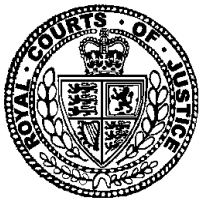

Neutral Citation Number: [2021] EWHC 1658 (Admin)

Case No: CO/572/2020

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

IN THE MATTER OF AN APPEAL UNDER SECTION 40A OF THE MEDICAL ACT 1983

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23/06/2021

Before :

THE HONOURABLE MR JUSTICE LANE

- -

Between :

General Medical Council	**Appellant**
- and –	
Dr Louise Armstrong	**Respondent**

- -
- -

For the Appellant: No appearance and no representation
For the Respondent: ***Mr Ivan Hare QC***, instructed by GMC Legal

Hearing date: 27 May 2021

- -

Approved Judgment

Lane J:

1. The appellant appeals against the determination of the Medical Practitioners Tribunal ("MPT") on 21 January 2020 that the respondent's fitness to practise was not impaired. The appellant asks the court to quash the MPT's decision on non-impairment; to substitute a finding of impairment; and to remit the matter of sanction to the MPT, to be determined in the light of the court's judgment.

Preliminary issue

2. The hearing on 27 May 2021 had been arranged to take place remotely, via Microsoft Teams. This accorded with the wishes of both parties. The hearing had originally been due to take place in March 2021 but was adjourned, by reason of the respondent requesting extra time in order to arrange legal representation.

3. The adjourned hearing was listed for 14 April 2021 before Lavender J. Prior to that hearing, the respondent had applied for a further adjournment in order to arrange legal representation. That application was opposed by the appellant, following which the court indicated that it would hear the respondent's application at the start of the hearing on 14 April; and that the hearing would proceed remotely. In the event, Lavender J adjourned the hearing because on the morning of it, it emerged that (through an oversight) the respondent had not been sent the sign-in details for the remote hearing. Efforts to contact the respondent that morning met with no response. In his order, Lavender J drew the attention of the respondent to the following:-

> "The court has the power to proceed with the Appellant's appeal in the absence of the Respondent (and any representative of the Respondent). The Appellant has indicated that it will invite the court to exercise that power in the event that the Respondent does not appear and/or is not represented at the re-scheduled hearing."

4. Following the assignment of the case to me, I caused an email to be sent by the Administrative Court Office to the respondent, asking if she would confirm if she was proposing to take part in the hearing on 27 May, despite the time difference between the United Kingdom and Australia, where it is understood the respondent is currently residing. On 25 May 2021, the respondent emailed the Office as follows: "Thank you for your email. I will not be attending the case and I will not be represented. Many thanks". That email was copied to Ms Eden of GMC Legal.

5. Unsurprisingly, therefore, on 27 May there was no attendance by the respondent or any representative of hers. I heard submissions from Mr Hare QC, for the appellant, on the preliminary issue of whether, in view of the respondent's non-attendance, I should continue with the hearing of the appeal. At the end of those submissions, I delivered an *ex-tempore* judgment on the preliminary issue. Unfortunately, however, I was subsequently informed that the recording function on *Microsoft Teams* had failed, with the result that no transcript could be made. Accordingly, what follows in paragraphs 6 to 10 below is not a verbatim reproduction of my judgment, albeit that I have endeavoured to set out all the salient matters.

6. Mr Hare drew my attention to the judgment of Lewis J (as he then was) in General Medical Council v Theodoropolous [2017] EWHC 1984 (Admin). At paragraphs 21 to 26 of his judgment, Lewis J concluded that the power of this court to hear an appeal under

section 40A in the absence of a party is to be found in the inherent jurisdiction of the court; rather than anything in the 1983 Act or the Civil Procedure Rules. In deciding whether to proceed with such an appeal where a party does not attend, and the court is satisfied that the notice of hearing has been properly sent and there is no record of attempts to inform the court why a party is not attending or to request an adjournment, Lewis J derived assistance from the judgment of the Court of Appeal in General Medical Council v Adeogba [2016] 1 WLR 3867. Although Adeogba was concerned with a party who failed to attend a Tribunal hearing, Lewis J considered that it was appropriate to adapt the language of the Court of Appeal's judgment so as to identify the following criteria for deciding whether to proceed:-

> "(i) the nature and circumstances leading to the respondent being absent, and in particular, whether the absence is deliberate and voluntary and such as to amount to a waiver of any right to attend; (ii) whether an adjournment might result in the respondent attending; (iii) the likely length of any adjournment; (iv) whether the respondent is or wishes to be legally represented or by his conduct has waived any right to be represented; (v) whether the respondent would be able to give instructions to a legal representative before or during the hearing; (vi) the extent of the disadvantage to the respondent of not being able to attend; (vii) the general public interest; (viii) the effect of delay on the memories of witnesses." (paragraph 28)

7. Lewis J observed that other criteria mentioned by the Court of Appeal were not apposite to an appeal hearing. I respectfully agree.

8. Taking the relevant criteria in turn, (i) it is plain from her email that the respondent has made a deliberate decision not to attend the hearing, either in person (via remote means) or by means of a representative. Her email could not, in my view, be clearer in this regard. The respondent has waived her right to attend the hearing. (ii) Accordingly, it is manifest that an adjournment is highly unlikely to result in the respondent attending. She has not requested a further adjournment. (iii) In the circumstances, consideration of the likely length of any adjournment is irrelevant. I would, however, merely note at this point that any further delay in an appeal which has already been adjourned previously on two occasions would be highly undesirable. (iv) The respondent's email constitutes a waiver of her right to be represented. (v) The question of whether the respondent would be able to give instructions to a legal representative before or during the hearing is, accordingly, immaterial. In any event, since the beginning of the Covid 19 pandemic, remote hearings have assumed a form in which it is perfectly possible for such instructions to be given during the hearing. There has, so far as I am aware, been no indication by the appellant that she has encountered difficulties in giving instructions to a legal representative (as opposed to arranging for such representation). (vi) In assessing the extent of any disadvantage to the respondent not being able to attend the hearing, it is plainly relevant to have regard to criterion (i) above. A party who waives their right to attend necessarily forfeits any advantage they may have obtained by attending the hearing. It is also important to remind myself that, as Lewis J held at paragraph 30 of Theodoropoulos, the extent of any disadvantage in relation to an appeal is limited, compared with that in relation to a first-instance Tribunal hearing, where findings of fact (including credibility) may be at issue. That said, the fact that an appeal is concerned with legal arguments cannot, of course, mean that the court will likely conclude that proceeding in the absence of a party or their representative is fair. On the present case, the most important factor limiting the significance of criterion (vi) is, as I have said, the categorical decisions of the respondent not to attend or be represented. (vii) Mr Hare was, in my view, right to submit that the public interest criterion in the present case is

