Neutral Citation Number: [2023] EWHC 1772 (Admin)

Case No: CO/99/2023

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT
SITTING IN LEEDS

ON APPEAL FROM A DECISION OF THE
MEDICAL PRACTITIONERS TRIBUNAL

Leeds Combined Court Centre
1 Oxford Row, Leeds, LS1 3BG

Date: 13/07/2023

Before :

MRS JUSTICE HILL

- -

Between:

DR SUDHEER SHABIR — **Appellant**

- and -

THE GENERAL MEDICAL COUNCIL — **Respondent**

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- -

Fiona Horlick KC and **Mark Ainsworth** (instructed by Weightmans) for the Appellant
Alexis Hearnden (instructed by the General Medical Council) for the Respondent

Hearing date: 19 June 2023

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Approved Judgment

This judgment was handed down remotely at 10:30 am on 13/07/23 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

Mrs Justice Hill:

Introduction

1. The Appellant qualified as a doctor in 2018. From 28 November to 9 December 2022, he appeared before a Medical Practitioners Tribunal ("the Tribunal"), facing an allegation of sexual misconduct during his consultation with Patient A on 23 September 2019. The Tribunal found that the Appellant's fitness to practise was impaired by reason of his misconduct and directed that his name be erased from the medical register. The Appellant appeals the Tribunal's findings of fact, as is his right, under the Medical Act 1983, section 40. He does not dispute that, on the facts found as proved, erasure was an appropriate sanction.

The facts

2. The Appellant qualified from Hull and York medical school in 2018. He completed his foundation year one training, with rotations in emergency medicine, respiratory medicine and general surgery, in the West Yorkshire area. During his foundation year two, he spent a significant period of time as part of the Bradford Teaching Hospitals Covid-19 team. At the time of his consultation with Patient A, he was one month into a four-month rotation in primary care at Highfield Medical Practice ("the practice"). By this point in his rotation, the Appellant was able to see patients alone, but was afforded longer for each appointment (30 minutes) than the experienced GPs. After each group of four appointments he would have a debrief with his supervisor.

3. On 23 September 2019, Patient A attended the practice for an appointment. She said that she was prone to tonsillitis and was feeling dizzy with a sore throat. She did not know the Appellant, but had seen him previously when he sat in on an appointment she had had with another GP. The Appellant's examination of Patient A took place in two distinct parts but was treated as one consultation by the Tribunal, because the Appellant confirmed that he did not finalise his record of it until part two of the consultation had concluded. The consultation was split in this way because the Appellant wanted to re-test Patient A's blood sugar level before allowing her to leave the practice. For this reason, after the first part of the consultation, she left the consulting room and went to the waiting area of the practice where she was given a sugary drink. Some time thereafter, she returned to the consulting room where she was seen by the Appellant again.

4. The day after the consultation, Patient A reported to the practice that the Appellant had touched her breasts during both parts of the consultation when the same was not necessary. He denied any such touching. She reported the matter to the police. The Appellant referred himself to the General Medical Council ("GMC").

5. The concerns about the Appellant's conduct were framed as one overarching "Allegation" before the Tribunal, described in two paragraphs.

6. Under paragraph 1, which was split into a series of sub-paragraphs, it was alleged that he had carried out two examinations of Patient A's breasts that were not clinically indicated. Specifically, it was alleged that his first examination of Patient A involved him putting his hand inside her bra, touching the underside of her breasts and feeling around her breasts; and that the second examination involved him lifting her sweatshirt

over her breasts and her breasts out of her bra, and pressing both breasts, her nipples and her breast area with his hand. Further, it was alleged that he had failed to (i) explain the nature and purpose of his actions; (ii) obtain Patient A's verbal consent; (iii) offer her a chaperone; (iv) offer her privacy to get undressed and dressed; (v) ask her to remove her bra; or (vi) record his actions in her medical records.

7. Under paragraph 2, it was alleged that his touching of Patient A's breasts as alleged in the first two parts of paragraph 1 was sexually motivated.

8. The Tribunal heard evidence from Patient A, the Appellant, Dr Nigel Williams (an expert instructed on behalf of the GMC) and Dr Russell Roberts and Dr Nadeem Akhtar (two character witnesses relied on by the Appellant). The Tribunal also considered documentary evidence, including Patient A's medical record, her written account dated 24 September 2019, the Appellant's written account, the transcripts of the interviews conducted by the police with both Patient A on 6 November 2019 and the appellant on 2 December 2019, both parties statements to the GMC and further written character references on the Appellant's behalf.

9. On 7 December 2022 the Tribunal issued its Determination of the facts, finding all parts of the Allegation against the Appellant proved. On 8 and 9 December 2022, respectively, the Tribunal concluded that his fitness to practice was impaired by reason of misconduct; and that the appropriate sanction was erasure of his name from the medical register. The Tribunal also ordered that he should be immediately suspended pending any appeal.

The legal framework

10. The overarching legal principles relevant to an appeal of this kind were recently summarised by Collins Rice J in *Sawati v General Medical Council* [2022] EWHC 283 (Admin) at [46]-[50]. I gratefully adopt the parts of her summary that are relevant to this case (which does not involve an appeal against sanction), as follows:

> "46. This is an appeal to which CPR Part 52 applies: the High Court will allow an appeal if satisfied that the Tribunal decision was (a) wrong or (b) unjust because of serious procedural or other irregularity in its proceedings.
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> 47. There is no dispute about the proper approach of the High Court to appeals brought under section 40 of the Medical Act 1983…
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>> 102. Derived from *Ghosh* are the following points as to the nature and extent of the section 40 appeal and the approach of the appellate court:
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>> (i) an unqualified statutory right of appeal by medical practitioners pursuant to section 40 of the 1983 Act;
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>> (ii) the jurisdiction of the court is appellate, not supervisory;
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>> (iii) the appeal is by way of a rehearing in which the court is fully entitled to substitute its own decision for that of the tribunal;

> (iv) the appellate court will not defer to the judgment of the tribunal more than is warranted by the circumstances...
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> 48. Since the degree of warranted deference depends on case-specific circumstances, 'material errors of fact and law will be corrected and the court will exercise judgment, but it is a secondary judgment as to the application of the principles to the facts of the case'. I am reminded of guidance in *Gupta v GMC* [2002] 1 WLR 1691 at paragraph 10 that the Tribunal has an advantage because it has had a better opportunity to judge the credibility and reliability of oral evidence given by witnesses.

