Primary Health Lists

The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008
National Health Service (Performers Lists) (England) Regulations 2013

[2014] PHL 2248

Dr Kochummen John (GMC No. 2692335)

Appellant

V

NHS England (North East London Regional Team)

Respondent

Judge	Mr Duncan Pratt
Specialist Medical Member	Dr P Garcha
Specialist Member	Mrs M Harley

Sitting on 8 – 10 and 15 December 2014

DECISION AND REASONS

1. The decision of the Tribunal is that the appeal is dismissed and that Dr Kochummen John's application for inclusion in the Medical Performers List is refused.

The Appeal

2. Dr Kochummen John is a registered medical practitioner who appeals by notice dated 6 August 2014 against the decision of NHS England made on 11 July 2014 refusing to include his name on the Medical Performers List ["the List"].That refusal was expressed to be on three of the discretionary grounds within Regulation 7 (2) of the National Health Service (Performers Lists)(England) Regulations 2013 ["the Regulations"], namely unsuitability, criminal convictions and efficiency, as more fully described at paragraph 6 below.

3. Dr John was represented by Mr M Horne of Counsel, instructed by Ms Hilary King of Hempsons, solicitors. NHS England was represented by Ms N Bruce

(Counsel) instructed by Ms R Crean, both of Capsticks, solicitors. The hearing took place on 4 days, from 8 – 10 December and 15 December 2014.

4. Page references in this decision are to pages of the appeal hearing bundle.

The Legal Framework

5. Under Regulation 17 of the Regulations, this appeal proceeds as a redetermination and the Tribunal may make any decision which NHS England could have made.

6. The provisions of the Regulations which are engaged are:
Reg 7 (1) [NHS England] may refuse to include a Practitioner in a performers list on the grounds set out in paragraph (2)
(2) The grounds on which [NHS England] may refuse to include a Practitioner in the performers list are, in addition to those prescribed in the relevant Part, that
(a) it considers the Practitioner is unsuitable to be included in the performers list having considered the information and documentation provided under regulation 4(2) and-
    (i) in the case of a medical practitioner, regulation 26 ….
(e) the Practitioner has been convicted in the United Kingdom of any criminal offence (other than murder) committed on or after the day prescribed in the relevant Part, and has been sentenced to a term of imprisonment (whether suspended or not) of over six months;….
(g) it considers that there are reasonable grounds for concluding that including the Practitioner in a performers list would be prejudicial to the efficiency of the services which those included in that list perform.
    [these 3 grounds are respectively referred to in this determination as unsuitability, criminal conviction and efficiency grounds]
(3) Where [NHS England] is considering a refusal of a Practitioner's application under a ground contained in paragraph (2) it must, in particular, take into consideration –
    (a) the nature of any matter in question;
    (b) the length of time since that matter and the events giving rise to it occurred;
    (c) any action or penalty imposed by any regulatory or other body as a result of that matter;
    (d) the relevance of that matter to the Practitioner's performance of the services which those included in the relevant performers list perform, and any likely risk to the Practitioner's patients or to public finances;
    (e) [is irrelevant];
    (f) whether, in respect of any list, the Practitioner –
        (iii) was removed from it, ….

and if so, the facts relating to that event and the reasons given for such action by the holder of the list.

<u>Reg 10 (1)</u> *Where [NHS England] considers it appropriate for the purpose of preventing any prejudice to the efficiency of the services which those included in a performers list perform or for the purpose of preventing fraud, it may impose conditions on a Practitioner's – (a) initial inclusion in a performers list…"*

7. The burden of proving facts and satisfying us that the case for not including Dr John in the List is proved lies upon NHS England, and the standard of proof is the balance of probabilities.

8. The parties agree that this Tribunal should accept the verdicts of a Jury delivered at Inner London Crown Court on 10 February 2005 on an Indictment against Dr John, including as to the several elements of the three offences of dishonesty of which he was convicted (see paras 16-20 below). We are not in a position to go behind the verdicts of the jury.

9. We have also taken account of the following guidance documents, and reports of legal decisions placed before us:
    a. General Medical Council: Good Medical Practice;
    b. NHS England Medical Appraisal Policy (Version 1 Oct 2013);
    c. *Karwal v The GMC* [2011] EWHC 826;
    d. *Uddin v Betsi Cadwaladr University Health Board* [2012] UKFTT 223 (HESC);
    e. *Ho v Halton & St Helens Primary Health Care Trust* [2011] PHL 15402;
    f. *Shah v NHS England* [2013] UKUT 0538 (AAC) and sub nom *Shah v S.E Essex PCT* [2014] UKFTT 0771 (HESC).

<u>Evidence received</u>

10. In addition to the 1242 page bundle of documents prepared for the hearing a number of other documents were handed in, by agreement, during the hearing. They were numbered in accordance with pagination of the hearing bundle as follows:
    Skeleton arguments of the parties, pages 54 a-n and 54 o-s respectively;
    Certificates of attendance by Dr John at several recent educational courses, pages 922 (b) – (f);
    A quotation for professional indemnity cover offered by All Medical Professionals Ltd at a premium of £19,610 pa including tax, contained within an email exchange dated 13 November 2014, pages 1089 a – c;
    Letters written by Dr John's solicitors in 2011 and 2012 to local General Practitioners requesting testimonials for the purpose of a hearing for restoration to the GMC register, pages 930 a – n;

Similar letters written in 2013 for the purpose of seeking updated testimonials for a further hearing in May 2013, pages 1010 a – h;
Similar letters written in October 2014 to providers of previous testimonials enquiring if they are able to confirm the views they previously expressed remain the same, pages 1038 a- d;
NHS England Medical Appraisal Policy Version 1 October 2013, pages 1243-1272.
The Tribunal was also provided with a copy of the Indictment No T 20037934 from the Crown Court at Inner London on three counts of which Dr John was convicted on 10 February 2005. For purposes of identification we now paginate this document as 548 a – d (following the sentencing remarks of Judge Pardoe).

11. The Tribunal heard oral evidence from Dr Henrietta Sophia Lefanu Seymour Hughes, Medical Director and Responsible Officer for the North Central and East London Area Team of NHS England, on behalf of the Respondent.

12. We heard oral evidence on behalf of the Appellant from:
    a. Dr Kochummen John;
    b. Dr Thota Chandra Mohan;
    c. Dr Syed Zishan Haider;
    d. Dr Jagan John (the eldest son of Dr K John and now senior partner of the GP practice at King Edward Medical Centre).

    Their witness statements within the hearing bundle were also read by the Tribunal, as were the statements of the following witnesses whose attendance for cross-examination was not required:
    Mr Kaleem Haider, 15 October 2014
    Dr Honer Kadr, 14 October 2014.

Background to the decision of NHS England

13. Dr Kochummen John is aged 67. He qualified in medicine in Mysore, India, in 1973 and obtained further medical qualifications in the UK in 1980. Between those dates he worked in various junior hospital posts in the UK but from 1981 he undertook training in General Practice, before becoming in 1982 the GP principal of what was (then) a small General Practice called King Edward Medical Centre in Barking. It was and remains a deprived area. He and his GP wife Dr A John built it up to around 6,200 NHS patients by December 2004 when he ceased practice in the circumstances summarised below. While in NHS practice he was on the Performers List and, prior to that, the Medical List.

14. The following is merely a summary of the evidence we have read and heard, all of which we have considered. While practising as a GP, Dr John did some sessional work as a Clinical Assistant in Cardiology at Oldchurch (now Queens)

Hospital, Romford from 1986 to December 2004, and until 2000 as a Clinical Assistant in psychogeriatric medicine at Warley Hospital, Brentwood. He was Chair of the Coronary Artery Prevention Committee and was instrumental in setting up, together with hospital Consultant colleagues, a one stop Chest Pain Clinic in the area which improved the care pathway locally.

15. Dr John also took on a number of roles in the administration of primary care, among which were Secretary to a GP fundholding group, Co-Chair (with Dr Mohan) of the Primary Care Group (which followed, organisationally, fundholding groups in 1999 and preceded the Primary Care Trust) and Lead for the local Prescribing Committee. When the Primary Care Trust was established he became its Chairman. Both the PCG and PCT held and managed their own budgets.