very substantial. The appeal commenced in February 2020 and remains unresolved over fifteen months later. Appeals under section 40A possess a fixed, strong public interest element. Notwithstanding that the respondent does not, it seems, wish to practise as a doctor in the United Kingdom in the near future, there remains a significant public interest in resolving whether she should be allowed to do so; in addition to the broader public interest in whether the Tribunal's approach to a doctor's dishonesty was wrong. (viii) In the circumstances, the effect of the delay is unlikely to have any impact upon the memories of witnesses. As we shall see, the respondent admitted the facts of the allegations made against her. Although a number of witness statements were taken from third parties, in the event, only the appellant was called to give oral evidence.

9. Despite the wide-ranging nature of criteria (i) to (viii), the court should not shut its mind to other relevant matters. In the present case, I agree with Mr Hare that, in deciding whether to proceed, it is relevant that the appellant does not invite this court to determine any sanction, were it to conclude that the respondent's fitness to practise is impaired. In that eventuality, the issue of sanction would need to be considered by the MPT on remittal. The respondent would have the right to appear and/or be represented at that stage. In the circumstances, this additional criterion carries some, albeit limited, weight in favour of proceeding.

10. Standing back and considering all the criteria, I was entirely satisfied that I should exercise my inherent power to proceed with the hearing of the appeal, in the absence of the respondent.

The allegations

11. The respondent qualified as a doctor in 1999 from the University of Newcastle upon Tyne. She completed her General Practitioner training in 2004 and then worked as a GP at various practices in the North of England. In 2012 she emigrated to Australia, working as a GP specialising in minor surgery, dermoscopy and women's health. She returned to the United Kingdom at the end of 2015 and, at the time of the events relevant to the present proceedings, the respondent was working as a locum GP in the North East of England or holding herself out as available to work as a doctor.

12. It is alleged that, in 2016, the respondent worked as a locum GP at several practices when she was not registered on the required Medical Performers List ("MPL"). It is further alleged that on 29 September 2017, the respondent sent a message to Ms Ashleigh Mitchell, the Contract Performance & IT Administrator at Battle Hill Health Centre, falsely stating that the respondent was on the Newcastle MPL. Ms Mitchell referred her concerns to NHS England. It was alleged that the respondent failed to cooperate with investigations by NHS England despite several requests to do so. It is necessary to record at this point that the Tribunal did not find the allegation of non-cooperation to amount to misconduct and that the appellant takes no issue with that finding.

13. After NHS England had raised its initial concerns with the GMC, in October 2017, the respondent was notified of the GMC's investigation by a letter dated 30 October 2017. On 14 May 2018, an interim order of suspension was imposed on the respondent's registration for a period of twelve months. She was notified by an email letter on 15 May 2018. It was alleged that the respondent did not disclose her suspension, when she completed application forms for "Nuffield Health" and "Push Doctor". Furthermore, in June 2018, when applying for the position of GP at a practice in Australia, it is alleged

that the respondent failed to disclose that her registration in the UK was subject to an interim order of suspension. The GP Recruitment Manager, Mr Lozinski, emailed the GMC on 24 August 2018 to seek clarification about the respondent's registration status. On 29 August 2018, the respondent withdrew her application to practise in Australia.

The Tribunal hearing and decision

14. At the Tribunal hearing, the respondent admitted all of the allegations. As I have already mentioned, the Tribunal found that the allegation relating to non-cooperation did not amount to misconduct So far as the other allegations were concerned, whilst not being registered on the required Medical Performers List, the respondent worked at Garden Park Surgery between 23 December 2015 and 3 June 2016; at Second Street Surgery on 15 January 2016; at Battle Hill Health Centre between 17 January 2016 and 29 September 2017; at Waterloo Practice between 10 March 2016 and 30 August 2016; at Biddlestone Health Group between 26 April 2016 and 21 June 2016; at Stanley Medical Group on 27 September 2017; and at Wellspring Medical Practice between 7 October 2016 and 14 November 2016. The respondent worked as a GP Health Screener for Nuffield Health between 21 May 2018 and 7 June 2018, when she was suspended from the medical register on an interim basis. She was also recorded as due to work for Nuffield Health between 8 June 2018 and 30 July 2018, again when she was so suspended.

15. On 29 September 2017, the respondent sent a message falsely stating that she was on the Newcastle MPL, or words to that effect. On 20 December 2017, in response to the question, "Have there been any proceedings of medical negligence or professional misconduct against you?" when completing the application form for Nuffield Health, the respondent falsely stated that there had not. On the application form for Push Doctor of 11 April 2018, in response to the question, "Are you currently the subject of any investigation or proceedings by anybody having regulatory functions in relation to health/social care professions?", the respondent falsely stated that she was not.

16. On 19 April 2018, the respondent was due to work as a locum GP at Gas House Lane Surgery, when she was not registered on the required MPL. The same was true in respect of Wellspring Medical Centre on 27 April 2018.

17. In emails of 3 October and 6 October 2017, the respondent falsely stated that she had no plans to work as a GP in the UK and no intention to practise as such in that country. When questioned on 7 June 2018 about her suspension, the respondent falsely said that she was not aware that she had been suspended, or words to that effect. She also falsely said that the GMC's investigation related to her working in England under a Scottish Performers List membership, or words to that effect. She also falsely said that she had received correspondence from the GMC that day (7 June) notifying her that she had been suspended for six months, or words to that effect.

18. Similar false statements occurred the same month, in connection with the respondent's application for a position as GP in Australia. The respondent falsely claimed that she was not suspended; that it was possible in the United Kingdom to practise medicine as a doctor in a hospital or private practice without being registered with the GMC, or words to that effect; that she had voluntarily withdrawn her registration, or words to that effect; and that there had been an administrative error in respect of her registration.