11. The fact that the appeal is a rehearing rather than a review makes little, if any, difference to the approach that should be adopted when considering the degree of deference to be shown to findings of primary fact by an appellate court: *Arowojolu v General Medical Council* [2021] EWHC 2725 (Admin) at [90]-[98] and *Byrne v General Medical Council* [2021] EWHC 2237 (Admin) at [16].

12. The degree of deference shown to the court below will differ depending on the nature of the issue below, namely whether the issue is one of primary fact, of secondary fact, or rather an evaluative judgment of many factors. The governing principle remains that set out in *Gupta* at [10], such that the starting point is that the appeal court will be very slow to interfere with findings of primary fact of the court below: *Byrne* at [12] and [13].

13. Findings of fact, particularly if founded on an assessment of the credibility of witnesses, were described by Leveson LJ in *Southall v General Medical Council* [2010] 2 FLR 1550 at [47] as "virtually unassailable", but this is not to be read as meaning that it is "practically impossible" to challenge them: *Byrne* at [14], citing *R (Dutta) v General Medical Council* [2020] EWHC 1974 (Admin) at [22].

14. As Morris J explained in *Byrne* at [15], the circumstances in which the appeal court will interfere with primary findings of fact have been formulated in a number of different ways:

    (i) Where "any advantage enjoyed by the trial judge by reason of having seen and heard the witnesses could not be sufficient to explain or justify the trial judge's conclusions": per Lord Thankerton in *Thomas v Thomas* [1947] AC 484 approved in *Gupta*;

    (ii) Findings "sufficiently out of the tune with the evidence to indicate with reasonable certainty that the evidence had been misread" per Lord Hailsham in *Libman v General Medical Council* [1972] AC 217;

    (iii) Findings "plainly wrong or so out of tune with the evidence properly read as to be unreasonable": per Girvan LJ in *Casey v General Medical Council* [2011] NIQB 95 at [6] and Warby J (as he then was) in *Dutta* at [21](7); and

    (iv) Where there is "no evidence to support a…finding of fact or the trial judge's finding was one which no reasonable judge could have reached": per Lord Briggs in *Perry v Raleys Solicitors* [2019] UKSC 5.

15. Morris J considered that the distinction between the last two of these formulations was a "fine" one. To the extent that there was a difference, he adopted, in the Appellant's favour, the former: *Byrne* at [15].

16. Having reviewed the authorities, he distilled the following principles in relation to the credibility and reliability of witnesses:

> "17. First, the credibility of witnesses must take account of the unreliability of memory and should be considered and tested by reference to objective facts, and in particular as shown in contemporaneous documents. Where possible, factual findings should be based on objective facts as shown by contemporaneous documents: *Dutta* §§39 to 42 citing, in particular, *Gestmin* and *Lachaux*.
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> 18. Secondly, nevertheless, in assessing the reliability and credibility of witnesses, whilst there are different schools of thought, I consider that, if relevant, demeanour might in an appropriate case be a significant factor and the lower court is best placed to assess demeanour: Despite the doubts expressed in *Dutta* §42 and *Khan* §110, the balance of authority supports this view: *Gupta* §18 and *Southall* at §59.
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> 19. Thirdly, corroborating documentary evidence is not always required or indeed available. There may not be much or any such documentary evidence. In a case where the evidence consists of conflicting oral accounts, the court may properly place substantial reliance upon the oral evidence of the complainant (in preference to that of the defendant/appellant): *Chyc* at §23. There is no rule that corroboration of a patient complainant's evidence is required: see *Muscat* §83 and *Mubarak* §20.
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> 20. Fourthly, in a case where the complainant provides an oral account, and there is a flat denial from the other person concerned, and little or no independent evidence, it is commonplace for there to be inconsistency and confusion in some of the detail. Nevertheless the task of the court below is to consider whether the core allegations are true: *Mubarak* at §20".

17. He also observed that where an allegation is met with a "simple denial", the "credibility of the denial can only be assessed by reference to the credibility of the evidence supporting the allegation which is denied": *Byrne* at [113].

18. As to the duty to give reasons:

(i) The purpose of a duty to give reasons is to enable the losing party to know why they have lost and to allow them to consider whether to appeal: *English v Emery Reimbold & Strick* [2002] 1 WLR 2409 at [16] and *Byrne* at [24].

(ii) It will be satisfied if, having regard to the issues and the nature and content of the evidence, reasons for the decision are apparent, either because they are set out in terms or because they can readily be inferred from the overall form and content of the decision: *English* at [26] and *Byrne* at [24];

(iii) There is no duty on a tribunal, in giving reasons, to deal with every argument made in submissions: *English* at [17]-[18];

(iv) In a straightforward case, setting out the facts to be proved and finding them proved or not will generally be sufficient both to demonstrate to the parties why they have won or lost and to explain to any appellate tribunal the facts found: *Southall* at [56] and *Gupta* at [13];

(v) Where the case is not straightforward and can properly be described as "exceptional", the position will be different: a few sentences dealing with "salient issues" may be essential: *Southall* at [56];

(vi) Specific reasons for disbelieving a practitioner are not required in every case that is not straightforward: *Byrne* at [119]; and

(vii) Where a Tribunal's stated reasons are not clear, the court should look at the underlying materials to seek to understand its reasoning and to identify reasons which cogently justify the decision. An appeal should not be allowed on grounds of inadequacy of reasons unless, even with the benefit of knowledge of the evidence and submissions made below, it is not possible for the appeal court to understand why the tribunal reach the decision it did: *English* at [89] and [118] *Byrne* at [27].

Grounds of Appeal

19. The Appellant advanced five grounds of appeal, the first four of which overlapped. Ms Horlick KC appeared for the Appellant with Mr Ainsworth, who had represented him before the Tribunal. She contended that the errors made out in the first four grounds also needed to be consider cumulatively.

Ground 1: Inherent improbability

20. The concept of inherent improbability is well-established: see, for example, *Secretary of State for the Home Department v Rehman* [2001] UKHL 47 at [55], where Lord Hoffman said that "cogent evidence is generally required to satisfy a civil tribunal that a person has behaved in some other reprehensible manner"; see also *Re B (Children)* [2008] UKHL 35 at [2].

