Neutral Citation Number: [2020] EWHC 1974 (Admin)

Case Nos: CO/5041/2019
CO/5047/2019

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

Remotely at
Royal Courts of Justice,
Strand, London WC2A 2LL

Date: 22/07/2020

Before:

MR JUSTICE WARBY

- -

Between:

The Queen on the application of Dr Ashish Dutta	**Claimant/ Appellant**
- and -	
General Medical Council	**Defendant/ Respondent**

- -
- -

James Counsell QC (instructed by **Morris Law Ltd**) for the **Claimant**/**Appellant**
Alexis Hearnden (instructed by **GMC UK**) for the **Defendant/Respondent**

Hearing dates: 10-11 June 2020

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Approved Judgment

Mr Justice Warby:

1. This is the consolidated hearing of two related cases: (1) a judicial review claim ("the Claim") by Dr Ashish Dutta ("Dr Dutta") against the General Medical Council ("GMC") in respect of a decision of August 2016, to refer certain allegations for investigation; and (2) an appeal by Dr Dutta ("the Appeal") against a decision to suspend him from practice made by a Medical Practitioners Tribunal ("Tribunal") after a hearing in 2019. The GMC is the respondent to the Appeal.

I. The background

2. Dr Dutta trained and qualified as a cosmetic surgeon. At the relevant times he was practising as such, and he still is practising, at clinics in Newcastle, Sunderland and London.

3. This case arises from allegations that Dr Dutta was guilty of misconduct in his professional dealings with four patients, between 2009 and 2015. On 11 April 2009, he performed a breast augmentation operation on a woman referred to as "Patient A" ("the Augmentation Operation"). There was a follow up scan in August 2010. Patient A was then referred to another surgeon, "Dr B", who carried out two further operations on her. In 2014, Patient A complained to Dr Dutta about Dr B, alleging that he had indecently assaulted her. In 2015, Dr Dutta performed a series of seven procedures on "Patient C", two gynaecomastia procedures on "Patient D", and one operation on "Patient E".

4. The GMC is a body corporate on which Parliament has conferred regulatory functions in respect of medical practitioners, with the over-arching objective of protecting the public. Its functions and powers are defined and governed, so far as relevant, by the Medical Act 1983 ("the Act") sections 1 and 35C, and by the General Medical Council (Fitness to Practise) Rules Order of Council 2004 ("the Rules").

5. The scheme created by the Act and the Rules, so far as relevant to this case, can be shortly summarised.

    (1) If an allegation is made to the GMC that a registered practitioner's fitness is impaired by reason of misconduct it is investigated. The process is governed by Part 2 of the Rules.

    (2) The initial stage is consideration by the Registrar, who determines whether the allegation is one of misconduct within the meaning of s 35C(2) of the Act. In order to make that determination, the Registrar may carry out investigations. If the Registrar considers that the allegation does fall within s 35C(2) then, subject to some exceptions, the allegation must be referred for investigation. The exception relevant to this case is a time-bar, commonly known as the "5-year rule", contained in Rule 4(5).

    (3) If an allegation is referred, the Registrar must write to the practitioner, giving notice of the allegation and giving him an opportunity to respond.

    (4) The allegation is then considered by Case Examiners. They may refer the case to the GMC's Medical Practitioners Tribunal Service ("MPTS"), or to the GMC's

Investigation Committee, which may itself refer the allegation to the MPTS. The MPTS then puts the matter before a Tribunal.

(5) The procedure before the Tribunal is governed by Part 4 of the Rules. The standard of proof is the ordinary civil standard.

6. Key features of the pre-Tribunal procedure followed in this case, so far as relevant, are these:

(1) In September 2014, there was a conversation between a police officer and a GMC official ("the 2014 Conversation"). The police had spoken to Patient A in the context of an investigation into the conduct of Dr B. They told the GMC of some things that Patient A had said about Dr Dutta.

(2) In November 2015, the GMC opened an internal investigation into Dr Dutta's fitness to practise. This followed a referral from an inspector of the Care Quality Commission ("CQC"), which reported concerns about Dr Dutta's conduct towards and/or record-keeping in respect of Patients C, D and E.

(3) On 16 November 2015, Patient A made a witness statement ("the 2015 Statement"). This was in connection with a Fitness to Practise process relating to Dr B, but the statement made reference to Dr Dutta. He was not accused of any improper assault, but the patient made a number of allegations about Dr Dutta's qualifications, his medical treatment of Patient A, and his response to her complaints about the behaviour of Dr B.

(4) Some of these allegations related to events in 2009 ("the 2009 Allegations"). In summary, they were a failure to provide appropriate advice prior to the Augmentation Operation; offering a financial incentive to have that operation swiftly; mishandling the operation; and then telling her there was nothing wrong. There was also an allegation ("the 2010 Allegation") that, when the 2010 Scan was carried out, Dr Dutta falsely reported that it showed nothing wrong, even though the radiologist told her that both breasts were full of infected fluids and the implants needed immediate removal.

(5) In June 2016, an internal triage request was made, to enable the GMC to consider Patient A's allegations about Dr Dutta. The request was evidently granted.

(6) On 18 August 2016, an Assistant Registrar of the GMC ("AR"), acting under delegated powers, reviewed allegations about Dr Dutta's conduct in respect of Patients A, C, D and E, and made a decision under Rule 4 on whether to refer all or any of them for investigation. The decision ("the Referral Decision") was to refer all but one of them. In the process, a decision had to be made as to whether the 5-year rule applied to the 2009 Allegations ("the Five-Year Decision"). Having taken legal advice, the AR proceeded on the footing that the 5-year rule was not engaged. As will be seen, this was essentially on the basis that the 2010 Scan was part of the same course of treatment as the Augmentation Operation, and the 2014 Conversation was within 5 years of that.

(7) On 24 November 2016, Dr Dutta was notified of the Referral Decision, and sent a copy of the 2015 Statement. Dr Dutta was not told of the 2014 Conversation, nor

of the Five-Year Decision. The Rules do not require the Registrar to notify the practitioner of such a decision, unless it is to the effect that the 5-year rule does apply, so that allegations should not go forward for investigation. An investigation ensued.

(8) On 8 February 2019, the Case Examiners completed a report setting out their reasons for deciding to refer Dr Dutta's case to the MPTS. The Case Examiners referred the 2009 Allegations. But they did not refer the 2010 Allegation. They had consulted an expert. He had examined the ultrasound report from the 2010 Scan, which provided no support for that allegation. The expert described Dr Dutta's care at that stage as "adequate and appropriate".

(9) On 15 February 2019, Dr Dutta was told of the Case Examiners' decision. This was done by letter which enclosed the Case Examiners' report and an Annex A, setting out 23 allegations of misconduct. The case that was, in due course, put before the Tribunal was in substantially the same terms as Annex A. Dr Dutta was not told at this stage about the Five-Year Decision or the 2014 Conversation.

(10) On 12 September 2019, after his solicitors had made enquiries, Dr Dutta was told about the Five-Year Decision and the 2014 Conversation. The written decision itself was disclosed on Wednesday 23 October 2019. That was 2 working days before the Tribunal hearing was due to start.

(11) Dr Dutta threatened to apply to the Tribunal to strike out the 2009 Allegations on the grounds of a breach of Rule 4(5). The GMC responded by pointing to the decision of this Court in *R (Lee) v General Medical Council* [2015] EWHC 135 (Admin) [2016] 4 WLR 34 (Haddon-Cave J), that only the Registrar has jurisdiction to make a decision on the 5-year rule. Dr Dutta's legal team did not pursue the application to strike out, nor did they apply to adjourn to enable them to challenge the Five-Year Decision by way of judicial review.

7. The hearing before the Tribunal occupied 17 days between 28 October 2019 and 20 November 2019. It is convenient to refer to the 23 allegations as "charges". In summary:-

(1) Eight of the charges related to Patient A. Charges 1 to 6 reflected the 2009 Allegations. Charges 7 and 8 related to events on and after 14 July 2014.

(2) Eight charges (nos. 9-16) related to the procedures carried out on Patient C, and the alleged failures of recording in respect of those procedures.

(3) Two charges (nos. 17 & 18) related to Patient D, consisting of failures to make records in respect of the two procedures of 2015.

(4) Four charges (nos. 19-22) related to Patient E.

(5) One charge (no. 23) alleged that Dr Dutta carried out the procedures on Patients C, D and E in a room which was inadequate in various respects.

8. By the end of the factual stage of the proceedings, the ambit of the dispute had reduced. Dr Dutta had made admissions in relation to some of the allegations, some

had been withdrawn, and others were dismissed after a successful submission of no case to answer. The matters that remained for decision were, in summary:-

(1) Whether, in 2009, Dr Dutta:

a. inappropriately pressurised Patient A to undergo breast augmentation surgery by offering her a discount, for financial motives [**Charges 1(a) and 2**] ("the Discount Charges");

b. failed to obtain adequate informed consent to the surgery [**Charge 3(a)**]; and

c. falsely told Patient A that he would not be using PIP implants during the surgery, or words to that effect [**Charges 3(b), 4 and 5**].

