they lived in XXX;
Admitted and found proved

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

d. the dosages of item 1, 2a and 2b were excessive.
Admitted and found proved

14. When you issued the prescriptions as described at paragraph 13 you:

a. attempted to cover up that that the prescriptions were for Patient B as you wrote them in your own name;
Admitted and found proved

b. in respect of item 2 you:

i. inputted a false Quadramed/Adastra number on the prescribing record;
Admitted and found proved

ii. backdated the prescription to 31 March 2023.
Admitted and found proved

15. You knew you:

a. should not have been prescribing to Patient B:

i. by virtue of your close personal relationship;
Admitted and found proved

ii. as it was not an emergency situation;
Admitted and found proved

iii. as they had not been formally booked into the UCC;
Admitted and found proved

b. the prescription was not issued by you on 31 March 2023;
Admitted and found proved

c. you needed to keep accurate records.
Admitted and found proved

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

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

Schedule 1

Item	Prescription number	Date of prescription	Date dispensed	Quadramed/Adastra number	Pad number	Medication prescribed
1	XXX	29 September 2022	29 September 2022	Unavailable	Unavailable	XXX
2	XXX	27 February 2023	19 May 2023	Missing	XXX	XXX
3	XXX	8 August 2023	30 September 2023	XXX	XXX	XXX

Schedule 2

Item	Prescription number	Date of prescription	Date dispensed	Quadramed/Adastra number	Prescribing pack number	Medication prescribed
1	XXX	11 June 2022	10 June 2022	Unavailable	Unavailable	XXX
2	XXX	31 March 2023	30 September 2023	XXX	XXX	XXX

The Admitted Facts

12. At the outset of these proceedings, through his counsel, Mr Brassington, Dr Wayawa made full admissions to each of the 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), the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

13. Mr Brassington clarified to the Tribunal that Dr Wayawa admitted paragraph 9(a) on the basis that, although the prescriptions were written as prescribed for him on their face, the medication was in fact always intended for XXX, Patient B, who lived in XXX. Dr Wayawa explained in his witness statement that Patient B had been under ongoing medical treatment overseas and that he issued the prescriptions to enable her to continue that treatment.

14. Mr Breen confirmed that the GMC was content with the doctor's admission on this basis, and it did not ask the Tribunal to conduct a 'trial within a trial', to consider any other interpretation of paragraphs 9(a) and 13, which had been pleaded as 'alternative' charges. The Tribunal therefore proceeded on the basis that there had been an admission and facts found that Dr Wayawa had intended the medications in Schedule 2 for use by Patient B, XXX.

Impairment

15. The whole of the Facts alleged having been admitted by Dr Wayawa and found proved, the Tribunal then had to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of those facts, Dr Wayawa's fitness to practise is currently impaired by reason of misconduct.

Witness Evidence

16. At the start of the hearing Dr Wayawa made full admissions to the whole of the Allegation and Mr Brassington confirmed that there was no challenge to the witnesses' evidence, or to the GMC case as outlined by Mr Breen. As a result, no GMC witnesses were called to give oral evidence at the factual stage of the hearing. The Tribunal was bound by the Rules to receive into evidence the signed witness statements.

17. Dr Wayawa provided his own witness statement dated 2 September 2025, a reflective statement dated 30 September 2025, a supplementary statement undated and also gave oral evidence at the hearing.

Expert Witness Evidence

18. On behalf of the GMC, evidence was relied on from Mr C, Senior Consultant in Emergency Medicine. Mr C provided his report dated 6 August 2024 and a supplementary report dated 29 May 2025.

Documentary Evidence

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

- Witness statement Ms D, Lead Pharmacist, GDT Healthcare, dated 15 April 2025
- Witness statement Ms E, Director of Governance, GDT Healthcare dated 16 April 2025
- NHS Counter Fraud Intelligence Report
- Prescription XXX, dated 11 June 2022
- Prescription Pad Allocation and Return Form, 9 – 16 June 2022
- Patient A Prescription XXX, dated 29 September 2022
- Death certificate of Patient B, dated 5 November 2023;
- Medical report of Patient B, dates 25 November 2025.

Submissions

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

20. Mr Breen, on behalf of the GMC, submitted that Dr Wayawa's fitness to practise is impaired by reason of his misconduct. Mr Breen referred the Tribunal to relevant paragraphs in *Good Medical Practice (2013) (GMP)* and to the *Good Practice in proposing, prescribing, providing and managing medicines and devices (2021)* ('GMC Prescribing Guidance').

21. Mr Breen submitted that the Tribunal had read and considered the evidence contained within the bundle and had heard and read the doctor's evidence in relation to his reflections. The Tribunal had also heard his explanations as to his motivations and the context surrounding the admitted misconduct.

22. Mr Breen submitted that the doctor had admitted that, on three occasions, he inappropriately prescribed medication to Patient A in excessive quantities. He submitted that the doctor admitted that on or around 17 May 2023 he backdated a prescription and deliberately failed to record the information on the prescribing record.

23. In relation to the events of 17 May 2023, Mr Breen submitted that the doctor admitted that he had attempted to conceal that the prescription was for Patient A, and to avoid detection. In relation to those matters, the doctor had admitted dishonesty.

24. Mr Breen further submitted that in respect of his prescribing on 8 August 2023, Dr Wayawa admitted to having inputted a false Quadramed/Adastra number on the prescribing record, to give the false impression that the prescription had been issued to another patient, and again to avoid detection. He has admitted dishonesty in respect of that conduct.

25. In relation to paragraph 9 of the Allegation, Mr Breen submitted that the doctor had also admitted to inappropriately prescribing medication to himself, in excessive doses and in a non-emergency situation.

26. Mr Breen further submitted that on or around 10 August 2023, the doctor had admitted to inputting a false Quadramed/Adastra number and backdating the prescription in an attempt to avoid detection, giving the false impression that it had been issued to another patient. He admitted dishonesty in relation to those matters.

27. Lastly, Mr Breen submitted that Dr Wayawa had admitted to inappropriately prescribing medication between 10 June 2022 and 10 August 2023 to Patient B, in excessive doses, and to attempting to conceal those prescriptions by again inputting a false Quadramed/Adastra number and backdating the prescription.

28. Mr Breen submitted that the doctor's misconduct involved repeated acts of dishonesty and concealment over an extended period of time. These, Mr Breen said, are admissions to very serious conduct.