21. In *Re H (Minors) (Sexual Abuse: Standard of Proof)* [1996] AC 563, Lord Nicholls summarised the concept thus:

> "73. The balance of probability standard means that a court is satisfied an event occurred if the [tribunal] considers that, on the evidence, the occurrence of the event was more likely than not. When assessing the probabilities the [tribunal] will have in mind as a factor, to whatever extent is appropriate in the particular case, that the more serious the allegation the less likely it is that the event occurred and, hence, the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability…Built into the preponderance of probability standard is a generous degree of flexibility in respect of the seriousness of the allegation.

> 74. Although the result is much the same, this does not mean that where a serious allegation is in issue the standard of proof required is higher. It means only that the inherent probability or improbability of an event is itself a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred. The more improbable the event, the stronger must be the evidence that it did occur before, on the balance of probability, its occurrence will be established".

22. The Appellant accepted that the Tribunal had directed itself to the concept of inherent improbability and the importance of cogent evidence: the relevant legal principles are set out at pages 7-8 of the Determination.

23. However, Ms Horlick submitted that the Tribunal had failed to give any or any proper weight to the fact that the serious allegation of sexual assault made by Patient A was inherently improbable. The Appellant was working in a supervised environment where he would meet with his supervisor for a debrief after every four patients. His supervisor may have "popped in" to the room at any point, as there was an "open door" policy. Nurses, healthcare assistants, receptionists and administrative staff were providing him with support. The Tribunal had heard specific evidence that one nurse and one healthcare assistant had come into the consultation room during the course of the first part of the consultation with Patient A. There was no curtain or screen and the door to the consultation room was closed but not locked. His supervising doctor would have access to his consultation notes. If a patient returned on a further occasion and was seen by another doctor, they would inevitably look more critically at his notes than those of a more experienced doctor.

24. Further, the Appellant would have known that to behave in the way Patient A alleged would place him at risk of erasure: the stakes for him could not be higher. Ms Horlick relied on the recognition in *Casey* at [15], that "sexual impropriety by a doctor is something which has an intrinsic unlikelihood". That was all the more so here, given the nature of the environment in which the Appellant was working.

25. However, at no point had the Tribunal addressed the inherent improbability of this serious allegation; the words "cogent" and "cogency" were not included in any part of its analysis; and although the Tribunal did recite parts of the evidence of Patient A's evidence, this was quite different from conducting an assessment of whether that evidence was cogent.

26. The closing submissions made on behalf of the Appellant to the Tribunal had specifically addressed the issue of inherent improbability and the need for cogent evidence. Mr Ainsworth had reiterated the relevant law to the Tribunal. The Tribunal then properly directed itself as to the burden and standard of proof and the key authorities on inherent improbability as noted at [20]-[21] above. In those circumstances, for this ground of appeal to succeed, I would need to be satisfied that the Tribunal had left the concept of inherent improbability "wholly out of account": *Khan v GMC* [2021] EWHC 374 (Admin) at [89]. In my judgment, that test is not met.

27. The Tribunal correctly identified that the central dispute was whether the Appellant had acted as Patient A alleged. In approaching that question, it immediately took into

account his good character, having directed itself that this could be relevant to his propensity to act as alleged: [24]-[25] of the Determination. It was therefore, effectively, considering the likelihood of the Appellant acting as Patient A had alleged. The Tribunal was aware of the nature of the supervision of the Appellant at the material time. However, as Ms Hearnden highlighted, this aspect of the evidence should not be overstated: (i) there was no evidence to suggest that it was likely anyone would come into the consultation room without knocking; (ii) the reference to an "open door" policy concerned access to support from the supervisor; and (iii) neither the nurse nor the healthcare assistant referred to came into the room unannounced or unprompted. Further, *Arunkalaivanan* at [51] emphasises that the fact a doctor would be placing their career at risk by behaving in a particular way does not mean they did not in fact do so:

> "…what is alleged is a short assault which appeared to offer limited opportunity for sexual gratification before Mr Arun then rushed off to collect his child. It is inherently unlikely that he would risk an eminent career as a urogynaecologist on that basis. Having said that, the very nature of abuse of trust cases is that the perpetrator takes advantage of that unlikelihood".

28. The Tribunal had to weigh the inherent improbability of the Appellant acting as alleged against the relative improbability of Patient A fabricating the allegations and putting herself through the ordeal involved in doing so: *Byrne* at [111]. The Tribunal specifically found that there was no reason why Patient A would fabricate her account: [66] of the Determination.

29. In my judgment although the Tribunal did not use the term "cogent" or "cogency", its Determination included a detailed assessment of the credibility and reliability of the evidence on which the GMC relied, principally that of Patient A. The Tribunal was required to consider the evidence, to do so critically, to do so with the burden and standard of proof in mind and to consider the strengths and weaknesses of the evidence. Part and parcel of that process is the consideration of the concept of inherent improbability and the credibility of evidence. The Tribunal had carried out that task. I accept Ms Hearnden's submission that the Tribunal was not required to make a separate, "standalone" finding on inherent probability.

Ground 2: Inconsistencies in Patient A's account

30. Patient A had given accounts of her consultation with the Appellant in the following: (i) her handwritten statement dated 24 September 2019 (prepared by her father, but signed by her); (ii) an Achieving Best Evidence ("ABE") police interview on 6 November 2019; (iii) her witness statement for the GMC dated 11 May 2021; and (iv) her oral evidence before the Tribunal.

31. Across and within these accounts, there were several inconsistencies. These related to (i) whether, during the first part of the consultation, (a) the Appellant had felt her right or left breast first; and (b) the Appellant had felt her breasts inside her bra or taken them out of her bra; and (ii) whether, during the second part of the consultation, (a) the Appellant or Patient A had lifted up her sweatshirt; (b) the Appellant had taken her breasts out of the bra separately or together; and (c) Patient A was sitting on a chair or lying down on a bed or table.

32. Ms Horlick challenged the way in which the Tribunal dealt with these inconsistencies in a range of ways.

33. **First**, she submitted that the Tribunal had failed to identify these inconsistencies and decide whether and to what extent they impacted on a Patient A's credibility: instead, the Tribunal simply referred to the inconsistencies in her account and then immediately dismissed, excused or minimised them.