(2) Whether, in 2014, Dr Dutta:

a. failed to refer Patient A to a surgeon other than Dr B, having been told that she did not trust Dr B and that he had touched her in various inappropriate ways [**Charge 7**]; and

b. failed to take appropriate action in relation to Dr B's reported behaviour, by using inappropriate language to Patient A, speaking to another individual on the phone and laughing about the matter [**Charges 8(a) to (c)**], and failing to report Dr B for investigation [**Charge 8(d)**].

(3) Whether, in 2015, Dr Dutta failed to obtain and record adequate consent and maintain adequate records of the treatment of Patients C, D and E as set out in the allegations (**various).**

9. In its Determination on the Facts (Stage 1), dated 13 November 2019, the Tribunal found that, in relation to Patient A, the GMC had proved the Discount Charges: **Charges 1(a) and 2)**, and **Charges 3(a),** and **8(a) to (c)**. In relation to Patients C, D and E, the Tribunal upheld charges of failing to obtain adequate informed consent: **Charges 11(b), 12(b) and 13(b)**. The other charges that remained for decision were found not proved.

10. The Tribunal went on to hold, in a Determination on Impairment (Stage 2), dated 18 November 2019, that by reason of those facts, and those he had previously admitted, Dr Dutta's fitness to practise was impaired. In a Determination on Sanction (Stage 3) dated 20 November 2019, the Tribunal imposed a suspension of Dr Dutta's registration under s 35D of the Act, for a period of 9 months. That sanction is itself suspended pending the outcome of this hearing.

II. These proceedings

11. On 23 December 2019, Dr Dutta issued proceedings in the Claim. The Claim alleges that the Five-Year Decision was wrong, so that the Referral Decision was wrong, in so far as it relates to the 2009 Allegations. The GMC maintains that the Claim lacks arguable merit, and in any event – as is common ground – it is brought out of time. A judicial review claim must of course be brought promptly and in any event within three months of the decision complained of.

12. On 12 March 2020, Dr Dutta made an application for an extension of time for bringing the Claim, relying on CPR 3.1(2)(a) ("the Extension Application"). The issues for determination in the Claim are whether the Extension Application should be granted; if so, whether the application for permission ("the Permission Application") should be granted; and if so, whether the Claim should be upheld to any extent.

13. On 23 December 2019, the same day that he issued the judicial review Claim Form, Dr Dutta filed an Appellant's Notice against the Tribunal's direction for suspension. His grounds of appeal contend that the Determination on the Facts was wrong, and so (consequentially) were the Determination on Impairment and the Determination on Sanction. Dr Dutta challenges all the findings against him in the Determination on the Facts, save those which reflect admissions by him.

14. By Order dated 7 May 2020, HHJ Saffman gave directions for this hearing: a rolled-up hearing of the Permission Application (including the Extension Application) and, if permission is granted, the Claim, consolidated with the hearing of the Appeal.

15. Judge Saffman directed a remote hearing so that, although the proceedings were in formal terms in Leeds, I heard them from Court 13 at the Royal Courts of Justice, and Counsel both attended via video conference. I am very grateful to Counsel for the clarity and high quality of their arguments, which I heard over the best part of two days.

III. Conclusions

16. For the reasons that follow, my conclusions are these:

    (1) The Tribunal erred in finding the Discount Charges proved: those findings are procedurally flawed and untenable. The Appeal succeeds to that extent. Dr Dutta has not established that, applying the appropriate standard of appellate review, the Court should interfere with any of the Tribunal's other findings.

    (2) But none of the 2009 Allegations should have been before the Tribunal. It is just to grant the Extension Application. The Permission Application is granted. Upon review, Dr Dutta's case is upheld: the Five-Year Decision was unlawful and so was the Referral Decision, insofar as it relates to the 2009 Allegations.

17. I shall hear Counsel on the form of order that should follow from these conclusions. It would appear, however, that they must lead to the quashing of the AR's decision to refer the 2009 Allegations as well as the Determination on Impairment and the Determination on Sanction, both of which were based in substantial part on the 2009 Charges. Fresh decisions on impairment and – if it arises - sanction will have to be made, by reference to the other charges found proved. There may be additional or alternative options.

IV. The Appeal

The nature of the appeal

18. The appeal is brought pursuant to s 40 of the Act, which provides for a right of appeal against (among other things) a direction for suspension. Such an appeal is by way of

re-hearing: PD52D paragraph 19 (displacing the general rule in CPR 52.21(1) that "every appeal will be limited to a review of the decision of the lower court"). The Court can allow an appeal where the Tribunal's decision was "(a) wrong; or (b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court": r 52.21(3).

19. The right approach to appeals under s 40 has been considered in a number of authorities. I have been referred by the GMC to the following, all being appeals concerning decisions of the GMC: *Gupta* [2001] UKPC 61 [2002] 1 WLR 1691 [10] (Lord Rodger), *Raschid* [2007] EWCA Civ 46 [2007] 1 WLR 1460 [18-20] (Laws LJ), *Yassin* [2015] EWHC 2955 (Admin) [32] (Cranston J), and *Bawa-Garba* [2018] EWCA Civ 1879 [60-67], [94]. Both Counsel cite *Southall* [2010] EWCA Civ 407 [47]. Mr Counsell QC relies on *Casey* [2011] NIQB 95 [6] (Girvan LJ). Another case of some importance, that is cited within those referred to by Counsel, is *Meadow* [2006] EWCA Civ 1390 [2007] QB 462.

20. It is unnecessary to rehearse all the passages relied on. Not all of them seem to me to be helpful, or even relevant to the task before me in this case. A number of the passages cited emphasise the importance of deferring to the professional expertise and judgment of the Tribunal on whether the practitioner's failings amount to serious professional misconduct, and what sanction is called for in order to provide adequate protection to the public: see, for instance, *Raschid* [18-19], *Yassin* [32 (ii), (ix)], *Bawa-Garba* passim.. Those are well-established aspects of the jurisprudence, but they have no bearing on the issues for my decision. This is a challenge to the Tribunal's fact-finding processes at Stage 1. A specialist Tribunal may of course have specialist expertise that is relevant at that stage, but this is not such a case. If the Court finds that the Tribunal went wrong at the first stage, it should quash the conclusions at all three Stages, unless persuaded that the error would have made no difference to the outcome. That, as Ms Hearnden rightly accepts, is a high threshold, which is not readily satisfied: *R (Smith) v North Eastern Derbyshire Primary Care Trust* [2006] 1 WLR 3315 , 3321.

21. Bearing that in mind, the points of most importance for the purpose of this case can be summarised as follows:

(1) The appeal is not a re-hearing in the sense that the appeal court starts afresh, without regard to what has gone before, or (save in exceptional circumstances) that it re-hears the evidence that was before the Tribunal. "Re-hearing" is an elastic notion, but generally indicates a more intensive process than a review: *E I Dupont de Nemours & Co v S T Dupont (Note)* [2006] 1 WLR 2793 [92-98]. The test is not the "Wednesbury" test.

(2) That said, the appellant has the burden of showing that the Tribunal's decision is wrong or unjust: *Yassin* [32(i)]. The Court will have regard to the decision of the lower court and give it "the weight that it deserves": *Meadow* [128] (Auld LJ, citing *Dupont* [96] (May LJ)).

(3) A court asked to interfere with findings of fact made by a lower court or Tribunal may only do so in limited circumstances. Although this Court has the same documents as the Tribunal, the oral evidence is before this Court in the form of transcripts, rather than live evidence. The appeal Court must bear in mind the

advantages which the Tribunal has of hearing and seeing the witnesses, and should be slow to interfere. See *Gupta* [10], *Casey* [6(a)], *Yassin* [32(iii)].

(4) Where there is no question of a misdirection, an appellate court should not come to a different conclusion from the tribunal of fact unless it is satisfied that any advantage enjoyed by the lower court or tribunal by reason of seeing and hearing the witnesses could not be sufficient to explain or justify its conclusions: *Casey* [6(a)].

(5) In this context, 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: *Yassin* [32(v)].

(6) The appeal Court should only draw an inference which differs from that of the Tribunal, or interfere with a finding of secondary fact, if there are objective grounds to justify this: *Yassin* [32(vii)].

(7) But the appeal Court will not defer to the judgment of the tribunal of fact more than is warranted by the circumstances; it may be satisfied that the tribunal has not taken proper advantage of the benefits it has, either because reasons given are not satisfactory, or because it unmistakably so appears from the evidence: *Casey* [6(a)] and cases there cited, which include *Raschid* and *Gupta* (above) and *Meadow* [125-126], [197] (Auld LJ). Another way of putting the matter is that the appeal Court may interfere if the finding of fact is "so out of tune with the evidence properly read as to be unreasonable": *Casey* [6(c)], citing *Southall* [47] (Leveson LJ).

22. Ms Hearnden places heavy reliance on another passage from *Southall* [47], where Leveson LJ observed that

> "… it is very well established that findings of primary fact, particularly if founded upon an assessment of the credibility of witnesses, are virtually unassailable."

