Neutral Citation Number: [2019] EWHC 2624 (Admin)

Case No: CO/518/2019

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 09/10/2019

Before :

MR JUSTICE JULIAN KNOWLES

- -

Between :

DR UDODIRI OKPARA	**Appellant**
- and -	
GENERAL MEDICAL COUNCIL	**Respondent**

- -
- -

Arfan Khan (instructed by **DCK Solicitors**) for the **Appellant**
Alexis Hearnden (instructed by **General Medical Council**) for the **Respondent**

Hearing dates: 12 June 2019

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Approved Judgment

The Honourable Mr Justice Julian Knowles

Introduction

1. This is an appeal pursuant to s 40 of the Medical Act 1983 (the MA 1983). The Appellant, Dr Udodiri Okpara, appeals against the decisions of the Medical Practitioners Tribunal by which it (a) found proved a number of allegations against him of sexual misconduct towards a nurse, and held that his fitness to practise was impaired as a consequence; and (b) imposed the sanction of erasure from the register of medical practitioners kept by the Registrar of the General Medical Council (the GMC) pursuant to s 2 of the MA 1983.

2. The Respondent to the appeal is the GMC, which is the statutory regulator for the medical profession established by s 1 of the MA 1983.

3. The Tribunal made its fact-finding determination on 19 September 2018. The sanction was imposed on 9 January 2019.

4. The Appellant appeals both decisions on the following grounds:

    a. The Tribunal erred in law on the burden and standard of proof in that it reversed the burden of proof, and failed to conduct a sufficiently critical and anxious scrutiny of the evidence to the requisite standard of proof on a balance of probabilities (Ground 1).

    b. The Tribunal erred in law by failing to take into account and/or give sufficient weight to the prejudice arising out of delay in making the complaint (Ground 2).

    c. The Tribunal was wrong to impose the sanction of erasure when the lesser sanction of suspension was reasonable and appropriate (Ground 3).'

The factual background

5. The GMC accused Dr Okpara of misconduct between 2014 and 2016 when he was a Locum Registrar in the Accident and Emergency Department at the University Hospital of Wales (UHW) in Cardiff. The complainant in each case was Ms A, a staff nurse at the hospital. The allegations against the Appellant are set out at [2] onwards of the Tribunal's fact-finding determination. They relate to a number of occasions when Dr Okpara was said to have made inappropriate sexual and other remarks to Ms A and/or to have made unwanted sexually motivated physical advances to her.

6. The allegations were as follows. I have numbered the allegations per the paragraph numbers of the fact-finding determination where they are set out.

    Allegation 2 (the touching incident)

7. Dr Okpara was alleged to have said to Ms A that he liked her bottom, or was obsessed with her bottom, or words to that effect. It was also alleged that he pulled suggestive faces at Ms A, touched her bottom with his hands, tried to link his legs with hers whilst sitting next to her at a desk, stood closer to her than was necessary, and made

unnecessary physical contact. All of this is said to have happened in the period covered by the following dates: 19 May 2014-16 May 2015, 2 December 2015-12 December 2015 and 4 May 2016-9 August 2016.

Allegation 3(a) and (b) (the drinks invitation)

8. It was alleged that on an occasion prior to 16 May 2016, Dr Okpara invited Ms A out to 'drink champagne' and then gave her his telephone number.

Allegation 3(c)-(d) (the incident in a relatives' room)

9. Shortly after the drinks incident, Dr Okpara was alleged to have led Ms A into a relatives' room in the hospital after asking to speak to her confidentially about a patient. That was a pretence. He then shut the door, stood in front of it, pressed his hand against the door, told Ms A that he wanted a hug, or words to that effect, ignored Ms A's comments that she felt threatened, and said 'if you give me a hug I'll let you out', or words to that effect.

Allegation 4 (the blood sample incident)

10. On an occasion prior to 16 May 2015, whilst Ms A was in the process of taking blood from a patient, Dr Okpara was said to have walked in and drawn the curtain around the patient's bed, stood behind Ms A, and remained standing with his groin touching Ms A's bottom.

Allegation 5 (the underwear incident)

11. Dr Okpara was alleged to have offered to buy Ms A underwear. Ms A was said to have 'laughed it off' by 'walking away' saying 'the way to a girls heart isn't through underwear its through diamonds and channel [Chanel]' (*sic*).

Allegation 6(a)-(b) (the Facebook incident)

12. Ms A alleged that during a night shift on 10 – 11 June 2016, the Appellant came and sat next to her whilst she was using a computer and sent her a 'friend request' on Facebook (the well-known social networking website). He is then alleged to have said 'Are you not going to accept ?' It was not in dispute that Ms A accepted that request. However, Ms A alleged that the Appellant watched, and waited for her to go to her phone and accept the friend request he had just sent to her.

Allegation 6(c)-(n) (the sluice room incident)

13. Later the same night, the Appellant was alleged to have sent a message to Ms A stating 'thanks gorgeous' following her acceptance of his invitation to become friends on Facebook. He then followed her into a sluice room (where bodily fluids and other bio-waste is disposed of). He was said to have stood behind her, placed his arms around Ms A's waist trapping her arms by her sides, and placed his groin against her bottom, and then placed his one hand down the waist of Ms A's trousers and touched the right side of her bottom with the cup of his hand and commented on her underwear. He was then alleged to have smelled her neck, made groaning noises and ignored her request for him

to desist. He was alleged to have said 'please just a little longer' and 'it's ok you just have this effect on me' (or words to that effect).

Allegation 7 (the staff room incident)

14. It was alleged that during a night shift at 3am on 8 August 2016 when Ms A was eating her meal in the staff room Dr Okpara came in and stood behind her and placed his hand on her shoulder and his groin against the back of her torso. He ignored her request to stop, and said, 'Why ? I'm just standing here. When you like someone it's hard not to be this close', or words to that effect.

Allegation 8

15. This was an over-arching allegation that the conduct in [2]-[6] and [7(b)-(e)] was sexually motivated.

The Appellant's case at trial

16. The Appellant's case is set out at [15] *et seq* of the Tribunal's fact-finding decision. He denied all of Ms A's specific allegations about his behaviour towards her; he also denied that most of the encounters she described where the conduct took place, happened. For example, he said that he could be sure that he would never have been present when Ms A was taking blood from a patient.

17. As well as denying the truth of Ms A's allegations, Dr Okpara made a series of allegations about Ms A's behaviour which the Tribunal said mirrored in some respects her account of his behaviour. These included:

    a. That Ms A had behaved flirtatiously towards him from when they first met;

    b. That it was Ms A who had asked him to invite her as a 'friend' on Facebook;

    c. That Ms A had, for no obvious clinical reason, sought help from him to take blood from a patient;

    d. That Ms A wanted him to buy her an expensive Louis Vuitton handbag, which he resisted;

    e. That it was Ms A who was constantly making physical contact with him, and not the other way around.