34. The material part of the Tribunal's Determination is thus:

> "26. Patient A was challenged that her recollection of events was inaccurate or inconsistent with Dr Shabir's recollection of events because she was so unwell during the Consultation. Patient A was adamant that her feeling unwell and in her own words "dizzy", "lolling to the side" and "out of it" during the Consultation related to how she was feeling physically and had no bearing on her mental capacity. This was corroborated by the expert witness Dr Williams who confirmed that tonsillitis does not affect cognition. Patient A described feeling sweaty and feverish, but her temperature reading recorded by Dr Shabir in her medical records was normal and not elevated. Patient A recalls being informed by Dr Shabir that her blood sugar level was "dangerously low" and this was the reason she needed to have drinks and a biscuit and wait in the waiting room before being seen again in Part two of the Consultation. However, the Tribunal noted that Patient A's medical record recorded her blood sugar level at 5.1 at the start of Part one of the Consultation, which Dr Shabir accepts is within the normal range but a little on the low side and by Part two of the Consultation it is recorded as having increased to 7.9. Furthermore, Dr Shabir recorded that Patient A was alert and orientated in time and place. The Tribunal also noted that Dr Shabir was able to obtain a detailed history from A. The Tribunal did not accept that Patient A was so unwell that it would have affected her ability to recall or to have misunderstood material elements of the Consultation. The Tribunal accepted Patient A's evidence that she had consented to all of the tests and examinations that were recorded in the medical record.
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> 27. Patient A was clear during her oral evidence that her recollection of the events at the Consultation had however been affected by the passage of time. She further asserted that it was difficult at this stage for her to remember what she actively recalled from the Consultation and how much of her memory had been augmented by subsequently reading the more contemporaneous documents. She stated, in her oral evidence, that it was not her mental capacity but the length of time and the trauma of the events that had caused her to block out minor details.
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> 28. As above, there were areas of the consultation that Patient A and Dr Shabir did agree on that were not all a reflection of a memory recalled after reading a document. For example, Patient A said that she had three blood sugar level tests during the Consultation. This did not appear in the medical record. Dr Shabir confirmed that there were three blood sugar level tests during the Consultation in his oral

> evidence and confirmed that the second reading had not been recorded as the reading was identical to the first. Therefore, Patient A could recall parts of the Consultation without being guided or reminded by her medical records. The Tribunal determined that the small number of inconsistencies in Patient A's evidence were insignificant in terms of what were likely to be more routine elements of a consultation to a patient, e.g. blood pressure readings, temperature and Pulse oximetry readings.
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> 29. Patient A was clear that the handwritten account created on 24 September 2019 and incorporated into her written statement dated… May 2021 was her freshest recollection of events as it had been prepared the day after the Consultation. She apologised for any inconsistences [sic] between her statement for the GMC…the handwritten version of events and her police interview. She stated that the police interview was a horrible experience.
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> 30. The Tribunal considered whether Patient A may have become confused during her ABE interview and when giving oral evidence about the precise mechanics of her breasts being touched, in terms of whether it was her left or right breast that was touched first due to the passage of time between the various statements provided by Patient A, and the fact that the incident was a traumatic event. The Tribunal decided that whilst Patient A may struggle to recall all of the minutiae of the Consultation, in particular the sequence of those more routine elements such as blood pressure testing and that she may have blocked out certain elements in her recollection of the mechanics of the order in which our breasts were touched any such inconsistencies were not persuasive or enough to suggest that Patient A had abandoned her GMC witness statement in preference to the contemporaneous handwritten account as submitted by Dr Shabir's Counsel".

35. In my judgment these paragraphs do not show the Tribunal inappropriately simply accepting a "series of excuses" as Ms Horlick alleged.

36. Rather, they illustrate the Tribunal addressing, first, the key manner in which Patient A's evidence had been challenged before the Tribunal, namely that she had been so unwell she had formed a mistaken belief in what happened. Patient A had rejected this suggestion. The Tribunal's reasoning at [26] of its Determination shows it weighing up the credibility of Patient A's evidence on this issue, by reference to other pieces of evidence, and ultimately accepting her rejection of the suggestion. This was not, in my judgment, a finding that can be characterised in any of the ways described by Morris J in *Byrne* at 15, as set out at [14] above.

37. Having rejected the illness "theory", the Tribunal went on to consider the impact of the passage of time and the traumatic nature of the incident on Patient A's memory, at [27]-[30] of its Determination. The Tribunal had correctly directed itself at page 10 of the Determination that the passage of time and the trauma of events are both matters which can adversely impact on a witness's evidence. These had been specifically raised by Patient A in her evidence. Accordingly, the Tribunal was entitled, indeed arguably

required, to take them into account as relevant factors in assessing Patient A's account. The Tribunal ultimately accepted that these matters helped explain the inconsistencies in the accounts she had given in her ABE interview and her oral evidence. The Tribunal had also noted at [29] that Patient A had described the ABE interview as a "horrible experience". In my judgment the Tribunal was entitled to accept Patient A's account that these matters had impacted on her memory of the detail; and its assessment in this regard cannot be characterised as an erroneous factual finding in the senses described in *Byrne* at [15].

38. **Second**, Ms Horlick contended that the Tribunal had fallen into the same error as that identified by Warby J in *Dutta* at [42] thus:

> "Instead of starting with the objective facts as shown by authentic contemporaneous documents, independent of the witness, and using oral evidence as a means of subjecting these to "critical scrutiny", the Tribunal took the opposite approach, starting with Patient A's evidence. It is an error of principle to ask "do we believe her?" before considering the documents".

39. She submitted that the Tribunal here had, similarly, asked itself "do we believe Patient A?", and only then, having decided that it did, looked to see if any inconsistencies in her account, or reason why she might fabricate her account, were sufficient to "dislodge" that view. This "two stage" exercise was inappropriate and effectively reversed the burden of proof. Rather, the Tribunal should have assessed her evidence critically and determined its cogency, and that it had failed to do.