16. On 10 February 2005, after a Crown Court trial lasting (Dr John told us) about a month, during which he elected not to give evidence, he was convicted of three offences of dishonesty.

17. The first offence was a conspiracy with a Mr T, to defraud the Department of Work and Pensions by dishonestly representing that Mr T was incapable of performing work and suffered from such disabilities that he required 24 hour assistance. This resulted in a loss to that Department of £30,000 which, in due course, Dr John was required to repay under a compensation order. The dates in the Indictment for the conspiracy are 1 April 1996 to 17 May 2002 although Dr John volunteered in his statement [739] and in his oral evidence that he first certified Mr T as unfit for work on 6 May 1993. In addition Dr John told us that he wrote two letters on Mr T's behalf in support of a claim to a higher level of Disability Living Allowance, one of which said that he was unable to work and needed 24 hour care. He also told us that he completed a couple of DWP questionnaires which were sent to him. We did not have access to the evidence adduced by the prosecution.

18. The second offence was using false instruments between 14 January and 4 March 2002: two estimates for repairs for flood damage to the King Edward Medical Centre which he knew or believed to be false in that they purported to be genuine competitive estimates by two independent firms known as Fretwell & Sons Ltd and Base Builders) with the intention of inducing a person at Zurich Municipal (insurers) to accept them as genuine and by reason of accepting it, to do or onto to do some act to his own of any other person's prejudice.

19. The third offence was also using a false instrument on or about 3 April 2002: a receipt which purported to show that £2,600 had been paid to a firm called Base Builders for the fitting of remote controlled locks, which was and which

he knew or believed to be false, in that no payment had been made, with the intention of inducing the responsible person in Barking and Dagenham Primary Care Trust to accept it as genuine and so to do or not to do some act to his own or any other person's prejudice [i.e. pay money to the Practice in respect of that work].

20. On 15 June 2005 Dr John was sentenced by HHJ Pardoe:
    a. On the first matter to two years' imprisonment suspended for two years, and a £30,000 compensation order to the DWP and to pay a fine of £10,000.
    b. On the second and third matters to six months imprisonment (concurrent) suspended for two years.

21. HHJ Pardoe [sentencing remarks 546-548] treated the first matter as the most serious because, among other things, "in the assessment of entitlement to such benefits, medical assessment by the claimant's medical practitioner is of crucial importance and the system makes that abundantly clear". He also remarked that "the jury's verdict is that your medical opinions, assisting [Mr T] to obtain this benefit, were made dishonestly. The basis of that conclusion in the evidence was that you , and you alone of all the doctors who saw [Mr T], saw [him] on an almost daily basis in your surgery where he acted as handyman and that you also made use of his services in your home as gardener and again, on occasion, as handyman....and knowing that [Mr T] was far from immobile and not in need of the high level of assistance in care required for obtaining the disability living allowance benefit he was enjoying, nevertheless certified him as in a medical condition amounting to immobility and which required constant care. That, in my judgment, was indeed dishonest and a serious dishonest breach of trust in your capacity as an experienced medical practitioner, certifying a patient in the obtaining of a welfare benefit and doing so over a long period of time."

22. HHJ Pardoe felt able to suspend the sentence of imprisonment for two reasons: firstly that Dr John was suffering from lymphoma cancer and had recently been operated on for the removal of cancerous tumours from the kidney and had suffered a minor heart attack; secondly that "you are unlikely ever to practise again". In the event, as Dr John disclosed in his application to the GMC for restoration to the register "this diagnosis [of cancer] was not confirmed".

23. On 21 December 2005 the PCT notified Dr John of its decision to remove him from the Medical Performers List on the basis of his criminal conviction and sentence of more than 6 months. We observe that, prior to 1 April 2013, it was *mandatory* to remove a medical practitioner from the List if he was convicted

of a criminal offence resulting in a sentence in excess of 6 months imprisonment. The current regulation makes it a discretionary ground.

24. On 30 May 2006 the General Medical Council (GMC) erased Dr John from the medical register. In that same year Dr John attended 3 courses in clinical education, a similar number in 2007 and 2008, and in the following calendar years between 5 and 12 courses, until in 2012 he attended 13 courses [108 - 109]. In February 2012 he applied to the GMC to be restored to the medical register.

25. That application was heard over 2 days by a Fitness to Practise Panel ("FtPP) of the Medical Practitioners Tribunal Service (MTPS) but referred to in evidence from time to time under the title of the body it replaced for professional disciplinary purposes, the General Medical Council (GMC), in September 2012. It decided that the public interest could now be served by making provision for Dr John's return to unrestricted practice, but that not having practised medicine for 8 years there may have been some deskilling. The Panel therefore adjourned the hearing to enable a Performance Assessment to be carried out [90].

26. At the adjourned hearing the results of the Performance Assessment were considered. The assessment team leader Dr Cox gave evidence: Dr John's performance overall was acceptable. He had scored above a standard score in areas such as knowledge and simulated surgery [357 C - D]. There were some areas where it had fallen below an acceptable standard [356]. One feature which caused the team to grade him unacceptable on a number of occasions was a tendency during consultations to interrupt patients more often than was helpful [357 A]. Dr Cox's team had been unable to carry out a full Performance Assessment because (for example) it was not feasible to carry out an actual performance test in practice [359 E] or to consider his record-keeping.

27. In the event the FtPP was satisfied and granted Dr John's application to be restored to the Register. Its decision letter with reasons, dated 3 May 2013, is at pp 87 – 92.

28. Although the jurisdiction of the FtPP was confined to the question of restoration, the FtPP also made observations about a proposed plan for return to work, which have featured in this case. As explained at that hearing in May 2013 the plan was in short that Dr John would be supervised by a Dr Mohan (with whom he had previously co-chaired the local Primary Care Group and held office together in the GP fundholding group which preceded it) in the same manner as Dr Mohan trained GP Registrars: initially by having him sit in with Dr Mohan and observe for up to 2 weeks, then Dr Mohan would observe

him practising for another 2 weeks. Thereafter Dr John planned to practise at King Edward Medical Centre for an introductory period under the supervision of his son Dr Jagan John.

29. Dr Cox was pressed in evidence for his opinion about the appropriateness of the plan [365 – 367]. In his view the timing of the process should depend on progress not a predetermined guess of two weeks [365 D] and he felt that the second question, about which he said he could give no opinion at all, was about the objectivity of medical or clinical supervision being between father and son [366 D] but agreed after it was put to him that Dr Mohan would continue to have a mentoring role that it had "*the makings of a plan* that, first of all, secures patient safety and, secondly, eases Dr John back into practice". [367 C].

30. The FtPP commented in its decision letter [92]: "The Panel have been encouraged by the information with which it has been presented about your plan for a phased return to work. It accepted the evidence of Dr Mohan and Dr Jagan John and is confident that your performance will be closely supervised by them".

31. This plan was slightly refined in the course of Dr John's application for inclusion in the List (see below).

32. On 19 June 2013 Dr John's name was formally restored to the GMC GP Register. Thereafter he has been able to practise medicine other than as an NHS GP on the Performers List, although he has not done so.

33. On 11 September 2013 Dr John applied to be included in the medical Performers List. On 15 October 2013 Dr John's solicitors sent to NHS England a copy of a quote for professional indemnity insurance provided by All Medical Professionals Ltd [688 – 706]. On 22 October 2013 NHS Shared Business Services Ltd emailed Dr John in connection with his application to join the List, stating that "as you have been out of general practice for 2 or more years, you need to contact the Deanery where you will have to sit an exam and the Deanery will allocate a training practice and the length of time you need to be on the Induction and Refresher Scheme ("the I & R Scheme") [147]." Hempsons responded on behalf of Dr John [153 – 5] asking that NHS England consider the particular circumstances of the case and "not as a matter of routine impose a requirement that he must first sit an exam set by the Deanery/ the Local Education and Training Board and be allocated to a course". They pointed to the fact that he recently and satisfactorily passed a performance assessment by a Panel appointed by the GMC, and to the plan for a supervised return to practice (see above) which they said "met with the

approval of [the FtPP]. Panel". Further information was requested from him by NHS England on 18 March 2014 [685-687], including for sight of the sentencing remarks of the Crown Court Judge (see above).