However, it is clear from paragraph [47] read as a whole, that this sentence does not purport to represent a distinct principle, imposing a more exacting test than those I have identified. Rather, it is intended to be a distillation of the jurisprudence I have summarised. *Southall* [47] also shows that the passage I have quoted from *Casey* [6(c)] reflects high authority. It is a variation of words used by Lord Hailsham, sitting in in the Privy Council, in *Libman v General Medical Council* [1972] AC 217, 221F.

<u>*The grounds of appeal*</u>

23. These can be summarised as follows:

(1) The Tribunal's conclusion that the Discount Charges were made out was procedurally flawed and/or wrong, because the Tribunal made errors of principle in its approach, reached findings of fact that were not open to it as a matter of principle, and (in any event) the only conclusion that any reasonable Tribunal could have reached on the evidence was that Patient A's recollection, that she was

offered a discount if she agreed to undergo the procedure the following week, was wrong.

(2) The Tribunal's findings that Charges 3(a), 11(b), 12(b) and 13(b) ("the Consent Charges") were made out was contrary to the evidence, irrational and/or plainly wrong.

(3) Further and alternatively, the Tribunal's approach to the Discount Charges is so fundamentally flawed as to taint all its other findings of fact against Dr Dutta. For that reason, and for a number of supplemental reasons relating to Charges 3(a) and 8, all those other findings are unsafe and should be quashed.

Assessment

The Discount Charges

24. These were as follows:-

1 **In March 2009, during a consultation, you inappropriately pressurised Patient A to undergo breast augmentation surgery ('the surgery') in that you:**

(a) offered a discount of £600 if Patient A agreed to undergo the surgery the following week.

2 **Your conduct as set out at paragraph 1(a) … above was financially motivated.**

25. In support of the Discount Charges, the GMC relied on the evidence of Patient A. In her witness statement, she said that when she went to see Dr Dutta in March 2009, he "said that if I agreed to have the surgery the following week he would be able to give me a £600 discount as he was already operating on someone else that week and I wouldn't have to pay theatre fees if I had the operation on the same day as them. I agreed to have the operation the following week". Her account was that he made the offer on the stairwell of the clinic. She said that, looking back, she realised that she had been pressurised into agreeing and felt he had done a "hard sell" on her. There was then a pre-op clinic on 2 April 2009. She transferred the money for the operation to the clinic that day. The operation was then scheduled to take place on 4 April but, the day after the pre-op, she was telephoned by the receptionist to be told that the operation had had to be moved. It was then "rescheduled for 11 April 2009", which is when it took place. This was, she told the Panel, within "a couple of weeks" of the stairwell discount offer. On this account, therefore, that offer must have been made in late March 2009. Her oral evidence was that it was in the middle or at the end of March, "a couple of weeks before the operation".

26. In his statement Dr Dutta, having consulted his records from 10 years earlier, said that Patient A had been considering breast augmentation for some time. On an occasion in the latter months of 2008, when she was coming in for injectable treatments, he had outlined the costs to the patient and arranged to see her again to discuss the matter

further, allowing a cooling off period. He next saw her on 5 March 2009. They had a discussion about the operation before arranging the pre-op consultation for 2 April, and the operation six weeks after 5 March. She was quoted the standard price and paid a deposit of £500. He did not pressurise Patient A into agreeing to the operation only a week after it was first discussed, or offer her a discount for that purpose. An appointment the following week could not have been arranged. He did not see her again until the pre-op consultation on 2 April. In due course, she paid the standard price.

27. There was documentary evidence on which Dr Dutta relied in support of his account. In particular:-

(1) There was an appointment print-out, listing dates on which Patient A attended the practice, the duration of the appointment, and in most instances the reason for her attendance. The print-out included a 30-minute appointment on 5 March 2009 for "treatment", a 15-minute appointment on 2 April 2009 for unspecified reasons, and an appointment on 11 April 2009 when, by common consent, the Augmentation Operation took place. The print-out did not include any late March visit.

(2) There was a printed booking form for 5 March 2009, filled out in manuscript, with extensive annotations. In two places it recorded that Dr Dutta had quoted £3,000 in total for breast augmentation. It said that £500 had been "paid on 5/3/09" and that a receipt for that sum had been provided in person on the same date. These entries were signed by "LINDA". The form dealt with the booking process for the procedure, recording "emailed Hugh 5/3/09". It set out the Schedule of treatment as "Pre-op Thursday 2nd April '09 at 1:30pm" and "Date of procedure Saturday 11th April '09 at 11:00". There was also a manuscript annotation against "Balance due" which was evidently filled in later, stating "2,500 paid 03/04/09".

(3) There was an email timed at 15:54 on 5 March 2009 from Linda at the clinic to Hugh McDonald at the hospital ("Dear Hugh"), setting out "details of new bookings", including that for Patient A. It requested theatre time at 11am on 11 April 2009, and asked for confirmation.

(4) There was an email in reply from Mr McDonald (the Anaesthetic Co-ordinator) at 15:57pm the same day, confirming all the bookings by stating "This will be fine".

(5) There was a letter from Dr Dutta dated 11 March 2009, confirming receipt of the £500 deposit, the date and time of the procedure, and the follow up review appointments thereafter.

28. Patient A was cross-examined by reference to these documents. Her response was to dismiss them as fabrications. She told Counsel "I think these aren't correct. I think these have all just been mocked up". When Counsel then queried this, the witness disputed what she had just said:-

> "Q. Your explanation for how it is that your recollection differs from all these documents is that these are mock-ups?
>
> A: No, I didn't say that. You said that."

It was not the GMC's case that any of the documents had been fabricated or tampered with. Counsel confirmed as much to the Chair. The authenticity of these records was not in dispute between the parties. This was not the only occasion on which Patient A suggested forgery or falsification of the records. Later, Counsel questioned her account of what had been said when her breasts were scanned, suggesting it was inconsistent with the contemporary records. The witness said "That is the truth and I don't believe these documents. I think they have been falsified".

29. There was evidence from Dr Dutta's wife, Wendy, a Registered Nurse who was the Practice Manager at the clinic, that she could "categorically state" that it was not the case that any discount had been offered. Her reasoning was that the practice never offered discounts to secure earlier surgery, and the booking process with the hospital required 2 weeks' notice. She also gave evidence that she had been present on 5 March 2009, and witnessed no discount being offered.

30. It is necessary to set out the relevant section of the Tribunal's reasoning in full. I have emphasised some passages of particular importance.

> "[29] The Tribunal noted that *neither party sought to challenge Patient A's credibility*. It is also noted that she made some concessions during her oral evidence, which enhanced her credibility.
>
> [30] Dr Dutta argued that her account that she was offered a discount if she were to have the procedure the next week cannot be correct as the initial consultation took place on 5th March 2009, yet the procedure was not undertaken until 11th April 2009, and therefore not the following week. He relies upon the documentation within her medical records to rebut her account. He also argued that the practice of the clinic was to offer a fixed price and not to offer discounts.
>
> [31] However, the Tribunal noted that whilst weight could be assigned to the documentation, it is not determinative. The Tribunal noted the record of Patient A's appointments with Dr Dutta, including a 30-minute appointment on 5th March 2009, commencing at 1:30pm. It also noted the email from Dr Dutta to Mr. McDonald at the hospital in which the procedure was to be undertaken, dated 5th March 2009 and sent at 3:54pm, detailing that the date of the procedure was to be 11th April 2009. A questionnaire completed by Dr Dutta after his consultation with Patient A was completed after the email as it details that Mr. McDonald had been emailed. *As such, the documentation does not preclude that between 1:30pm and 2pm Dr Dutta offered the discount to Patient A, but between then and the sending of the e-mail, it had become clear that the procedure could not be undertaken so soon.*
>
> [32] The Tribunal took into account Ms. Dutta's evidence that during the consultation she did not witness any discount being offered, however, it bore in mind Patient A's

> evidence that the offer had been communicated in the stairwell and not the consultation room.
>
> [33] *The Tribunal assessed that Patient A's account of Dr Dutta offering her a discount was emphatic and assured,* and that whilst it may be expected that recollections of events could be inaccurate and have evolved over time, it is *less likely that an event would be contrived in its entirety as a result of the passage of time*.
>
> [34] The *rationale which Patient A claimed Dr Dutta stated at the time, namely savings on hospital theatre booking fees, aligned with the process and cost components of such arrangements as he described in his oral evidence*. The Tribunal deemed it *unlikely that Patient A would have had such an understanding* of this process and associated cost structure had she not been provided this information by Dr Dutta.
>
> [35] The Tribunal noted that Dr Dutta stated in his oral evidence that he had previously offered Patient A discounts for fillers if undertaking a botox procedure. Further, the Tribunal noted that documentation within the bundle concerning Patient C in which it was stated that Dr Dutta had offered a discount, albeit in different circumstances and whilst working for NU Clinic.
>
> [36] The Tribunal also noted *the aforementioned questionnaire* completed on the day of Dr Dutta's consultation with Patient A on 5th March 2009, in which it *states that she had been given a quote by Dr Dutta. This supports her assertion that the price was discussed.* Patient A paid the deposit for the procedure on the date of the consultation and this indicates that a procedure and price were arranged with immediate effect."