40. The material part of the Tribunal's Determination continued as follows:

> "31. The Tribunal also noted that, initially, Patient A's complaint to the Practice was to raise that he had touched her breasts in Part one of the Consultation during the chest examination and that he had undertaken an unnecessary breast examination in Part two and, for this reason this is what her complaint and recollection of events is concentrated upon. However, when Patient A received the response from Dr Shabir, in which he denied the breast examination, it was only then Patient A reported the matter to the Police. In her statement to the GMC she wrote: "This is when I knew that something was wrong because he hadn't mentioned the breast examination. What he said was nothing like what had happened. I knew that he shouldn't have done it because if it was something I needed for medical reasons he would have put it in his response. Dr Shabir's response…is what made me report the matter to the police".
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> 32. The Tribunal concluded that Patient A gave an honest account in her oral evidence and admitted that she could not recall every detail of the Consultation. Her evidence in relation to the memorable aspect of the Consultation involving the alleged "examination" of her breasts during both parts of the Consultation was consistent and clear. In oral evidence, she confirmed recalling both the sensation of Dr Shabir feeling her breasts in both parts of the Consultation and recalled seeing her breasts out of her bra with her top lifted up during Part two.

> 33. The Tribunal noted that Patient A reported that Dr Shabir appeared gentle, professional and caring throughout the Consultation. The Tribunal also noted that Patient A reported never having had an intimate examination by a male doctor and had never had a breast examination. On both these points and given that she was attending with tonsillitis symptoms, the Tribunal concluded that the touching of her breasts would have been particularly memorable.
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> 34. Patient A also confirmed that she trusted Dr Shabir and assumed that everything Dr Shabir was doing was for a reason. For example, when dealing with her blood sugar level".

41. In my judgment the Tribunal had not erred in the way identified in *Dutta*.

42. This was not a case in which the "objective facts" were likely to be "shown by authentic contemporaneous documents", per *Dutta*. As counsel for the GMC had submitted to the Tribunal, and as Ms Hearnden repeated before me, a doctor would not be expected to record sexually motivated touching of a patient's breasts in their medical notes. Further, while both Patient A and the Appellant had written reasonably contemporaneous accounts of events, these represented their own contradictory versions of what happened and so did not show the "objective facts". Rather, this was a case where the central dispute largely turned on one person's word against another. The Tribunal was therefore entitled to place substantial reliance on the oral evidence of the respective parties.

43. Further, a fair reading of the Determination as a whole does not support the suggestion that the Tribunal fell into the trap of starting with the proposition that it believed Patient A. In fact, the Tribunal referred to a series of "building blocks" which justified its acceptance of her evidence in respect of both parts of the consultation. These were (i) the Tribunal's rejection of the illness "theory"; (ii) its acceptance that the passage of time and trauma had impacted on her accounts in the ABE interview and her oral evidence; (iii) her complaint the day after the consultation that the Appellant had inappropriately touched her breasts; (iv) her decision to report the matter to the police only when she knew he had denied the touching of her breasts, such that she thought "something was wrong"; (v) the Tribunal's assessment of her evidence on the "memorable aspect" of the examinations of her breasts as "consistent and clear"; (vi) Patient A's recollection in her oral evidence of "both the sensation of Dr Shabir feeling her breasts in both parts of the Consultation and…seeing her breasts out of her bra with her top lifted up during Part two" (as accurately summarised by the Tribunal: see [47] below); (vii) the Tribunal's finding that as she had never had a breast examination before, she would have no obvious source of information about the detail of one, including the "telling detail" of the Appellant's enquiry about possible breast discharge, other than these events; and (viii) its finding of the absence of a reason for her to fabricate her account: see, in particular, [26]-[34], [50]-[51] and [61]-[67] of the Determination.

44. **Third**, Ms Horlick submitted that the inconsistencies in Patient A's various accounts related to key elements of her account. This was not a scenario where there had been a series of consultations and where it might be thought that the patient had got confused about what happened on a particular day. These were relatively simple allegations and yet Patient A changed almost every part of her account. The inconsistencies illustrated

that Patient A's evidence was simply not "cogent", as was required (see *Rehman* at [20] above), but the Tribunal had failed to address them properly.

45. Having considered the totality of Patient A's evidence, the submissions made before the Tribunal and its Determination, I cannot accept this submission.

46. The Tribunal was plainly live to the issue of the inconsistencies in Patient A's accounts. This had been a key theme of the hearing, having been raised by counsel for the GMC in his opening note and having featured at length in the closing submissions.

47. Counsel for the GMC did not, in his words, "shrink away" from them in his closing submissions. Rather, the GMC's case was that (i) some inconsistencies were to be expected, not least in light of the passage of time; (ii) there was "an awful lot of correlation between her initial handwritten statement and her GMC statement"; (iii) the inconsistencies that emerged in the ABE interview might be explained by the passage of time and the fact that she did not appear to have re-read her handwritten account before the interview; and (iv) Patient A had remembered what counsel described as "the main thing" namely the feeling of the Appellant's hands on her and both her breasts being exposed. This was an accurate summary of Patient A's evidence at D1/49 of the transcript:

> "…the main things I remember is feeling dizzy in the corridor and the lady having to walk me to the consultation room and then obviously the feeling of his hand on my breasts and when they were both out; that's the feeling, that's what keeps replaying in my mind; that's the thing that I remember and I can't shake off…I remember looking down and seeing my breasts out and then I don't think I was looking down when he was actually touching me; I think I was actually looking away. That's why I explained more of the feelings".

48. Mr Ainsworth's closing submissions were to the effect that (i) the inconsistencies taken together meant that Patient A's evidence lacked cogency; (ii) the passage of time was not an adequate explanation because there were parts of her initial handwritten account that she later departed from; (iii) the ABE interview process is the "gold standard" for interviewing, took place only 5 weeks after the consultation and yet in it, Patient A departed significantly from her initial handwritten account; (iv) in her oral evidence before the Tribunal she initially adopted her statement to the GMC but later abandoned it, in favour of her handwritten account; and (v) some elements of the charges, such as the suggestion that the Appellant had lifted up her sweatshirt, could not be made out, as they had been drawn from her statement to the GMC and did not feature in her handwritten account.

49. It was against this background that the Tribunal came to deal with the inconsistencies in Patient A's accounts in respect of each part of the consultation (as summarised at [31] above).

