Neutral Citation Number: [2017] EWHC 1247 (Admin)

Case No: CO/3140/2016

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26/05/2017

Before:

LADY JUSTICE SHARP
VICE PRESIDENT OF THE QUEEN'S BENCH
and
MR JUSTICE DINGEMANS

- -

Between:

General Medical Council	**Appellant**
- and -	
(1) Dr Nilesh Pravin Jagjivan	**Respondents**
(2) Professional Standards Authority for Health and Social Care	

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- -

Ivan Hare QC (instructed by GMC Legal) for the Appellant
Anthony Haycroft (instructed by Berrymans Lace Mawer) for the First Respondent
Fenella Morris QC (instructed by Browne Jacobson) for the Second Respondent

Hearing date: 8 May 2017

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Approved Judgment

Lady Justice Sharp:

Introduction

1. This is the judgment of the court. This is the hearing of an appeal by the General Medical Council ('the GMC') against the determination by the Medical Practitioners Tribunal ('the Tribunal') dated 24 May 2016 under the Medical Act 1983 ('the 1983 Act') in respect of conduct of Dr Nilesh Jagjivan. This is the first appeal brought by the GMC under its new powers, in force since 31 December 2015 (by virtue of Article 17(1) of SI 2015/794); and it raises a point of importance about the GMC's jurisdiction to appeal pursuant to the provisions of section 40A of the 1983 Act.

Background

2. Dr Jagjivan was employed as a cardiology Registrar within the University Hospitals of Leicester NHS Trust. The relevant conduct occurred at a consultation with a 27-year-old female patient ('patient A') on 22 October 2013. Patient A had been referred to hospital by her GP with a history of chest pain, palpitations and dizziness. She was assessed by nurses and a Foundation Year 1 doctor, and an ECG performed on her caused concern. The Clinical Decisions Unit was very busy and prioritised the treatment of patients who might be discharged home. Patient A was one such patient.

3. Dr Jagjivan therefore had a consultation with patient A, and issues then arose about what Dr Jagjivan suggested to patient A should be done to raise her heart rate. Patient A alleged, but Dr Jagjivan denied, that Dr Jagjivan had: (i) said there were 3 different places to get excited and pointed at her nipples and vagina; (ii) said she could put pressure "down there" and pointed towards her vagina; (iii) said "it's a bit 80's and some people aren't comfortable doing this", and (iv) said she could stimulate "down there", referring to her vagina, to excite herself and raise her heart rate. It was also alleged by patient A, but denied by Dr Jagjivan, that whilst patient A's hand was hovering above her vagina on top of her trousers he: (i) told patient A there was another way to make her heart beat faster; (ii) indicated towards patient A's vagina; and (iii) placed his hand on top of patient A's hand.

4. The Tribunal made adverse findings of fact about Dr Jagjivan's conduct during the consultation, and accepted patient A's account of what Dr Jagjivan had said and done as set out above. However the Tribunal did not find that the conduct was sexually motivated. The Tribunal held that the conduct was deplorable and amounted to misconduct, but did not find that Dr Jagjivan's fitness to practise was impaired by reason of misconduct. The Tribunal therefore did not direct that Dr Jagjivan's name should be erased or suspended from the register, or that his registration should be conditional on his compliance with requirements imposed for the protection of members of the public.

Issues on appeal

5. The GMC contends that the Tribunal should have made a direction pursuant to section 35D of the 1983 Act, and it appeals pursuant to section 40A of the 1983 Act. Dr Jagjivan submits that the GMC does not have jurisdiction to appeal, but that if it does, the appeal should be dismissed as the Tribunal's decision was not wrong.

6. The Professional Standards Authority for Health and Social Care ('PSA') has joined as a party to the appeal, and supports the GMC's appeal. If there is no jurisdiction for the GMC to appeal against the Tribunal's refusal to give a direction, then the PSA seeks permission to appeal out of time pursuant to the provisions of the NHS Reform and Health Care Professions Act 2002 ('the 2002 Act').

7. If the GMC does have jurisdiction to appeal, or if the PSA is granted permission to appeal, then issues arise as to: (1) the approach to be taken by this court to findings of fact made by the Tribunal; (2) whether fresh evidence in the form of another patient's evidence about a consultation which took place on 6 April 2017 should be admitted; and (3) whether to allow or dismiss the appeal.