31. There are several strands to this reasoning, but in my judgment Ms Hearnden has fairly encapsulated the essence of it in her submissions. Paragraph [29] meant the witness was not being accused of lying. Paragraph [30] is recitation of Mr Counsell's submissions, in which he relied on the contemporaneous documents. Paragraph [31] was the Tribunal's response. As Ms Hearnden put it: what they are doing here is saying "We have Patient A's account. We believe her. Do the documents show that she must be wrong? No. The documents cannot be a complete answer". The remaining paragraphs comprise supplemental reasoning and analysis. Paragraph [33] is a clear statement that the Tribunal believed Patient A's account. Paragraphs [34] to [36] identify aspects of the evidence that are said to be consistent with aspects of the patient's account, and make the point that it is unlikely she would have invented it.

32. Ms Hearnden submits that, taken overall, this is a legitimate and unexceptionable approach. Unduly semantic analysis should be avoided. In substance, the Tribunal were saying that the documents relied on by Mr Dutta are "not enough to unseat their confidence in the evidence given by Patient A on this point". Putting it another way, Ms Hearnden says that the crux of the Tribunal's reasoning was that "they believed

her", and then went on to look at whether her account chimed with other things they knew.

33. That analysis was offered by way of response to the central criticisms of Mr Counsell. In my judgment, it falls well short of providing an adequate answer to those criticisms. I have well in mind the high threshold to be crossed when it comes to a finding of fact, but I find myself compelled to accept Mr Counsell's critique, and to reject the Tribunal's approach as wrong in principle and untenable, for a number/host of reasons.

34. First, Mr Counsell is right, in my opinion, to submit that it was not open to the Tribunal as a matter of procedural fairness to reach the factual conclusions it did. In substance, the Tribunal found the Charges proved on the footing that the alleged discount offer was or might have been made to Patient A by Dr Dutta between 1:30pm and 2pm on 5 March 2009 but not fulfilled because, at some unspecified time during the 2 hours or so between then and 3:54pm (when the practice emailed the hospital) it had, in some unspecified manner and for some unspecified reason, "become clear" that the procedure could not be undertaken within a week. That is the effect of paragraph [31] of the Determination. As the GMC accepted at the hearing before me, the first time the parties became aware of this version of events was when they saw the Determination.

35. It was not an interpretation of events that had ever been put forward by the GMC. One important reason for that, no doubt, is that this was not the evidence of Patient A. Indeed, this version of events was at odds with several aspects of her account. I shall come to that. In any event, this is not a version of events that had ever been put to Dr Dutta by the GMC for comment or response. A tribunal of fact in proceedings of this kind is not wholly constrained by the way the parties put their cases. It is entitled to test other hypotheses, and to form its own view. Sometimes, when preparing a judgment, a point of fact or law that has not been fully explored may occur to the tribunal. In these circumstances, if the point is one of moment, the usual and proper course is to refer the matter back to the parties. It is not fair to find against a party on a factual point of substance without giving that party a reasonable opportunity to address the point beforehand.

36. This was a novel suggestion that had no direct support in any of the oral or documentary evidence, and was not easy to reconcile with either. It was a new case theory that, in principle, might have been supported or undermined by additional documentary evidence. Fairness required that before reaching a conclusion on such a theory it should be disclosed to Dr Dutta and his legal team, and that they should be given a reasonable opportunity to understand it, investigate it evidentially, call such evidence as they might, and make submissions about it. The GMC also ought to have been made aware that the Tribunal was considering a finding to this effect. It might have had something to say, evidentially or by way of submission.

37. Mr Counsell has identified the hospital records as a possible source of documentary evidence as to whether the booking was ever rearranged. I cannot tell whether there was or would have been any such evidence. But nor can it be said that the deprivation of the opportunity to investigate or, at the minimum, make submissions, is inconsequential. Ms Hearnden has not made that argument.

38. In any event, I regret to say, in my judgment the Tribunal's reasoning process is vitiated by at least three fundamental errors of approach. First, the Tribunal approached the resolution of the central factual dispute by starting with an assessment of the credibility of a witness's uncorroborated evidence about events ten years earlier, only then going on to consider the significance of unchallenged contemporary documents. Secondly, the Tribunal's assessment of the witness's credibility was based largely if not exclusively on her demeanour when giving evidence. Thirdly, the way the Tribunal tested the witness evidence against the documents involved a mistaken approach to the burden of proof and the standard of proof.

39. There is now a considerable body of authority setting out the lessons of experience and of science in relation to the judicial determination of facts. Recent first instance authorities include *Gestmin SGPS SA v Credit Suisse (UK) Ltd* [2013] EWHC 3650 (Comm) (Leggatt J, as he then was) and two decisions of Mostyn J: *Lachaux v Lachaux* [2017] EWHC 385 (Fam) [2017] 4 WLR 57 and *Carmarthenshire County Council v Y* [2017] EWFC 36 [2017] 4 WLR 136. Key aspects of this learning were distilled by Stewart J in *Kimathi v Foreign and Commonwealth Office* [2018] EWHC 2066 (QB) [96]:

> "i) *Gestmin*:
>
> - We believe memories to be more faithful than they are. Two common errors are to suppose (1) that the stronger and more vivid the recollection, the more likely it is to be accurate; (2) *the more confident another person is in their recollection, the more likely it is to be accurate.*
>
> - Memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is even true of "flash bulb" memories (a misleading term), i.e. memories of experiencing or learning of a particularly shocking or traumatic event.
>
> - *Events can come to be recalled as memories which did not happen at all or which happened to somebody else.*
>
> - The process of civil litigation itself subjects the memories of witnesses to powerful biases.
>
> - Considerable interference with memory is introduced in civil litigation by the procedure of preparing for trial. Statements are often taken a long time after relevant events and drafted by a lawyer who is conscious of the significance for the issues in the case of what the witness does or does not say.
>
> - *The best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable facts. "This does not mean that oral testimony serves no useful purpose… But its value lies largely… in the opportunity which cross-*

examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. *Above all, it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth".*

ii) *Lachaux*:

- Mostyn J cited extensively from *Gestmin* and referred to two passages in earlier authorities.[45] I extract from those citations, and from Mostyn J's judgment, the following:

- "Witnesses, especially those who are emotional, who think they are morally in the right, tend very easily and unconsciously to conjure up a legal right that did not exist. It is a truism, often used in accident cases, that *with every day that passes the memory becomes fainter and the imagination becomes more active.* For that reason, a witness, however honest, rarely persuades a judge that his present recollection is preferable to that which was taken down in writing immediately after the incident occurred. Therefore, *contemporary documents are always of the utmost importance…*"

- "…I have found it essential in cases of fraud, *when considering the credibility of witnesses, always to test their veracity by reference to the objective fact proved independently of their testimony, in particular by reference to the documents in the case, and also to pay particular regard to their motives and to the overall probabilities…"*

- Mostyn J said of the latter quotation, "these wise words are surely of general application and are not confined to fraud cases… it is certainly often difficult to tell whether a witness is telling the truth and I agree with the view of Bingham J that *the demeanour of a witness is not a reliable pointer to his or her honesty."*

iii) *Carmarthenshire County Council*:

- The general rule is that oral evidence given under cross-examination is the gold standard because it reflects the long-established common law consensus that the best way of assessing the reliability of evidence is by confronting the witness.

- However, oral evidence under cross-examination is far from the be all and end all of forensic proof. Referring to paragraph 22 of *Gestmin*, Mostyn J said: "…*this approach applies equally to all fact-finding exercises, especially where the facts in issue are in the distant past.* This approach does not dilute the importance that the law places on cross-examination as a vital component of due process, but it does place it in its correct context.

[45] The dissenting speech of Lord Pearce in *Onassis and Calogeropoulos v Vergottis* [1968] 2 Lloyd's Rep 403, 431; Robert Goff LJ in *Armagas Ltd v Mundogas SA* [1985] 1 Lloyd's Rep 1, 57."

I have emphasised passages that have particular resonance in this case.

40. This is not all new thinking, as the dates of the cases cited in the footnote make clear. *Armagas v Mundogas*, otherwise known as *The Ocean Frost*, has been routinely cited over the past 35 years. Lord Bingham's paper on "The Judge as Juror" (Chapter 1 of *The Business of Judging*) is also familiar to many. Of the five methods of appraising a witness's evidence, he identified the primary method as analysing the consistency of the evidence with what is agreed or clearly shown by other evidence to have occurred. The witness's demeanour was listed last, and least of all.