The Tribunal's fact-finding determination

18. The Tribunal found all of the allegations proved except for Allegation 6(a)-(b) (the Facebook incident). Its decision can be summarised as follows.

19. The Tribunal addressed Allegation 2 at [23]-[35]. It set out the competing accounts from Ms A and Dr Okpara, including his denial of the allegations. It set out his evidence that she would intentionally bump into him in the corridor, and that she had made flirtatious comments about the size of his arms when they first met. At [28] the

Tribunal said that given the competing evidence from Ms A and Dr Okpara, it took into account evidence from witnesses (all of whom were hospital employees) about Ms A's character. This was to the effect that she was 'timid' and 'prudish' and 'quite religious with strong values'. It said his account of her behaviour, including that she had been flirtatious towards him from the beginning, was 'wholly inconsistent' with the picture of her painted by these witnesses. It said he had provided no 'plausible' response to this allegation. Accordingly, taking all of the evidence into account, the Tribunal said that it found Allegation 2 proved on the balance of probabilities.

20. In relation to Allegation 3(a)-(b), having set out the competing versions, the Tribunal said at [42] that it found Ms A's accounts in her statement and evidence of what occurred consistent, and that it rejected Dr Okpara's 'generalised denials'. Accordingly, it found this allegation proved ([43]).

21. The Tribunal dealt with Allegation 3(c)-(d) at [44] onwards in its decision. It found the allegation proved. It said Ms A's account was supported by complaints about it she had made to two colleagues, Craig Davies and Vicki Brown.

22. Allegation 4 was addressed by the Tribunal at [51] and following. It set out the competing accounts from Ms A and Dr Okpara. It noted that Ms A had told Vicki Brown that when she was taking blood from a patient, he had stood behind her and rubbed his crotch against her back. It said that Dr Okpara had said he had never taken a patient's history whilst a nurse was taking blood. However, the Tribunal said that his reason for never having been present was not mentioned in his statement. On the other hand, it said Ms A's evidence was 'detailed and consistent'. It found the allegation proved on the balance of probabilities.

23. The Tribunal addressed Allegation 5 at [60] and following. It set out Ms A's account and Dr Okpara's version of events that she had joked in front of other staff that he was going to buy her a Louis Vuitton handbag. It noted that Ms A had said to three witnesses that he had offered to buy her gifts including underwear. The Tribunal said that it found the allegation proved and that it did not consider his evidence to be plausible given what it had heard about Ms A's character and 'his propensity to mirror the allegations against him back at Ms A without any credible evidence to support his allegations'.

24. Allegation 6(a)-(b) was found not proven by the Tribunal between [67] and [71] because of what it said were discrepancies in Ms A's accounts of what had happened.

25. Allegation 6(c)-(n) was dealt with at [72] *et seq*. Dr Okpara admitted replying 'thanks gorgeous' when Ms A accepted his friend request (Allegation 6(c)) but denied the remainder of the allegation. The Tribunal found proved the remainder of the allegation about what happened in the sluice room. It relied by way of corroboration on a 'WhatsApp' message which Ms A had sent to a friend immediately afterwards in which she complained that Dr Okpara had put his hand down her trousers. It said this was a 'crucial contemporaneous record'. It also relied upon complaints by Ms A to Vicki Brown, Craig Davies and Stefan Simpson. It rejected Dr Okpara's account that nothing could have happened in the sluice room because of the presence of faeces and vomit, which he said he could not tolerate. The Tribunal found Ms A to be credible and that her evidence was supported by that of the witnesses it had referred to.

26. In relation to Allegation 7 the Tribunal set out the competing versions of what was said to have happened (at [83] onwards). Dr Okpara's evidence was that there had been interaction between them in the staff room, but it had been a joke about some ibuprofen tablets in Ms A's bag which he suggested she had taken from the department, a suggestion she had not found funny. It took into account a WhatsApp message Ms A had sent that night to Vicki Brown expressing concern about having to work with Dr Okpara that night. It accepted Ms A's evidence and rejected Dr Okpara's account and so found this allegation proved.

27. In relation to Allegation 8, the overarching allegation, the Tribunal found at [90] that Dr Okpara had persistently behaved in a sexually motivated manner towards Ms A over a period of about three years.

Finding on sanction

28. The fact-finding determination was given on 19 September 2018. The Tribunal reconvened for submissions and a determination on impairment on 20 September 2018. The Appellant did not give further evidence, but submissions were made on his behalf that he recognised that the actions the Tribunal had found proven represented misconduct and acknowledged that they were a serious departure from the standards to be expected of a doctor**.** No positive representations were made as to impairment.

29. The Tribunal determined that the facts found proved amounted to misconduct and stated that it had no evidence of insight or remediation from the Appellant. As such, the Tribunal concluded that a risk of repetition remained**.** The GMC made submissions on sanction on 20 September 2018 with the Appellant's counsel making his submissions on 21 September 2018. The matter then went part-heard and the Tribunal did not reconvene until 8 January 2019 when the decision on sanction was handed down. The Appellant neither attended on that date nor was represented, the Appellant having indicated via email that he was content for the hearing to proceed in his absence**.**

30. Submissions were made on the Appellant's behalf as to his good character, as to his personal difficulties, the absence of evidence that he had been sexually aroused during any of the incidents and the fact that the Appellant was willing to undertake a process of remediation. He had been working since 2016 and there had been no further incidents.

31. In reaching its decision on sanction the Tribunal said that it had regard to the fact that the purpose of sanction is not to be punitive, but to protect patients and the wider public interest. It acknowledged ([32]):

> "… that [the Appellant] is an excellent doctor of previous good character with a 22-year unblemished career. It also acknowledged that the public interest is served by the retention of clinically competent doctors. However, it considered that it must balance the overall public interest with [the Appellant's] interests in light of its findings at stage 1 and stage 2 of the process."

32. However, it characterised the Appellant's conduct thus ([33]):

> "… his actions and behaviour towards Ms A spanned a period of some two years. The Tribunal accepted that there may have been difficult circumstances in [the Appellant's] private life, but determined that a prolonged course of persistent, escalating and targeted predatory behaviour directed to a work colleague, on shift, in a clinical setting could not be excused, or even mitigated, by personal circumstances"

33. The Tribunal gave little weight to the testimonials before it, noting that they were not on letter headed paper, were undated, were written prior to the findings of fact and did not identify which hospital the authors worked at.

34. A submission made on the Appellant's behalf that there had been insufficient time between the decision on misconduct and impairment for him to show insight and remediation was rejected by the Tribunal, which said at [39] that, 'whilst [the Appellant] has every right to deny the allegations, it had rejected his account of events. Indeed, it found that his blanket denials, and series of counter claims against Ms A, demonstrated a complete lack of insight.'

35. The Tribunal considered mitigating and aggravating factors, including the fact that the Appellant had used his position for his own sexually motivated behaviour towards Ms A, and the fact that the incidents had happened in a demanding clinical setting.