29. Mr Breen submitted that while the Tribunal may find that there is a low risk of repetition in relation to the doctor prescribing to friends, it may equally find that there remains a higher risk of repetition in relation to prescribing to family members.

30. Mr Breen submitted that, given the course of conduct and the doctor's own evidence, there remains an ongoing risk of repetition in this case. He said that in reality, and in his words, the doctor appeared to be the "kingpin" in respect of his family's medical arrangements while they were in XXX.

31. Mr Breen submitted that the doctor had not yet demonstrated full insight into his misconduct. While he had expressed remorse and offered some reflection, the depth of understanding of the seriousness of his actions remained limited.

He submitted that, when considering remediation, the Tribunal should take into account the scale and duration of the misconduct and the repeated acts of concealment and dishonesty over an extended period.

32. Mr Breen reminded the Tribunal of the Overarching Objective, which has three components:

1. To protect, promote and maintain the health, safety and wellbeing of the public;
2. To promote and maintain public confidence in the medical profession; and
3. To promote and maintain proper professional standards and conduct for members of that profession.

33. Mr Breen submitted that, in this case, all three limbs of the Overarching Objective are engaged. He said that the doctor's repeated acts of dishonest prescribing, concealment, and record falsification raise serious concerns about the protection of patients and the public. The nature and extent of the misconduct undermine public confidence in the profession, because members of the public are entitled to expect that registered medical practitioners will act with honesty and integrity at all times.

34. While dishonesty can, in some circumstances, be remediated, Mr Breen submitted that in the present case, given the nature, extent, and repetition of the dishonest conduct, it was necessary to find that the doctor's fitness to practise is impaired in respect of all three limbs of the Overarching Objective.

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

35. Mr Brassington submitted that he did not seek to persuade the Tribunal that the submissions made by Mr Breen lacked force when it considered the issues of misconduct or current impairment. He recognised that those submissions properly reflected the seriousness of what had been admitted. The principal difference between the parties, he said, lies only in the route by which the Tribunal should properly reach its decision on impairment.

36. He reminded the Tribunal that there is neither a burden nor a standard of proof attached to this stage of the process; it is a matter for the Tribunal's own professional judgment, based upon the facts which have been admitted and found proved.

37. Turning first to the issue of misconduct, Mr Brassington stated unequivocally that the doctor accepts that his behaviour amounted to serious misconduct. He did not seek to dissuade the Tribunal of that conclusion in any way. Rather, he submitted that the Tribunal should consider the context in which these extremely poor decisions were made.

38. He reminded the Tribunal that Dr Wayawa came from the most humble beginnings, from one of the most deprived areas of the world and was raised in circumstances of deep poverty and deprivation. Through the generosity of others, including members of his community, he had obtained a scholarship to study medicine in Poland, where his fees were paid by the Polish Government and his living costs supported by donations from his community.

39. Mr Brassington submitted that this background was not offered to engender sympathy, but to explain the doctor's character and motivations: that he is a man with a profound sense of duty, gratitude, and service to others. Testimonials within the bundle describe him as compassionate, civic-minded, and selfless, someone who consistently places the welfare of others above his own.

40. Mr Brassington invited the Tribunal to understand how this sense of obligation to help those he loves and those who seek his assistance had, at times, distorted his professional judgement and boundaries. His motivation was never personal gain, but rather a misguided desire to assist.

41. Mr Brassington submitted that none of this excused the misconduct which the doctor fully accepted but it did contextualise it. He submitted that the doctor had developed genuine insight. In his written reflections, he said, Dr Wayawa accepted the dishonest nature of his conduct and acknowledged that such behaviour, regardless of motive, undermines public confidence in the profession. He recognised that his failure to maintain professional boundaries and his inability to say "no" to those close to him led directly to his misconduct.

42. Mr Brassington invited the Tribunal to have particular regard to the expressions of regret, apology, and insight contained in his Reflective Statement, and the evidence given orally before the Tribunal. He submitted that Dr Wayawa gave evidence humbly, in what is his fourth language, while clearly ashamed of his actions.

43. Mr Brassington referred the Tribunal to the evidence of Dr F, the doctor's Responsible Officer from the Manchester University NHS Foundation Trust, where the doctor has been

employed since November 2024. He drew attention to her account of the action plan implemented upon his appointment, including prescribing audits, supervision, and compliance monitoring all of which revealed no concerns.

44. Mr Brassington also referred to the testimonial from Dr G, Dr Wayawa's Clinical Supervisor, who confirmed that pharmacy audits had identified no irregularities and that the doctor had received positive feedback for his clinical work, teamwork, and attitude.

45. The evidence before the Tribunal, Mr Brassington submitted, demonstrates that, in over twelve months of clinical practice, there had been no repetition of any concerns. This, he said, was compelling evidence that the risk of repetition is vanishingly low.

46. Mr Brassington also referred to the CPD activities undertaken by the doctor, which he submitted were targeted, relevant, and timely, including training on ethics, prescribing governance, and professional boundaries.

47. With regard to the risk of repetition Mr Brassington submitted that while the pressures which contributed to the misconduct have not disappeared, the doctor has now established a clear personal and professional framework to safeguard against recurrence. He had confronted the cultural and familial dynamics that previously influenced his poor decisions and had developed assertiveness and boundaries appropriate to a practising clinician in the UK.

48. Mr Brassington accepted that the GMC's description of the doctor as the "kingpin" within his family may be apt, but submitted that it is now a protective factor, not a risk factor. He submitted that the doctor's role, age, and position of responsibility within his family are what will ensure that these errors are never repeated. He submitted that the doctor is acutely aware of the devastating consequences this process has had both personally and professionally.

49. Mr Brassington submitted that the public interest must also be considered. He acknowledged that public confidence in the profession is paramount. However, he invited the Tribunal to recognise that this is a case where misconduct can be remediated.

The Relevant Legal Principles

50. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof, and the decision concerning impairment is a matter for the Tribunal's judgement alone.

51. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct and that the misconduct was serious ('serious professional misconduct'), and then whether the finding of that misconduct which was serious led to a finding of impairment of fitness to practise. The Tribunal took into account that not every misconduct is serious professional misconduct and not every instance of serious professional misconduct will automatically result in a finding of impairment. The Tribunal was mindful of the court's judgement in the case of *Schodlok v GMC [2015] EWCA Civ 769* that it should not inappropriately aggregate non-serious misconduct when deciding if the doctors fitness to practice is impaired.