19. The respondent also knew when she worked or was due to work at the above-mentioned practices in the United Kingdom that she was not registered on the MPL, and that she should have been. She also sent an email falsely stating that she was on the Newcastle MPL, when she knew she was not. She completed the above-mentioned application forms knowing that she was subject to a fitness to practise investigation. She sent the emails of 3 and 6 October 2017 regarding alleged absence of plan/intention to practise in the UK, knowing that their content was false. The same was true with her response to Mr D on 7 June 2018 about her suspension. She knew that the GMC's investigation did not include working in England under a Scottish Performers List membership; and that she had not received correspondence informing her that she had been suspended for six months. She applied for a position in Australia, knowing that she had been suspended from the medical register on an interim basis. When speaking to Mr E, about that position, she knew she had been suspended and had not voluntarily withdrawn her registration. She knew there had not been an administrative error in respect of her registration and she also knew that it was not possible to practise medicine as a doctor in a hospital or private practice without being registered with the GMC.

20. The respondent gave oral evidence "at the impairment stage of the hearing" (determination, paragraph 11). The Tribunal recorded the appellant's submissions that the Tribunal had, first, to find whether the facts it had found amounted to misconduct and, secondly, whether her fitness to practise was currently impaired by reason of that misconduct. The appellant's representative addressed the persistent nature of the respondent's dishonesty, despite being given several opportunities to "come clean". Even after matters had been referred to the appellant and the respondent placed on an interim order of suspension, there was further dishonest conduct. Any acknowledgement by the respondent of her misdeeds, and any remediation by attending relevant courses, had to be seen in the context of the respondent's dishonest conduct, which was "lengthy, persistent and multi-faceted" (paragraph 15).

21. Counsel for the respondent, whilst accepting that the respondent's conduct fell below the standards expected of a registered medical practitioner and amounted to misconduct, submitted that the respondent's current fitness to practise was not impaired. The respondent had "fully engaged with these proceedings and has left her family in Australia to attend this hearing in order to give oral evidence to the Tribunal … This shows great commitment to this process" (paragraph 18). The respondent had "shown genuine remorse" and was "ashamed of the way she behaved and has recognised that she should have sought help and looked for other sources of employment, rather than acting dishonestly". The respondent "has demonstrated a high level of insight" (ibid.) The respondent accepted that "practising as a GP without being registered on the MPL potentially put patients at risk" and that "her dishonest conduct could have an impact on public confidence in the medical profession". However, the respondent "has sought to remedy her misconduct by attending various courses and has undertaken a significant amount of personal reading". The respondent had also "taken the difficult step to remove herself from a damaging relationship and has sought treatment from a psychologist" (paragraph 19).

22. Beginning at paragraph 22, the Tribunal set out the relevant legal principles. At paragraph 23, it reminded itself of the overarching objective, as set out in section 1(1B) of the 1983 Act, which requires the appellant:-

> "(a) to protect, promote and maintain the health, safety and well-being of the public,

(b) to promote and maintain public confidence in the medical profession, and

(c) to promote and maintain proper professional standards and conduct for members of that profession."

23. The Tribunal continued:-

"27. The Tribunal must determine whether Dr Armstrong's fitness to practise is impaired today, taking into account Dr Armstrong's 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.

28. 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*. In particular, the Tribunal considered whether its findings of fact showed that Dr Armstrong's fitness to practise is impaired in the sense that she:

'a. Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. Has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. Has in the past breached and/or is liable 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."

24. At paragraph 34, the Tribunal addressed the issue of dishonesty. Of particular relevance, in the Tribunal's view, was the requirement for doctors to be "honest and trustworthy, and act with integrity and within the law". A doctor must make sure that his or her conduct justifies patients' trust and the public's trust in the profession. Doctors must "always be honest about [their] experience, qualifications and current role". If suspended from a medical post or if restrictions are placed on their practise, a doctor must "without delay inform any other organisations [they] carry out medical work for and any patients [they] see independently" (paragraph 35, quoting the General Medical Practice).

25. At paragraph 36, the Tribunal noted the respondent's oral evidence "that fellow practitioners would be 'disgusted' at her dishonest conduct". The Tribunal concurred, stating that the conduct "would be considered as deplorable by fellow practitioners and was a breach of a fundamental tenant of the profession. In addition, it brought the profession into disrepute". The Tribunal concluded that the respondent's dishonest conduct "did fall far short of the standards of conduct reasonably expected of a doctor and was so serious as to amount to misconduct".

26. Beginning at paragraph 37, the Tribunal addressed the issue of whether that misconduct meant that the respondent's fitness to practise was currently impaired. In fairness to the Tribunal, it is necessary to set out the totality of their findings on this issue:-

"38. In determining whether a finding of current impairment of fitness to practise is necessary, the Tribunal looked for evidence of insight and remediation, and the

likelihood of repetition, balanced against the three limbs of the statutory overarching objective.

39. The Tribunal acknowledged Dr Armstrong's full admissions. It noted that Dr Armstrong has fully engaged with these regulatory proceedings and has flown from Australia in order to give oral evidence to the Tribunal. It found Dr Armstrong to be a frank and honest witness, who provided clear answers to all of the questions put to her. She stated that she was ashamed of what she had done. The Tribunal accepted that her apology was genuine and considered her to be genuinely remorseful.

40. The Tribunal also accepted that Dr Armstrong fully understood that her dishonesty had a significant impact on others. It was clear from her oral evidence and also particularly from her reflective piece that she understood the requirement for a GP to be on the MPL and that failure to be on the list could have an impact on patient safety. Further, it was clear that Dr Armstrong was aware of the impact that her actions could have had on public confidence in the medical profession. In her oral evidence, Dr Armstrong told the Tribunal that she wanted to write to the witnesses involved in her case once the proceedings were over. She accepted that these were 'good and kind' people. Her distress at having been dishonest to them was clear to the Tribunal. Therefore, the Tribunal was satisfied that Dr Armstrong has developed full appreciation of the gravity and impact of her actions.