34. However on 11 July 2014 NHS England notified Dr John of its decision (see para 2 above) [56 – 61], against which Dr John now appeals. It relied on the grounds of unsuitability, criminal convictions and efficiency. Its reasons (more fully set out at pp 59-61) were referenced to the factors set out at Regulation 7 (a), (b), (c), (d) and (f) set out above. Among other things Dr Hughes (the signatory of the letter) relied on the convictions related directly to his role as a GP and involved dishonesty, and that the Judge's sentencing remarks specifically referred to "a serious dishonest breach of trust in your capacity as an experienced medical practitioner". The events giving rise to these convictions were between 22 and 11 years old but occurred over a period from 1992 to 2003 and were not an isolated incident. The length of sentence reflected the seriousness and was only suspended because of exceptional circumstances of poor health and the fact that Dr John was unlikely ever to practise again. NHS England further reasoned that public confidence in NHS GPs would be damaged if Dr John were included in the List, given his conviction for offences of fraud resulting in inappropriate payments from public funds (DWP and NHS) and that if included in the List he would be paid as an NHS GP out of public funds. Reliance was also placed on Dr John's lack of insight in (firstly) failing fully to accept the basis for his conviction or to take responsibility for his actions as reflected in his evidence to the FtPP and (secondly) proposing that on his return to work after a break of 8 years he should be supervised by his son rather than undertaking an I & R course run by the Deanery; such an unsuitable and inappropriate suggestion gave rise to further concerns about his insight.

<u>Position of the parties</u>

<u>NHS England</u>

35. The primary position of <u>NHS England</u> is that its decision should be upheld and Dr John's application for inclusion in the Performers List should be refused on each of the three grounds relied on in its original decision (see para 34 above).
36. The nub of the case as presented by NHS England was that Dr John was unsuitable to be on the List, by reason of his dishonest behaviour resulting in the convictions, the seriousness of that dishonesty (all in the context of his work as a GP), the need to preserve the confidence of patients in the integrity of practitioners and the service generally, and crucially, Dr John's unwillingness to address or admit his dishonest conduct, and his evasive attitude and lack of truthfulness now. Ms Bruce described this as "an indicator for risk in the future". NHS England did not have sufficient confidence in his ability to stand

back and learn from mistakes or in his dealings with the various administrative services of the NHS which rely on integrity. It was also argued that those around him offering support or mentoring in varying ways also displayed a lack of insight (which Ms Bruce called a "collective lack of insight") so that there was no realistic prospect of remedying Dr John's own lack of insight.

37. If the Tribunal was not persuaded that he should not be admitted to the Performers List because of unsuitability or the criminal convictions, then the alternative position of NHS England was that Dr John should only be included on the Lists subject to conditions for the purpose of removing any prejudice to the efficiency of the services (an alternative purpose under the Regulations being the prevention of fraud). It was argued that there was a cumulative impact on the services from factors such as the inadequacy of monitoring and supervision, the need to tell patients about the circumstances of Dr John's convictions and if necessary provide an appointment with another doctor and/or at another time if the patient preferred not to see Dr John, the dilemma for patients who found they needed to ask this doctor for a sick note or other benefit-related document who might be embarrassed to do so, or who might feel he was a "soft touch" to obtain one, and the need for probity and objectivity in arm's length dealings with the NHS administration.
<u>Dr John</u>

38. The position of <u>Dr John</u> changed in two respects during the hearing. But he contended throughout that he should be included in the List; the reasons of NHS England for not agreeing to do so were wrong and should not be upheld. That position was very fully amplified in a skeleton argument [54 a – n] which the Tribunal has considered in its entirety but the main thrust be summarised as follows.

39. The skeleton argument on behalf of Dr John accepted that the convictions were serious (while maintaining that NHS England overstated the factual basis for those convictions). It also accepted that the dishonesty found by the jury was incompatible with the professional standards expected of a GP, and that such behaviour damaged the public interest by undermining public confidence in the profession. However Dr John argued that this did not mean that it should never be possible to rehabilitate himself sufficiently to resume practising as an NHS GP. It was almost 10 years since his convictions and over 12 years since the most recent date on which dishonesty was alleged in the Indictment on which he was convicted. He argued he was genuinely remorseful and had learned from his mistakes. In his view NHS England had given no credit for a number of factors including his "unblemished clinical performance" in the past, his commitment to medical services in the Barking area, evidenced by his role in setting up and administering local services, and the devastating impact

of his behaviour on himself and his family. He had also kept his medical knowledge up to date (see eg para 24 above) and had passed a GMC Performance Assessment demonstrating that his performance was acceptable by reference to the standards expected of a GP currently in practice.

40. Dr John put his insight into the events giving rise to his convictions in the forefront of his case (paras 21 to 23 of his skeleton argument). He pointed to, among other things, his acceptance of the criminal verdicts and subsequent erasure from the GMC register, his remorse expressed to colleagues such as Drs Haider and Mohan, and his son's view that he was a changed man, being readier to listen. When Dr John's attitude to his convictions was further developed, it was that he had not known or believed at the time that what he was doing was dishonest, but following conviction he recognised that that is what it looked like to a jury and it was indeed dishonest. When he gave further details of what it was he had in fact done, he admitted only that he had been guilty of "woeful lack of care and attention" [witness statement para 17 – p. 741] in the information he had provided to the DWP (he also told us in evidence "the mistake I made was not to add another paragraph saying this is the state of affairs of the patient at the moment but it may change and he needs to be reassessed [in due course]") or in accepting information or documents provided to him by others, mainly his Practice Manager Linda. He should have checked whether it was genuine [see e.g. his evidence to the FtPP p 481 F – G]. He went on to describe his conduct as "serious errors and misjudgements" and later told the FtPP that his "main mistake" was not to write to the DWP saying that in between times, Mr T was able to walk around [504 C and 505 E].

41. He further relied on what he termed his complete acceptance of the need for a monitored and supported return to work; however this was one aspect of his position which changed and must therefore be summarised separately below.

42. Dr John also placed reliance on the decision of the FtPP to restore his name to the register to resume medical practice, and its conclusion that restoration would involve no risk to patients and would be in the wider public interest. It was argued that although this Tribunal was not bound by that decision it was in the public interest that there should be consistency of decision making, that the FtPP decision should therefore carry considerable weight, and that the role of NHS England in administering the Performers List was directly analogous to that of the GMC and its panel.

43. Dr John's position on the arrangements for re-entering practice changed. In his application, and on the appeal and during the first day of the hearing Dr John's position was that he was not in the position of other GPs who had a career

break in that he had maintained his knowledge and skills and his performance had recently been assessed by the GMC and he had maintained regular contact with his old practice through his family who continued to run it. He proposed that he should initially spend a period of supervision by Dr Mohan, during which he would sit in on Dr Mohan's consultations for at least 2 weeks and if Dr Mohan was then satisfied he was ready, he would undertake consultations himself which Dr Mohan would observe, again for 2 weeks, and then Dr John would see Dr Mohan's patients on his own for a period and Dr Mohan would afterwards review the records and discuss the consultations with him [see eg pp 771-772]. After that, Dr John would return to practise at King Edwards Medical Group, where Dr Jagan John would provide supervision and support, including a 2 week "shadow induction" scheme.

44. On the second day of the hearing Dr John abandoned that proposal. It was indicated on his behalf that, having heard Dr Hughes' concerns (mainly as to the lack of objectivity in his plan, and treating him differently to other "returnees") during her oral evidence, he accepted them and was willing to undertake an I & R scheme arranged by the Deanery.

45. While it is right to say that Dr John's skeleton argument did concede that if this Tribunal did not find his return to work plan provided sufficient assurance, he was willing to undertake the I & R Scheme (if necessary as a condition of inclusion in the List) the whole thrust of his case during cross-examination of Dr Hughes was that his own plans were robust and satisfactory, and it would be unreasonable to require him to substitute an I & R Scheme.

46. The second change in Dr John's position was that in final submissions he argued that "the balance is in favour of a *conditional inclusion*". It was submitted that specific conditions could require him to complete a Deanery I & R Scheme and also to work only as a salaried GP or a locum (which it was submitted would be proportionate for the purpose of preventing fraud): see submissions at paragraphs 19 and 21. The precise extent and wording of the conditions was left to the Tribunal. It follows from these submissions that Dr John also accepts that his inclusion in the List would otherwise be prejudicial to the services which those on the List provide and that the second condition was appropriate and proportionate for the purpose of preventing fraud, since that is a necessary basis for our having jurisdiction to impose such conditions (see Reg 10 (1) set out at paragraph 6 above).