The first part of the consultation

50. The Tribunal explicitly referred to Patient A's inconsistency about the order in which her breasts were touched during the first part of the consultation at [30] of the Determination. This issue had emerged in her ABE interview, because Patient A had

initially referred to her right breast, then her left breast and then said "It's all just mixed up". The Tribunal concluded that Patient A may have "blocked out certain elements of her recollection of the mechanics of the order in which her breasts were touched", having accepted Patient A's evidence that the passage of time and the trauma of the events had led to her becoming confused in the ABE interview. These were explanations it was entitled to accept for the reasons given at [37] above.

51. The Tribunal recited the two accounts which suggested a difference between "took my breast out" and "put his hand inside my bra" at [39]-[40] of the Determination, without explicitly commenting on the difference. The Tribunal was not required, in giving its reasons, to address each alleged inconsistency addressed in submissions individually: *English* at [17]-[18]. It appears that the Tribunal considered that this was the sort of "inconsistency and confusion in some of the detail" which is "commonplace": *Byrne* at [20]. In my judgment the Tribunal was entitled to do so.

52. Overall, the Tribunal accepted Patient A's account of the touching of her breasts in the first part of the examination because of the reasons summarised at [43] above; and in light of her specific evidence on this part of the consultation that the Appellant was "using his hands not the stethoscope when he touched her breasts". It is notable that after the "mixed up" comment referred to above, the Appellant said "All I can remember is him feeling them": see the Determination at [37]-[51].

53. In my judgment this was an example of a Tribunal correctly focussing on the task of determining whether the "core" allegation was true: *Byrne* at [20]. Notwithstanding the inconsistencies in Patient A's account, the Tribunal accepted the GMC's submission that there was a high degree of consistency in her account of the core allegation: both the accounts cited by the Tribunal had referred to the Appellant having "felt around" Patient A's breast. In my judgment it cannot be said this was an assessment that was "plainly wrong" or can be characterised in one of the other ways described in *Byrne* at [15].

The second part of the consultation

54. The Tribunal explicitly addressed Patient A's varying accounts of whether she or the Appellant had lifted up her sweatshirt in this part of the consultation in the Determination at [61]. The Tribunal accepted her final oral evidence on the issue, to the effect that as she has said in her initial handwritten account, it was the Appellant who had done so. In my judgment the Tribunal was entitled to accept Patient A's final evidence on this issue. As Ms Hearnden rightly submitted, the issue of who lifted up Patient A's sweatshirt was likely to be a less important part of the detail that did not "stick" in Patient A's memory. Further, the Tribunal noted at the end of the same paragraph that it was agreed that in the first part of the consultation, it was Patient A who had lifted up her sweatshirt. The Tribunal therefore apparently considered that this provided a potential reason for Patient A's confusion in respect of the same issue in the second part of the consultation. This was a rational approach.

55. Patient A's inconsistency with respect to whether the Appellant had taken her breasts out of the bra separately or together in the second part of the consultation emerged in her ABE interview where she suggested that he had taken one breast out and then put it back before taking the other one out. The Tribunal plainly accepted that the impact of trauma had led to the Appellant becoming confused in her ABE interview about the

order in which her breasts were touched in the first part of the consultation (see [50] above). The Tribunal may well have taken a similar view with respect to her account in the ABE interview about the second part of the consultation, as it did not refer to it in the material part of the Determination. The Tribunal accepted the evidence she had given consistently in her other accounts, namely that both breasts were released at the same time. Her account had been to this effect in her initial handwritten account, her statement to the GMC and in her oral evidence: see the Determination at [53], [54] and [62]. The Tribunal had earlier observed that Patient A has a clear recollection of "seeing [both] her breasts out of her bra" during the second part of the consultation. Accordingly, the factual finding that both breasts were "out" together was one the Tribunal was fully entitled to make.

56. As to whether Patient A was sitting on a chair or lying down on a bed or table, the Tribunal did not appear to regard this as significant. Again, in my judgment, it can properly be classified as "inconsistency and confusion in some of the detail" which is "commonplace": *Byrne* at [20]; and the Tribunal was not required to address each alleged inconsistency individually: *English* at [17]-[18].

57. Overall, the Tribunal accepted Patient A's account in respect of the second part of the examination for the reasons summarised at [43] above; and because of her specific evidence that she recalled "both seeing her breasts out of her bra and the feeling of Dr Shabir's hands on her breasts": see the Determination at [52]-[67]. Again, therefore, I consider that the Tribunal was correctly focussing on the task of determining whether the "core" allegation was true: *Byrne* at [20].

58. For these reasons I do not accept that the Tribunal's approach to the inconsistencies in Patient A's evidence was flawed in the sense set out in *Byrne* at [15].

59. **Fourth**, Ms Horlick contended that the case was on all fours with *Casey*, such that the Tribunal should have given more reasons for preferring the account of Patient A over that of the Appellant. She relied on *Casey* at [15] thus:

> "As was made clear in *Southall* in a case which is not straightforward and is exceptional a doctor is entitled to understand the basis on which his case has been rejected. The concept of exceptionality without definition is not a particularly helpful test to be applied by a panel or by an appellate court since different courts may have different views as to what is exceptional. However, the underlying principle emerging from cases such as *Gupta* is that reasons should be given if, in the circumstances of the individual case, fairness requires it. Ultimately the court is the arbiter of what procedural fairness requires. In the present case whether one applies a test of fairness a test of exceptionality or a test of lack of straightforwardness, the circumstances in this case called for an explanation as to why the evidence of the doctor was rejected. The assertion that the patient was a consistent, reliable and credible witness when the circumstances clearly undermined her consistency and reliability points to a lack of focussed reasoning as to why she should be considered reliable on the one remaining allegation that she had not abandoned. It calls into question the reasoning process that led the panel to conclude that, by necessary inference, the doctor was unreliable and incredible. It is not

> possible to see the chain of reasoning which led to this ultimate conclusion. This is one of those cases of which Leveson LJ spoke in *Southall* in which the doctor is entitled to some explanation dealing with the salient issues explaining why his evidence was rejected even if only by reference to his demeanour, his attitude or his approach to specific questions. As in that case, in this case the matter ultimately turned on the question of the honesty and integrity of the witnesses. In looking at the issue of honesty and integrity it was highly relevant to balance properly the way in which the patient had formulated and pursued her complaints over time and the way in which the doctor dealt with the case against him bearing in mind that sexual impropriety by a doctor is something which has an intrinsic unlikelihood."