36. Working from the lowest sanction upwards the Tribunal considered the options in the Sanction Guidance and specifically suspension and erasure. It considered and rejected suspension on the grounds that the Appellant's misconduct was so serious as to be fundamentally incompatible with continued registration. It concluded at [62] of its determination:

> "Therefore, the Tribunal concluded that erasing Dr Okpara's name from the Medical Register would be the only proportionate sanction to impose in order to serve the public interest, maintain public confidence in the medical profession and send a message to the medical profession that this behaviour is unacceptable."

Legal framework

37. The relevant principles were not materially in dispute between the parties.

38. Section 40 of the MA 1983 provides a right of appeal to the High Court against a sanction imposed by the Tribunal:

> "(1) The following decisions are appealable decisions for the purposes of this section, that is to say—
>
> (a) a decision of a 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;
>
> ...
>
> (7) On an appeal under this section from a Medical Practitioners Tribunal, the court may—
>
> (a) dismiss the appeal;
>
> (b) allow the appeal and quash the direction or variation appealed against;
>
> (c) substitute for the direction or variation appealed against any other direction or variation which could have been given or made by a Medical Practitioners Tribunal; or
>
> (d) remit the case to the TRIBUNALS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court,
>
> and may make such order as to costs (or, in Scotland, expenses) as it thinks fit."

39. The over-arching objective of the GMC in exercising its functions is the protection of the public (s 1(1A)). The pursuit by the GMC of its over-arching objective consists of the following aims:

    a. to protect, promote and maintain the health, safety and well-being of the public;

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

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

40. By virtue of CPR PD52D, [19.1], appeals under s 40 are by way of re-hearing. However, such an appeal 'is a re-hearing without hearing again the evidence': see *Fish v General Medical Council* [2012] EWHC (Admin) 1269, [28]. Applying CPR r 52.21, the Court must allow the appeal if the decision of the Tribunal was wrong or unjust because of serious procedural or other irregularity.

41. In *Yassin v the General Medical Council* [2015] EWHC 2955 (Admin), [32], Cranston J considered the scope of an appeal under s 40 in the following terms:

> "Appeals under section 40 of the Medical Act 1983 are by way of re-hearing (CPR PD52D) so that the court can only allow an appeal where the Panel's decision was wrong or unjust because of a serious procedural or other irregularity in its proceedings: CPR 52.11. The authorities establish the following propositions:

i) The Panel's decision is correct unless and until the contrary is shown: *Siddiqui v. General Medical Council* [2015] EWHC 1966 (Admin), per Hickinbottom J, citing Laws LJ in *Subesh v. Secretary of State for the Home Department* [2004] EWCA Civ 56 at [44];

ii) The court must have in mind and must give such weight as appropriate in that the Panel is a specialist Tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserves respect: *Gosalakkal v. General Medical Council* [2015] EWHC 2445 (Admin);

iii) The Panel has the benefit of hearing and seeing the witnesses on both sides, which the Court of Appeal does not;

iv) The questions of primary and secondary facts and the over-all value judgment made by the Panel, especially the last, are akin to jury questions to which there may reasonably be different answers: *Meadows v. General Medical Council* [197], per Auld LJ;

v) The test for deciding whether a finding of fact is against the evidence is whether that finding exceeds the generous ambit within which reasonable disagreement about the conclusions to be drawn from the evidence is possible: *Assucurazioni Generali SpA v. Arab Insurance Group* [2003] 1 WLR 577, [197], per Ward LJ;

vi) Findings of primary fact, particularly founded upon an assessment of the credibility of witnesses, will be virtually unassailable: *Southall v. General Medical Council* [2010] EWCA Civ 407 , [47] per Leveson LJ with whom Waller and Dyson LJJ agreed;

vii) If the court is asked to draw an inference, or question any secondary finding of fact, it will give significant deference to the decision of the Panel, and will only find it to be wrong if there are objective grounds for that conclusion: *Siddiqui*, paragraph [30](iii).

viii) Reasons in straightforward cases will generally be sufficient in setting out the facts to be proved and finding them proved or not; with exceptional cases, while a lengthy judgment is not required, the reasons will need to contain a few sentences dealing with the salient issues: *Southall v. General Medical Council* [2010] EWCA Civ 407, [55]-[56].

ix) A principal purpose of the Panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the medical profession so particular force is given to the need to accord special respect to its judgment: *Fatnani and Raschid v. General Medical Council* [2007] EWCA Civ 46, [19], per Laws LJ.

x) An expert Tribunal is afforded a wide margin of discretion and the court will only interfere where the decision of the Tribunal is wrong: see *R(Fatnani) v General Medical Council* [2007] EWCA Civ 46."

42. The proper approach of an appeal court to the sanctions determination of a Tribunal was recently discussed in *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879, [60]-[67]. The Court of Appeal (Lord Burnett of Maldon CJ, Sir Terence Etherton MR and Rafferty LJ) said that a Tribunal's sanctions determination (in that case, that suspension rather than erasure was an appropriate sanction for the failings of Dr Bawa-Garba which had led to her conviction for gross negligence manslaughter) is an evaluative decision based on many factors, a type of decision sometimes referred to as 'a multi-factorial decision'. This type of decision, a mixture of fact and law, has been described as 'a kind of jury question' about which reasonable people may reasonably disagree: *Biogen Inc v Medeva Plc* [1997] RPC 1, 45; *Pharmacia Corp v Merck & Co Inc* [2002] RPC 41, [153]; *Todd v Adams (t/a Trelawney Fishing Co) (The Maragetha Maria*, [2002] 2 Lloyd's Rep 293, [129]; *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] 1 WLR 1325, [46].

43. It has been repeatedly stated in cases at the highest level that there is limited scope for an appellate court to overturn such a decision. At [64] the Court of Appeal quoted Lord Clarke in *Re B (A Child) (Care Proceedings)* [2013] 1 WLR 1911, [137]:

> "… it has traditionally been held that, absent an error of principle, the Court of Appeal will not interfere with the exercise of a discretion unless the judge was plainly wrong. On the other hand, where the process involves a consideration of a number of different factors, all will depend on the circumstances. As Hoffmann LJ put it in *In re Grayan Building Services Ltd (In Liquidation)* [1995] Ch 241, 254, 'generally speaking, the vaguer the standard and the greater the number of factors which the court has to weigh up in deciding whether or not the standards have been met, the more reluctant an appellate court will be to interfere with the trial judge's decision'."

44. At [67] of *Bawa-Garba* the Court said that this general caution applies with particular force in the case of a specialist adjudicative body, such as the Medical Practitioners Tribunal, which (depending on the matter in issue) usually has greater experience in the field in which it operates than the courts: see *Smech Properties Ltd v Runnymede Borough Council* [2016] EWCA Civ 42, [30]; *Khan v General Pharmaceutical Council* [2017] 1 WLR 169 at [36]; *Meadow* at [197]; and *Raschid v General Medical Council* [2007] 1 WLR 1460, [18]-[20]. It therefore said that an appeal court should only interfere with such an evaluative decision on sanction if (a) there was an error of

principle in carrying out the evaluation, or (b) for any other reason, the evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide (citations omitted).