41. The Tribunal went on to consider the issue of remediation. Whilst it accepted that it is difficult to demonstrate remediation following a finding of dishonesty, the Tribunal considered that, in this case, to the extent possible, Dr Armstrong had endeavoured to demonstrate remediation of her conduct. It noted that Dr Armstrong had completed a Fundamentals of Medical Ethics Course in August 2019 and a further Medical Professionalism Course in December 2019. In her oral evidence, Dr Armstrong explained broadly to the Tribunal what she had learnt from these courses. The Tribunal also had regard to the extensive reading list that Dr Armstrong has provided and considered that she had reflected on her misconduct in detail.

42. The Tribunal considered the risk of repetition. Whilst the Tribunal accepted that Dr Armstrong's dishonest conduct continued for a period of over two years, it noted that is clear from the evidence before it that for the duration of her dishonest conduct Dr Armstrong was subject to a combination of significant factors in her personal life which affected her thinking and decision making. These included financial pressures, adverse health events in her close family and being the victim of an abusive and controlling partner. The Tribunal acknowledged that Dr Armstrong did not seek to use this as an excuse for her behaviour, for which she took sole responsibility. Dr Armstrong told the Tribunal that she has now put measures in place to ensure her conduct is not repeated, including making the difficult decision to end her relationship and seek support from a psychologist. The Tribunal was satisfied that Dr Armstrong has put measures in place to ensure her misconduct is not repeated. Due to the unique circumstances, the Tribunal determined that the likelihood of repetition in this case was exceptionally low.

43. The Tribunal also had regard to the positive testimonials provided on behalf of Dr Armstrong. It noted that her colleagues who provided the testimonials did so with knowledge of the Allegation against her and that they had no concerns with her honesty, probity or integrity.

44. The Tribunal was particularly mindful to balance its thoughts on insight and remediation with all three limbs of the statutory overarching objective. It was satisfied that, given the level of insight demonstrated, the attempts at remediation undertaken and the testimonials it has seen, the risk of repetition of Dr Armstrong's behaviour was extremely low and that she did not pose an ongoing risk to patient safety.

45. The Tribunal went on to consider the need to uphold proper professional standards and maintain public confidence in the medical profession. The Tribunal had regard to the reminder in *Grant* of the need to take account of the wider public interest and it gave these issues careful consideration. The Tribunal took the view that the confidence of members of the public fully informed of the circumstances of this case, would not be undermined were there to be a finding of no impairment in this case.

46. In addition, given the circumstances of this case, it concluded that its duty to promote and uphold proper professional standards for the profession was satisfied by this rigorous regulatory process which had resulted in a finding of serious professional misconduct.

47. The Tribunal was mindful of the submissions it had heard in regard to the case of *Uppal*. It noted the finding of no impairment in relation to an incident of dishonesty in what had been determined to be exceptional circumstances. The conduct in this case arose during a period in which Dr Armstrong was subject to a combination of multiple, significant adverse life stressors. The Tribunal was satisfied that the particular circumstances of this case were also exceptional. For the reasons it has set out, it was satisfied that a finding of no impairment was appropriate in this case and met the requirements of the statutory overarching objective.

48. The Tribunal therefore determined that Dr Armstrong's fitness to practise is not currently impaired."

Legal framework

27. As already mentioned, at paragraph 23 of its decision, the Tribunal set out the objectives referred to in section 1(1B) of the 1983 Act. It is important to note that those objectives are to be pursued as part of the "over-arching objective", defined in section 1(1A) as "the protection of the public". Accordingly, when one refers in this context to the protection of the public, this is to be read as including not only the promotion and maintenance of the public's health, safety and well-being, but also the promotion and maintenance of public confidence in the medical profession, as well as the promotion and maintenance of proper professional standards and conduct.

28. That point is driven home by section 40A, which concerns appeals by the GMC against decisions of an MPT. Section 40A(4) states that consideration of whether a decision of the Tribunal is sufficient for the protection of the public involves consideration of whether that decision is sufficient:-

> "(a) to protect the health, safety and well-being of the public;
>
> (b) to maintain public confidence in the medical profession; and
>
> (c) to maintain proper professional standards and conduct for members of that profession."

29. Section 40A(3) provides that the appellant may appeal against "a relevant decision" to this court "if they consider that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public". What is meant by a "relevant decision" is exhaustively set out in section 40A(1). Section 40A(1)(d) refers to "a decision not to give a direction under section 35D". In Raychaudhuri v General Medical Council [2019] 1 WLR 324, the Court of Appeal held that a decision not to make a direction that a person's fitness to practise is impaired falls within section 40A(1)(d) and is, accordingly, appealable to this court.

30. By reason of section 40A(6), I may dismiss the appeal, allow it and quash the relevant decision; substitute for the relevant decision any other decision which could have been made by the Tribunal; or remit the case to the MPT service for them to arrange for a Tribunal to dispose of the case in accordance with the directions of the court. In the present case, the appellant invites me to allow the appeal; quash the Tribunal's decision that the respondent's fitness to practise is not currently impaired; substitute a decision that her fitness to practise is so impaired; and remit the case so that the Tribunal may determine the issue of sanction, in the light of the finding of impairment.

31. In General Medical Council v Jagjivan [2017] 1 WLR 4438, the Divisional Court, at paragraph 40 of its judgment, summarised the approach to be taken by this court on an appeal under section 40A. Synthesising what it considered to be relevant authorities, the Divisional Court articulated the following propositions:-

    (i) Since appeals under section 40A are governed by CPR 52, the court will allow an appeal if it is "wrong" or "unjust because of a serious procedural or other irregularity in the proceedings" in the Tribunal;

    (ii) It is not appropriate to add any qualification to the test in CPR 52 that decisions are "clearly wrong";

    (iii) The court will correct material errors of fact and law but must be extremely cautious about upsetting a conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of the witnesses, whom the Tribunal has had the advantage of seeing and hearing, in contrast to the appellate court;

    (iv) Where the question is one of what inferences are to be drawn from specific facts, the court is under less of a disadvantage and may draw any inferences that it considers are justified on the evidence;

    (v) In regulatory proceedings, the court will not have the professional expertise of the Tribunal and, as a consequence, will approach "with diffidence" Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and public standards in the profession and sanctions;

    (vi) There may, however, be matters, such as dishonesty or sexual misconduct, where the court is likely to feel it can assess what is needed to protect the public more easily for itself and therefore attach less weight to the expertise of the Tribunal. Whilst according an appropriate measure of respect to the

Tribunal's judgment, the court will not defer to the Tribunal's judgment more than is warranted by the circumstances;

(vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice. This is because of the overarching concern of the professional regulator to protect the public;

(viii) A failure to provide adequate reasons may constitute a serious procedural irregularity.