Proceedings before the Tribunal

8. Patient A made witness statements dated 6 October 2014 and 10 April 2015 about the consultation on 22 October 2013 and about the complaints that she made immediately after the consultation. Dr Jagjivan made a statement dated 10 May 2016 setting out his response to the allegations of misconduct. Statements as to Dr Jagjivan's good character were made by a number of his colleagues.

9. A number of other witnesses made statements about the investigations made after the events in question for example. One witness, Dr Rajesh Chelliah made a statement about walking into the cubicle during the examination of patient A at a time when patient A was lying on the bed at a 45-degree angle exposed from the waist up.

10. The hearing before the Tribunal began on 16 May 2016, and continued on 17 to 19, 24, 26 and 27 May 2016. Patient A gave evidence on the first day of the hearing. Dr Jagjivan gave evidence on the third day of the hearing and the witness statements about his good character were read. Dr Jagjivan did not mention his sexuality in his written witness statement, but started his oral evidence by making very brief reference (in three sentences) to the fact that he was not attracted to men or women, and had no sexual experience. Closing submissions were then made. The Tribunal retired at various points to make its findings of fact, to determine whether there was misconduct and impairment, and to decide whether a warning ought to be given to Dr Jagjivan.

The Tribunal's determination

11. The determination as to fact was handed down. The Tribunal's material findings on the allegations against Dr Jagjivan were that:

    i) "2. In the course of a consultation with patient A on 22 October 2013 you:

    (a) caused patient A to remain partially undressed for longer than was necessary." This allegation was denied and found not proved.

    "(b) caused patient A to perform squatting exercises when her breasts were exposed". This allegation was admitted and found proved.

    "(c) suggested to patient A that she undertake 10 squats when this action was not a recognised technique for: (i) undertaking an exercise echocardiogram, or;

(ii) raising the heart rate substantially". This allegation was admitted and found proved.

"(d) failed to communicate appropriately with patient A in that you told patient A words to the effect of: (i) there were 3 different places to get excited and pointed at her nipples and vagina; (ii) she could put pressure "down there" and pointed towards her vagina; (iii) "it's a bit 80's and some people aren't comfortable doing this"; and (iv) she could stimulate "down there", referring to her vagina, to excite herself and raise her heart rate." This allegation was not admitted but was found proved.

"(e) failed to communicate appropriately with patient A in that whilst patient A's hand was hovering above her vagina on top of her trousers you: (i) told patient A there was another way to make her heart beat faster; (ii) indicated towards patient A's vagina; (iii) placed your hand on top of patient A's hand." This allegation was not admitted but was found proved.

"(f) examined patient A's breast from behind". This allegation was not admitted and was not found proved.

ii) "3. Your conduct as alleged in paragraph 2 (a)-(f) was sexually motivated." This allegation was not admitted and not found proved.

12. The Tribunal set out its reasons for not finding that Dr Jagjivan's actions were sexually motivated. It noted that "ordinarily, it would be likely to find such statements to have been sexually motivated" but gave three reasons for not making such a finding in this case. First, extensive testimonial evidence showed no one had heard him engage in the slightest sexual banter or inappropriate communication of a sexual nature. Secondly, the Tribunal had borne in mind Dr Jagjivan's evidence about his sexuality, which the Tribunal accepted. Thirdly, the Tribunal found no evidence to support the GMC's contention that Dr Jagjivan was seeking to pursue a sexual relationship with patient A. For those reasons: "the Tribunal … determined that these statements were more likely to have been the result of non-sexual motivation within the specific context of this consultation. There is therefore a lack of reliable evidence upon which to draw the inference of sexual motivation."

13. Submissions on impairment were made, and the Tribunal was directed to determine whether the allegations proved amounted to misconduct; and if so, what, if any, sanction ought to be imposed.

14. In its determination on impairment, the Tribunal said this: "…although it did not find sexual motivation, the Tribunal is of the view that what [Dr Jagjivan] said and did could all too easily be construed by others as implying a sexual motive". It found that Dr Jagjivan did not treat patient A with dignity, he had used unacceptable words which were interpreted by patient A as sexual and caused distress, and that his actions were deplorable. The Tribunal found misconduct in relation to the matters proved at paragraphs 2(d) and 2(e). The Tribunal did not find that Dr Jagjivan's fitness to practise was impaired by his misconduct. Submissions were then made about whether the Tribunal should warn Dr Jagjivan about his conduct. After further consideration the Tribunal determined that it was not appropriate or proportionate to issue a warning.