45. I was also referred to *Bijal v General Medical Council* [2002] Lloyds Law Reports 60 (PC), where Lord Hoffman said:

> "The Committee was rightly concerned with public confidence in the profession and its procedures for dealing with doctors who lapse from professional standards. But this should not be carried to the extent of feeling it necessary to sacrifice the career of an otherwise competent and useful doctor who presents no danger to the public in order to satisfy a demand for blame and punishment".

The parties' submissions

Submissions on behalf of the Appellant

46. In relation to Ground 1, Mr Khan on behalf of Dr Okpara submitted that the Tribunal had erred at [18] of its fact-finding determination when it had said that the Appellant's denial of the allegations, and counter arguments, diminished his credibility. Having set out Dr Okpara's counter-allegations against Ms A, the Tribunal then said at [17]-[18]:

> "17. The Tribunal found that these allegations were wholly inconsistent with the remarkably similar descriptions of Ms A by other witnesses. They portrayed her as concerned to behave professionally, rather timid and inhibited, a very private person who did not discuss her private life at work and was anxious not to 'ruffle any feathers', make a scene or be the centre of attention.
>
> 18. The Tribunal found the combination of blanket denial and counter arguments diminished Dr Okpara's credibility as a witness."

47. Mr Khan submitted that [18] wrongly reversed the burden of proof which, on a balance of probabilities, lay with the GMC as the complainant, and failed to apply the correct standard of proof.

48. Mr Khan went on to submit that the Tribunal did not scrutinise the evidence with sufficient care, and he relied in particular on *Re H and Others (Minors)* [1996] AC 563, 586 where Lord Nicholls said:

> "When assessing the probabilities the court 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".

49. He also referred me to *In re D (Secretary of State for Northern Ireland intervening)* [2008] 1 WLR 1499, [27-28] where Lord Carswell said:

> "27. Richards LJ expressed the proposition neatly in *R (N) v Mental Health Review Tribunal (Northern Region)* [2006] QB 468, para 62 where he said:
>
> > "Although there is a single civil standard of proof on the balance of probabilities, it is flexible in its application. In particular, the more serious the allegation or the more serious the consequences if the allegation is proved, the stronger must be the evidence before a court will find the allegation proved on the balance of probabilities. Thus the flexibility of the standard lies not in any adjustment to the degree of probability required for an allegation to be proved (such that a more serious allegation has to be proved to a higher degree of probability), but in the strength or quality of the evidence that will in practice be required for an allegation to be proved on the balance of probabilities."
>
> In my opinion this paragraph effectively states in concise terms the proper state of the law on this topic. I would add one small qualification, which may be no more than an explanation of what Richards LJ meant about the seriousness of the consequences. That factor is relevant to the likelihood or unlikelihood of the allegation being unfounded, as I explain below.
>
> 28. It is recognised by these statements that a possible source of confusion is the failure to bear in mind with sufficient clarity the fact that in some contexts a court or Tribunal has to look at the facts more critically or more anxiously than in others before it can be satisfied to the requisite standard. The standard itself is, however, finite and unvarying. Situations which make such heightened examination necessary may be the inherent unlikelihood of the occurrence taking place (Lord Hoffmann's example of the animal seen in Regent's Park), the seriousness of the allegation to be proved or, in some cases, the consequences which could follow from acceptance of proof of the relevant fact. The seriousness of the allegation requires no elaboration: a Tribunal of fact will look closely into the facts grounding an allegation of fraud before accepting that it has been established. The seriousness of consequences is another facet of the same proposition: if it is alleged that a bank manager has committed a

> minor peculation, that could entail very serious consequences for his career, so making it the less likely that he would risk doing such a thing. These are all matters of ordinary experience, requiring the application of good sense on the part of those who have to decide such issues. They do not require a different standard of proof or a specially cogent standard of evidence, merely appropriately careful consideration by the Tribunal before it is satisfied of the matter which has to be established."

50. The reference to Regent's Park is to what Lord Hoffmann said in *Secretary of State for the Home Department v Rehman* [2003] 1 AC 153, where the Special Immigration Appeals Commission had held that the Secretary of State had not established to a high degree of probability that the applicant, who was the subject of a deportation order, was likely to be a threat to national security. The House of Lords held that where past acts were relied on, they should be proved to the civil standard of proof. Lord Hoffmann said, at [55]:

> "I turn next to the commission's views on the standard of proof. By way of preliminary I feel bound to say that I think that a 'high civil balance of probabilities' is an unfortunate mixed metaphor. The civil standard of proof always means more likely than not. The only higher degree of probability required by the law is the criminal standard. But, as Lord Nicholls of Birkenhead explained in *In re H (Minors) (Sexual Abuse: Standard of Proof)* [1996] AC 563, 586, some things are inherently more likely than others. It would need more cogent evidence to satisfy one that the creature seen walking in Regent's Park was more likely than not to have been a lioness than to be satisfied to the same standard of probability that it was an Alsatian. On this basis, cogent evidence is generally required to satisfy a civil Tribunal that a person has been fraudulent or behaved in some other reprehensible manner. But the question is always whether the Tribunal thinks it more probable than not."

51. Mr Khan submitted that the Tribunal in its fact-finding determination did not direct itself to these principles, and specifically *In re D*, supra, and therefore erred in law. He said that it had not conducted a sufficiently critical and anxious analysis of the evidence, which was required given the serious nature of the allegations, and the serious consequences for Dr Okpara if they were proven.

52. He gave as an example, Allegation 4 (the blood sample incident). He said that at [57] the Tribunal had said that the patient was looking across Ms A's shoulder and would not have noticed what Dr Okpara was said to have been doing. He said that conclusion was unsustainable, because she said in her initial account that the patient was looking at him, and then later that she was not looking at what was happening on the patient's face. He said the evidence was contradictory and did not support the Tribunal's conclusion.

53. Next, he said that although the Tribunal relied upon the evidence of the complainant's witnesses on her character in holding that her account was credible, it did not take into account they were her close friends.

54. He also said that Tribunal did not take into account the character evidence of the Appellant when looking at the issue of credibility or the likelihood of the allegations being true.

55. Mr Khan also made a number of points on the evidence, including that in relation to Allegation 4, Ms A had said that she had bent over whilst taking the patient's blood, whereas Vickie Brown said she had said she had knelt down. He also said that the Tribunal did not analyse the inconsistencies in the complainant's evidence regarding the delay in her making the complaints. He also said the Tribunal did not critically or anxiously scrutinise the issue of motive and whether Ms A was motivated by resentment towards Dr Okpara. He also argued that it had been agreed the hospital had concerns about Dr Okpara's non-attendance, late cancellation of shifts, causing staffing difficulties. That meant that any evidence from the complainant's witnesses, had to be approached with caution, since they were hospital staff, and not entirely impartial.