52. The Tribunal must determine whether Dr Wayawa's fitness to practise is currently impaired, taking into account his 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.

53. 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 *CHRE v NMC and Paula Grant* [2011] EWHC 297 (Admin). The Tribunal noted that any of the following features are likely to be present when a doctor's fitness to practise is found to be impaired:

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 and/or is liable in the future to bring the medical profession into disrepute; and/or

c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The Tribunal's Determination on Impairment

Misconduct

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

55. The Tribunal considered of particular relevance the following paragraphs of the Good Medical Practice ('GMP) ('2013') and the GMC Prescribing Guidance:

GMP

14 You must recognise and work within the limits of your competence.

15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a) adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient
b) promptly provide or arrange suitable advice, investigations or treatment where necessary
c) refer a patient to another practitioner when this serves the patient's needs.

16. In providing clinical care you must:

a) prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs
b) provide effective treatments based on the best available evidence

19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

21 Clinical records should include:
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.

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

71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.

a You must take reasonable steps to check the information is correct.
b You must not deliberately leave out relevant information.

<u>GMC Prescribing Guidance</u>

19 You should only propose, prescribe or provide medicines treatments and devices if you have adequate knowledge of the patient's health, and you are satisfied that the medicines serve the patient's needs (see GMP paragraphs 6-7). You must consider:

1. *the suitability of the mode of consultation you are using, for example face to face or remote, taking account of any need for physical examination or other assessments*
2. *whether you have sufficient information to prescribe safely, for example if you have access to the patient's medical records and can verify relevant information*
3. *whether you can establish two-way dialogue, make an adequate assessment of the patient's needs and obtain consent*
4. *whether you can share information appropriately after an episode of care*

60 In these circumstances, you should propose, prescribe or provide a limited quantity and dose – one that is sufficient to make sure the patient receives suitable care until a) they are able to see an appropriate health professional who has access to the relevant information from their medical records or b) you are able to verify that information yourself. In making this decision you should consider the possibility that the patient may be obtaining medicines from other sources.

66. Wherever possible, you must avoid prescribing for yourself or anyone you have a close personal relationship with.

70 In addition to the above guidance, before proposing or prescribing medicines or treatment remotely to patients who are overseas, you should also consider:

a. *how you or local healthcare professionals will monitor their condition*
b. *differences in a product's licensed name, indications and recommended dosage*
c. *whether you have adequate insurance or indemnity arrangements in place to cover your practice in all relevant countries*
d. *whether you need to be registered with multiple regulatory bodies, including in the country you are based, in the country the patient is based, and in the country where the prescribed medicines are to be dispensed.*

<u>Patient A</u>

56. The Tribunal first considered Paragraphs 1-8 relating to Patient A. Patent A was prescribed XXX on three separate occasions:

29 September 2022 - XXX
'27 February 2023' – XXX*
08 August 2023 – XXX

This prescription was admitted as backdated and related to a prescription issued in May 2023.

57. The Tribunal has considered the expert evidence regarding the prescriptions issued to Patient A, specifically the XXX prescriptions. The expert noted:

"[XXX] is not appropriately prescribed from a UCC unless as a one-off dose for a patient who is away from home and requires the medication and is already on it from her GP... The starting dose is [XXX]."

58. In this case, the Tribunal noted that:

- Patient A was a XXX but, in the records, provided the Tribunal could find no reference to her being on XXX at the time. Mr C explained that in an emergency situation a XXX could be an appropriate prescription, however, the prescription issued by Dr Wayawa was for a substantially higher dose XXX and for multiple XXX over an extended period, not a single "emergency" dose;

- The prescription was issued from a UCC and in a non-emergency situation, outside of normal GP care;
- The quantity of XXX prescribed was significant, and the expert concluded that this could pose a risk of harm to the patient;
- Dr Wayawa did not make adequate medical records to document the prescribing or clinical assessment.

59. The Tribunal accepted the expert's view that this prescribing was seriously below the standard expected of a reasonably competent locum middle-grade doctor working in an urgent care/emergency out-of-hours setting.

60. The Tribunal concluded that the prescribing of XXX to Patient A was seriously below the standard expected of a reasonably competent locum middle-grade doctor working in urgent care. It took into account that the evidence showed that Patient A had a XXX diagnosis, according to her GP records.

61. In light of the findings above, the Tribunal concluded that Dr Wayawa's conduct in prescribing medications to Patient A as set out in Schedule 1 was seriously deficient. Between 29 September 2022 and 8 August 2023, Dr Wayawa inappropriately prescribed medication in a non-emergency context, for a patient who had not been formally booked into the UCC, and in quantities that were excessive. In particular, the prescribing of XXX was seriously below the standard expected, given its non-emergency use, the excessive quantity provided, and the failure to make adequate clinical records.

62. The Tribunal decided that its findings in respect of paragraph 1 of the allegations amounted to serious professional misconduct.

63. The Tribunal was mindful of the judgement of the court in *Schodlok* and that it should not aggravate non-serious misconduct inappropriately. In this case, the Tribunal considered that paragraphs 2-4, 5-7 10-12 and 14-16 were intrinsically aspects of the manner and circumstances in which Dr Wayama had issued the prescription, and it was therefore appropriate to consider them together regarding the question of misconduct.

64. Considering paragraphs 2, 3 and 4, the Tribunal noted that these all related to prescription 2 on Schedule 1 of the allegations and the manner in which Dr Wayawa had gone about issuing the prescription.

65. On or around 17 May 2023, Dr Wayawa had compounded his inappropriate prescribing by backdating a prescription to 27 February 2023 and deliberately failing to record the prescription in the appropriate prescribing record. The Tribunal had also found, by his admission, that these actions were a deliberate attempt to conceal the prescription and avoid detection, and were therefore dishonest. The Tribunal was satisfied that this would be regarded by fellow professionals as deplorable and was serious professional misconduct.

66. Similarly, in relation to paragraphs 5, 6 and 7 and the prescription issued on or around 08 August 2023, Dr Wayawa had inputted a false Quadramed/Adastra number on the prescribing record in order to give the impression that the prescription had been issued to another patient, again with the intent to avoid detection. He had admitted that he had known that he should not have been prescribing for Patient A, had knowingly backdated the prescription and breached a requirement to keep accurate records, all of which was dishonest conduct.