32. In Bawa-Garba v General Medical Council [2019] 1 WLR 1929, the Court of Appeal reiterated that the task of an appellate court under section 40A is to determine whether the decision of the Tribunal was wrong. At paragraphs 60, 61 and 67, the court (comprising the Lord Chief Justice, the Master of the Rolls and Raffety LJ) held that the issue of whether a practitioner's fitness to practise has been impaired is an evaluative one, of a type sometimes referred to as a "multi-factorial decision", comprising a mixture of fact and law. There is, accordingly, limited scope for an appellate court to overturn such a decision. At paragraph 67, the court held that an "appeal court should only interfere with such an evaluative decision if (1) there was an error of principle in carrying out the evaluation, or (2) for any other reason, the evaluation was wrong, that is to say, it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide".

Dishonesty

33. Whilst fully mindful of its binding nature, I do not consider that the judgment in Bawa-Garba requires any fundamental re-examination of the case law examined by the Divisional Court in Jagjivan or, indeed, of the Divisional Court's conclusion in that case, that the appellate court's intensity of scrutiny of a Tribunal's findings is likely to be heightened where dishonesty is at issue, albeit that the appeal remains one of review. The point, it seems to me, is not merely that, when it comes to dishonesty, the appellate court is in territory where specialist expertise is less likely to play a decisive role. There is also the expectation that medical (and other) professionals will be honest when undertaking their regulated activities; and that this expectation is a key component of any regulatory regime for protecting the physical safety of the public and promoting and maintaining public confidence in the profession. The appellate court will, therefore, be expected to scrutinise the Tribunal's decision, in order to satisfy itself that the Tribunal has recognised the inherent weight to be given to the importance of honesty; and that, consequently, the Tribunal needs to identify weighty factors in favour of the person concerned, if it is to conclude that the protection of the public does not necessitate a finding of impairment.

34. Lewis J's judgment in Theodoropolous had this to say about dishonesty:-

> "35. The importance of honesty and integrity on the part of members of a profession, including the medical profession is generally recognised in the case law: see, e.g. *Bolton v Law Society [1994] 1 WLR 512: Makki v General Medical Council [2019] EWHC 3180 (Admin)* at paragraph 43. Findings of dishonesty lie at the end of the spectrum of gravity of misconduct: *Tait v The Royal College of Veterinary Surgeons* [2003] UKPC 34 at paragraph 13.

36. Dishonesty will be particularly serious where it occurs in the performance of a doctor's duties or involves a breach of the trust placed in a doctor by the community: see *Khan v General Medical Council [2015] EWHC 301 (Admin)*. Honesty and integrity are also fundamental in relation to qualifications and the system of applying for medical positions. Thus, in *Makki v General Medical Council [2009] EWHC 3180 (Admin)*, the court dealt with a registered medical practitioner who had misrepresented the extent of his experience when applying for a post in a hospital. Irwin J as he then was said at paragraph 44 of his judgment:

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

37. Similar views were expressed by Parker J in *Naheed v General Medical Council [2011]* where a doctor applied for a post and dishonestly included someone else's career as her own in her application. At paragraph 25 of his judgment, Parker J said that:

> "… the authorities make clear that for a doctor honesty, certainly in the matter here involved, is indeed fundamental and it does not appear to me that the panel acted in any way disproportionately in deciding that, having regard to the mitigating features that I have outlined, nonetheless erasure from the register would be justified".

38. Furthermore, the case law recognises that where a doctor engages in deliberately dishonesty, and lacks insight, erasure may, in practical terms, be inevitable. In *Farah v General Medical Council [2008] EWHC 731 (Admin)*, the court was dealing with a doctor who had been convicted of one offence of theft and five of using a false instrument. He had stolen 18 prescriptions and forged five of them to obtain drugs for his own use. The panel imposed a sanction of erasure of the practitioner's name from the register. As Sullivan J as he then was observed at paragraph 21:

> "21. There is no reason to disbelieve the Panel's assertion that they did consider those mitigating factors, but given the nature of the Panel's finding that there had been a persistent lack of insight into that dishonesty, whatever the mitigating factors, were, the inevitable consequence was that erasure from the Register was an entirely proportionate response to the appellant's conduct. The Panel was entitled to come to the view that where a doctor had engaged in deliberate dishonesty and abused his position as a doctor, and had then shown a persistent lack of insight into that conduct, he simply could not continue to practise in the medical profession. This, the Panel's conclusion as to sanction was, in practical terms, inevitable once it had reached the conclusion it did about the appellant/s lack of insight into his dishonest conduct" …"

35. Nicklin J recited those paragraphs in his judgment in General Medical Council v Nyamasve [2018] EWHC 1689 (Admin). That case involved a doctor who acted dishonestly by working as a locum, without informing his agency or hospital that he was not in possession of a licence to practise. At paragraph 14, Nicklin J identified:-

> "14. … the importance of the requirement to hold a licence to practice and the role it plays in protection of the public. A doctor is only allowed to practise if he or she has the relevant licence to practise. The licence can only be obtained on the GMC being satisfied that the relevant doctor has complied with all the requirements as to the ongoing training, which are consistent with ensuring that the public is adequately protected from doctors whose competence falls below an acceptable level."

36. At paragraph 17, Nicklin J said:-

> "17. … It is not simply that public confidence in doctors is likely to be diminished if doctors are dishonest. It also has a practical importance in the regime of licence to practise. If dishonesty is practised at the stage of revalidation and obtaining a licence to practise or alternatively a doctor fails to get the necessary licence to practise, then he or she is not being properly subject to the regime, the purpose of which is the protection of the public and the maintenance of proper standards."

37. It is relevant that in Nyamasve the Tribunal had made a finding of impairment. What was at issue in the appeal was whether the Tribunal's sanction was a proper one, given Dr Nyamasve's dishonesty. Nicklin J held that it was not. The present respondent's case, accordingly, faces the difficulty that it is very rare indeed for a person who has committed serious professional misconduct by reason of dishonesty to escape a finding of impairment.