56. Mr Khan made a number of other points about what he said were inconsistencies in the evidence, such as whether Dr Okpara had offered to buy Ms A underwear, or asked her what her favourite colour was. I need not set them all out.

57. Mr Khan said that the Tribunal, without disbelieving the complainant, ought to have held through anxious scrutiny that, in the absence of independent direct credible corroborating evidence, it could not resolve the conflict of evidence, and so could not find proven Allegation 2 where both parties were of good character.

58. Mr Khan also said that the Tribunal reversed the burden of proof when it said that Dr Okpara had not provided any reason why Ms A should make allegations against him. He said that In *R v GJB* [2011] EWCA Crim 867, the trial judge's summing-up had referred to the fact that the defendant could not explain why the complainant could remember the appearance of the defendant's bedroom. Stanley Burnton LJ noted that 'this comment, at a crucial point in the summing up, effectively reversed the onus of proof' (para 12).

59. In relation to Ground 2, Mr Khan said that the Tribunal failed to have regard to what he said was the prejudice to the Appellant arising from allegations of sexual impropriety said to have occurred so long ago as 2014. Consequently, he said the Tribunal failed to give regard to the guidance given by Fulford LJ in *R v PS* [2013] EWCA Crim 992 in respect of non-recent sexual misconduct, which was relevant to determining the issue of prejudice, namely that delay in making an allegation can place a defendant at a material disadvantage in challenging allegations arising out of events that occurred many years ago, and this is particularly so in cases where the defence amounts to a simple denial. Also, the longer the delay, the more difficult meeting the allegation often becomes because of fading memories and the unavailability of evidence. A difficulty compounded by the fact that it may be unclear what evidence has been lost. He said in particular that the delay in this case meant that

CCTV evidence, which might have assisted the doctor in resisting the allegations against him, was not (or no longer) available.

60. In relation to Ground 3, Mr Khan submitted that the Tribunal erred by failing to apply [93] of the Sanctions Guidance, which provides:

> "Suspension may be appropriate, for example, where there may have been acknowledgment of fault and where the Tribunal is satisfied that the behavior or incident is unlikely to be repeated".

61. He said that Dr Okpara had acknowledged fault when he admitted to being impaired following the Tribunal's fact-finding determination. He also said that Dr Okpara did not have any prior convictions or similar incidents and, therefore, there was nothing to show a propensity to repeat the misconduct.

62. He also submitted (in writing although he did not pursue it in oral submissions) that the Tribunal failed properly to apply [91] of the Sanctions Guidance which provides:

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

63. Mr Khan made a number of other forensic points including that the Tribunal had not treated the Facebook messages as being evidence of non-aggressive behaviour despite these allegations having been found not proven. He also said that the Tribunal proceeded on the basis that the Tribunal had found that 'Dr Okpara restrained Ms A by holding her arms from behind in the sluice room incident. However, he said Ms A's evidence was that it was the hug from behind which prevented her moving her arms, and that it was the left arm of the Appellant that held her. He also said that in considering the public interest, the Tribunal had failed to take into account the personal mitigation, namely that he was a sole breadwinner in his family with three young children who would suffer through the sanction of erasure as the Appellant would no longer be able to work as a doctor.

64. Overall, Mr Khan said that the Tribunal erred in the evaluative exercise at the stage of sanction, and should have imposed a sentence of 12 months' suspension, which could have been reviewed at the end of the period of 12 months. The issue of whether Dr Okpara's fitness to practise was still impaired could have been considered at that point. He said that the doctor had accepted his impairment and had recognised that his actions would have the potential to cause harm and bring the profession into disrepute. He said that Dr Okpara was not a risk and presented no danger and that the Tribunal had therefore erred by imposing the sanction of erasure.

Submissions on behalf of the Respondent

65. On behalf of the GMC, Ms Hearnden submitted as follows.

66. Firstly, she helpfully set out a Chronology of relevant events:

19.04.14-16.05.15	First stint as locum at the hospital
03.03.15	Ms A reports her concerns to Wayne Parsons
May-December 2015	Dr Okpara was working in the USA
December 2015	Second stint as locum at the hospital, 10 days
04.05.16-09.08.16	Third stint as locum at the hospital
11.08.16	Ms A initial account given to hospital
18.08.16	Dr Okpara returned to the USA
27.10.16	Dr Okpara notified by the Respondent of the investigation by email, attaching letter dated 19 October 2016
	Witness statement of Dr Mower, recording her face-to-face conversation with Dr Okpara and his initial reaction to being informed that an allegation had been made against him
21.02.17	Ms A's witness statement to the GMC
07-21.09.18	Tribunal hearing
19.09.18	Determination on the facts

20.09.18	Determination on misconduct and impairment
09.01.19	Determination on sanction
	Appellant's notice
03.05.19	Amended grounds and skeleton argument

67. She said that Ground 1 is a challenge to the Tribunal's findings of fact. She submitted that the present case was a paradigm example of a Tribunal making primary findings of fact, founded upon the assessment of the credibility of witnesses, which, as such, are should be virtually unassailable: *Southall v General Medical Council* [2010] EWCA Civ 407.

68. In relation to [17]-[18] and the alleged reversal of the burden of proof, she submitted that the Tribunal was tasked with undertaking a critical assessment of the case as presented by the GMC to determine whether or not the evidence was sufficiently cogent and persuasive to discharge the burden of proof. She said that the submissions by both parties and the legal advice given by the Chair made it clear that the burden was on the GMC to the civil standard, the balance of probabilities. The Chair gave the appropriate good character direction on propensity and credibility at the fact stage. She said that it was open to the Tribunal to conclude that the GMC had failed to discharge the burden of proof without making a positive finding that either party had lied. The Tribunal formed the clear view that Ms A's evidence was credible, whereas Dr Okpara's evidence was not.

69. Ms Hearnden said that the submissions advanced on behalf of Dr Okpara as to the ways the Tribunal supposedly failed to scrutinise the evidence sufficiently carefully were just attacks upon its findings of fact. She said many of those submissions were put to the Tribunal (eg, that it was improbable that the patient would not have noticed Dr Okpara standing and touching Ms A), whilst some were not (for example, the possibility that Ms Brown and Mr Davies were simply corroborating Ms A's account by reason of loyalty or friendship) was not put in cross-examination to Ms Brown. Overall, she said, none reveal that the Tribunal's decision on the facts were wrong.