41. A recent illustration of these principles at work is the decision of the High Court of Australia in *Pell v The Queen* [2020] HCA 12. That was a criminal case in which, exceptionally, on appeal from a jury trial, the Supreme Court of Victoria viewed video recordings of the evidence given at trial, as well as reading transcripts and visiting the Cathedral where the offences were said to have been committed. Having done so, the Supreme Court assessed the complainant's credibility. As the High Court put it at [47], "their Honours' subjective assessment, that A was a compellingly truthful witness, drove their analysis of the consistency and cogency of his evidence …" The Supreme Court was however divided on the point, and the High Court observed that this "may be thought to underscore the highly subjective nature of demeanour-based judgments": [49]. The High Court allowed the appeal and quashed Cardinal Pell's convictions, on the basis that, assuming the witness's evidence to have been assessed by the jury as "thoroughly credible and reliable", nonetheless the objective facts "required the jury, acting rationally, to have entertained a doubt as to the applicant's guilt": [119].

42. Comparison of the passages from *Kimathi* that I have highlighted at [39] above with the parts of the Tribunal's reasoning that I have highlighted at [30] reveals the following flaws. Instead of starting with the objective facts as shown by authentic contemporaneous documents, independent of the witness, and using oral evidence as a means of subjecting these to "critical scrutiny", the Tribunal took the opposite approach, starting with Patient A's evidence. It is an error of principle to ask "do we believe her?" before considering the documents. Further, the Tribunal's approach to the oral evidence of Patient A involves the second of the two "common errors" identified by Leggatt J in *Gestmin.* Reliance on a witness's confident demeanour is a discredited method of judicial decision-making. Paragraphs [29] and [33] of the Determination provide a clear illustration of the "fallacy" identified by Leggatt J.

These flaws are all the more significant given the antiquity of the events in dispute, which were ten years old at the time of the hearing. As Mostyn J emphasised in the *Carmarthen* case, the older the events, the more important it is to hold fast to these principles of reasoning. The flaws are surprising, as Mr Counsell had expressly referred the Tribunal to the passage from *Kimathi* that I have cited. I would add two points. First, the second emphasised sentence in paragraph [33] does not clearly or sufficiently acknowledge the fluidity of memory, or the fact that an honest witness can construct an entirely false "memory". Secondly, the fallacy that confident evidence from an honest witness is accurate evidence is starkly illustrated by Patient A's insistence that the authentic documents shown to her in cross-examination must have been faked. It is plain that her only basis for saying so was that the documents were at odds with what she was saying. She was seeking to "explain away" the problem in a way that maintained her belief in her own account, a classic symptom of cognitive dissonance.

43. The third error I have mentioned emerges from paragraph [31] of the Determination. When deciding what to make of the apparent mismatch between its impressionistic assessment of Patient A and the contemporaneous documents, the Tribunal's approach was to ask itself whether the documentation was "determinative", and such as to "preclude" the novel case theory which the Tribunal came to adopt. This was, in effect, to require Dr Dutta to establish to the criminal standard a defence to the Charge (and to an amended version of the Charge, which had not been put to him). The Tribunal's task was, however, to assess the evidence in the round and decide whether the GMC had discharged the burden of showing that it was more likely than not that pressure was applied by means of a discount offer, for financial motives, as alleged in **Charges 1(a) and 2**.

44. Mr Counsell has submitted that there are additional problems with the Tribunal's reasoning. He identifies the following as matters omitted from the reasoning process (1) the dangers of accepting uncorroborated testimony about matters that were ten years old (2) the inherent probabilities, bearing in mind that the professional relationship continued for several years before the patient made any complaint about these matters and (3) the Tribunal's conclusions, that other aspects of the evidence of the same witness were not reliable. These may be characterised as allegations of failure to take all relevant factors into account. I am not sure Mr Counsell's first point is separate and distinct from the flaws with which I have dealt already. It is however fair to say that the other two points do not feature in the Tribunal's reasoning. A tribunal of fact need not give comprehensive reasons, addressing every point or argument. Summary reasons are often sufficient in the context of fitness to practise proceedings. But the obligation to give reasons is context-specific, and the fact that no reference was made to the adverse conclusions reached in respect of other aspects of Patient A's testimony lends support to my conclusion that the Tribunal's decision on this issue cannot stand.

45. The most important points in this context are the Tribunal's rejection of other evidence given by Patient A about what happened at the pre-operative assessment, and its reasons for rejecting her evidence. It is by now notorious that one kind of breast implant, known as PIP, has been identified as hazardous to health. On the basis of Patient A's evidence, the GMC alleged that on 2 April 2009 Dr Dutta "falsely told Patient A that you would not be using PIP implants during the surgery, or words to

that effect", knowing that this was untrue, with the consequence that his conduct was dishonest (**Charges 3(b), 4 and 5**). Mr Counsell fairly submits that this was the most serious charge faced by Dr Dutta. It is certainly a very serious set of allegations. The Tribunal found these allegations were not proved, for reasons given in the Stage 1 Determination at paragraphs [52-57].

46. In summary, Patient A's account was that before seeing Dr Dutta she had heard a BBC Radio 4 programme called "Medicine Now" discussing concerns about breast implant ruptures affecting French women. No record of the programme nor any other evidence could be found to support this. The evidence of an expert witness was that he would have known of it, if there had been any such programme. The evidence of the two experts was that "the issues with PIP implants had not been identified in 2009 and that Patient A could therefore not have known about them as stated". The Tribunal found this led to "questions regarding ... her ability to recall accurately the events from so long ago, and in light of all the developments since then". In this context the Tribunal gave "significant weight" to the submission of Mr Counsell that if things had taken place as Patient A maintained, it would have been "almost inconceivable" that she would have continued to see him and use his services for a further 5 years, as she did.

47. This is a distinctly different approach to fact-finding, in which the Tribunal bases its approach on acknowledged facts, and recognises that these point to the probability that the witness had come to believe a falsehood, with the consequence that a serious charge, based on her honest recollection, was unsustainable. The Tribunal should of course have made a rounded assessment of the witness's reliability, rather than approaching each charge in isolation from the others. The fact that its reasons in relation to Charges 1(b) and 2 do not reflect an awareness of their own finding that the witness was not reliable on the related Charges 3 to 5 is, in the circumstances of this case, a matter that further undermines its findings.

48. I do not accept the full weight of Mr Counsell's challenge to the reasoning at [34-36] of the Determination, but I do conclude that it does not assist the GMC. In one respect its procedural fairness is questionable; in another, I doubt that any weight could be attached to it; and in any event, none of the three factors which the Tribunal treated as corroborative or supportive of its conclusions can bear significant weight. Patient A's apparently accurate knowledge of the way hospital booking fees work was said to support the accuracy of her recollection, but could be equally well explained by her long association with Dr Dutta and others, before and after 5 March 2009, in the course of which she had the opportunity to gain considerable experience of procedures. The finding that she had been given this information by Dr Dutta at the meeting of March 2009 was not based on any evidence from her, nor was the proposition put to Dr Dutta. The Tribunal treated Dr Dutta's admission that he offered discounts on botox procedures as probative of Patient A's version of events, without addressing Dr Dutta's evidence (in cross-examination) that he would not give discounts for surgery as it risked "enticing someone to have surgery". The fact that the procedure and price were discussed and arranged with immediate effect was common ground, and surely neutral at best.

49. For these reasons, my conclusion is that the Tribunal's factual determination on Charges 1(a) and 2 cannot stand. Nor do I consider that there is any room for a re-hearing of those charges. Any such hearing would take place 12 years after the event.

The procedural difficulties would be considerable. There would be at least a question as to whether it could be carried out by the same Panel. But in any event, having reflected carefully on the matter, I accept Mr Counsell's submission that the evidence before the Tribunal was not capable of founding a decision that these Charges were made out. It is relevant to note that the Tribunal did not find that anything that had been asserted by the GMC or Patient A had probably taken place. It identified a different version of events, which it considered could not be ruled out. The only reasonable conclusion available, in all the circumstances, and in the light of the unchallenged documents relating to the Augmentation Operation, was that Patient A's recollection that she had been offered a discount to have surgery quickly was not reliable, and the GMC's case was not proven.

50. I doubt that it will be controversial that this conclusion would of itself necessitate the quashing of the Second and Third Stage Determinations, and a direction for re-determination of those stages. But among the reasons for that view is the fact that the Tribunal's decision-making at those stages clearly placed considerable weight on its adverse findings on Charges 1(a) and 2. In paragraph 78 of the impairment Determination it concluded that Dr Dutta

> "… adopted a disingenuous smokescreen in the instant proceedings, particularly when considering his use of documentation to seek to discredit Patient A's assertion of being offered a discount…".

The conduct of a disingenuous defence, and a consequent assessment that the practitioner lacked insight, are plainly matters that are likely to have influenced the conclusions at these latter stages.

The Consent Charges

51. The four charges to which I have given this collective label took different forms. I have used italics to identify some notable features of the wording used.

(1) Charge 3(a) alleged that on 2 April 2009 Dr Dutta consulted with Patient A and

> "… failed to (i) *obtain adequate informed consent* in that *you did not advise Patient A of the risks* of the surgery including [nine specified kinds of risk] …"

The Tribunal found this proved save in respect of one of the nine risks, namely "anaesthetic complications".