67. The Tribunal was satisfied that this would be regarded by fellow professionals as deplorable and was serious professional misconduct.

68. The Tribunal also noted that Dr Wayawa failed to inform Patient A's GP of the prescriptions issued, as in paragraph 8. Taken together as the issuing of the prescription and characterising the manner in which Dr Wayama had conducted himself in doing so, including the non-emergency prescribing, the excessive quantities, the inadequate record-keeping, the deliberate attempts to conceal prescriptions, and the failure to communicate with the patient's GP, this was a serious departure from the standards expected of a reasonably competent doctor. The Tribunal considered that Dr Wayama had breached the requirements of both GMP and the GMC guidance on prescribing, with regards to prescribing, maintaining clinical records and honesty, as above. These actions, in the view of the Tribunal, constituted serious professional misconduct. Accordingly, the Tribunal determined that Dr Wayawa's conduct in relation to the three Schedule 1 prescriptions amounted to misconduct.

Self-prescribing/for Patient B

69. Dr Wayawa self-prescribed on two occasions.

Self-Prescribing Prescription One XXX – 11 June 2022
The information indicates that the prescription contained:

- *XXX*

Self-Prescribing Prescription Two XXX) – 31 March 2023
The information indicates that the prescription contained:

- *XXX*

70. Due to the admissions and the Tribunal's findings - there being no need to go further into the alternative nature of paragraphs 9(a) and 13 - that Dr Wayama had self-prescribed but always with the intention to provide the medications for the use of Patient B, paragraphs 9 to 12 and 13 to 16 then, in the view of the Tribunal, covered the same misconduct relating to the two prescriptions in Schedule 2.

71. Between 10 June 2022 and 10 August 2023, Dr Wayawa prescribed medication in a non-emergency situation and in excessive quantities. The expert report concluded that such prescribing fell *"seriously below the standard expected of a reasonably competent practitioner"*, particularly given the potential for serious side effects associated with the medications involved. The Tribunal accepted the expert's opinion that these actions presented a risk of harm, either to Dr Wayawa or to any patient for whom such medication might have been used.

72. The Tribunal took into account that it had found, as Dr Wayawa had admitted, that the medication was intended for Patient B, who was under follow-up and receiving treatment in XXX. It was clear from the evidence that Patient B had been seriously unwell at the time and the Tribunal accepted that there is some, limited, mitigation in that regard. The expert evidence and documentation confirmed that Patient B had been prescribed these medications overseas.

73. The Tribunal noted that the evidence concerning the dates of issuing and dispensing the second prescription dated 31 March 2023 did not accord with the doctor's oral evidence that he had issued the prescription and arranged its immediate dispensing. This tended not to support an implication of urgency for that prescription. Further, the Tribunal considered that other, more legitimate methods of obtaining XXX would have been open to Dr Wayama.

74. The Tribunal accepted the expert's opinion that this prescribing was seriously below the standard expected of a reasonably competent practitioner. The expert noted that prescribing for someone with whom a doctor has a close personal relationship creates an inherent conflict of interest and breaches the core principles of professional boundaries and objectivity. Further, the expert emphasised that prescribing medication for an individual outside the UK, without a proper clinical assessment or access to their full medical records, represents a significant departure from safe prescribing practice. The Tribunal considered that Dr Wayama had breached the requirements of both GMP and the prescribing guidance, with regards to prescribing, maintaining clinical records, as above.

75. The Tribunal found that the prescribing occurred in a non-emergency context and involved excessive quantities of medication. These factors, combined with the lack of a formal patient booking and clinical oversight, rendered the prescriptions wholly inappropriate. Dr Wayawa's actions were aggravated by the deliberate steps he took to conceal the true nature of the prescribing. In particular, he wrote the prescriptions in his own name and, in relation to one prescription, inputted a false Quadramed/Adastra number and backdated the entry to 31 March 2023.

76. The Tribunal found that Dr Wayawa undertook these actions knowingly, appreciating that he should not have prescribed for a family member, that the situation did not constitute an emergency, that Patient B was not formally booked into the UCC, and that the backdated entry and false system number would create the false impression that the prescription had been legitimately issued. These actions were dishonest, as admitted, which breached the requirement of honesty in GMP.

77. While the Tribunal acknowledged that Dr Wayawa's motivation may have been to assist a family member in need of medical treatment, his conduct breached fundamental tenets of Good Medical Practice, including the obligations to maintain professional boundaries, to prescribe safely and appropriately, and to act with honesty and integrity.

78. The Tribunal was prepared to accept that there had been a genuine desire on the doctor's part to help Patient B. However, the circumstances did not excuse or justify the inappropriate prescribing behaviour. Even if the medication was intended for Patient B, Dr Wayawa should not have prescribed in this manner, outside of an emergency, in excessive doses, or without proper clinical oversight or record-keeping. The Tribunal was satisfied that the conduct in paragraphs 9 and 13 was serious professional misconduct.

79. In respect of the events of the second prescription in Schedule 2, which appeared on the evidence of the prescribing logs to have been issued on 10 August 2023 but backdated to read '31 March 2023' the Tribunal had found that Dr Wayawa inputted a false Quadramed/Adastra number on the prescribing record. As admitted, these actions were undertaken in the knowledge that he should not have been prescribing to himself (or, alternatively, to Patient B), that the prescription was not issued on the backdated date, and that accurate records were required to be kept. The doctor had admitted that this was a deliberate attempt to avoid detection and admitted dishonest conduct.

80. The Tribunal found that Dr Wayawa's actions described in paragraphs 10, 11, 12, 14, 15 and 16 which represented the prescribing and the manner in which it was committed, were a serious breach of Good Medical Practice. The Tribunal concluded that Dr Wayawa's conduct in relation to the second prescription on Schedule 2 was seriously below the standard expected, demonstrated dishonesty, and amounted to serious professional misconduct.

81. In relation to the first prescription of Schedule 2, which had been issued on 11 June 2022, for XXX, in all the circumstances of the prescribing, admitted and found proved in relation to paragraphs 14a, 15 and 16, including the dishonesty and the alternative option of legitimately sourcing XXX, the Tribunal was satisfied that this too would be regarded as deplorable conduct by fellow professionals and was serious professional misconduct.