70. For example, she pointed out that Mr Khan said Ms Brown's evidence was unreliable owing to inconsistencies, particularly as to whether Ms A was bent over or kneeling down, and she said 'that inconsistency does not receive any acknowledgment in the Tribunal's judgment'. She said that, in fact, the Tribunal had said at [58] that Ms A had re-iterated in her oral evidence that she was bending over 'and not kneeling as had been indicated in the statement of Vicki Brown'. Ms Hearnden said, therefore, that the Tribunal did not simply accept the evidence in an uncritical way; it was persuaded by Ms A's evidence as to the events alleged.

71. As for the complaint that the Tribunal did not direct itself to the relevant principles on how to approach the evidence, as set out in *Re H* [1996] AC 563 and *Re B* [2009] AC 11, she said was incorrect. She points to the fact that the Chair, in giving legal advice, referred to both cases.

72. As to Ground 2, and the alleged prejudice caused by delay, Ms Hearnden said that the delay here was limited and that the case cited by Mr Khan, *R v PS*, supra, which concerned allegations of sexual assault brought to trial 34 years after the event was therefore of no relevance. Specifically in relation to the absence of CCTV, she said this was ventilated with Ms A and the Tribunal was therefore aware of the Appellant's argument that he may have been able to rely upon CCTV evidence in support of his contention that he was not in the rooms/bays where Ms A said that incidents took place and the fact that he had been unable to access such evidence.

73. In relation to Ground 3, Ms Hearnden disputed that Dr Okpara had acknowledged fault at the impairment stage. She said that he had acknowledged the seriousness of the Tribunal's finding; but that it fell short of an acknowledgement of fault or responsibility such that the Tribunal could properly find that the Appellant demonstrated insight such that there was a reduced risk of repetition.

74. She said that GMC was entitled to place little weight on the testimonials submitted by Dr Okpara which had not been submitted eight weeks before the hearing as required by the Sanctions Guidance and so had not been verified by the GMC. Alternatively, even if they should have been afforded greater weight it was insufficient to tip the balance in favour of suspension rather than erasure, given the seriousness of the underlying findings and the concerns over Dr Okpara's insight: that assessment was for the Tribunal to make.

75. Contrary to Mr Khan's written submission that the Tribunal did not apply [92] of the Sanctions Guidance, Ms Hearnden pointed to the fact that it was expressly referred to at [54] of the Tribunal's decision. She said that the Tribunal was entitled to conclude that a suspension would not meet the need to satisfy the overriding objective in the face of misconduct which was so serious it was fundamentally incompatible with continued registration.

76. With regard to the public interest, Ms Hearnden said the Tribunal acknowledged the value in retaining competent doctors, but said that imperative had to be balanced against the need for public protection and public confidence in the medical profession. Here, contrary to Mr Khan's submissions to the contrary in his written submissions, she said that the Tribunal properly assessed that balance as favouring erasure in light of the seriousness of the misconduct.

Discussion

Ground 1

77. I begin with Mr Khan's complaint that the Tribunal reversed the burden of proof in [17]-[18] of its fact-finding determination. I set out these paragraphs earlier.

78. The starting point of my analysis is that there can be no doubt that the Tribunal had well in mind throughout that the burden of proof lay upon the GMC, and that Dr Okpara did not bear the burden of proving anything. At [7] of its fact-finding determination the Tribunal expressly directed itself in these terms.

79. This paragraph followed on from the Chair's legal advice to the Tribunal which was to the effect that the GMC bore the burden of proof and that Dr Okpara did not have to prove anything. She referred in her advice to the judgment of Baroness Hale in *Re B (Care Orders: Standard of Proof)* [2009] AC 11, [3] *et seq*, such that the inherent probabilities are to be taken into account, where relevant, in deciding where the truth lay**.** I will return to this point shortly. A good character direction was also given on credibility and propensity**.** The Tribunal was also invited to consider why the allegations were not made earlier, noting that this should not give rise to the assumption that they were untrue.

80. Hence there can be no doubt that the Tribunal clearly understood where the burden of proof lay and what the standard of proof was that had to be applied.

81. The Tribunal also made the following points in other paragraphs:

    a. The only direct evidence came from the complainant, Ms A, and Dr Okpara. In these circumstances, 'the Tribunal determined that the credibility of Ms A and Dr Okpara was of particular importance in this case' [8];

    b. Dr Okpara did not have an opportunity to respond to the allegations at the time;

    c. There were some differences between Ms A's initial account (11 August 2016) and her statement given to the GMC (21 February 2017), which were broadly consistent rather than contradictory, the latter providing additional detail to the former [14];

    d. Whilst rebutting Ms A's allegations in such unequivocal terms, Dr Okpara also introduced what were, in effect, a series of allegations about Ms A's behaviour towards him, eg, that she behaved flirtatiously [16];

    e. These allegations were wholly inconsistent with the description of Ms A's character which other witnesses had given and all of which were consistent [17];

    f. In his oral evidence, the Appellant had resorted to denial or evasion when asked to confirm simple facts and despite his allegations of 'coquettish' behaviour on the part of Ms A did not provide any plausible explanation as to why she would behave in the way he described [21]**.**

82. Whilst I accept that [17]-[18] of the Tribunal's fact-finding determination were perhaps unfortunately phrased, and that their meaning has to be teased out, when these two paragraphs are read carefully in context I am not satisfied, overall, that they amount to an error reversing the burden of proof such that I can overturn the Tribunal's findings, as Mr Khan contended.

83. Of course, the credibility of a respondent in disciplinary proceedings, just like that of a defendant in a criminal trial, cannot be regarded as diminished simply by virtue of the fact that they deny the allegations against them. A legal direction to that effect would obviously be wrong. The whole purpose of disciplinary proceedings or a trial is to determine whether the regulator or prosecutor has proved its case to the requisite standard. But given the Tribunal had clearly directed itself as to the burden and standard of proof, [17]-[18] cannot sensibly be read in such a way. What the Tribunal was saying, in my judgment, is that because Dr Okpara had advanced a positive case about Ms A's alleged behaviour that was wholly at odds with other evidence, and therefore the Tribunal did not believe him about this aspect of his case, that in turn made the Tribunal less willing to believe him when he said that nothing untoward had occurred between him and Ms A. In other words, what the Tribunal was saying was that because it doubted the credibility of one part of Dr Okpara's case, that caused it to doubt the credibility of the other part of his case. That was entirely unremarkable and legitimate reasoning albeit it was, as I have said, slightly clumsily expressed.

84. I therefore reject the argument that the Tribunal reversed the burden of proof.

85. I turn to Mr Khan's complaint that the Tribunal did not scrutinise the evidence with sufficient rigour, having regard to the seriousness of (and, he would say, inherent improbability of) the allegations made by Ms A against Dr Okpara.

86. The starting point is that this was a case about credibility, and the issues were straightforward. There was no room for misunderstanding. In respect of each allegation, the issue was whether the GMC had proved to the civil standard that the allegation happened in the way Ms A alleged. In each case, the Tribunal had competing accounts from Ms A and Dr Okpara together with, in some instances, evidence of complaints to other persons either orally or in the form of WhatsApp messages. It was on the basis of that material that the Tribunal had to make its decision.