FINDINGS AND REASONS

Overview of the witnesses

47. Before setting out our findings on the various issues we set out our impression of the witnesses from whom we heard.

48. Dr Hughes was an impressive professional witness who was balanced, thoughtful and objective in the responses she gave, in particular to Mr Horne in the course of a searching and thorough cross-examination. She was ready to make concessions where appropriate and also to add caveats where appropriate. We found her to be scrupulously honest and fair (although challenged from time to time on the basis that she had not been fair) and was at times painfully careful in finding the right and balanced reply. She had a clear grasp of her role and the obligations she had to discharge, including the distinction between the function of NHS England in administering the Performers List and the function of the GMC and its Fitness to Practice Panel, and took very seriously her role (as Responsible Officer) to offer and provide support to practitioners who were in difficulties. She demonstrated that she empathised with what Dr John and his family had been through during and after the criminal proceedings and GMC processes, and gave appropriate credit to his resilient determination to keep up his continuing education during the intervening years. In our judgement she was able to support the opinions she offered with detail. This was particularly so in relation to her concerns about Dr John's insight, and her concerns about Dr John's plans for a return to practice, involving as they did (in her opinion) a lack of objectivity in the supervising process, a potential conflict of interest and treating Dr John differently and more favourably than other doctors returning to practice.

49. Dr Kochummen John was an articulate and polite witness. He was extremely, and justifiably, proud of the fact that he was the first medically qualified person from his family and that he had built up a sizable GP practice from very modest beginnings in a deprived area of London, to which he felt a great attachment. He was also proud of his additional achievements in promoting improvements in the cardiac care pathway in his area, in taking administrative roles in primary health in his area over many years before his arrest, and in the leading roles he had played in his Rotary Club and his Church. He had clearly been devastated by his conviction and erasure, and we accept that he went into his shell for some years thereafter, before resuming his active interest in medical issues. It is to his credit that he then undertook the continuing education courses set out in the bundle, and ultimately satisfied the GMC Performance Assessment team in the areas where it was possible to test a doctor who was not in current practice (that is to say excluding areas like record keeping). In our judgement Dr John's self-image is rooted in his role as a doctor/ professional man who enjoyed the respect of his peers and community. In a striking reply to his own Counsel, when asked who he thought had been the victims of his crimes, he said "I am the victim of the crime because the sufferings I have gone through. I suffered in health, family life and associations with other organisations and in respect to my own profession. So I

had to resign from everything, so I am the victim. I don't think anybody else but my family. Nobody has suffered as much as I have." His motivation in returning to NHS practice after a break of about 10 years, and at the age of 67, is at least partly to restore the position and reputation he previously enjoyed, before he chooses to retire, although we do not discount that he also has some altruistic motives as he described. Sadly, we were also driven to the conclusion that he is unable to be frank and honest with himself about what he did, and is therefore unable to be honest with others, including this Tribunal, now. We found his account of his own wrongdoing tortuous and not credible.

50. Dr Haider (a neighbouring GP) was an amiable and unchallenging personality who had unconditionally accepted all that Dr John had told him about the circumstances of his conviction. He had provided counselling to Dr John around a year after his convictions, for which he told us he was qualified by reason of his medical experience and interests. He did not appear to consider there was anything unusual about Dr John choosing him as a counsellor despite his being the father of Dr John's Practice Manager, or that this might mediate what Dr John confided in him. Although he had concluded Dr John was depressed and had a guilt complex he had not advised him to consult his own GP about treatment; we found that surprising but must assume that whatever psychological sequelae were present were sufficiently mild not to need treatment . What Dr Haider knew or understood was entirely derived from Dr John. He did not think any more widely than that. He therefore expressed the view that Dr John "was dependent on his Practice staff blindly and was following what they are saying but he accepted responsibility for depending on them" and drew a distinction between recklessness and being dishonest at the time: "there are two categories [of dishonesty], one is that others perceive you have been dishonest and the other that you dishonestly did things at the time". He told us that Dr John did not think he was dishonest at the time of his acts, but realised after conviction that it was dishonest. This is precisely Dr John's own position. Dr Haider was able to say that he still regarded Dr John as an honest person.

51. Dr Mohan was pleasant in manner and had a positive and supportive attitude to Dr John whom he had known for 30 years. He had known him particularly well whilst working with him in various capacities including as Co-Chair of the local Primary Care Group (predecessor of the PCT) in which role they managed the commissioning of care and the finances and administration of the Group. Nevertheless Dr Mohan preferred to describe himself as a close professional colleague of Dr John in local primary healthcare, rather than a friend. However his evidence suggested a close relationship prior to Dr John's conviction, which had resumed when he met Dr John on a Tube journey about 2 or 3 years ago. He said Dr John had used the words "I have been very dishonest in what I have

done", but he too completely accepted Dr John's account of how he had come to be convicted, namely that he had relied too much on others in relation to the insurance claim and the claim for funds from the PCT, and so far as the certification for Disabled Living benefit was concerned, that he should have said that the patient would need reviewing again in the future. Dr Mohan was less than candid in claiming he held responsible posts to which he had not in fact ever been appointed: firstly in a testimonial on behalf of Dr John in which he described himself (among other things) as the appraisal lead for the area [375] and secondly in evidence on oath to the FtPP [373 G – H] and in a further testimonial letter [774] when he described himself as joint chair of the Barking and Dagenham CCG. His explanations of how this had occurred were unpersuasive and demonstrated a careless regard for the truth. This is of some importance in the context of Dr John's proposal that Dr Mohan should supervise his re-introduction to practice, in light of his history on probity (a plan which was abandoned in the course of the hearing). Dr Mohan trained GP Registrars within his practice including two who had been referred to his practice having had "difficulties" in their home Deanery areas. He had never asked these trainees anything about those difficulties in order not to embarrass them. If he were to supervise Dr John he would not tell patients in his own practice about the convictions for dishonesty unless the patient asked; otherwise he would just introduce him as a trainee. He agreed that this was designed to avoid embarrassment to Dr John rather than to give proper information to the patient. He did not differentiate in this respect between Dr John and the situation of the other GP Registrars he dealt with. We do not consider that Dr Mohan would have been able to identify or raise difficult issues with Dr John as would be necessary. Nor did he propose to be totally open with patients about Dr John. We would not have considered Dr Mohan to be suitable to provide remedial training to Dr John; however Dr John abandoned his proposal for re-entry to general practice involving Dr Mohan.

52. Dr Jagan John (Dr Kochummen John's eldest son) has an impressive curriculum vitae. He has energetically modernised the King Edward Medical Centre and taken on additional healthcare roles including Clinical Director of Barking & Dagenham Clinical Commissioning Group, Lead for Integrated Case Management, End of Life Care and Patient Forums and a number of others more fully set out at paragraph 2 of his witness statement [724]. In addition he told us he is Director of Health 1000, part of the Prime Minister's Challenge Fund. We have no reason to doubt that he is an excellent GP with a wide involvement in primary healthcare beyond King Edwards Medical Centre. We also noted that he trod a careful line between being a member of his profession and being his father's son. It was a difficult position for him. We note he too accepted without question his father's position about the dishonesty of his actions [see e.g. paras 12 – 13 of his witness statement, p

726]. He said his father would not have anything to do with insurance or grant claims if he re-joined the practice for 2 – 3 sessions a week. A salaried GP had left their practice last year. He was not sure if a new one would be appointed. Indeed even if Dr John completed the I & R Scheme satisfactorily it was not automatic that he would be taken on at King Edward Medical Centre because of changes in contract and financial pressure of the sort which had caused 3 or 4 local practices to close. This contradicted his father's evidence that a new doctor was coming to start work in 2 – 3 months' time so that there would be enough "bodies" to manage the practice without his working more than a few sessions a week. Dr Jagan John envisaged that King Edward Medical Centre would make leaflets available to patients explaining that Dr K John was returning to practise and stating that he had been convicted of these offences "to make the position transparent" but felt that those patients who had previously known his father would not need further explanation (those who had volunteered an opinion to him were asking when, not whether, his father would return to the practice) and that further explanation would only be necessary for patients who had joined the practice since his father's conviction. We considered his expectations about the extent of disclosure of information, the arrangements for talking to patients who had registered since the conviction or who were unwilling or unsure about seeing Dr John, and the impact on how the practice was run (and consequently the experience of the patients), were over-sanguine. So was his confidence that he could deal his father (in his capacity as supervisor initially and then as senior partner) in the same way as he did any other doctor working for the Practice. In our judgement this was an understandable but significant consequence of the difficult position he was in as a loyal and supportive son.