38. As we have seen, the Tribunal in the present case was satisfied that the circumstances were "exceptional". In so finding, it made reference to Professional Standards Authority for Health and Social Care v General Medical Council, Uppal [2015] EWHC 1304 (Admin). Before me, Mr Hare properly drew to my attention two other appeal cases in which a finding of dishonesty did not lead to impairment. Mr Hare informed me that, besides Uppal, these were the only such cases that the appellant had been able to identify. Since these cases would, no doubt, have been prayed in aid by the respondent, had she or her representative attended the hearing, it is particularly important for me to have close regard to them.

39. Dr Uppal was a junior doctor, working in a general medical practice. She spoke on the telephone to the mother of a baby, who had been diagnosed with a viral illness and whose condition was said to have worsened. Dr Uppal provided advice to the mother, saying that if the mother continued to have concerns she should take the baby to A & E. On 19 December 2011, Dr Uppal received a letter from the hospital informing her that the baby had been admitted to hospital and had required intubation and ventilation. That was confirmed in a later letter sent to the practice. On 30 December 2011, Dr Uppal told a more senior doctor in the practice that she had spoken to the baby's mother following the letter from the hospital, which was not true. She also said, falsely, that the mother had told Dr Uppal that the baby's condition had deteriorated after Dr Uppal had provided the telephone advice. On 13 January 2012, at a meeting with other doctors of the practice, Dr Uppal was informed that the baby's mother had not spoken with her subsequently; but Dr Uppal still maintained that she had spoken to the mother. Being told that the telephone records could be checked, she suggested she may have used her mobile telephone. Having been told that the records for that could be checked, Dr Uppal then admitted to one of the doctors that she had never called the baby's mother. Dr Uppal's evidence to the Tribunal was she had lied to her senior colleagues in the context of a difficult working environment in which she was unsupported, uncomfortable and

constantly monitored. She felt unable to explain the mistake. The Tribunal accepted that Dr Uppal had felt uncomfortable and unhappy in the practice.

40. At paragraph 14, the Tribunal found that the misconduct related to an isolated incident over a short period of time more than two years previously; that the dishonesty did not impact upon patient care, was not for financial gain and did not seem to benefit Dr Uppal personally in any way; and that when confronted with her behaviour she admitted lying and immediately apologised, subsequently always accepting full responsibility for her actions. The Tribunal did not find that Dr Uppal was impaired to practise. On appeal by the PSA, Lang J dismissed the appeal. At paragraph 34, Lang J held:-

> "34. … the question whether or not its decision was unduly lenient is ultimately one for this Court, … whether, having regard to the material facts, the decision reached had due regard for the safety of the public and the reputation of the profession (per Lord Phillips at [73]). In this case, the Panel had regard to all the relevant factors in reaching its decision, including the public interest, and it correctly directed itself in law. I consider that the Panel was justified, in the exercise of its judgment, in concluding that Dr Uppal's fitness to practise was not impaired, on the basis of the evidence before it, and for the reasons it gave. This was an exceptional case, on the facts. It does appear, on the evidence, that this was an isolated lapse in an otherwise unblemished career, and that the risk of repetition was extremely low, not least because of her insight and the steps taken to remediate. The Court has received updating evidence from Dr Warwick describing her "exemplary professional behaviour" as a "dedicated and effective G.P". On the basis of these findings, I consider that the Panel was entitled to conclude that patients and the public were not at risk. Professional standards have been upheld, and public confidence in the profession maintained, by the fact that Dr Uppal has undergone a rigorous disciplinary assessment of her fitness to practise, resulting in a finding of misconduct on her record, with the option of a warning, by way of sanction."

41. In Professional Standards Authority for Health and Social Care v a decision of the Conduct and Competence Committee of the Nursing and Midwifery Council dated 22 March 2016 [2017] CSIH 29, the Inner House of the Court of Session was concerned with an appeal involving a nurse who administered the wrong drug to an end of life patient, thereby depriving the patient of 24 hours of pain relief. In a dishonest attempt to cover up what happened, the nurse destroyed two vials of morphine; made incorrect entries in the control drugs book, including a false signature of a colleague; and failed to report the drugs error to her manager. While the specific charges were admitted, the nurse challenged the allegation that her fitness to practise was impaired by reason of her misconduct. The committee agreed. The appellant said there were two elements to the charges; first, their clinical nature and, second, dishonesty. As to the first, the committee concluded that there was a single and isolated clinical error which amounted to a serious departure from the standards expected of a nurse. As to dishonesty, the committee took into account all the circumstances and testimonials before it, and the evidence from the nurse's manager, all of which was to the effect that she was an honest person and a good and caring nurse. She had health issues at the time of the incident. She described how she "panicked" and acted "impulsively". Nevertheless, her actions amounted to dishonest misconduct which breached fundamental tenets of the profession and brought it into disrepute. The committee noted that the nurse had produced two "reflective pieces" reflecting on matters and lessons learned and the impact on the nurse of the incident, including demotion. She had undertaken numerous courses since the events in question and was again working as normal. For the ten months preceding the hearing

she had been in a very different nursing environment with a decreased workload. The committee took account of the early admissions and that the nurse had "learned a difficult lesson". There was no other such incident in her career. Regard was had to the nurse's health problems at the time. The committee decided it could be assured that she would not repeat her misconduct and she had engaged fully with the process and taken responsibility from the outset. In the view of the committee "a right minded member of the public, in hearing all of the circumstances of the case, would not require a finding of current impairment". Rather, the public interest was best served "by returning a capable, competent and caring nurse to unrestricted practice" (paragraph 12).

42. The Inner House has held that there was no warrant in the statutory scheme before it that, if misconduct was proved, the Tribunal should consider penalty, and if a sanction was thought to be appropriate, a finding of impairment must follow:

> "Not every case of misconduct will result in a finding of impairment. An example might be an isolated error of judgement which is unlikely to recur where the misconduct is not so serious as to render a finding of impairment plainly necessary. On the other hand, misconduct may be so egregious that, whatever mitigatory factors arise in respect of insight, remediation, unlikelihood of repetition, and the like, any reasonable person would conclude that the registrant should not be allowed to practise on an restricted basis, or at all" (paragraph 27).
>
> The Inner House concluded that the committee was entitled to find that, notwithstanding her admitted dishonesty, the nurse's fitness to practise was not impaired.