<u>Impairment</u>

82. In determining whether Dr Wayawa's fitness to practise is currently impaired, the Tribunal considered both the personal and public components of impairment, in accordance with *Cohen v GMC* [2008] EWHC 581 (Admin) and *CHRE v NMC and Grant* [2011] EWHC 927 (Admin). The Tribunal also took into account the three limbs of the overarching objective as referred above.

83. The Tribunal noted that Dr Wayawa's misconduct involved multiple and serious instances of dishonesty over an extended period. There were five occasions of dishonest conduct, which only came to an end because Dr Wayawa was investigated and caught, rather than through any voluntary decision to stop. The dishonesty was deliberate and sustained, involving repeated attempts to conceal prescribing activity through the use of false information, including backdating prescriptions and inputting false Quadramed/Adastra numbers.

84. The Tribunal was particularly concerned that Dr Wayawa's conduct demonstrated a disregard for fundamental principles of professional honesty and integrity. His actions were not isolated or momentary lapses of judgment; rather, they formed part of a pattern of behaviour designed to conceal improper prescribing. On three occasions he prescribed to Patient A, and on two occasions to himself, despite knowing that the prescriptions were not justified by any emergency circumstances. The Tribunal also found that Dr Wayawa had taken deliberate steps to conceal that Patient A had attended to see him, and that the timing of the prescriptions was inconsistent with any genuine emergency need.

85. Turning to the development of insight and any remediation undertaken, the Tribunal accepted that Dr Wayawa has shown genuine remorse. In his reflective statement and oral evidence, he expressed regret for his misconduct and demonstrated an understanding of how his actions breached professional standards. He had apologised to the Tribunal, to the profession, and to his representatives. He accepted that he had acted dishonestly, acknowledged the potential impact on public trust, and recognised that convenience and personal motivations had influenced his poor decisions.

86. The Tribunal noted that Dr Wayawa set out in his reflections that he had developed a framework to prevent recurrence of his misconduct, and it tested the doctor on this in his oral evidence. Dr Wayawa described a recent situation in which he was asked to provide assistance with a medical report but refused, demonstrating some ability to apply professional boundaries in practice. Since the events, he has also been subject to supervision in prescribing and has had the opportunity to reflect deeply on his actions. The Tribunal found credible his evidence that he has now developed the ability to say "no" in circumstances where he might previously have overstepped professional boundaries.

87. The Tribunal determined that Dr Wayawa's actions are capable of remediation, and he has taken meaningful steps towards this. Dr Wayawa had provided details of CPD he had undertaken which was targeted, relevant and appropriate. Moreover, the CPD had been undertaken soon after the events in question.

88. The Tribunal also considered that the death of Patient B the individual for whom some of the prescriptions were intended has removed a key factor contributing to his misconduct. The Tribunal considered that he now has an appreciation that giving in to a desire to help his friends and relatives inappropriately threatens his ongoing suitability for practice.

89. The Tribunal accepted the positive testimonials attesting to his otherwise good character and clinical competence, in particular, including the reports from the Dr Wayawa's Responsible Officer and Clinical Supervisor.

90. In terms of the risk of repetition, the Tribunal considered that Dr Wayawa's reflective work, remorse, and the significant personal and professional consequences he has already faced mean that the risk of repetition is very low. It does not consider him to pose a current risk to patient safety.

91. However, the Tribunal had found that there had been a pattern of dishonest conduct, carried out over a period of time and involving deliberate attempts at concealment. In addition, the doctor's prescribing had been seriously below standard, and the expert had identified a risk of harm in relation to the self-prescribing. The Tribunal concluded that a finding of impairment is necessary in order to uphold proper professional standards and maintain public confidence in the medical profession. Dr Wayawa's misconduct had involved serious and repeated dishonesty which was incompatible with the high standards expected of a doctor. Even where the risk of repetition is low, the public would rightly expect the regulator to mark such conduct as unacceptable.

92. Accordingly, the Tribunal determined that while Dr Wayawa is not impaired on the grounds of patient safety, his fitness to practise is impaired on public interest grounds, namely, the need to uphold proper professional standards and to maintain public confidence in the medical profession.

Determination on Sanction - 19/11/2025

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

93. Having determined that Dr Wayawa'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

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

95. The Tribunal received further evidence on behalf of Dr Wayawa at this stage of the hearing, including a stage 3 defence bundle and a video, concerning the doctor's charitable work XXX.

Submissions

GMC

96. Mr Breen submitted that the appropriate and proportionate sanction, in light of the Tribunal's findings, was to erase the doctor's registration from the medical register. He submitted that this is plainly not a case in which conditions, suspension or a lesser sanction could adequately meet the overarching objective. He reminded the Tribunal that it has found multiple serious incidents of dishonesty, committed over a period of time, and that there were five separate dishonest acts, all of which were deliberate.

97. Mr Breen submitted that the Tribunal has already determined that the dishonesty only came to an end because the doctor came under investigation, rather than through any voluntary decision to stop. He noted the Tribunal's findings that the doctor engaged in repeated attempts to conceal improper prescribing, including backdating prescriptions, providing false information, and importing false Quadramed/Adastra data. He submitted that the Tribunal has also found that the doctor's conduct demonstrated a disregard for fundamental principles of professional integrity, and that the actions were not an isolated or momentary lapse, but a pattern of behaviour designed to conceal improper prescribing activity.

98. Mr Breen submitted that the prescribing of medication to Patient A on three occasions, and to himself on two occasions, without any emergency justification, further underscores the seriousness of the misconduct. He reminded the Tribunal that it has found the doctor took deliberate steps to conceal Patient A as the intended recipient, and that the timing and circumstances of the prescriptions were inconsistent with any genuine emergency need.

99. Turning to the Sanctions Guidance (2024) ('SG'), Mr Breen submitted that several paragraphs of the SG support the need for a sanction which marks the seriousness of

repeated dishonesty and maintains public confidence in the profession. He referred to the sections dealing with aggravating factors, the difficulty of remediating dishonesty, and the principle that dishonest conduct, particularly where sustained over time, undermines trust in the profession.

100. He submitted that, although the Tribunal has rightly considered issues of insight and remediation, the SG makes clear that such matters must be balanced against the persistence, deliberateness and gravity of the misconduct.