Unsuitability/ Criminal Convictions

53. The issues of suitability and criminal convictions are to some extent overlapping and may conveniently be dealt with together.

54. The parties agree that we should accept the verdicts and findings of Dr John's criminal trial. There are a number of necessary inferences which flow from those findings. Each of the offences of which Dr John was convicted involves a necessary finding that he knew or believed at the time of his actions that what he was doing was dishonest. Indeed, the trial Judge made that clear in his sentencing remarks (see paragraph 21 above). If Dr John's own account, given to the FtPP and to us, were to be accepted, he was not dishonest and could not be guilty of the offences. These verdicts were reached after (as Dr John told us) a trial of about one month in which both Mr T and the NHS employee to whom he had given the purported invoice gave evidence which was accepted by the jury. Dr John did not elect to give evidence.

55. The seriousness of the dishonest breach of trust caused the Judge to conclude that only a custodial sentence could be justified for it, but found it possible to suspend that sentence because of his health and his expectation that as a result of these verdicts he was unlikely ever to practise again. In fact, Dr John's health has not proved to be as poor as he then thought, and of course he has been restored to the GMC register so can presently practise medicine in any context other than on the NHS Performers List.

56. We do not have independent evidence as to exactly how many representations in the form of medical certification Dr John made to the DWP. He himself told us that he completed one certificate and wrote two letters to the DWP at the request of Mr T (although he told the FtPP at one point that he had only written one letter asserting that Mr T needed 24 hour care: 505 B) and answered a couple of questionnaires. In his witness statement Dr John adopted an account he had put in writing to the GMC when applying to be restored to the register, of how he had come to give medical opinions in support of Mr T's disability claim [739 – 41]. Among other things he claimed that on 6 May 1993 he had issued a certificate for 6 months stating Mr T was unfit to work, and that this was based on the reports of various hospital doctors who had seen him for various medical problems. It does not seem to us that that can have formed any part of the prosecution case since the dates of the conspiracy alleged start only on 1 April 1996. He also said he had written two letters to the DWP at Mr T's request, one in September 1996 and another much later "enumerating his medical problems for his disability claim". But we note the compensation order of £30,000 in respect of the conspiracy to defraud the Department of Work and Pensions (which has been paid) and this must roughly equate to the value of the Disability Living Allowance paid over the 8 years of the conspiracy alleged. The Court appears to have accepted that Dr John's actions were responsible for the whole of this loss.

Honesty and probity

57. It is impossible to reconcile Dr John's description of his own behaviour (now given on many occasions over the years to his family, to Drs Haider and Mohan, to the GMC, to the FtPP and now to this Tribunal) with the offences of which he was convicted. If he is correct, he was not guilty. However the evidence accepted by the jury included (as Dr John informed us) evidence from Mr T himself and documents Dr John had submitted to the DWP. We need go no further than the verdicts and the factors set out in the Judge's sentencing remarks to conclude that we cannot accept Dr John's evidence to us on this point.

58. However there were other factors which reinforced us in our conclusion that he was not being candid in his evidence to us. His answers to difficult questions

were at times skilful in evading the main thrust and returning quickly to his basic position that he regarded himself as being dishonest because he had been so careless. When questioned by his own Counsel he had no difficulty in understanding and was able to articulate prompt replies. But when questioned by Ms Bruce he sometimes professed difficulty in understanding (e.g. "I don't understand some of the hard English words so be a little lighter"). Although we were alert to the possibility that he was being taxed with difficult or lawyerly language, and sometimes intervened to rephrase a question, there appeared to be no difference between the questions posed by Mr Horne and Ms Bruce, certainly in regard to his understanding of his own conduct. He disclaimed expert knowledge of the meaning of dishonesty and tried to draw a distinction between dishonesty at the time and dishonesty appreciated by others or afterwards. In truth his own appreciation of his conduct afterwards does not amount to an admission of dishonesty in any event. However we have no doubt that Dr John is well able to understand dishonesty. He is a well-educated, fluent and cultivated professional man with many decades of experience in responsible positions. He simply chooses to construct a bizarre meaning of dishonesty with which he can live more comfortably.

59. Dr John's explanations in relation to each of the two offences of using a false instrument were also flawed and not believable. For example, he told us that the two false estimates which he had sent to Zurich Insurers in support of a claim for the repair of flood damage were in fact prepared by Mr T and given to him by his Practice Manager Linda. He professed not to have known this at the time although he did say that Mr T was paid directly by the insurers to his address which was on the estimates. We asked him, in view of his previous evidence that Mr T lived just across the road from the surgery, was a long-standing patient and was in and out very frequently, how he had not recognised that it was Mr T's address on the bogus was documents. He then agreed that he would have recognised Mr T's address but that in fact (contrary to what he previously said) Mr T had used other addresses within St Mary's Estate so that Dr John would not have recognised them. We were unable to believe this change of explanation.

60. The other offence of using a false instrument (an invoice for installing remote controlled locks when the work had not been done) also involved an invoice from Base Builders, the alias of Mr T which had been used within the previous 3 months in preparing an estimate for repair of flood damage. Dr John's explanation was essentially that the work was supposed to be done later in the same day that the invoice was put into his hand by his Practice Manager, just as he was about to attend a meeting at the local PCT, so that he was able to deliver it to the relevant officer for payment. In fact the work was not done that day but (he said) was done later, so that payment was accelerated but it

was not otherwise an improper claim. During his explanation of these events Dr John said that the PCT employee who was taking notes for the meeting also had a role in the processing of invoices so he gave the invoice to her. When he returned to the surgery and discovered the new locks had not in fact been installed he told his Practice Manager to get somebody immediately and a few days later saw the lady to whom he had handed the invoice (whose name he could not remember) and told her "Look the work has not been done I hope I will not be taken to Court". She had just laughed and said "Get the work done that's OK". Dr John then volunteered that at his Criminal trial that lady was called to give evidence and denied the conversation or ever having seen Dr John before. The jury accepted her evidence. We can see absolutely no reason for the PCT employee to deny ever meeting Dr John (a thing easily established if she attended meetings with him). We are unable to accept Dr John's account, inherently unlikely as it is and which has been contradicted on oath elsewhere.

61. In assessing whether Dr John was unworldly or careless in regard to making claims on public funds (such as this application for payment of money which was awarded for achieving prescribing targets) we note that Dr John had occupied responsible administrative roles such as Secretary of the GP fund holding group, then Co-Chair, with Dr Mohan, of the Primary Care Group, during which time he was elected lead for the local prescribing committee on the guidance and implementation of measures to be taken by practising GPs to save NHS resources and allow prescribing savings to be reinvested for the betterment of patients. This latter role is with the very scheme which provided the funds for the upgrading of the security locks on his premises. If anyone should have known how it worked, it was him. Moreover we accept the evidence of Dr Hughes that all these prescribing incentive schemes, even allowing for small local variations, require that the work for improvement of the practice shall first be approved (which this was not), then completed, invoiced and paid before the PCT (or its successor) will pay out. Even on Dr John's own account this was not a paid invoice for completed work and he therefore received payment before he should otherwise have done. We note that Dr John's account of his conversation with the PCT employee necessarily accepted that presenting the invoice was a representation that it had been paid.

<u>Conclusion on honesty and probity</u>

62. As we have indicated already, we found his evidence on the behaviour which led to criminal convictions to be tortuous, and not credible and we were unable to accept it. Sadly his unwillingness to confront his own dishonesty leads him to persist in dishonest explanations to colleagues (including those who gave evidence to us) and to this Tribunal. He continues to try and

minimise his own blameworthy conduct by sticking doggedly to an account which does not survive close examination, and has continued to mislead or attempt to mislead his close family, professional colleagues over many years, and NHS England and this Tribunal in the course of this application and appeal.