Statutory provisions relating to appeals

15. A qualified medical doctor is known under the relevant legislation as a medical practitioner. The profession of medical practitioners was, as a matter of history, an entirely self-regulated profession. Proceedings for misconduct were brought by the GMC against a medical practitioner before a Tribunal known as a Fitness to Practise Panel. A medical practitioner could appeal against adverse findings and sanctions to the Judicial Committee of the Privy Council. The GMC had no right of appeal.

16. Weaknesses were exposed in the system of regulation. From the point of view of the medical practitioner the GMC could be seen as both prosecuting and being involved in making determinations of fact. The enactment of the Human Rights Act 1998, which gave domestic effect to the European Convention on Human Rights ('ECHR'), provided an impetus to make changes to the disciplinary structures and to Tribunals. From the point of view of the public, the lack of an overall regulator charged with promoting the interests of patients and other members of the public was considered to have led to some systemic failings in certain hospitals.

17. Changes were made to the structure of the GMC, its investigatory committee and Tribunals, and appeals for doctors were directed to the Administrative Court, Queen's Bench Division rather than to the Privy Council. Further, the 2002 Act was enacted and the Council for Healthcare Regulatory Excellence ('the Council'), the predecessor body to the PSA, was created. The Council was given a right of appeal pursuant to section 29 of the 2002 Act. It is relevant to note that before it was amended, section 29 of the 2002 Act provided in part that:

> "(1) This section applies to-
>
> ……..
>
> (c) a direction by the Professional Conduct Committee of the General Medical Council under section 36 of the Medical Act 1983 (professional misconduct and related offences); …
>
> (2) This section also applies to-
>
> (a) a final decision of the relevant committee not to take any disciplinary measure under the provision referred to in whichever of paragraphs (a) to (h) of subsection (1) applies; …
>
> (3) The things to which this section applies are referred to below as `relevant decisions;
>
> (4) If the Council considers that-
>
> (a) a relevant decision falling within subsection (1) has been unduly lenient, whether as to any finding of professional misconduct or fitness to practise on the part of the practitioner concerned (or lack of such a finding), or as to any penalty imposed, or both …".

18. The Council could refer to the court a relevant decision which was considered to be unduly lenient. This reference was treated as an appeal: see section 29(7) of the 2002 Act. The Council was also given the right to appeal against directions, determinations, disciplinary orders, steps or corresponding measures (as appropriate for each regulator) of other healthcare regulators including the Statutory Committee of the Royal Pharmaceutical Society, the Professional Conduct Committee of the General Dental Council and the General Optical Council.

19. In 2014 there was a consultation on proposed changes to the 1983 Act and the 2002 Act. It was proposed to permit the GMC to appeal against Tribunal decisions. Responses to the consultation were analysed and amendments were made to the 1983 Act and the 2002 Act by the General Medical Council (Fitness to Practise and Overarching Objective) and the Professional Standards Authority for Health and Social Care (References to court) Order 2015 ('the 2015 Order'). The 2015 Order provided the GMC with a right of appeal pursuant to section 40A of the 1983 Act. Amendments were also made to the grounds on which the PSA (as successor to the Council) could make a reference to the court under section 29 of the 2002 Act. Provision was made to prevent a medical practitioner being confronted with appeals by both the GMC and the PSA (see further, paragraph 23 below).

20. Section 40 of the 1983 Act provides a right of appeal to the medical practitioner. Section 40 provides in part that:

> "(1) The following decisions are appealable decisions for the purposes of this section, that is to say-
>
> (a) a decision of the Medical Practitioners Tribunal under section 35D above giving a direction for erasure, for suspension or for conditional registration or varying the conditions imposed by a direction for conditional registration …".

21. Section 40A of the 1983 Act provides in part that:

> "(1) This section applies to any of the following decisions by the Medical Practitioners Tribunal-
>
> …….
>
> (d) a decision not to give a direction under section 35D;
>
> (2) A decision to which this section applies is referred to below as a 'relevant decision'.
>
> (3) The General Council may appeal against a relevant decision to the relevant 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.