101. Mr Breen submitted that it would not be sufficient to take no action in response to the finding of impairment.

102. Mr Breen submitted that this is not a case in which conditions would be proportionate, workable or sufficient to protect the public or uphold proper professional standards. He stated that conditions must be capable of addressing the concerns identified, and that the Tribunal must be satisfied that the doctor can respond to remediation or supervision. Here, he submitted, the concerns centre on sustained dishonesty, which does not lend itself to remediation through conditions. He further submitted that conditions could not satisfy the need to maintain public confidence, given the findings of repeated concealment and manipulation of prescribing processes.

103. Mr Breen submitted that suspension was not the appropriate and proportionate sanction in this case. He stated that the SG indicated that suspension can be used to reflect the seriousness of the misconduct, to provide a clear deterrent, and to signal to the profession and the public that such behaviour is entirely unacceptable. He noted that the Tribunal had found there had been a serious departure from relevant standards and that the Tribunal had found that there was a risk of repetition of misconduct, albeit low.

104. Mr Breen submitted that erasure, according to the SG, may be the proper sanction, where the doctor does not present a risk, but this sanction was necessary in order to maintain public confidence, such as when there had been a blatant disregard for safeguards.

13. Mr Breen submitted that factors in the SG which indicated erasure as a sanction were present in the case. He stated that there had been a particularly serious departure from standards and dishonesty was difficult to remediate. The departure from standards in GMP had been deliberate or reckless. In the circumstances, the GMC contended, the doctor's

continued registration is fundamentally incompatible with the standards expected of a registered medical practitioner, despite his developed insight.

On behalf of Dr Wayawa

105. On behalf of Dr Wayawa, Mr Brassington began by reminding the Tribunal that the SG is guidance to the Tribunal and is not directive. It is intended to assist but does not direct the Tribunal's decision-making. He submitted that the Tribunal is perfectly entitled to depart from the SG, provided that it has a proper basis for doing so and gives clear reasons. Ultimately, he said, the Tribunal must apply its own judgement.

106. Mr Brassington submitted that the purpose of any sanction is well-established as being:

- to protect patients and the public,
- to maintain public confidence in the profession, and
- to promote and maintain proper professional standards.

107. Mr Brassington submitted that it is never the purpose of a sanction to punish a doctor. He reminded the Tribunal that the doctrine of proportionality applies expressly to its decision-making: the Tribunal is required to impose no more than is necessary to achieve its statutory purpose. To do more would be to punish, which would be impermissible.

108. Mr Brassington submitted that, as the GMC has properly acknowledged, the Tribunal must consider the available sanctions in ascending order of gravity. He said that he would address the issue of erasure, including the impact that such a sanction would have on the doctor personally. He would also address the wider public interest, given the substantial charitable and community work undertaken by Dr Wayawa, and the many individuals who are dependent upon his continued ability to work.

109. Mr Brassington accepted that, in fitness to practise proceedings, personal mitigation carries less weight than in other settings because the aim is not to punish. However, he submitted that the wider considerations in relation to Dr Wayawa's community works do not simply concern private hardship but have a material public interest dimension, because the doctor's loss of registration would affect far more than his own immediate family.

110. Turning to paragraph 25 of the SG, Mr Brassington submitted that several mitigating factors were clearly present. There was evidence that the doctor understands the problem, has insight, and had made genuine attempts to remediate. Dr Wayawa had admitted the facts, he had apologised, and the Tribunal had already recognised the tangible steps he had taken to ensure that his behaviour is not repeated. Dr Wayawa was otherwise adhering to GMP, his previous character was exemplary and he had no previous fitness to practise history.

111. In relation to Patient A, he submitted that the Tribunal may properly take into account the pressures placed upon the doctor by a member of his church community, who was aware of his work and sought his assistance. He accepted that the doctor buckled under that pressure and should not have done so; but these circumstances explain, though they do not excuse, how such lapses occurred. Although in a relatively short period, it was relevant to say there had been no repetition.

112. In relation to the prescription involving Patient B, Mr Brassington submitted that significant stress, anxiety and emotional concern had been operating. Mr Brassington made clear that this did not justify the misconduct, as the Tribunal had rightly observed, but it provided important context for a departure from an otherwise long and unblemished path of practice.

113. Mr Brassington submitted that the Tribunal may also consider that there has been no repetition of such conduct since the matters came to light. While the timeframe is not long, the absence of recurrence is not irrelevant.

114. Turning to paragraph 34 of the SG, Mr Brassington relied particularly on the testimonial of Dr H, who set out a long professional relationship with the doctor and described Dr Wayawa's contributions to humanitarian and charitable work in underprivileged communities in Africa. Dr H wrote that the doctor's efforts had never been for personal gain but reflected an altruistic nature and a deep commitment to societal benefit.

115. Mr Brassington submitted that such accounts help to provide a rounded and accurate picture of the individual appearing before the Tribunal. He observed that fitness to practise proceedings often fail to convey the full character of a practitioner who may struggle to express himself under the stress of giving evidence. The testimonials therefore served an important role in illuminating the doctor's true conduct and values.

116. At paragraph 42 of the SG, the importance of expressions of regret and apology is recognised, Mr Brassington said. He submitted that the doctor had accepted responsibility, expressed deep remorse, and offered sincere apology. He is a man of genuine regret and contrition.

117. Turning to paragraphs 45–49, Mr Brassington submitted that the doctor had demonstrated reflection, remediation, and insight, taking timely steps to apologise and to accept that he ought to have acted entirely differently. He reminded the Tribunal that cultural differences and linguistic barriers can influence how insight is expressed and submitted that the Tribunal should approach this element with sensitivity.

118. Mr Brassington also reminded the Tribunal of the statement from the Responsible Officer, which he described as unusually strong, supportive, and persuasive evidence of the doctor's professional standing, engagement, and future potential.

119. Turning to the sanction of suspension, Mr Brassington referred to paragraph 91 of the SG, noting its acknowledged deterrent effect and its role in signalling to the profession and the public that such behaviour is unacceptable. He accepted that suspension has a punitive element, though that is not its purpose.

120. He submitted that, under paragraph 92, the Tribunal should consider whether the misconduct, taken in its full context, is fundamentally incompatible with continued registration. He submitted that it is not. The context of the misconduct, the admissions, the insight shown, and the absence of any repetition all support the conclusion that the doctor's behaviour, though serious, does not cross that threshold.