Benefit to Dr John?

63. Dr John asserts he did not benefit from his own dishonesty. But if, as the sentencing remarks make clear, Mr T was indeed performing handyman tasks at King Edwards Medical Centre (which Dr John conceded he did occasionally, going errands for the Practice Manger, to whom he was close) or was working at Dr John's own home (which Dr John denied during this hearing) then there was an indirect benefit to Dr John. At that trial Mr T gave evidence which was challenged on behalf of Dr John, but Dr John elected not give evidence.

64. Whoever gained, the significant thing is that public funds were the loser. As to the offence involving an insurance claim to Zurich Insurance, Dr John told us that the insurance company did not pay the figures claimed in the two (false) invoices for flood repairs, but paid a lower figure assessed. Again we have no independent evidence about this, and Dr John did not provide any documentary evidence of the sums claimed and paid, but the nub of the allegation found proved is that it was intended to induce the insurer to accept that the figures falsely claimed as genuine estimates for the work, and so to pay that or a similar sum.

65. A similar point arises in relation to the presentation of the invoice for upgrading the locks before the work was done would have been paid into the practice account prematurely and there would arguably be some benefit to the practice in that regard. While we accept that any such benefit is unlikely to have been of great monetary value, we do not accept that Dr John can properly claim that he received no benefit at all.

66. But the real concern arising from this offence is the cavalier disregard for the relationship of trust and confidence that must underpin the working arrangements between a GP and a PCT or other local NHS administration. Even more so where one of the parties is a senior and well respected GP who participates in the local administration of NHS primary care.

Inference from admitted "error" of reliance on others

67. Dr John repeated at a number of points in his evidence that he had too readily accepted information or documents from his staff (specifically the Practice Manager Linda) without checking their accuracy or truthfulness. He regarded this as a grave fault, and seemed at times to equate it to dishonesty on his own part. We do not know whether Dr John's defence at his criminal trial was put in

this way, but if it was it could not have been accepted by the jury whose verdicts mean that relevant dishonesty was not this failure to check or supervise staff; it was his own personal dishonesty. Linda was not present at this hearing to comment on Dr John's explanations, which we found unattractive in the circumstances of his convictions. Although he denied he was blaming staff for what had led to his convictions, it seems inescapable to us that that is exactly what Dr John was doing in relation to the two offences of using a false instrument. On his account he was careless but Linda was the agent of dishonesty, and must either have known they were bogus documents or was failing in her duty in not securing proper quotes or ensuring the work would be done before an invoice was submitted. This is not the behaviour of a doctor demonstrating probity which is compatible with being included on the Performers List.

Plans for return to practice: his expected role

68. Dr John's position about the practice he would resume and the responsibility he would have within the practice has changed significantly over the course of this application. In his application for membership of the Medical Defence Union dated 11 September 2013 Dr John stated (under a certificate of truth) that he would be a principal or partner and would work 7 sessions per week [127]. In his application to the GMC to be restored to the Medical Register Dr John said "if I returned to practice I would personally be more involved in checking financial transactions and ensuring that all payments were being made appropriately" [553 bottom of page]. But his evidence to the FtPP was that he intended to return to practice part-time, as his wife reduced from full-time commitment [491 H – 492 B]. In his application for inclusion in the List Dr John said he would be working in King Edwards Medical Group "full time up to 8 sessions per week". But in his first witness statement Dr John said [740 para 47] that he would work at King Edward Medical Centre for about 3 sessions a week over the next 4 years and in addition would do weekly sessions with Dr Kadr at his Cardiology clinics to complete a diploma. Putting this information together, it appeared that Dr John's expectation was to resume work as a principal but doing (at least on the most recent plans) about 3 sessions a week. When he gave evidence to us, Dr John said he planned to work only 2 – 3 sessions per week and in a salaried capacity; this was the first time we are aware of this salaried role being spelled out. The practice did not need more from him than this because it had appointed a salaried doctor to start in 2 – 3 months' time, so that the work was fully covered. This suggestion was denied by Dr Jagan John when he later gave evidence; indeed he said they were having difficulty finding anyone willing to do 2 – 3 sessions a week. Dr Jagan John did not know if they would take on another partner in light of his mother's imminent retirement.

69. In closing submissions it was suggested that we consider a condition limiting Dr John to practise in salaried or locum employment (although the terms of the offer of professional indemnity which we saw expressly stipulated no locum work: 1089 a).

70. There is some support for the inference that Dr John had expected to resume a role as a principal in the practice from the courses he attended. These include some courses on practice management issues as well as clinical issues: he attended a course on "Surgery Premises" on 4 October 2011, a course on Management in Practice on 25 September 2012 [789-90] and a further course on "Management in Practice" including sessions on "effectively creating a business plan to grow your business" as recently as 16 October 2014. He said he had been proposing to expand the practice and take out a loan to do so.

71. We found this shifting picture of what Dr John would be doing on resumption of practice perplexing. It may be that confining his plans to salaried employment was a response to the terms of the professional indemnity insurance offer he received in October 2014, which (among other things) required him to warrant that he was under supervision, a position which would be effectively impossible to warrant if he were a principal rather than a salaried GP.

72. His original suggestion that he would be personally involved in financial transactions was far from reassuring. While it is perfectly sensible for a doctor hoping to return to practice to update himself on changes to the framework in which a medical practice operates, attending a course about creating a business plan to grow the business suggested that even in October 2014 Dr John was contemplating having a role in the running of the practice and its development. Taken together with the conflict between his own assertion that King Edwards Medical Centre had appointed a salaried doctor to start in 2 – 3 months, and the denial of this by Dr Jagan John, we doubted how much reliance could be placed on Dr John's assurances about his plans, which appeared to have changed significantly in the space of just over a year and those changes appeared motivated by expediency to secure a return to practice, rather than being primarily for the benefit of the welfare of patients.

<u>Proposals for return to practice: supervision</u>

73. We were invited also to consider Dr John's insight in the context of his proposals to return to practise under the supervision of Dr Mohan and subsequently his son, with additional mentorship from Dr Haider. This loomed large in the evidence and submissions we heard. We refer to paragraphs

paragraphs 43 – 45 above for a summary of the various changes which occurred in Dr John's proposal.

74. We unhesitatingly accept the criticisms and reservations about Dr John's plans which were put forward by NHS England, including those put forward in Dr Hughes' witness statement at paragraphs 92 – 95 [574-5] and in her oral evidence to the Tribunal.

75. We accept that an absolutely key part of a return package is to have independent supervision. None of Dr Mohan, Dr Haider, or Dr Jagan John was in a position to do so in our judgement, either as a matter of fact or of perception. It should have been clear to Dr John and those immediately involved that this was the case. If this was not clear on paper, it was crystal clear by the time Drs Haider, Mohan and Jagan John had given evidence: we refer to our findings at paragraphs 50 – 51 above. Dr Mohan was a close professional colleague who had shared positions of responsibility with Dr John and whose own candour was open to criticism. Moreover if Dr John came to his practice to sit in for a period of time he did not seem to think that it was necessary to inform patients of anything about Dr John other than that he was retraining. He adopted the evidence he had previously given to the FtPP [387 E and 388 B – C]: "I do not think I will be going into any further details….because I do not think that that is anything to do with the patient's point of view". If, however, it were to be explained to a patient that Dr John had been erased and then restored, some patients would take it fine and others would ask to see somebody else. This would be settled in reception. If they asked him about it "I would have to be open and tell them that he had some misappropriation problems". Dr Mohan told us he did not know about the details of the offences, did not know he was convicted on three counts but knew it was "something to do with financial dishonesty". It follows that any further explanation given by Dr Mohan to a patient would be brief and arguably incomplete. All those who had been proposed to be involved in his return to practice plan shared the same understanding on the nature of the wrongdoing which had been given to them by Dr John and which we have found to be incredible.
76. We also accept that it was not be justifiable for NHS England to make an exception in favour of Dr John from the requirements for returning for practice after an extended break (for whatever reason), namely that each should participate in the Deanery I & R Scheme. Not only would that be unfair as between doctors but would also make it impossible for Dr Hughes to monitor or benchmark the performance of Dr John against a standard to be expected of returning practitioners who are otherwise monitored in a standard way under the I & R Scheme.