60. However, while the principles set out in *Casey* are of general application, I agree with Ms Hearnden that *Casey* is distinguishable on its facts: the complainant had abandoned her allegations of a "highly sexualised encounter" involving cupping of her breasts and visualisation of her pubic area, maintaining only an allegation that the doctor placed a stethoscope on her nipple. The Tribunal failed to consider how the abandonment of the most serious allegations affected the reliability of the complainant's evidence on the remaining allegation. The inconsistencies here were of a different kind: the Appellant did not abandon any of her core allegations; and she raised the issue of sexual motivation only after the Appellant responded to her initial complaint by denying the touching of her breasts. Further, as [11]-[12] of *Casey* make clear, the issue was not the fact of the inconsistencies in the witness's account but the fact that the Tribunal had characterised her evidence in the way that no reasonable tribunal could have done. By contrast, here the Tribunal was entitled to conclude that Patient A had been largely consistent on the key elements of the allegations, and explained its reasoning on this issue, as set out at [33]-[58] above.

Ground 3: Consistency in the Appellant's account

61. Ms Horlick relied on the fact that the Appellant had made an unusually long and detailed record of his consultation with Patient A. Dr Williams agreed that the Appellant's note was more detailed than would be expected if he was an experienced doctor. She also submitted that in contrast to Patient A, the Appellant had given an entirely consistent account of events throughout: from his written response to Patient A in September/October 2019, through his police interview in November 2019 to his statement in these proceedings and his oral evidence before the Tribunal. She contended that the Tribunal had erred by failing to take this factor into account or failing to afford it sufficient weight.

62. I cannot accept this argument. The Tribunal expressly referred to the consistency of the Appellant's accounts at the outset of its consideration of the central issues, saying:

> "23. The Tribunal noted that Dr Shabir's written account and subsequent police interview and witness statement are consistent with each other. The Tribunal noted that Dr Shabir has never strayed from his original account of the events, which he relied on in his police interview. Dr Shabir's clear assertion was that he had never touched Patient A's breasts at all, either in Part one or Part two of the Consultation."

63. Accordingly, the Tribunal was well aware of the consistency argument, but was simply unpersuaded by it. I remind myself that on an appeal against findings of fact based on an assessment of the credibility of witnesses, the court should usually defer to the Tribunal's judgment on matters of weight, interfering only where the assessment was "plainly wrong" or can be characterised in one of the other ways described in the case-law, as summarised by Morris J in *Byrne* at [15] (see [14] above). I do not consider that this test is met with respect to the weight the Tribunal chose to attach to the consistency argument. I say this not least because, as Ms Hearnden submitted, although the Appellant's account had been consistent, it was still, in essence, a bare denial of the allegations.

64. Ms Horlick also contended that the Tribunal had erred by failing to give reasons for rejecting the Appellant's highly detailed note and his consistent account of events based on it. The reasons given did not enable the Appellant to understand why the findings had been made against him, as fairness required, per *Casey* at [15] et al.

65. Again, I cannot accept this. Read as a whole, the Tribunal's Determination makes clear why Patient A's evidence was accepted. This was principally because the Appellant's key challenge to Patient A's evidence – to the effect that she had been so unwell that she was mistaken as to what happened in the consultation – had been rejected; and because she was found to be credible on the core allegations as explained under Ground 2. Specific reasons for disbelieving a practitioner are not required in every case where the defence has been rejected: *Byrne* at [24]-[25] and [119]. Further, as the Appellant's case was a "simple denial that the event or events had taken place", the credibility of that denial could "only be assessed by reference to the credibility of the evidence supporting the allegation which is denied": *Byrne* at [113]. The Tribunal performed that task and explained its reasoning for finding Patient A's account credible. At the heart of this case was what was ultimately, a relatively straightforward factual dispute. Accordingly, the reasons provided here met the requirements of fairness. It was not necessary for the Tribunal to address specifically or in isolation why it had rejected the Appellant's account.

Ground 4: Good character

66. Under this ground the Appellant challenged the Tribunal's approach to the evidence of his good character.

67. The Tribunal addressed this issue at [24]-[25] of the Determination, in the context of its consideration of those areas of the evidence where there was a dispute between the accounts from Patient A and from the Appellant. The Tribunal found as follows in respect of the Appellant's good character evidence:

> "24…The Tribunal…noted that Dr Shabir received several excellent testimonials from his professional colleagues, which attest to his clinical ability and his appropriate conduct with colleagues and patients.
>
> 25. The Tribunal noted that save for the references provided by Miss Grey and Dr Robertson, the remaining referees had known Dr Shabir after this incident had been reported and during the period when he was operating under conditions and his interaction with female patients was being monitored. Dr Grey had worked in the same department as Dr

> Shabir before this incident along with others and she had no concerns about his interactions with female patients. Dr Robertson did have access to Dr Shabir's portfolio which included some historical data and I had spoken to Dr Shabir's clinical supervisor and no concerns had been reported about Dr Shabir. Having taken into account the early stage of his career where Dr Shabir was in a more supervised environment and the period when he was operating under conditions, the Tribunal concluded that the references although attesting to doctor Dr Shabir's good character, provided limited assistance in relation to propensity given the nature of the allegations, when considering the wider evidence before it and assessing the facts".

68. The Appellant accepted that the Tribunal directed itself properly on the law as to good character and references. At pages 14-16 of the Determination it had referred to the principles summarised recently in *Sawati* at [53]-[56]. These are, in essence, that good character is relevant to the doctor's credibility as a witness (as it makes it more likely that the doctor's account is credible) and to propensity to act in the way alleged (as it makes it less likely that the doctor will have done so); and that the weight to be applied to good character is a matter for the Tribunal.

69. However, it was the Appellant's case that the Tribunal had erred in the approach it took to his good character evidence. Ms Horlick submitted that rather like its excusing or minimising of the weaknesses in Patient A's evidence, the Tribunal had taken a flawed approach by dismissing or minimising the strengths in the Appellant's good character evidence. She contended that having afforded limited weight to the character evidence because it related to periods of time when the Appellant was supervised, the Tribunal had also erred by failing to follow through its own logic, in that it was inherently improbable that the Appellant would behave as alleged while supervised.