121. He submitted that there is no evidence that future remediation would be unsuccessful, nor any indication of unwillingness or inability to engage. On the contrary, the doctor has been subject to interim conditions since February, has complied fully, and has demonstrated continued safe and responsible practice.

122. As to the length of any suspension, he submitted that it should be short; he accepted that the conduct must be marked as serious and deferred entirely to the Tribunal's judgment on duration.

123. Turning to erasure, Mr Brassington acknowledged that some of the features described in paragraph 107 may be engaged. He accepted that the misconduct involved

elements of concealment and dishonesty. However, he submitted that when set against the full context, the admissions, the insight, and the steps taken towards remediation, erasure would be disproportionate.

124. He invited the Tribunal to consider the broader public interest—including the doctor's extensive humanitarian work. Mr Brassington referred specifically to the doctor's recent reflection describing the construction of a clean water well XXX, personally funded to provide daily access to clean drinking water for around 50 families. This, he submitted, is a concrete expression of the doctor's compassion, service, integrity and commitment to the welfare of others.

125. Mr Brassington submitted that the doctor's appearance before his regulator is a matter of profound shame to him; this conduct is entirely out of character and represents his first and only lapse. The wider public interest, he submitted, includes the impact on those who rely on his humanitarian contribution; individuals whose access to basic human needs, such as clean water, are profoundly shaped by his efforts.

126. Mr Brassington submitted that the public, properly informed, might well consider the doctor's actions to have been misguided attempts to help others, undertaken under pressure, and that while dishonest, they do not negate his status as a fundamentally good man and a good doctor. As one testimonial put it: "If there is one person in need, he will help."

127. In conclusion, Mr Brassington submitted that the appropriate and proportionate sanction, and the one that achieves the statutory purpose without going further, is a period of suspension. He asked the Tribunal to provide the doctor with the opportunity to make amends, to continue the insight and remediation he has already begun, and to return in due course as a safe, responsible and compassionate practitioner.

The Relevant Legal Principles

128. The decision as to the appropriate sanction to impose, if any, is a matter for this Tribunal exercising its own judgement. The Tribunal must consider its determination on impairment and take those matters into account during its deliberations on sanction. It must consider the least restrictive sanction first and then, if necessary, consider the other sanctions.

129. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Wayawa's interests with the public interest. It has borne in mind that the purpose of a sanction is not to be punitive, but to protect patients and maintain public confidence, although it may have a punitive effect.

130. The Tribunal has taken account of the Overarching Objective, which includes to protect and promote the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, promote and maintain proper professional standards and conduct for members of the profession.

The Tribunal's Determination on Sanction

131. Before considering what action, if any, was appropriate in this case, the Tribunal considered and balanced the aggravating and mitigating factors.

132. The Tribunal considered the following to be aggravating factors in this case:

- Dr Wayawa's misconduct had been repeated on five occasions in a 12-month period, on each case involving dishonesty, and only ceasing when he was discovered;
- Dr Wayawa had attempted to conceal his actions.

133. Having found the aggravating factors in the case, the Tribunal identified the following mitigating factors:

- Dr Wayawa has engaged with the GMC investigation and this hearing;
- Dr Wayawa has no previous fitness to practise history and was of previous good character;
- Dr Wayawa made early and full admissions into his conduct and had made no attempt to suggest that his actions did not amount to misconduct;
- Dr Wayawa apologised for his actions and demonstrated sincere remorse;
- He had provided the Tribunal with positive testimonials from colleagues and his RO which speak to Dr Wayawa maintaining his clinical practice with relevant CPD, keeping up to date with guidance, and otherwise being a good doctor;
- The Tribunal found Dr Wayawa had developed insight into his misconduct;
- Dr Wayawa's targeted CPD and remediation;

- There was no personal gain from the doctor's dishonesty.

134. The Tribunal balanced the aggravating and mitigating factors throughout its deliberations and went on to consider each sanction in order of ascending severity, starting with the least restrictive.

135. The Tribunal was mindful of the basis for its finding of impairment. It had found that it was unlikely that Dr Wayawa would repeat his misconduct, and that there was not a risk to patients in the future. However, the seriousness of the misconduct was such that a finding of impairment had been made in the wider public interests, that it was necessary to maintain both public confidence in the medical profession, and to uphold proper professional standards and conduct for members of the profession.

136. The Tribunal noted the submissions concerning Dr Wayama's family and the potential for personal effect on them from any sanction. It also noted that Dr Wayama is financially responsible for supporting charitable works XXX. However, the Tribunal only gave limited weight to the personal effects of a sanction, as it is well-established that personal mitigation is of less weight in determining regulatory sanction: *Bolton v Law Society* [1994] 1 WLR 512.

The Tribunal's Determination on Sanction

No action

137. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Wayawa's case, the Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action may be appropriate where there are exceptional circumstances, but the Tribunal should set out the exceptional factors and why those factors justified taking no action.

138. The Tribunal determined that there were no exceptional circumstances in this case which would make it appropriate to end the case by taking no action. It determined that, given the misconduct and the Tribunal's findings on impairment, action was required in order to uphold and maintain public confidence in the profession, and it would not be sufficient, proportionate or in the public interest, to conclude this case by taking no action.

Conditions

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

140. The Tribunal concluded, giving full weight to the seriousness of the misconduct, that imposing a period of conditional registration would fail to achieve public protection, and would not uphold the statutory overarching objective or maintain public confidence.

Suspension

141. The Tribunal then went on to consider whether to suspend Dr Wayawa's registration. In doing so, it bore in mind the following paragraphs of the SG:

91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

142. The Tribunal considered that the following paragraphs of the SG were also engaged:

97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.

...

e No evidence that demonstrates remediation is unlikely to be successful, e.g. because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f No evidence of repetition of similar behaviour since the incident.

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

143. The Tribunal concluded that the above paragraphs of the SG were applicable in this case and indicated that a period of suspension may be the appropriate and proportionate sanction in the circumstances. While Dr Wayawa's misconduct involved multiple, deliberate, and sustained acts of dishonesty, including attempts to conceal prescribing activity for Patients A and B, the Tribunal concluded that it did not amount to fundamental incompatibility with continued registration, for the following reasons.