> (4) Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it 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…
>
> (6) on an appeal under this section, the court may –
>
> (a) dismiss the appeal;
>
> (b) allow the appeal and quash the relevant decision;
>
> (c) substitute for the relevant decision any other decision which could have been made by the Tribunal;
>
> (d) remit the case to the MPTS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court …".

22. As can be seen, section 40A(1)(d) refers to a decision not to give a direction under section 35D. Section 35D of the 1983 Act provides in part that:

> .....
>
> "(2) Where the Medical Practitioners Tribunal find that the person's fitness to practise is impaired they may, if they think fit-
>
> (a) …. direct that the person's name shall be erased from the register;
>
> (b) direct that his registration shall be suspended …; or
>
> (c) direct that his registration shall be conditional on his compliance … with … requirements … for the protection of members of the public …;
>
> (3) Where the Tribunal find that the person's fitness to practise is not impaired they may nevertheless give him a warning regarding his future conduct or performance …."

23. Section 40B provides for notification to be given to the PSA if the GMC has appealed. Section 40B(1)(b) prevents the PSA from appealing pursuant to section 29 of the 2002 Act where the GMC has appealed. Section 40B(2) permits the PSA to become a party to the appeal where the GMC has appealed, and this is what has occurred in this case.

24. As a matter of procedure, tribunals follow a three-stage process: (i) they hear evidence and then make findings of fact; (ii) they hear submissions about whether the factual matters found amount to misconduct and make a finding on impairment; and (iii) they make a decision on sanction or warning: see paragraphs 17(2)(i)-(m) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004.

25. As appears from section 35D set out at paragraph 22 above, only if there is a finding of impairment may the Tribunal give directions as to erasure or suspension and give directions imposing requirements on compliance. A Tribunal may also give a warning to a medical practitioner, even if there is no finding of impairment. A medical practitioner does not have a right of appeal against a decision to impose a warning, but may seek to challenge any such decision in proceedings for judicial review.

The GMC has jurisdiction to appeal

26. Mr Ivan Hare QC, on behalf of the GMC, submits that in the proceedings against Dr Jagjivan, the Tribunal made a decision not to give a direction under section 35D, and thus section 40A(1)(d) of the 1983 Act provides jurisdiction to appeal. Mr Anthony Haycroft, on behalf of Dr Jagjivan, submits that on its proper construction, section 40A(1)(d) does not provide jurisdiction to appeal. This is because the Tribunal could only have given a direction under section 35D if it had found Dr Jagjivan's fitness to practise was impaired, and although the Tribunal found misconduct, it did not make a finding that Dr Jagjivan's fitness to practise had been impaired.

27. It seems to us that on the ordinary wording of section 40A(1)(d) the Tribunal in this case did make "a decision not to give a direction under section 35D" because at the conclusion of the hearing involving the allegations against Dr Jagjivan, a direction under section 35D had not been given. This point on construction is supported by the reference in section 40(A)(3) to "a finding or a penalty or both" since that wording demonstrates that a finding for the purposes of section 40A(3), need not be a finding of impairment, but may be a finding that there is no impairment. It also seems to us that Mr Haycroft's construction of section 40A(1)(d) involves inserting at the end of the relevant subsection words to this effect: "after determining that the person's fitness to practise is impaired" when those words are not present and do not require to be read into the section.

28. However in *Ruscillo v Council for Regulation of Health Care Professionals and others* [2004] EWCA Civ 1356; [2005] 1 WLR 717, a judgment of the Court of Appeal which binds us, a similar point arose to that we are now considering in relation to the interpretation of section 29 of the 2002 Act (as it was before amendment). That section (set out in paragraph 17 above) like section 40A, referred to a decision not to give a direction.

29. The Council in *Ruscillo* contended that the finding of the Professional Conduct Committee ('the PCC') that Dr Ruscillo had not been guilty of serious professional misconduct constituted a final decision (not to take any disciplinary measure). Counsel for Dr Ruscillo however contended that the finding of the PCC that Dr Ruscillo had not been guilty of serious professional misconduct could not be described as a decision not to take any disciplinary measure, as such a decision could only be taken once the PCC had made a finding of serious professional misconduct. Thus, it was argued on Dr Ruscillo's behalf that the finding that he had not been guilty of serious professional misconduct, precluded any possibility of the PCC making a decision to which section 29 of the 2002 Act could apply.