43. The third and final case is the Professional Standards Authority for Health and Social Care v the General Medical Council, Hilton [2019] EWHC 1638 (Admin). Following a complaint by a patient, at a meeting on 2 November 2016, Mr Hilton dishonestly informed the patient that Mr Hilton had known from his post-operative assessment that a screw used in the surgery of the patient had been misplaced. At the meeting, Mr Hilton had said that he had known about the misplaced screw post-operatively, that he had not wanted to worry the patient and that he had adopted a watch and wait approach. It was not, however, the case that Mr Hilton had known about the misplaced screw post-operatively.

44. At paragraph 25 of Freedman J's judgment, he noted that the Tribunal "was satisfied that the respondent had no malicious intention to deceive Patient A, merely to create a positive environment in which he could apologise to Patient A for his error and reassure him that there had been no adverse outcome resulting from that error". The Tribunal found that Mr Hilton's actions "were driven by his desire to put matters right for the patient and to reassure him" and that Mr Hilton "was not motivated to avoid litigation or to avoid payment of financial compensation. His approach was conciliatory. In short, there was no finding of an adverse motive". In dismissing the Authority's appeal, Freedman J noted that the limited role of the appellate court had been emphasised by the Court of Appeal in Bawa-Garba. At paragraph 80, he also noted the judgment of the Inner House in the case just mentioned. At paragraph 89, he had regard to the fact that the Tribunal had considered the matter to be "a very unusual case" and "an unusual and unique case". The Tribunal's reasoning was detailed. At paragraph 108, Freedman J held that "in the end, the central question is whether in all the circumstances, in deciding not to find

impairment, the Tribunal acted irrationally or perversely in coming to a conclusion that no reasonable Tribunal could come to in these circumstances …".

45. Freedman J derived assistance from the judgment in Uppal, albeit recognising that no two cases were the same (paragraph 110). Having considered all the points of criticism of the appellant, and bearing in mind, amongst other things, the multi-factorial nature of the assessment, he found that none of the criticisms advanced against the Tribunal's decision were "so fundamental that they impair the multi-factorial nature of the assessment. The Tribunal still found misconduct in the nature of dishonesty, and recognised that it would have to be an exceptional case where there was dishonesty without impairment" (paragraph 117). He concluded that paragraph as follows:-

> "This was an exceptional case on the facts. It was an isolated lapse in an otherwise unblemished career. The risk of repetition was extremely low. The testimonials of colleagues and patients all told a story. The Tribunal had well in mind that the central issue and the crux of the matter was the upholding of professional standards. The matters of impression which it reached about the lies were not such as to undermine the very basis of the decision. Further, the decision reached on impairment was not one which no reasonable tribunal could reach. I am persuaded that this is not a case where this Court can conclude on all the material before it that professional standards cannot be upheld or public confidence in the profession maintained without a finding of impairment. It therefore follows that the appeal in respect of Ground 1 generally is rejected."

Discussion

46. Mr Hare submits that the Tribunal's decision in the present case is wrong in that the Tribunal failed to have proper regard to the nature and extent of the respondent's dishonesty. Fully respecting the reviewing nature of my role, I am in no doubt that his criticism has force. Despite the fact that, at paragraph 15, the appellant's representative had submitted in terms that the respondent's dishonest conduct was lengthy, persistent and multi-faceted, the only reasoned engagement with these plainly important aspects is at paragraph 40 of the decision, where the Tribunal merely recorded the respondent's acceptance "that failure to be on the list could have an impact on patient safety" and that she "was aware of the impact that her actions could have on public confidence in the medical profession". At paragraph 42, the only inference drawn from the Tribunal's acceptance "that Dr Armstrong's dishonest conduct continued for a period of over two years" was that this "was subject to a combination of significant factors in her personal life which affected her thinking and decision-making", including financial pressures, adverse health events in her close family and being the victim of an abusive and controlling partner. Significantly, the respondent herself "did not seek to use this as an excuse for her behaviour, for which she took sole responsibility". The Tribunal then concluded that, because of the measures the respondent had put in place", the likelihood of repetition was "exceptionally low".

47. This is, with respect, an impermissibly incomplete engagement with the issue of dishonesty. There is a serious disconnect between the bald findings at paragraph 36 that the respondent's "conduct will be considered as deplorable by fellow practitioners and was a breach of a fundamental tenet of the profession. In addition it brought the profession into disrepute", and the Tribunal's findings that the respondent's fitness to practise was not currently impaired. Given this failing, the statement at paragraph 44 that the Tribunal "took the view that the confidence of members of the public fully

informed of the circumstances of this case, would not be undermined were there to be a finding of no impairment in this case" is unreasoned. For the reasons I shall give, I am in no doubt that such a hypothetical member of the public would take an entirely opposite view.

48. It is necessary to examine the significance of the respondent's dishonesty about being on the Performers List for England. The list derives from the National Health Service (Performers List) (England) Regulations 2013 (SI 2013/335). Regulation 3 requires the National Health Service Commissioning Board to prepare, maintain and publish a Medical Performers List. Regulation 4 requires the information and documentation in an application to satisfy certain requirements. The application must include the names and addresses of two referees who are willing to provide clinical references relating to two recent posts of certain minimum length or, where this is not possible, a full explanation as to why that is the case. Where the practitioner has one, the application must also include the applicant's most recent appraisal. There must be evidence that the applicant has in force an appropriate indemnity arrangement in respect of liabilities that may be incurred in carrying out the applicant's work. Furthermore, importantly, the application must also contain an enhanced criminal record certificate, which includes suitability information relating to children and vulnerable adults. The applicant must provide various undertakings, including to maintain an appropriate indemnity arrangement and to participate in any appraisal systems established by the Board. Regulation 5 imposes a duty on the Board, in considering an application, to satisfy itself that it has checked all the information and documents submitted, and that it obtains and considers references from the referees.

49. These are, clearly, highly important matters that go to the heart of the over-arching aim in section 1 of the 1983 Act. Yet the Tribunal's determination has no specific regard to them or to the consequences of someone practising (or being available to practise) when he or she is not on the list and, accordingly, cannot satisfy the Board (or, thereby, the public) of these matters.