(2) Charge 11(b) alleged that on 1 March 2015 Dr Dutta

> "… performed a procedure ("the third procedure") on Patient C. Prior to performing the third procedure you failed to … (b) *obtain adequate consent*, in that *the consent form was blank*."

This was found proved.

(3) Charge 12(b) related to a further procedure performed on Patient C, labelled "the fourth procedure". It was alleged that

> "… Prior to performing the fourth procedure you failed to … (b) *obtain informed consent* from Patient C in that you (i) *obtained it on the day* of the fourth procedure; (ii) *did not record* your full assessment of Patient C's concerns."

Both limbs of the charge were found proved.

(4) Charge 13(b) related to a "fifth procedure" performed on Patient C. It was alleged that

> "… Prior to performing the fifth procedure you failed to … (b) *obtain informed consent* from Patient C in that (i) there was *no signed consent form* (ii) there was *no record* of possible scarring (iii) you *did not record* your discussion of the treatment options."

The Tribunal found that all three limbs of this charge were made out.

52. Mr Counsell directs separate attacks at the Tribunal's reasoning on Charge 3(a), and at its approach to the other three "Consent Charges". I am not persuaded that the Tribunal was wrong on any of these Charges.

Charge 3(a)

53. The Tribunal's reasoning, at [41-47], can be summarised. Dr Dutta and his wife gave evidence that the discussion of risk, and the provision of a leaflet to patients, were standard procedure at the time. However, there were no documents to corroborate this. The signed consent form for the procedure was "otherwise blank"; the sections that should have listed the materials provided to the patient not completed. Nor did Dr Dutta's statement give details of the risks that were or would have been explained. Patient A said otherwise. The leaflet she said she had been given by Dr Dutta was one outlining post-operative care, not potential risks and complications. She had conceded in cross-examination that some risks had been explained, and the corresponding aspects of the charge had been deleted accordingly; but she maintained that she had not had a full explanation. That evidence was accepted, her concessions enhancing her credibility. But the Tribunal found that Dr Dutta, who is not an anaesthetist, was not obliged to explain the risks of anaesthetic complications.

54. Mr Counsell makes four main points. If the Tribunal were wrong to accept Patient A's uncorroborated evidence in support of Charges 1(a) and 2, it must follow that they were wrong to do the same in respect of Charge 3(a), which related to the same Operation. Further, the Tribunal rejected Patient A's evidence in respect of the PIP implant Charges 3(b)-5, which related to a conversation on the same occasion. The same approach should have applied in respect of Charge 3(a). It was wrong to treat Patient A's credibility as enhanced by the concessions she made; these illustrated the unreliability of her witness statement and undermined her credibility rather than enhancing it. The finding that the consent form was "otherwise blank" was simply wrong.

55. I do not consider that my conclusions on Charges 1 and 2 must lead me to quash the Tribunal's conclusions on Charge 3(a). The Tribunal's reasoning process is quite

different, and not open to the same criticisms. Here, it is not a question of accepting oral evidence based on demeanour, even when it is contradicted by documents, let alone a question of finding facts that nobody has asserted to be true. In this context, the key documents are absent. Nor (in contrast to the position in respect of the PIP Charges) was there other agreed or irrefutable evidence showing that a key aspect of Patient A's evidence was clearly or at least probably wrong. The Tribunal's point about credibility is really an aspect of evaluation, which cannot be categorised as central or clearly wrong. And the Tribunal was not wrong to say that there was a consent form which, apart from its signature, was blank. As Mr Counsell points out, there were two consent forms. Each was signed. One had some boxes ticked. The other did not. The point stands: the contemporaneous documents tend to support the view that the written procedures were not scrupulously carried out.

Charges 11(b), 12(b) and 13(b)

56. These charges all related to Patient C, and were advanced on the basis of documentary evidence, or a lack thereof. The Tribunal dealt in some detail with Charge 11(b) and, having found against Dr Dutta on that Charge, made similar points about the other two charges. Mr Counsell's principal attack is on the Tribunal's overall approach, for which purpose it is enough to quote what it said about Charge 11(b):

> "[82] The Tribunal considered the submission made by Mr Counsell QC, that consent is an ongoing process and although the consent form was not completed these matters were adequately discussed with Patient C, who had a similar procedure undertaken by Dr Dutta the prior month.
>
> [83] In reaching its decision on whether Dr Dutta failed to obtain adequate consent for this procedure the Tribunal balanced the evidence of the defence expert witness Mr. Percival that a lack of a signed consent form does not in and of itself prove that there was not adequate consent against paragraph 51 of the GMC guidance on consent which states:
>
>> "You must use the patient's medical records or a consent form to record the key elements of your discussion with the patient. This should include the information you discussed, any specific requests by the patient, any written, visual or audio information given to the patient, and details of any decisions that were made."
>
> [84] The Tribunal determined that the procedure, although similar to one some weeks earlier, was a distinct procedure and therefore required documentation of the consent process, by either details within the patient's medical records or a properly signed consent form.
>
> [85] The Tribunal was not satisfied with Dr Dutta's claim that adequate consent would have taken place but was just not clearly documented, and in the absence of either records or a

> signed consent form to evidence this they found this paragraph of the allegation proved. It also took into account its finding, particularly in relation to paragraph 12b of the allegation, which indicates a pattern of poor compliance with appropriate consent procedures."

57. Mr Counsell submits that the Tribunal reasoned that the fact that the consent form in the records was blank "must mean that adequate consent was not obtained". This was not a conclusion to which it could, or alternatively should, have come. The propositions that consent was a continuing process, and that failure to have the patient sign the form – although a serious failure in itself – did not necessarily indicate that the consent process had not been adequately completed were not just defence submissions. That was the agreed expert evidence. The Tribunal's attempt to "balance" this point against the GMC Guidance was misconceived, as they were not in conflict with one another. There was no evidence from Patient C. In the circumstances, it was not legitimate to reject Dr Dutta's evidence that informed consent was obtained; to do so was a reversal of the onus of proof.

58. The GMC's case remains as it was before the Tribunal: the gaps and flaws in the written records undermined Dr Dutta's case that on each occasion a patient came in there was a discussion about what was to happen for the next operation, and the patient would receive the necessary documents. The mere fact that a record is blank is not definitive proof that a conversation did not take place. But, the GMC submits, the Tribunal was entitled to reject Dr Dutta's assertion that he did acquire proper informed consent. In the absence of records or a signed consent form, and in the context of a pattern of poor compliance with appropriate consent procedures, it was entitled to infer the absence of informed consent. This is a matter on which the Court should show deference to the Tribunal.

59. Broadly, I accept the GMC's submissions. I have had misgivings about the formulation of these three Charges, which I consider to be imperfect. All three incorporate the proposition that Dr Dutta failed to obtain consent "in that" a record of his doing so was lacking. As everyone acknowledges, there is a real difference between failing to obtain informed consent and failing to record it; the former does not follow from the latter. This drafting flaw is most clearly apparent in Charge 11(b), which explicitly asserts, as the only particular of a failure to "obtain adequate consent", that "the consent form was blank". There is also an inconsistency, which I have failed to understand, in the description of the consent which Dr Dutta failed to obtain. In Charge 11(b), it is "adequate consent"; in Charges 12(b) and 12(c) it is "informed consent". Charge 3(a) spoke of "adequate informed consent". I cannot help feeling that charges could be formulated with greater precision and consistency.

60. I have, however, been persuaded by Ms Hearnden that these shortcomings are not fatal. In each instance the charge alleges, and the Tribunal found, that Dr Dutta not only failed to record the consent referred to, he also failed to obtain it. That is how the case was contested before the Tribunal. Paragraph [83] of the Determination expressly refers to the Tribunal's "decision on whether Dr Dutta failed to obtain adequate consent". In relation to Charge 12(b), there is an explicit finding that Dr Dutta "had not obtained informed consent" (paragraph [90]) and, in respect of Charge 13(b), the Tribunal found "a failure to obtain adequate, informed consent" ([94]).

61. The Tribunal's reasoning in the paragraphs I have cited is concise. It could perhaps have been a little clearer, but that is not a sufficient ground of appeal. I do not consider Mr Counsell's strictures to be well-founded. The Tribunal focussed on the question of whether consent was obtained. It did not reason that the deficiencies of the documentation meant that there "must have been" a failure to obtain consent. The standard of proof, as I have mentioned, is the balance of probabilities and, in this context, I see no reason to doubt that the Tribunal followed the guidance of its legally qualified member on that point. Paragraph 51 of the GMC guidance contained an emphatic mandatory requirement to record "the key elements of your discussion". Against that background, and in all the circumstances, the Tribunal was entitled to treat proof that a record was lacking as enough to create an evidential presumption, or *prima facie* case, that consent had not been obtained. It was entitled to assess Dr Dutta's evidence, which was in general terms, and to conclude that he had failed to rebut that evidential presumption.