30. At paragraph 39 of *Ruscillo,* Lord Phillips MR, giving the judgment of the court said that "as a matter of natural use of language" there was force in this contention made on behalf of Dr Ruscillo. However, the court considered that having regard to the purpose of the section, the Council did have jurisdiction to appeal even though a finding of professional misconduct (which was the forerunner to impairment) had not been made. This was because section 29 of the 2002 Act was aimed at a failure to find that the conduct did not amount to professional misconduct just as much as if the Tribunal had imposed too lenient a penalty. Moreover, the contrary construction would have produced an anomaly as the court pointed out at paragraph 46:

> "…section 29(4)(a) of the Act makes express provision for the Council to have regard to the lack of a finding of professional misconduct when considering whether a decision falling within sub-section (1) has been unduly lenient…What is quite clear, however, is that in some circumstances a failure to find professional misconduct where professional conduct should have been found is a relevant consideration in deciding whether a reference should be made to the High Court. It would be anomalous if, under section 29(4)(b), no regard could be had to an erroneous failure to find professional misconduct."

31. The overarching objective of the GMC in exercising their functions is the protection of the public: see section 1 of the 1983 Act. The protection of the public involves the pursuit of the following objectives: (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 the profession: see section 1(1B) of the 1983 Act. Section 40A empowers the GMC to appeal against a 'relevant decision' by a Tribunal if it considers that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public: see section 40A(3).

32. In our judgment, it would be anomalous (to say the least) if the GMC's right of appeal was confined to cases where the Tribunal had made a finding of impairment or imposed some sanction, and no regard could be had to an erroneous failure by the Tribunal to find an impairment of fitness to practise. As Mr Hare QC points out, where the Tribunal has made a finding of impairment or imposed some sanction the

decision has at least provided a measure of protection for the public, whereas the same cannot be said where the Tribunal erroneously finds no impairment or merely imposes a warning.

33. *Ruscillo* was decided in 2004, and the correctness of the decision has not been doubted. The 2015 Order was made in the light of that decision, and the wording of section 40A is materially similar to the wording of section 29 of the 2002 Act. It is an established principle of statutory interpretation that "when Parliament uses a word or term, the meaning of which has been the subject of judicial ruling in the same or similar context, then it may be presumed that the word or term was intended to bear the same meaning": see *Lowsley v Forbes* [1999] 1 AC 329 at 340F-G, per Lord Lloyd of Berwick. In our judgment that principle applies here. Both sections refer to decisions not to give directions, which directions can only be given after serious misconduct or impairment of fitness to practise has been found. It follows that in our judgment, the judicial interpretation of the material wording of section 29 of the 2002 Act in *Ruscillo* should be applied to the similar wording of section 40A.

34. Mr Haycroft submits that the judgment in *Ruscillo* was heavily influenced by the mischief at which section 29 of the 2002 Act was directed, and that we could only take a similar course if the wording of section 40A of the 1983 Act was sufficiently wide to permit the construction contended for by the GMC without doing violence to the language. We are satisfied that the wording of section 40A of the 1983 Act is sufficiently broad to accommodate the construction contended for by the GMC.

35. Accordingly, we reject Dr Jagjivan's jurisdictional challenge.

36. We should record that we were provided with a copy of a Skeleton Argument in a forthcoming GMC appeal mounted pursuant to the provisions of section 40A of the 1983 Act, in which a point under Article 6 of the ECHR has been raised. One of the arguments advanced in the Skeleton Argument is that there is an inequality of arms because although a medical practitioner cannot appeal against a warning where there is no finding of impairment, the GMC can challenge earlier parts of the decision-making of the Tribunal for the purpose of obtaining a direction. If there is no equivalence between the position of the GMC and the medical practitioner on rights of appeal (a point about which we make no finding) we would not consider that the appropriate remedy would be to remove a right of appeal provided by statute to the GMC. Mr Haycroft did not however advance the Article 6 argument before us and it is not necessary for us to consider it further.