77. It was argued that the FtPP had endorsed or approved Dr John's proposal when it restored him to the medical register, and so offered him encouragement that it was an acceptable plan. This was not of course any part of its function or jurisdiction. But in any event it is difficult to spell out of the evidence of the Principal Assessor Dr Cox, upon which this argument is based, anything but a limited and reluctant indication that it had "the makings of a plan" [365 A – 367 C]. Indeed he too raised as a question the objectivity of clinical supervision between father and son. We do not accept that in stating towards the end of its written determination [92] that "the Panel have been encouraged by information with which has been presented about your plan for a phased return to work" the FtPP was endorsing this as a plan in preference to a Deanery I & R Scheme (about which it had heard nothing) or with full and proper knowledge of the factors which NHS England must take into account.

78. The FtPP's jurisdiction was simply to grant or withhold registration. We must consider Dr John's proposal for his return to work in the context of the regulatory issues for our decision. In our judgement those proposals self-evidently lacked the critical features of objectivity and denied NHS England the ability properly to monitor and compare his progress through a standardised programme for re-entry such as the I & R Scheme.

79. But Dr John abandoned his proposal on the second day. He said it was because he had heard Dr Hughes' objections during her oral evidence the previous day. However there was no novelty in the points she made. They are to be found in her witness statement which Dr John had considered before making a second witness statement of his own. It says little for Dr John's capacity for constructive reflection that he only realised how hopeless his own proposal was (if indeed he did) after Dr Hughes gave evidence. His inability to appreciate the arguments about objectivity reinforce our conclusion that Dr John shows lack of insight into what is necessary to give appropriate and measurable reassurance to NHS England and patients.

80. Part of the explanation for this may be that he attached little importance to the role of NHS England, telling us that he was "under the impression that the GMC was the supreme body. We could practise anywhere in England [once registered by the GMC] and that is it. This NHS body [NHS England] has come when I was out of the office so I was surprised….I thought NHS England would take merits on what the GMC had found…". This was in itself a surprising observation since despite being out of practice since shortly before his conviction in 2005, he was previously on a Performers List, and prior to that on a Medical List, working in an NHS primary care structure under predecessor bodies to NHS England, within a regulatory framework. Indeed he held responsible positions within those local structures. His evidence above gave

the impression that he had considered it a formality to be included on the Performers List once the FtPP had directed his restoration to the medical register, and that NHS England (in its regulating capacity) had somehow popped up during his absence and surprised him.

81. In the context of the abuse of the relationship of trust and confidence between Dr John and the NHS which is a feature of his criminal offences, this attitude raises further concerns about his insight into the importance of that relationship. We are not persuaded that he has insight into the importance of a constructive and co-operative attitude towards NHS England.

82. We formed the impression that Dr Mohan was relieved to be standing down from the role of prospective supervisor/ trainer. He said he had advised Dr John to agree to the I & R Scheme. Presumably as an experienced trainer within the Deanery area he is well aware of it, and it would be surprising if he too had come to the same realisation as Dr John only at the eleventh hour. Ms Bruce referred to a collective lack of insight from Dr John and those immediately involved in his proposal for supervision during his return to work, and there is something in that. At the least, there is a reluctance, particularly by Dr Mohan and Dr Haider, to ask difficult questions or raise difficult issues.

83. Until the current Regulations came into force in April 2013 it was mandatory to refuse inclusion in the Performers List if the Practitioner had been convicted in the U.K. of any criminal offence committed on or after the day prescribed in the relevant Part, and had been sentenced to a term of imprisonment of over six months. An application by Dr John to be included in the List at any time prior to 1 April 2013 would have been bound to fail because of his conviction and sentence. Since that date, refusal has been discretionary. Nevertheless it is of interest to note the history of Parliament's attitude to the seriousness of convictions of this sort, in the context of suitability to be included in the Performers List.

84. Self-evidently, the more serious the offences, and the more intimately involved they are with the functions of a doctor providing NHS services on the Performers List, and operating in a relationship of trust and confidence, the more likely it is that a criminal conviction as described in the Regulations will operate to deny a doctor inclusion in the Performers List. These offences in our judgement fall on the wrong side of the line in each of those respects. They are serious offences of dishonesty as the sentencing remarks (and indeed the sentence) make clear. They occurred over a period of time between April 1996 and May 2002, so were not a single lapse and it is not suggested there were any extraordinary factors responsible which would be unlikely to recur. They involved a serious breach of trust in his position as a GP not only vis a vis the

NHS but also vis a vis the DWP and an insurer. Substantial sums of money were lost from public funds (and which he has repaid under a compensation order). The betrayal of the relationship of trust and confidence in his dealings with the NHS administration by presenting an unpaid invoice before the work was done illustrates one of the many everyday situations of trust in which GPs on the Performers List interact with NHS administrative structures and which cannot realistically be independently policed all the time.

85. Therefore when applying the factors set out at Regulation 7 (3) (a) and (d) the balance falls firmly against inclusion on the List in our judgement.

86. Nevertheless it is now 9½ years since conviction and 12 ½ years since the conduct giving rise to conviction. We are specifically required by Regulation 7 (3) (b) to take account of the time which has elapsed since the matters in question. In our judgement it is necessary to consider this point in the context of Dr John's insight and (as we have found) persistence in minimising his conduct by untruthfully denying he was dishonest at the time, but was merely careless or even reckless. In our view this taints or mitigates the point about lapse of time which could otherwise be made in Dr John's favour. We have also taken account of the factors set out at Regulation 7 (3) (c) and (f). As to "(c) any other action or penalty imposed by a regulatory or other body" the relevant matters are that Dr John was subjected to a 2 year suspended sentence of imprisonment and was erased from the Medical Register by the GMC but restored following the hearing before the FtPP described above. These are serious penalties, although the restoration to the register means that Dr John is restored to his previous position, that he is free to practise medicine lawfully. As to "(f) whether he was removed from any List and if so the reason for it" Dr John was in consequence of his conviction removed from the Performers List. In a sense both these factors simply repeat or bring back into play the circumstances and consequences of the convictions.

87. Notwithstanding the various testimonials within the bundle we have concluded that a substantial number of NHS patients would be troubled, and many appalled by the idea that Dr John could return to practice in the place where he committed these crimes. His return to the Performers List, within the very NHS local structure whose trust and confidence he betrayed, would be likely to erode public confidence in the services which those on the List perform. He was responsible for substantial losses to public funds on a scale which would seem enormous to most of the patients within the very deprived area his practice serves.

88. It is said that many patients, in particular those who remember Dr John from the days when he practised from King Edwards Medical Centre, would

welcome him back. Doubtless there are such patients. We are told that about 3,000 out of the total of over 6,000 patients will be "new" in the sense that they have come onto the list since Dr John's conviction. They have nothing to look back to and no reason feel any loyalty to him. In our judgement that group is particularly liable to have its confidence in the system which presents Dr John as their GP undermined. They and indeed all the patients would have a right to be informed of the circumstances of his erasure and restoration before agreeing to be treated by him. But we have concluded that even if there is a high degree of disclosure, the effect of including Dr John on the Performers List so that he returned to practise at King Edward Medical Centre would damage patient confidence in the NHS primary health services.

89. If (as is proposed) a printed notice is displayed or distributed to patients attending the surgery, advising them that Dr John has returned to practice following his conviction for offences of fraud, so as to give patients the opportunity to ask to see another doctor, there would be substantial problems which arise from that process. Some patients are likely to be embarrassed to ask for sickness certificates from a doctor who is known to have abused that process. Others may be keen to seek sick certification from him on the basis that he can be pressurised to give certification in a marginal or inappropriate case. Others may be embarrassed to ask for an explanation or for an appointment with a different doctor; after all, even Dr Mohan did not want to embarrass his trainees by asking about the cause of their problems. If a patient does want to see a different doctor, it is unlikely that that request could always be met without the delay of arranging another appointment. If a patient wants to know more before making a decision, who will answer those questions? Even those close to Dr John seem to know very little about the detail of that dishonesty other than the sanitised version he has told them. In practice it would be the receptionist or Dr John himself. It is very unlikely that Dr John will tell patients the full truth of what his convictions involved, in light of our conclusions above that he has not told us the full truth. It would be unacceptable for patients to be misled in making a decision about whether to entrust their confidential problems to Dr John. We also accept the view of Dr Hughes that patients come to discuss their own problems, not those of the doctor. Even if (as Dr Jagan John explained and we accept for this purpose) the costs of making information notices available, arranging alternative appointments with another GP in the practice, or of spending his own time reviewing the consultation records generated by Dr John, in addition to Dr Jagan John's own workload, is carried by the partners of the practice (Dr Jagan John, his brother and his mother) or by Dr John himself, that does not altogether eliminate the inefficiency inevitably arising in the services which those on the Performers List perform.