87. The Tribunal was expressly directed by the Chair in accordance with the principles in *Re B,* supra, *Re H,* supra, and *Re D,* supra, to which Mr Khan made reference. *Re B* and *Re H* were referred to expressly. The Chair said:

> "… we must also have in mind, as stated in *Re H,* that a factor when considering all the circumstances to whatever extent is appropriate in this case is that the more serious the allegation, the less likely it is to have occurred, and, hence, the stronger the evidence should be before we conclude that the allegation is proved on the balance of probabilities. The more serious the allegation, the more cogent is the evidence required to overcome the unlikelihood of what is alleged and thus to prove it."

88. That was an impeccable direction. Accordingly, I do not accept Mr Khan's submission that the Tribunal did not have the right test in mind or that it misunderstood the correct evidential approach.

89. Among the points put to the Tribunal were the following.

90. In her closing submission at the fact-finding stage, counsel for the GMC invited the Tribunal to scrutinise the evidence, particularly the question as to whether or not Ms A was telling lies:

> "It was suggested to Ms A that she had made up stories and that they had snowballed out of control....You might think that it is extraordinary, I suggest, that Ms A had manufactured these allegations, and I ask you please to bear in mind that she was mortified when she was making her report, that is the clear evidence of the witnesses in the case....Ms A has travelled from Cardiff twice, bringing her mother with her for support, and I ask you please to bear in mind whether those are the actions of someone who is simply pedalling lies.
>
> She is a professional young woman. You might ask yourself, you are entitled to ask yourself, why on earth she would be concerned in the manufacture of lies about a colleague. [The Appellant] could offer no explanation for that. She is well liked, she is a respected professional, and it is a matter for a you to determine whether or not it is in any way credible that a young woman like Ms A would simply make up these lies, because you know as part of your everyday, common-sense, real-life experience that people tell lies for a reason. Beneath a life is a motivation – it could be a falling out, it could be jealousy, it could be pure wickedness – ...you and your colleagues, please, should assess whether you think that any of those strikes you as in any way likely".

91. Among the points made by Dr Okpara's counsel were the following:

a. He was of good character, a matter that was relevant to his credibility as a witness and to his propensity to do what he was accused of. The Chair directed the Tribunal accordingly;

b. He relied upon positive references from the University Hospital of Wales;

c. Three witnesses tendered by the Respondent had never witnessed inappropriate behaviour by him;

d. Counsel said:

> "The test, as you are aware, and I simply repeat for the benefit of the record, is not, 'Well, what reason does she have to lie?', or, 'Why would she say something that isn't true?' If that were the criteria, then [the Appellant], frankly, may as well go home because it is near impossible to prove that somebody is lying. He can't indeed he doesn't have to, the burden is not on him. Instead I ask you to consider the evidence as a whole, consider what other people say about [the Appellant], consider, as I will turn to in a moment, the absence of independent eyewitnesses,

the inconsistencies in the evidence, and analyse the details of this accusation"

e. The Tribunal was urged to exercise great caution when considering the previous inconsistent statements put to Dr Okpara concerning his submissions before the Interim Order hearing when he was unrepresented;

f. Finding the allegations not proved would not amount to finding that Ms A was lying. He said that the Tribunal could, when confronted with unanswered questions and inconsistencies, conclude that 'we just can't be satisfied that such serious allegations are met against a man of good character'.

92. Given the nature of the issues involved, it was not necessary in my judgment for the Tribunal to address in its fact-finding determination every single forensic point made on behalf of both sides in order to explain why it reached the decision that it did. That it did not do so does not mean that it did not scrutinise the evidence with sufficient care or rigour, given that I have rejected Mr Khan's central submission that it failed to approach the evidence correctly. In respect of each allegation the Tribunal set out what the allegation was; set out the competing evidence in relation to it (in summary form); and gave reasons for concluding why it found the allegation proved or not proved. The reasons it gave were sufficient and do not indicate any lack of care or adequate scrutiny. For example, where relevant, the Tribunal identified evidence which corroborated Ms A's account, eg, the evidence of Craig Davies and Vicki Brown and contemporaneous WhatsApp messages sent by Ms A. It also considered the inherent plausibility of the evidence given, for example, Dr Okpara's evidence that he had 'never' taken the history of a patient with a nurse present whilst taking blood samples, which the Tribunal found to be implausible. Dr Okpara suggested that it was implausible that a patient would not know what was happening if he was behaving inappropriately towards Ms A. The Tribunal considered this and preferred Ms A's account, which it said was detailed and consistent with her initial account.

93. Overall, as I have already said, reasons in straightforward cases will generally be sufficient in setting out the facts to be proved and finding them proved or not; with exceptional cases, while a lengthy judgment is not required, the reasons will need to contain a few sentences dealing with the salient issues: *Southall,* supra, [55]-[56]. The Tribunal's reasons in this case more than met that standard.

94. Finally, the Tribunal was entitled to take into account whether Dr Okpara could put forward an explanation as to why Ms A should make false accusations against him, provided that in doing so it bore well in mind that the burden throughout lay upon the GMC to prove its case. For the reasons I have given, there can be no doubt that it did keep this principle firmly in mind. The case of *R v GJB*, supra, referred by Mr Khan is not on point.

95. Ground 1 therefore fails.

Ground 2

96. I can deal with Ground 2 more shortly.

97. I set out the Chronology earlier. The allegations related to the period 2014 – 2016, when Ms A made her complaint to the hospital and the investigation commenced. There was nothing remarkable about this timescale, and the case cited by Mr Khan of *R v PS*, supra, which concerned allegations of alleged sexual misconduct decades previously, is therefore not relevant. The Tribunal was addressed on the absence of CCTV and other matters, and so would have had these forensic points well in mind when it considered whether the GMC had proved its case.

98. There is nothing in this ground of appeal, and it therefore fails.

Ground 3

99. I turn to the submission made on behalf of Dr Okpara that the Tribunal was wrong to have ordered erasure from the medical register and that it should, instead, have suspended him for a period of time.

Principles

100. The starting point is, as I have said, that the Tribunal is the body best equipped to determine the sanction to be imposed. The assessment of the seriousness of the misconduct is essentially a matter for the Tribunal in the light of its experience. It is the body best qualified to judge what measures are required to maintain the standards and reputation of the profession: *Bawa-Garba*, supra, [67] and [94]. I remind myself that I can only intervene if (a) there was an error of principle in carrying out the evaluation, or (b) for any other reason, the evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide.

101. The GMC publishes Sanctions Guidance for use by Tribunals when, among other things, considering what sanction to impose following a finding that a doctor's fitness to practise is impaired. The latest edition was published in 2018. It states that the main reason for imposing sanctions is to fulfil the statutory objectives in s 1 of MA 1983. It says the following about maintaining public confidence:

> "Maintaining public confidence in the profession
>
> 17. Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession ... Although the Tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor."