37. Finally, we should also record that we have taken no account of the content of the consultation paper produced before the making of the 2015 Order, to which reference was made in argument.

Permission to appeal would have been granted to the PSA

38. Although the point no longer arises, it was common ground that if the GMC did not have jurisdiction to appeal, then the PSA should in effect step into the GMC's shoes; and we should grant an extension of time for the PSA to appeal, waive the requirement for an Appellant's Notice and any response, and hear the PSA's appeal, mounted on precisely the same grounds as by the GMC, on the merits.

The correct approach to appeals under section 40A

39. As a preliminary matter, the GMC invites us to adopt the approach adopted to appeals under section 40 of the 1983 Act, to appeals under section 40A of the 1983 Act, and we consider it is right to do so. It follows that the well-settled principles developed in relation to section 40 appeals (in cases including: *Meadow v General Medical Council* [2006] EWCA Civ 1390; [2007] QB 462; *Fatnani and Raschid v General Medical Council* [2007] EWCA Civ 46; [2007] 1 WLR 1460; and *Southall v General Medical Council* [2010] EWCA Civ 407; [2010] 2 FLR 1550) as appropriately modified, can be applied to section 40A appeals.

40. In summary:

i) Proceedings under section 40A of the 1983 Act are appeals and are governed by CPR Part 52. A court will allow an appeal under CPR Part 52.21(3) if it is 'wrong' or 'unjust because of a serious procedural or other irregularity in the proceedings in the lower court'.

ii) It is not appropriate to add any qualification to the test in CPR Part 52 that decisions are 'clearly wrong': see *Fatnani* at paragraph 21 and *Meadow* at paragraphs 125 to 128.

iii) The court will correct material errors of fact and of law: see *Fatnani* at paragraph 20. Any appeal court must however be extremely cautious about upsetting a conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of the witnesses, who the Tribunal, unlike the appellate court, has had the advantage of seeing and hearing (see *Assicurazioni Generali SpA v Arab Insurance Group* (Practice Note) [2002] EWCA Civ 1642; [2003] 1 WLR 577, at paragraphs 15 to 17, cited with approval in *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] UKHL 23, [2007] 1 WLR 1325 at paragraph 46, and *Southall* at paragraph 47).

iv) When the question is what inferences are to be drawn from specific facts, an appellate court is under less of a disadvantage. The court may draw any inferences of fact which it considers are justified on the evidence: see CPR Part 52.11(4).

v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach 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 proper standards in the profession and sanctions, with diffidence: see *Fatnani* at paragraph 16; and *Khan v General Pharmaceutical Council* [2016] UKSC 64; [2017] 1 WLR 169, at paragraph 36.

vi) However there may be matters, such as dishonesty or sexual misconduct, where the court "is likely to feel that it can assess what is needed to protect the

public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal …": see *Council for the Regulation of Healthcare Professionals v GMC and Southall* [2005] EWHC 579 (Admin); [2005] Lloyd's Rep. Med 365 at paragraph 11, and *Khan* at paragraph 36(c). As Lord Millett observed in *Ghosh v GMC* [2001] UKPC 29; [2001] 1 WLR 1915 and 1923G, the appellate court "will afford an appropriate measure of respect of the judgment in the committee … but the [appellate court] will not defer to the committee'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, because the overarching concern of the professional regulator is the protection of the public.

viii) A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the Tribunal's decision unjust (see *Southall* at paragraphs 55 to 56).

Appeal allowed

41. The GMC submits that the Tribunal's judgment that Dr Jagjivan's actions were not sexually motivated was wrong and should be reversed.

42. The finding about the absence of sexual motivation was, as the Tribunal recorded in the final sentence of paragraph 50 and in paragraph 55 of the judgment, an 'inference' to be drawn from the facts. As noted above, the GMC took account of the fact that Dr Jagjivan had not engaged in sexual banter or inappropriate communication of a sexual nature, Dr Jagjivan's evidence about his sexuality, and the fact that there was no evidence to support the GMC's contention that Dr Jagjivan was seeking to pursue a sexual relationship with patient A.

43. As noted in paragraph 14 above, in its determination on impairment the Tribunal found that Dr Jagjivan's actions were deplorable, and the Tribunal found misconduct.