62. Mr Counsell has a distinct submission in relation to what the Tribunal said in its paragraph [87-89], when dealing with Charge 12(b). The Tribunal relied on a contemporaneous operation report, finding that it showed that Patient C did not know what procedure was being undertaken. Adequate and informed consent cannot have been obtained if that was the position. Mr Counsell submits that this is a misreading of the document in question, which (he says) recorded a conversation about a forthcoming procedure, not the operation which the patient was undergoing at the time. I see the force of this, but it is essentially the same argument that Dr Dutta advanced to the Tribunal and which it rejected. The Tribunal's reasons were that the wording of the document and surrounding circumstances weighed against Dr Dutta's contention. I remind myself that the assessment of the evidence is primarily for the Tribunal, and the appellate role is subject to the constraints I have mentioned. I do not believe I can find that the Tribunal's conclusion on this point was irrational, untenable, or otherwise wrong within the meaning of CPR 52.21.

"Taint" and safety

63. Mr Counsell invites me to deduce from the first stage Determination as a whole, and from paragraph [87] of the Determination on Impairment, that the Tribunal took a strongly unfavourable view of Dr Dutta generally, and came firmly to the conclusion that his explanations should not be accepted. Although, he concedes, that is in general a legitimate approach, in this case it was likely to have resulted from the Tribunal's rejection of Dr Dutta's response to Charges 1 and 2 and its "irrational preference" for the account given by Patient A. Thus, it is argued, the Tribunal's view of Dr Dutta, as a witness and more generally, has been inevitably and fatally "tainted" by its rejection of his evidenced in respect of charges 1 and 2, to the extent that "it would be unsafe to allow any of the other proved charges to stand". This is said to apply to charges in respect of Patients C, D and E, as it applies to those relating to Patient A.

64. I am not persuaded by this "taint" or "contagion" argument. "Safety" is a concept drawn from the criminal appeal jurisdiction, and inapt in the present context. And the approach urged upon me is too broad-brush. It is trite to observe that a Court or Tribunal may find a witness reliable or unreliable on some but not other aspects of his or her evidence. Just as in daily life, conclusions on these issues can be affected by the presence or absence of documentary corroboration, inherent probabilities, circumstantial matters, previous and subsequent conduct, and other factors. Here, I do

not detect in the Tribunal's Determinations any sign that they took against Dr Dutta on Charges 1 and 2 and carried through that adverse view to all their other adverse findings. Rather the contrary. Ms Hearnden's submission is that the Tribunal carefully considered each allegation, on the basis of the evidence relating to that charge, which it subjected to critical examination. That is borne out by the details of the Tribunal's reasoning.

65. The Tribunal's reasons for finding against Dr Dutta in relation to Charges 1 and 2 were not based on his credibility but on that of Patient A. The central flaw was not to dismiss what Dr Dutta said, but to play down the importance of the clinic's records, the authenticity and accuracy of which was not in doubt. The very next matter the Tribunal considered after Charges 1 and 2 was whether Dr Dutta had dishonestly represented to Patient A that the implants he was using were not PIP. Her evidence on that issue was rejected and Dr Dutta's case was accepted. The Tribunal's reasons for its other findings against Dr Dutta are rational, relevant, and sufficient, and they betray no indication that they were determined or affected by the Tribunal's thinking about Charges 1 and 2. The adverse finding I have quoted, that Dr Dutta used documents as a "smokescreen", comes from the Determination on Impairment, which was separate, and came days later. There is nothing in the first stage Determination to indicate that it was infected by that conclusion.

66. Mr Counsell has some specific points about Charge 8, the allegation of failure to take appropriate action after Patient A reported that she had been sexually assaulted by Dr B. It is submitted that the Tribunal's conclusion on this issue was heavily dependent upon its views as to the respective credibility of Patient A and Dr Dutta. It is also argued that the Tribunal's reasoning is deficient, as it fails to explain, adequately or at all, why Dr Dutta's account was rejected. I do not find these submissions persuasive, either. Charge 8 had five separate factual components. One was struck out. One was found not proved. The three that were found proved were (a) saying to Patient A "Oh, not another one", (b) saying to her words to the effect that Dr B had done the same thing to another patient, and (c) speaking to someone else on the phone about the incident and laughing about it. Dr Dutta admitted using the words in (a). The factual elements of (b) and (c) were established by reference to a recording of the telephone conversation, in which Dr Dutta, in the presence of Patient A, spoke to Marie, co-owner of the clinic. Dr Dutta's case was that the laughter, which he admitted, was nervous and hence not inappropriate. The Tribunal heard the recording, and found that Dr Dutta could be heard to laugh whilst "minimis[ing] Dr B's behaviour by stating that it would be commonplace in other countries." There are no grounds on which I could interfere with that finding of fact, or with the Tribunal's conclusion that this was "wholly inappropriate and undermining to the dignity of Patient A". The reasons, though concise, were sufficient.

V. The Claim

The Rules

67. At the relevant times Rule 4(5) provided as follows

> "No allegation shall proceed further if, at the time it is first made or first comes to the attention of the General Council, more than five years have elapsed since the most recent events giving rise to the

> allegation, unless the Registrar considers that it is in the public interest, in the exceptional circumstances of the case, for it to proceed."

68. Rule 2 (Interpretation) defined "allegation" to mean "an allegation that the fitness to practice of a practitioner is impaired …"

The Five-Year Decision

69. This was contained in the concluding paragraphs of the Referral Decision, as follows:

> "The allegations regarding Dr Dutta appears (sic) to have first come to the GMC's attention on 24 September 2014. However, as some of the other allegations relate to issues over five years before that date then have sought legal advice … to see whether these allegations might form a continuing course of conduct on the part of Dr Dutta.
>
> The legal adviser has concluded that:
>
> > "In my view the reviews and ultrasound scan all relate to the breast augmentation surgery and can therefore be properly considered to constitute one course of treatment. All of Patient A's allegations should therefore be considered as a composite whole allegation. As the most recent event giving rise to the allegation is 25 August 2010, and falls within the relevant period of less than 5 years, the composite allegation should be considered in time by reason of the continuing nature of the events. My view is that Rule 4(5) is not engaged."
>
> In view of the above advice, I am of the view that allegations that the clinical concerns about Dr Dutta do form a continuous course of conduct and therefore the 5-year rule is not engaged."

The "most recent event" referred to here was the 2010 Scan.

70. At the time of the Five-Year Decision and the Referral Decision the Registrar (and hence the AR) had the benefit of an 11-page document providing them with Guidance on "the approach to be applied … when deciding under rule 4(5) … whether …. to allow an allegation to proceed." The version in force at the time was headed "Revised Aide Memoire, July 2015" and has been referred to as the Aide Memoire. The document has no formal status, but it has been referred to by both parties, and I shall refer to it, as it provides some helpful information and analysis.

Delay

71. A convenient summary of the requirement of timeliness in judicial review claims is to be found in the recent judgment of the Court of Appeal in *R (Badmus) v Secretary of State for the Home Department* [2020] EWCA Civ 657 [59]:

> "… CPR 54.5(1) provides that a claim for judicial review must be made "promptly and … in any event not later than 3 months after the grounds to make the claim first arose". The Senior Courts Act 1981 s.31(6) provides that, where there has been "undue delay" in making an application for judicial review, the court may refuse to grant permission or relief "if it considers that the grant of the relief sought would be likely to cause substantial hardship to, or substantially prejudice the rights of, any person or would be detrimental to good administration". The expression "undue delay" in that provision is to be read as meaning a failure to act promptly or within three months: *R v Dairy Produce Quota Tribunal ex p. Caswell* [1900] 2 AC 738 at 746."

72. The provisions of s 31(6) do not mandate the refusal of permission or relief, even if the specified conditions are satisfied, and (as the Court made clear in *Badmus* at [86]), an extension of time can be granted pursuant to CPR 3.1(2)(a) even if there has been "undue delay".

73. The grounds to make the claim arose on 18 August 2016, when the Five-Year-Decision and the Referral Decision were made. But Dr Dutta could not have made the claim at that time, as he was not told about either of those decisions until 24 November 2016. That was already more than 3 months after the claim arose. At that time, he was told of the Referral Decision but not told of the Five-Year-Decision. He was not told of the latter until 12 September 2019, and was not given a copy until 23 October 2019: [6(10)] above. His case is that for the purposes of considering timeliness, time should be treated as running from that last date, that he acted promptly and there was no "undue delay" thereafter, or, if there was, it would not cause any relevant hardship or prejudice nor would it be detrimental to good administration to grant permission, and allow the Claim to proceed.

74. As the GMC accepts, ignorance of the very fact of the impugned decision can be a good reason for extending time, and a late claim may be allowed to proceed if brought promptly after the claimant becomes aware of the decision: see *R v Secretary of State for the Home Department, ex p Ruddock* [1987] 1 WLR 1482, 1575E-F (Taylor J), *R v Secretary of State for Foreign and Commonwealth Affairs, ex p World Development Movement Ltd* [1995] 1 WLR 386, 402H (DC) (Rose LJ). I note that in *Lee* ([6(11)] above) Haddon-Cave J decided the delay issue on the basis that "the claimant could and should have brought judicial review proceedings *within three months of the GMC's notification* on 28 August 2013 of its refusal to apply Rule 4(5)": [2016] 4 WLR 34 [51] (emphasis added).