102. The Sanctions Guidance points out at [24] that mitigating factors carry less weight when the concern is about patient safety or is of a more serious nature 'than if the concern is about public confidence in the profession'. Mitigating factors include (at [25]): insight into the problem, remediation, adherence to good practice, past record, the circumstances leading to the incidents of concern such as lack of training or supervision, personal and professional matters such as work-related stress, and the

lapse of time since an incident occurred. Having said at [31] that, when remediation is fully successful, a finding of impairment is unlikely, the Sanctions Guidance continues:

> "32. However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients, and should have taken steps earlier to prevent this."

103. The Sanctions Guidance provides for a range of sanctions, from taking no action ranging through the imposition of conditions, suspension and up to erasure ([66)]. At [67] the Guidance states:

> "67. The tribunal's written decision is known as the determination. It must give clear and cogent reasons (including mitigating and aggravating factors that influenced its decision) for imposing a particular sanction. It must show that it started by considering the least restrictive option, working upwards to the most appropriate and proportionate sanction. This is particularly important where the sanction is lower, or higher, than that suggested by this guidance and/or where it differs from those submitted by the parties. In addition, the determination should include a separate explanation as to why the sanction should last for a particular period."

104. The following, among other things, is said in connection with suspension ([92]):

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

105. Examples are given at [93] of when suspension may be appropriate, such as where there has been an acknowledgment of fault and the behaviour is unlikely to be repeated, or where there was deficient performance but there is evidence of insight and the potential for remediation, or where there is no evidence of the repetition of similar behaviour since the incident.

106. The Guidance deals with the sanction of erasure at [107] et seq. The following points, among others, are made:

> "108. Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For

example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor. 109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive). a A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.

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

a. A particularly serious departure from the principles set out in *Good medical practice* [a GMC publication] where the behaviour is fundamentally incompatible with being a doctor.

b. A deliberate or reckless disregard for the principles set out in *Good medical practice* and/or patient safety.
c. Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients (see further guidance below at paragraphs 129–132 regarding failure to provide an acceptable level of treatment or care).

d. Abuse of position/trust (see Good medical practice, paragraph 65: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').

e. Violation of a patient's rights/exploiting vulnerable people (see Good medical practice, paragraph 27 on children and young people, paragraph 54 regarding expressing personal beliefs and paragraph 70 regarding information about services).

f. Offences of a sexual nature, including involvement in child sex abuse materials (see further guidance below at paragraphs 151 - 159).

g. Offences involving violence.

h. Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 120–128).

i Putting their own interests before those of their patients (see Good medical practice paragraph 1: – 'Make the care of [your] patients [your] first concern' and paragraphs 77–80 regarding conflicts of interest).

> j Persistent lack of insight into the seriousness of their actions or the consequences."

107. Other matters relevant to the sanction of erasure are set out at [148-150]:

> "148. More serious action, such as erasure, is likely to be appropriate where a doctor has abused their professional position and their conduct involves predatory behaviour or a vulnerable patient, or constitutes a criminal offence.
>
> Sexual misconduct
>
> 149. This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child sex abuse materials) to sexual misconduct with patients, colleagues, patients' relatives or others. See further guidance on sex offenders and child sex abuse materials at paragraphs 151–159."
>
> 150. Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases."

Application to the facts

108. I turn to the nature of the conduct found proved against Dr Okpara. It can properly be described as sexually predatory behaviour towards Ms A over a sustained period of two years. The Tribunal so characterised it at [32]-[40] and it was right to do so. Indeed, some of Dr Okpara's conduct was capable (subject to being proved to the criminal standard) of amounting to the criminal offence of sexual assault contrary to s 3 of the Sexual Offences Act 2003, in particular, Allegation 2 (the touching incident); Allegation 4 (the blood sample incident); Allegation 6(c)-(n) (the sluice room incident), and Allegation 7 (the staff room incident). Allegation 3(c)-(d) (the incident in a relatives' room) was capable of amounting to the common law offence of false imprisonment.

109. In its decision the Tribunal said that Dr Okpara's conduct fell within [148], [149] and [150] of the Sanctions Guidance. In my judgment it was right to do so. Therefore, erasure was open to the Tribunal as a sanction which was likely to be appropriate for Dr Okpara's misconduct. The question for me is whether the Tribunal made an error of principle in carrying out its evaluation that erasure was in fact the appropriate sanction, or for any other reason, that that evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide.

110. Mr Khan said, first, that the Tribunal had misapplied the criteria in relation to suspension and in particular had misapplied [91]-[93] of the Guidance. I do not

consider there is any force in this criticism. The Tribunal expressly referred to [92] at [54]-[55] of its decision. The relevant part of [92] provides:

> "A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession)."

111. The Tribunal said that Dr Okpara's misconduct was fundamentally incompatible with continued registration, and for that reason suspension was not appropriate. In my judgment it was not wrong (in the sense I have explained) so to conclude, whether or not Dr Okpara had acknowledged fault (which, in my judgment, he had not). As a specialist Tribunal, it was entitled to conclude that sustained sexually predatory behaviour by Dr Okpara towards a colleague whilst on duty, once in the presence of a patient, and once following deception that he wanted to discuss a patient, was fundamentally incompatible with his continued work as a doctor.

112. Next, Mr Khan said that the Tribunal had not, or not sufficiently, taken into account the public interest and matters of personal mitigation, such as the fact that Dr Okpara some personal difficulties at the time and was the sole breadwinner. The Tribunal did refer to these matters at [32]-[33] but gave them little weight in light of the seriousness of the proven misconduct. Weight was a matter for the Tribunal and I cannot say that its decision was wrong.

113. Mr Khan also said that the Tribunal wrongly discounted the testimonials put forward by Dr Okpara, including because they were not on headed notepaper. However, I accept the submissions of Ms Hearnden for the GMC on this point. At [48] of her Skeleton Argument she pointed out that the GMC wrote to Dr Okpara in July 2017 informing him of his right to present testimonial evidence and that the Tribunal was more likely to place weight on testimonial evidence which it had verified. The letter went on to state that the GMC could only verify testimonials if sent at least eight weeks before the hearing. Contrary to the Guidance and the instructions in the correspondence, Dr Okpara's testimonials were not submitted at least eight weeks prior to the Tribunal hearing and were not verified by the GMC. In the circumstances, the Tribunal was entitled to attach little weight to then. In any event, in my judgment, given the very serious nature of Dr Okpara's misconduct, the testimonials were not capable of requiring the Tribunal to suspend Dr Okpara rather than ordering erasure.

114. None of the other forensic points made by Mr Khan is capable of showing that the Tribunal's decision was wrong.

115. Ground 3 therefore fails.

Conclusion

116. For these reasons, this appeal is dismissed. As I noted at the conclusion of the hearing, I am grateful to both counsel for the quality of their written and oral submissions.