50. As already observed, the Tribunal also failed to consider the significance of the fact that the respondent's dishonesty extended over a period of some two and a half years and of the sheer number of times that she resorted to it. This is graphically demonstrated in the decision and its schedules, which I have attempted to set out above. At paragraph 42, the reference to the length of the dishonest conduct is followed immediately, and without further analysis, by a set of circumstances which the Tribunal concluded amounted to sufficient mitigation. But, as I shall explain when dealing with the appellant's second ground of challenge, an acknowledgment of wrongdoing and attempts at reparation have only a limited part to play in cases of serious dishonesty. Furthermore, as Mr Hare submitted, far from explaining why the seriousness of the respondent's dishonest actions over this extended period of time should be regarded as of only limited significance, paragraph 42 of the decision raises in stark terms the following point, which also goes to the respondent's lack of insight. If financial and other pressures were affecting the respondent's "thinking and decision-making" over this period, when she was treating patients despite not being on the list, there is an obvious issue as to whether, as a doctor in this position, the respondent should have been engaging with patients at all. She did not stop spontaneously. Her change of heart occurred only when the New South Wales Medical Board began certain proceedings against her. In conclusion, therefore, the

Tribunal failed to engage with the weight of the public interest factors tending to a finding of impairment.

51. The second ground of challenge is that the Tribunal placed wholly excessive weight upon factors in favour of the respondent. So far as mitigation is concerned, there is no acknowledgment in paragraph 42 or elsewhere that, in cases of significant professional dishonesty, mitigation has a necessarily limited role. Although spoken in a case about the regulation of solicitors, Sir Thomas Bingham MR's words in Bolton v Law Society [1994] I WLR 512 at 598 also have relevance in the realm of medical regulation:-

> "The most serious [lapse] involves proven dishonesty, whether or not leading to criminal proceedings and criminal penalties. In such cases the Tribunal has almost invariably, no matter how strong the mitigation advanced for the solicitor, ordered that he be struck off the Roll of Solicitors …"

52. The fact that the assessment of impairment is forward-looking means the Tribunal must appreciate that any loss of public confidence in the regulatory regime, resulting from erroneously lenient decisions, is likely to be of an ongoing nature. It does not necessarily fall to be discounted or downplayed, merely because the practitioner in question is unlikely to repeat their dishonesty. Undue leniency risks undermining general public confidence in the ability of the regulatory regime to protect the public from harm. In the present case, there is a legitimate concern that the integrity of the list required to be kept by the 2013 Regulations would be put at risk, in that others may lie about being on it and yet escape formal sanction.

53. This brings me to the issue of exceptionality. As we have seen, the Tribunal in the present case, having regard to Uppal, stressed that its finding was, as in that case, exceptional. Exceptionality is rarely a substantive "threshold" test. Rather, the categorisation of a case as exceptional in the judicial context signifies that the nature of the issues in play are such that it will be only in an unusual or rare case that one set of factors will outweigh others. As I have already mentioned at paragraph 33, in cases such as the present, the consequences of a finding of dishonesty in the professional regulatory context are likely to be so profound, in terms of the overarching regulatory objective, that the factors on the other side, viewed as a whole, will need to be extremely strong, in order for a finding of no impairment to be justified. Competing factors of the required overall strength are unlikely to be frequently encountered.

54. With this in mind, I look at the factors to which the Tribunal had regard in the present case. I have already dealt with insight and risk of repetition. So far as remediation is concerned, the Tribunal found at paragraph 41 that "to the extent possible, Dr Armstrong had endeavoured to demonstrate remediation of her conduct". She went on what appears to be two one-day courses in August and December 2019, concerned respectively with medical ethics and medical professionalism. She also had shown the Tribunal an "extensive reading list", which, according to the Tribunal, demonstrated "that she had reflected on her misconduct in detail". It is very difficult to regard this as having any material bearing; and the Tribunal failed to explain why it was considered to do so.

55. By the same token, no more than limited weight can be placed upon the finding at paragraph 46 that the Tribunal's "duty to promote and uphold proper professional standards for the profession was satisfied by this rigorous regulatory process which had resulted in a finding of serious professional misconduct". Whilst I accept that the mere

fact of having to face allegations before the Tribunal may have some modest bearing on the public's view of the effectiveness of the regulatory regime, in the light of the extremely serious allegations proved against the respondent, it cannot rationally be concluded that the mere existence of the Tribunal process, resulting in a finding of "serious professional misconduct", but which did not lead to a finding of impairment and, so, any consideration of sanction, adequately addresses the legitimate concerns of the public.

56. In determining whether a case is exceptional, it is important not to make direct factual comparisons between one case and another. Freedman J was alive to this in Hilton and I am also. That said, the way in which the facts of other cases have been judicially addressed can shed light on what kinds of factors may or may not be regarded as possessing inherent weight or significance. Adopting this approach, what is striking about all three of the cases in which a finding of dishonesty did not lead to a finding of impairment, is that the dishonest conduct in each of them was an isolated incident; and that there was no question of financial gain. They were in the nature of uncharacteristic lapses in what may be described as "front-line" challenging clinical situations involving direct interaction between professional and patient (or patient's relative).

57. In the present case, for the reasons I have given, the respondent's dishonesty cannot be described as an isolated incident. She lied repeatedly, to different interlocutors over an extended period. She did so for financial gain. She did not do so in a stressful clinical situation. Accordingly, not only do these three cases not serve to support the Tribunal's conclusions in the present case; properly analysed, they serve only to underscore the deficiencies in the Tribunal's decision.

58. Accordingly, both grounds of challenge are made out. The Tribunal's decision that the respondent's fitness to practise was not currently impaired was not one which a reasonable Tribunal could reach. A finding of impairment was the only rational conclusion that, in the circumstances, could have been made. I therefore quash the decision on impairment and substitute a decision of my own, that the respondent's fitness to practise is currently impaired. I do so on the assumption that nothing professionally untoward has occurred whilst the respondent has been in Australia, following the conclusion of the Tribunal hearing. I am entirely prepared to accept that that is so.

59. I remit the matter for a Tribunal to make a decision on sanction.