70. I respectfully disagree. As Ms Horlick recognised, the authorities are clear that the matter of weight to be attached to good character evidence is "pre-eminently a matter for the fact finder and ought not to be disturbed on appeal unless the decision is one that no reasonable tribunal could have reached": *Sawati* at [55], citing *Martin v SRA* [2020] EWHC 3525 (Admin) at [54]. I do not consider that this test is met here.

71. The Tribunal was entitled to give limited weight to the character evidence on which the Appellant relied when considering his propensity to act as alleged, given the nature of the allegations and the limits of the character evidence. These limits were twofold, as the Tribunal explained. *First*, two of the doctors who gave character evidence were referring to the Appellant during an early stage of his career when he was operating in a more supervised environment. While this may mean that any concerning behaviour was likely to be picked up (as Ms Horlick submitted), it could also mean that it was less likely that the Appellant would engage in such behaviour while supervised (as the Tribunal presumably thought, hence finding this evidence of limited assistance). *Second*, the other two doctors had known the Appellant after this incident had been reported and when he was operating under conditions, with his interactions with female patients being monitored. In contrast, the Tribunal was well aware that, at the time of the consultation with Patient A, the Appellant was acting unsupervised in that he was permitted to see patients alone (albeit that this had only been the case for a short period of time).

72. Further, as Collins Rice J made clear in *Sawati* at [69], the weight given to an unblemished record may properly be less in the case of a doctor at an early stage in their career, as this Appellant was, than doctor with an established track record. While she also accepted that inexperience may be a correspondingly weightier consideration in understanding what happened, this was not such a case: the Appellant's inexperience was not said to help explain what happened, as he denied that the events alleged by Patient A had happened at all.

73. Ms Horlick also submitted that the Tribunal had failed to take into account the Appellant's good character when considering his credibility. Again, I cannot accept this. The Tribunal had directed itself that good character evidence could be relevant to credibility as well as propensity. Further, as noted at [63] above, the Tribunal specifically considered the issue of the Appellant's character as part of its approach to the question of whether it preferred his account of what happened during the consultation or Patient A's. This is underscored by the fact that in the paragraph of the Determination where it began its consideration of the character evidence ([23]), the Tribunal referred to the other key aspect of the Appellant's credibility, namely the fact that his accounts had always been consistent with each other and that he had "never strayed from his original account of the events". In those circumstances I cannot be satisfied that the Tribunal had left the issue of how his good character was relevant to his credibility "wholly out of account": *Khan v GMC* [2021] EWHC 374 (Admin) at [89].

74. For these reasons, I do not consider that any of grounds 1-4 are well-founded. It follows that there is no need to consider their cumulative impact.

Ground 5: Sexual motivation

75. This ground challenged the Tribunal's finding under paragraph 2 of the Allegation, to the effect that his touching of Patient A's breasts was sexually motivated.

76. The Tribunal's reasons for this finding are set out at [72]-[74] of the Determination. Having noted that the Appellant denied any touching of Patient A's breasts or that any breast examination took place, and that there was no medical record of any breast examination, the Tribunal considered its findings (under the first paragraph of the Allegation) that the Appellant had touched Patient A's breasts. It then said this:

> "73. The Tribunal concluded that Dr Shabir's touching of Patient A's breasts (which is an intimate examination) amounts to the touching of sexual organs. This touching was carried out in the absence of any clinical justification. Therefore, the Tribunal concluded that there was no plausible explanation or justification (clinical or otherwise) for Dr Shabir acting in the way he did. The Tribunal found that Dr Shabir's actions in relation to paragraphs 1(a) and 1(b) of the Allegation were undertaken in pursuit of sexual gratification".

77. The Appellant accepted that the Tribunal properly directed itself on the issue: it referred at pages 12-14 of the Determination to the definition of "sexual" in the Sexual Offences Act 2003, s.78 and the key principles derived from *Basson v General Medical Council* [2018] EWHC 505 (Admin), *Arunkalaivanan v General Medical Council* [2014] EWHC 873 (Admin) and *Haris v General Medical Council* [2021] EWCA Civ 763. In

Haris, it was held that sexual motivation can be inferred from (i) the fact that the touching was of the sexual organs; (ii) the absence of a clinical justification; and (iii) the absence of any other plausible reasoning for the touching.

78. However, Ms Horlick submitted that the Tribunal erred in failing to consider that there was another potential explanation for the Appellant's actions, namely that they were accidental, and arose from a clumsy attempt at a proper examination by a young and experienced doctor. She argued that the Appellant was conducting the examination "half-blind" due to the fact that Patient A was wearing a sweatshirt: it was possible that in putting his hands under her top with his stethoscope, he had inadvertently strayed on to her breast area. She submitted that the inference that his actions were undertaken for sexual motivation was not open to the Tribunal until they had ruled out other possibilities such as accidental touching, and it had failed to do this. The Tribunal had further erred by failing to consider his good character in the context of the issue of sexual motivation.

79. I cannot accept this submission. Patient A had given a clear description of the Appellant deliberately touching her breasts, including putting his hand insider her bra, touching the underside of her breasts and feeling around her breasts (in the first part of the consultation) and then lifting her breasts out of her bra, and pressing both breasts, her nipples and her breast area (in the second part of it). The Appellant had denied touching her breasts at all. There was no scope for accident or misinterpretation about this part of the evidence. As the Tribunal noted at [23] of its Determination, this was one of the areas of the evidence where there were "entirely different versions from Patient A and Dr Shabir was to what had happened". An explanation of accidental touching had never been the Appellant's case before the Tribunal. Ms Hearnden submitted that it is important to judge the Determination by how the case was put before the Tribunal. I agree.

80. On that basis, once the Tribunal had accepted Patient A's evidence as to the Appellant's touching of her breasts, in light of the totality of the evidence, it was entitled to conclude that there was an absence of clinical justification and other plausible explanation for it.

81. The Tribunal had given appropriate consideration to the Appellant's good character as explained in respect of Ground 4.

Conclusion

82. Accordingly, for these reasons, despite the comprehensive submissions from Ms Horlick and Mr Ainsworth, this appeal is dismissed.