90. We have also concluded that the inclusion of Dr John on the Performers List would unreasonably require NHS England to work in a relationship of trust and confidence with a practitioner who has demonstrated the persisting flaws which we have found above. He was in this very relationship with the predecessor body when he abused that position. A requirement of trust in a practitioner's honesty and integrity is central to many of the tasks performed by a practitioner on the List, such as submitting fair and accurate medical reports, or accurately and reliably recording matters relevant to the assessment of a Quality and Outcome Framework (QOF) for the purpose of achieving points which translate into payment, making claims for payments generally and other apparently quite mundane functions.

91. Mr Horne has submitted that acceptance of culpability is not a pre-condition for insight, relying on the observations of Raffety J in *Karwal (*see para 9 above) at paragraph 11 of her judgement:

> *"The Appellant has always maintained her innocence of the original findings whilst acknowledging their importance and seriousness when expressing a firm purpose of amendment. Though Mr Rawley QC couched the case for the GMC as equating maintenance of innocence with lack of insight, I am not persuaded of such a stark error. The FTTP was scrupulous to make clear that it did not see acceptance of culpability as a condition precedent for insight. The GMC's position seems to me to be sound and unassailable on this point. As the Indicative Sanctions Guidance makes clear, at a review hearing the Panel will "need to satisfy itself that the doctor has fully appreciated the gravity of the offence". The findings of the FTTP demonstrate its justifiable view that the Appellant had not fully appreciated the gravity of her offence, rather that she sought to minimise it and had lied about it. The Panel was entitled to take into account this want of candour and, sadly, continued dishonesty in reaching its conclusions on impairment."*[emphasis added]

92. That was an appeal under different legislation considering the GMC's Indicative Sanctions Guidance that it would "need to satisfy itself that the doctor has fully appreciated the gravity of the offence" when deciding whether the doctor's fitness to practise was impaired. We are considering the question of suitability for inclusion in the Performers List under Regulations specifically framed for that purpose, in which (among other things) the reliance of the system on the probity of those on the Performers List is of paramount importance, not only in relation to the legitimate expectations of patients, but also in relation to needs and requirements of the administration of the primary care system and its funds. Our discretion is at large and should not be fettered by any approach which attributes particular significance to the precise point in time at which full

and effective insight occurs. A doctor's acceptance that he knew or believed what he was doing was dishonest at the time of the offences is likely to be the most powerful and effective way of showing insight by acknowledging wrongdoing, identifying the flaws in himself which need to be addressed, and remedying them. Otherwise it is more difficult for the decision maker to accept assurances that a doctor has understood he was dishonest, appreciated its gravity and expressed genuine remorse, as the foundation for addressing and remedying those flaws.

93. However even if we had concluded that this appeal is on all fours with *Karwal*, our findings about Dr John's continuing want of candour and dishonesty (see paragraph 62 above) means that we are entitled to conclude, as we do, that Dr John is not suitable for inclusion in the Performers List.

94. On the basis of our findings above we conclude that Dr John should not be included in the Performers List on the ground that he is unsuitable and on the ground of his convictions and sentence of over 6 months imprisonment, suspended.

Consistency argument re decision of FtPP

95. It was submitted that there is a public interest in consistency between decisions of the MPTS (i.e. here the decision of the FtPP to restore Dr John to the medical register) and this Tribunal. It is however conceded that that decision is not binding upon us. Nor could it be since it arises under different legislation addressing different (even if overlapping) factors. The jurisdiction of this Tribunal is different, and must address additional factors than "fitness to practise", by reason of the fact that the practitioner seeks to have access to NHS patients and NHS payments under a statutory scheme which requires him or her to operate within a very extensive set of rules and practice requirements and in close co-operation with the administrative authorities running it. A perusal of (for example) the requirements within the Regulations on an application for inclusion and the undertakings required within that, illustrate this point in part. But the practical day to day arrangements place further responsibilities on the shoulders of practitioners. Dr Hughes described the distinction as being between "fitness to practise" under the GMC and "fitness for purpose" under the Performers List Regulations, which appears to us to be an apt description.

96. Apart from this crucial jurisdictional distinction we have heard extensive evidence which has been tested so that we are wholly satisfied as to the conclusions we have drawn. If those conclusions are different in any respect from those reached by the FtPP on any similar issues, then we cannot simply

jettison our own conclusions of fact in order to achieve consistency with that other body. That would be a denial of our function and judicial oath.

Efficiency

97. In the event that we are wrong in those conclusions, we have also considered the issue of efficiency. For the reasons set out above we conclude that it would not be possible to restore the relationship of trust and confidence which must exist between the practitioner on the List and NHS England and that that would adversely affect the efficiency of the services which those on the List perform. A practitioner who is unable or unwilling to be candid in such fundamental matters involving his own conduct and continues to be dishonest in misleading others, is not one in whom NHS England could have the necessary degree of trust in the many respects in which a GP has to be trusted to operate with probity on an almost daily basis.

98. Dr Hughes has pointed out (and we accept) that if Dr John were included in the Performers List and resumed practice, it would have an impact on the amount of management time spent on him; particularly time spent in monitoring any conditions imposed. This would impact adversely on the use of scarce resources and therefore on the efficiency of the services.

99. We have also concluded that for the reasons set out at paragraphs 88 – 89 the efficiency of the services experiences by patients would be prejudiced, even if the financial costs are absorbed so far as possible by the partners of the practice.

100. The cumulative effect of these prejudices to the efficiency of the services provided by those on the Performers List is potentially profound. We have considered the conditions proposed by Mr Horne in conjunction with his closing submissions and those proposed in the alternative by Ms Bruce but are unable to identify suitable conditions which would prevent the prejudice we have identified or prevent the risk of fraud.

101. We therefore conclude that the appeal also fails on the issue of prejudice to the efficiency of the services which those on the Performers List provide.

Proportionality

102. Before reaching our conclusions we also carefully considered whether refusal of inclusion on the Performers List is proportionate. We are acutely conscious of Dr John's desire to resume the profession for which he trained, to which he gave many years of his life and of which he is very proud. It has been his means of earning his living. However we have concluded that it inevitably follows from the seriousness of our conclusions above that the balance lies firmly in

favour of rejecting his appeal and that it is proportionate to do so. HHJ Pardoe clearly anticipated that Dr John would be unlikely to practise again, when sentencing him. He is now aged 67, an age at which many if not most professionals have retired or are contemplating retirement. On his own case he would wish to work until age 70 (a period of less than 3 years) and would have to pay over £19,000 a year in insurance premiums to do so. Nobody suggests that that is other than an admirable ambition but the loss of the opportunity to do so on the Performers List is not as severe as it would be for a younger man with a lower insurance risk. Nor is there any reason why Dr John should not practise medicine other than on the Performers List in primary care. We were told of his previous work as an assistant in a cardiac unit at a local hospital with Dr Kadr and that he wished to resume that work and complete a diploma. He was unable to explain why he had not done so when he was restored to the medical register in June 2013, but in any event he remains free to do so, or to practise privately or to practise medicine (as he told us he wished to do after finishing work at King Edwards Medical Centre) in Mexico on a charitable basis or as a medical missionary in India. We mention these plans simply to illustrate that denial of inclusion on the Performers List is not a denial of the opportunity to practise medicine.

103. We therefore dismiss this appeal and refuse Dr Kochummen John's application for inclusion on the Medical Performers List under Regulation 7 of the National Health Service (Performers List) (England) Regulations 2013 on the grounds set out in Regulation 7 (2) (a), (e) and (g).

Tribunal Judge Duncan Pratt
First-tier Tribunal (Health Education and Social Care)

Date Issued: 19 January 2015