44. In our judgment the Tribunal's failure to find that there was a sexual motivation for Dr Jagjivan's actions was wrong and unsustainable. On the facts as found in relation to paragraphs 2(d) and (e), in our view, such an inference was irresistible. Dr Jagjivan introduced the concept of getting 'excited' and pointed to patient A's nipples and vagina; he suggested putting pressure on her vagina where she could stimulate herself and, when patient A's hand was near her vagina told her that there was another way to make her heart beat faster and put his hand on top of patient A's hand. Dr Jagjivan gave no other explanation for making these statements. Indeed he denied having said them. In our view notwithstanding the fact that Dr Jagjivan had not been seen to have acted in any similar manner before and what Dr Jagjivan himself said about his sexuality and that he was not sexually attracted to patient A, there could be no motivation other than a sexual one for making statements to a partially dressed patient about intimate body parts and the stimulation of her vagina.

45. We should add that in his witness statement, which he adopted in evidence, Dr Jagjivan suggested that it was patient A who had decided to raise her heart beat by

pushing her hip against Dr Jagjivan's hip, and had her hand near her groin and pressed her thighs together. Dr Jagjivan said that he interpreted this as attempting to use physical stimulus and that: "feeling dismayed, I immediately pointed to her thighs, looked at her face and said "No. I don't think that's going to work and anything further would be clearly inappropriate" " (emphasis added). In oral evidence Dr Jagjivan confirmed that the word 'inappropriate' came from him and said he meant it in its truest form. He later confirmed that he was trying to establish a boundary by moving her hand. As we have said, the Tribunal rejected this part of Dr Jagjivan's evidence. It is not insignificant however that Dr Jagjivan expressed himself in these terms in attempting to blame patient A, since it connotes an apparent recognition by him of the obvious, namely the inappropriateness of such behaviour in a medical consultation, because of its sexual nature.

46. We therefore allow the appeal. We quash the Tribunal's finding that Dr Jagjivan's actions in paragraphs 2(d) and 2(e) of the allegation were not sexually motivated and substitute a finding that those actions in paragraphs 2(d) and 2(e) were sexually motivated.

47. The GMC's Notice of Appeal encompassed paragraphs 2(b) and 2(c) of the allegations (see paragraph 11 above). However, the GMC's submissions at the hearing were principally directed to paragraphs 2(d) and (e), and the evidence in relation to paragraphs 2(b) and (c) was rather different. The conduct there alleged did not involve the use of overt sexual language and patient A's back was turned during the squats. Although we would not have made the same finding, we do not consider we are able to say that the Tribunal's findings on sexual motivation in relation to paragraphs 2(b) and 2(c) were wrong.

48. We will come to consequential orders after dealing briefly with the application to adduce fresh evidence.

Fresh evidence

49. The fresh evidence is a witness statement made by a witness who alleges sexual misconduct by Dr Jagjivan at a consultation that took place on 6 April 2017. It is apparent that consideration is being given to further proceedings against Dr Jagjivan by the GMC arising from that evidence. It is right to record however that we were told that Dr Jagjivan substantially disputes the fresh evidence which has yet not been tested.

50. The court undoubtedly has jurisdiction to admit fresh evidence: see CPR Part 52.22(2) and *GMC v Adeogba* [2016] EWCA Civ 162; [2016] 1 WLR 3867 at paragraphs 24 to 35. However in circumstances where we have allowed the appeal without consideration of the fresh evidence, it is unnecessary for us to admit it, and we do not do so.

Disposal of the appeal

51. As earlier indicated, we quash the Tribunal's finding that the actions in paragraphs 2(d) and 2(e) of the allegation were not sexually motivated and substitute a finding that the actions in paragraphs 2(d) and 2(e) were sexually motivated. Paragraphs 2 and 3 of the finding should be amended accordingly. We will, as we were invited to

by the GMC, remit to the Tribunal the following issues: (1) impairment of fitness to practise; and (2) if there is a finding of impairment, whether a direction should be made under section 35D of the 1983 Act. This will enable the Tribunal to determine whether proceedings, if any, arising from the consultation on 6 April 2017 with the new witness should be heard together with these remitted proceedings. We are very grateful to Mr Hare QC, Mr Haycroft and Ms Morris QC, and their respective legal teams, for their assistance.