144. The Tribunal determined that the dishonesty, although serious, had not involved personal gain to Dr Wayawa. The Tribunal accepted that he had been motivated by a misguided attempt to help patients whom he believed had required assistance. The Tribunal gave significant weight to the doctor's clinical competence, genuine remorse, insight, and the relevant CPD he had undertaken, commencing from an early stage.

145. The Tribunal considered that, Dr Wayama's ongoing charitable and humanitarian work, both in the UK and in his home community XXX provided balance when considering the potential attitudinal issues arising from the proven dishonesty. It considered that the charitable work reflected well on his overall character and commitment to the welfare of others.

146. The Tribunal noted there has been no repetition of this behaviour, even though there had been only a relatively short period since the events. Dr Wayama had engaged constructively with the regulatory process. He had engaged early on in his remediation and development of insight. In balancing the seriousness of the misconduct against these mitigating factors, the Tribunal concluded that suspension would mark the gravity of the conduct, uphold public confidence in the profession, and maintain proper professional

standards, while allowing the doctor the opportunity to continue demonstrating remediation and safe practice in the future.

Erasure

147. The Tribunal acknowledged the GMC's submissions and considered whether it was necessary to go further than imposing suspension on Dr Wayawa's registration. The Tribunal had regard to the paragraphs of the SG which relate to erasure, some of which were as follows:

'108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.

109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.
b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.

148. The Tribunal concluded the misconduct present in this case was serious, and dishonest misconduct is acknowledged to invite sanctions at the higher end of the spectrum. In the final analysis, it considered that it could pull back from the sanction of last resort, due to its view that Dr Wayama had acted with the misguided intention of helping others, without seeking personal gain and he had made full admissions and early on sought to develop his learning and remedy his misconduct.

149. The Tribunal was clear that suspension for a significant period, in the particular personal circumstances outlined, would be a sanction having significant effects on Dr Wayama, both professionally and financially. Nevertheless, the Tribunal was satisfied that the misconduct in this case called for a serious response in terms of sanction, and that imposing a suspension was such a serious response. In the Tribunal's view, it would be disproportionate to go further and direct erasure.

150. The Tribunal therefore determined that a period of suspension would be an appropriate and proportionate sanction which would protect public confidence in the profession and promote and maintain proper standards of conduct and behaviour.

Length of the order and review

151. The Tribunal then went on to consider the length of such an order. The Tribunal reminded itself that the length of the suspension is a matter for the Tribunal's discretion, depending on the seriousness of the case. The Tribunal took account of paragraph 100 of the SG which sets out relevant factors to be considered when determining the length of suspension:

a) the risk to patient safety/public protection
b) the seriousness of the findings and any mitigating or aggravating factors
c) ensuring the doctor has adequate time to remediate

152. The Tribunal also took account of paragraphs 101 and 102 of the SG which sets out the areas and relevant factors to consider. It reminded itself that its primary consideration was to maintain public confidence and to uphold proper professional standards. Sending out a signal to the doctor, the wider profession and the public was also important, in order to demonstrate that behaviour of this sort will attract regulatory action. In terms of seriousness, the Tribunal considered that this required a period towards the higher end of the range.

153. The Tribunal determined that a period of nine months would be sufficient time to meet the seriousness of the findings and the public interest in the case and send the appropriate message to the profession.

Review

154. The Tribunal determined to direct a review of Dr Wayawa's case. It considered paragraph 164 of the SG which states, in part:

"[I]n most cases where a period of suspension is imposed, and in all cases where conditions have been imposed, the tribunal will need to be reassured that the doctor is fit to resume practice – either unrestricted or with conditions or further conditions. A review hearing is therefore likely to be necessary …"

155. Therefore, the Tribunal directed a review in this case. The review hearing will convene shortly before the end of the period of suspension. The Tribunal cannot bind the next tribunal. However, at the review hearing, the onus will be on Dr Wayawa to demonstrate how he has sufficiently dealt with the past concerns. To that end, it may assist the reviewing Tribunal if Dr Wayawa chooses to provide to that reviewing tribunal:

- Evidence of all the steps he has taken to keep his knowledge and skills up-to-date;
- Evidence demonstrating further development of insight into his misconduct and further remediation;
- Testimonials and references from appropriate persons who can speak to Dr Wayama's character and conduct.

156. Dr Wayawa is at liberty to provide any other information that he considers will assist him.

157. The Tribunal decided to impose a nine-month suspension with a review.

Determination on Immediate Order - 19/11/2025

1. Having determined to suspend Dr Wayawa's registration for a period of nine months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order of suspension.

Submissions

158. On behalf of the GMC, Mr Breen referred the Tribunal to the relevant paragraphs of the SG. He submitted that the GMC's position is that an immediate order is required given the findings of the Tribunal and the public interest.

159. On behalf of Dr Wayawa, Mr Brassington submitted that an immediate order is not necessary. He said that the Tribunal found the risk of repetition to be low, therefore an immediate order was not necessary to protect members of the public.

160. Mr Brassington submitted that Dr Wayawa has been working from November of last year. He has worked without incident, he has provided a hardworking, beneficial service to the patients of his hospital. There have been no complaints, no repetition of this misconduct at any point and his employers are well aware of the circumstances of this case. He submitted that in the circumstances of this case, and the references that have been provided, a member of the public would wish for a doctor to be put back into work. It was therefore not necessary nor otherwise in the public interest for there to be an immediate order.

161. Mr Brassington submitted that an immediate order was not required in Dr Wayawa's own interests.

The Tribunal's Determination

162. In reaching its decision, the Tribunal considered the relevant paragraphs of the SG and exercised its own independent judgement. In particular, it took account of paragraphs 172, and 173.

'*172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. …*

173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.'

163. The Tribunal determined that as the risk of repetition was low and there was no direct risk to patient safety, an immediate order was not necessary to protect the public. It noted that Dr Wayawa has performed well under the current order of interim of conditions. Further, it was of the view that an immediate order was not required to protect public confidence in the medical profession until the substantive order comes into force.

164. The Tribunal therefore determined not to impose an immediate order on Dr Wayawa's registration.

165. 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.

10. The Tribunal decided to revoke the current Interim Order of conditions. The Tribunal had determined that there was no risk to patient safety and an interim order was no longer in the wider public interest, for similar reasons as to its decision on the immediate order.

166. That concludes this case.