75. The GMC nonetheless takes two points.

    (1) First, it is submitted that the critical date is when the claimant came to know of the "material matters" (see *World Development,* 402G-H). It is suggested that Dr Dutta could and should have inferred from what he did know that the GMC had decided that the 5-year rule was not engaged. It was apparent to him that the GMC was not treating any of the allegations as time-barred by the five-year rule. He could and should have worked out for himself why that was, and acted sooner to challenge the decision.

(2) Secondly, the GMC maintains that to grant permission or relief now would be detrimental to good administration. The argument is that Dr Dutta chose to delay his judicial review challenge, and instead to allow a 17-day hearing to proceed, with all the resources that consumed, with a view to keeping open his options. He could and should have pursued the challenge immediately he was in possession of sufficient knowledge to do so. The consequences of a successful review challenge would be highly significant, and might extend to putting much of the expense to waste, and require the re-making of the Five-Year Decision, and fresh proceedings.

76. These are unattractive submissions, however skilfully they were presented. I reject both lines of argument. In my judgment, the claim was brought within 3 months after the date when Dr Dutta had enough information to proceed, which is when he received a copy of the Referral Decision; and in all the circumstances it was brought with reasonable promptness. Further, if the Claim has arguable merit (and it will be clear already that I believe it has more than that) it would in my judgment be detrimental to good administration and manifestly unjust to Dr Dutta to refuse any necessary extension of time and/or to refuse permission on the grounds of delay.

77. The GMC's first point seems to me to place too heavy an onus on the subject of an undisclosed decision, to work out that it has been made and why. The evidence clearly shows that Dr Dutta did not have actual knowledge that a decision had been made that the 5-year rule was not engaged at any time before 12 September 2019. In 2016, he did not have legal advice. When he did obtain expert advice, his lawyers were unable to identify the true nature of the AR's decision. On 3 September 2019, Clyde & Co wrote to the GMC, noting that some of the allegations dated back to 2009, and saying this:-

> "The current case commenced in 2016, meaning that a Registrar would have had to make a R4(5) determination that it was in the public interest for these allegations to proceed. Could you confirm when this happened, and let me have a copy of the determination?"

That is, in my view, a reasonable question. It is the question that led to the revelation of the existence and then the text of the Five-Year-Decision. The inference that the GMC may have concluded that the 5-year rule was not engaged may have been open to Clyde & Co, but it was far from obvious. Rule 4(3)(b) required the Registrar to notify a practitioner, if the Registrar considered an allegation was barred by the five-year rule and it was *not* in the public interest for the allegation to proceed. But the Rules did not require notification of a decision that it *was* in the public interest.

78. I am not attracted by the argument that the question the solicitors asked in September 2019 should have been asked years earlier, and that a failure to ask it represents undue delay. More compelling is Mr Counsell's criticism of the GMC's own lack of candour, in failing to disclose the Five-Year-Decision until more than three years after it was made, when put under pressure to do so. I remain unclear what good practical or policy reason there may have been for that reticence. The GMC has not offered an explanation. The mere fact that the rules do not require it does not seem to be sufficient. It is unbecoming of a public authority to criticise the subject of its decision

for delay in divining the existence of and/or the reasoning behind an undisclosed decision.

79. This undermines the GMC's second point. Its non-disclosure of the Five-Year-Decision until late October 2019 presented Dr Dutta and his legal team with an uncomfortable dilemma. He had belatedly been told of an arguably unlawful GMC decision on the 5-year rule. Three working days later, he was to face day one of a four-week fitness to practise hearing encompassing 23 separate allegations, only some of which were covered by that decision. His lawyers' first thought, to apply to strike out, was stymied by the legal obstacle. As the GMC pointed out, the Tribunal had no jurisdiction over the matter. Judicial review was the only available avenue. The decision taken was to reserve Dr Dutta's position and proceed with the substantive hearing, in the knowledge that if "acquitted" he would not need to pursue judicial review.

80. To contend that Dr Dutta should have sued the GMC in the Administrative Court at the same time as contesting the fitness to practise proceedings would be unreal. That has not been Ms Hearnden's submission. She has argued that it was unreasonable to leave the matter in abeyance. Dr Dutta could and should have applied urgently to this Court, seeking a short adjournment of the fitness to practise proceedings for that purpose. She cites *R (Mahfouz) v GMC* [2004] EWCA Civ 233 as an illustration of that approach in action. So it is. But it is not binding authority. It was very different on its facts, and each case must turn on its own particular circumstances. Here, I do not agree that the stance adopted by Dr Dutta was unreasonable, still less that the pursuit of proceedings on 23 December 2019 represented undue delay.

81. The fitness to practise hearing had been listed for months, and the final stages of preparation were under way. I accept Mr Counsell's submission that any delay in getting started would have put the fixture at risk, and there was a real chance that it would have to go off for a year or more, or at least that was a reasonable view to take. The case related to events most of which occurred many years earlier. Further delay would have been highly undesirable. Further, Dr Dutta's decision, and his intended course of action, were made quite clear to the GMC and the Tribunal. Mr Counsell said

> "We've considered carefully with Dr Dutta whether or not we should be asking you not to proceed with paragraphs 1 to 6 of the allegations and go to the Administrative Court now. We don't think that's sensible, for obvious reasons. We are here today and it would be crazy to do that."

Dr Dutta's conduct thereafter was consistent with that stance. The GMC's submission to me might have been more persuasive if it too had taken a clear and consistent position. But on 28 October 2019, Counsel for the GMC (not Ms Hearnden) said nothing to encourage an application to adjourn and an immediate application for judicial review. Nor did he say that the GMC would complain of delay if those steps were not taken. It lies ill in the GMC's mouth to complain now that Dr Dutta took a course which the GMC was not even criticising at the time, when his position was made plain. The need to pursue judicial review became clear when the Tribunal rendered its stage 1 Determination. The Claim Form was issued within six weeks.

The Merits

82. Rule 4(5) is concerned with whether "an allegation" should or should not proceed to the next stage. The two points in time that are critical for this purpose are "the time it is first made or first comes to the attention of the [GMC]" and the date of "the most recent events giving rise to the allegation". If more than five years have elapsed between the two, the "allegation shall [not] proceed". (The AR did not consider, and I am not concerned with, whether there were any "exceptional circumstances"; the GMC accepts there were none.)

83. The first matter for consideration is how to interpret and apply the term "allegation". The definition in Rule 2 does some, but not all of the work. An allegation must contain something that suggests that the practitioner's fitness to practise is impaired. What, though, if a patient makes a number of criticisms? The rule-makers must be presumed to have intended the term to be given a meaning that is practicable and workable for the purposes of the decision-making in question. As the Aide Memoire points out at para 2, the rule deals with the "*initial* consideration and referral" process. The context therefore points to "an allegation" being something less formal than a "charge". But it must nonetheless be something that identifies a discrete, specific item of behaviour that is capable of being tied to a point in time, else the rule could not be applied.

84. The Aide Memoire reflects the obvious reality, that an "allegation" may be presented in an assessable form by the complainant, or it may need some prior investigation and may need to be formulated by the GMC. In this case, there were several individual complaints and, following an investigation, the allegations were formulated by the GMC for consideration by the AR. As emerged in the course of the hearing, following some questions from me, they were set out in a document placed on the GMC's "Siebel" records system under the name of "Allegation Information". The document contained ten separate allegations, labelled (a) to (j). The first four and the last two related to Dr Dutta's conduct towards Patient A. Allegations (a) to (c) related to 2009. They alleged that Dr Dutta failed to provide appropriate advice before the Augmentation Operation, offered a financial incentive to have that operation the following week, failed to perform it competently, and falsely told the patient nothing was wrong. Allegation (d) related to the 2010 Scan. The allegation was that, having scanned the patient, Dr Dutta had "reported nothing wrong, even though the radiologist had told her both breasts were full of infected fluids and the implants needed immediate removal". In other words, this was the 2010 Allegation. Allegation (i) was that Dr Dutta "may not have been allowed to operate" during 2009. Allegation (j) was that he had been misrepresenting himself as a surgeon.

85. Allegation (d) is of course the allegation that did not in the event proceed as a charge, in the light of expert advice. It was, however, something for the AR to consider. Even so, I consider it clear that the legal advice provided was wrong, and the AR's Decisions taken in reliance on that advice were also wrong, as a matter of law. The AR's task was to apply the provisions of Rule 4(5) to each "allegation". There may be cases in which it is not easy to tease out and separate individual allegations from a mass of criticism. Here, though, the Allegation Information very properly and clearly divided up Patient A's complaints about the way Dr Dutta behaved. In relation to the Augmentation Operation, there were four separate and distinct topics. They were in

substance separate allegations, independent of one another, each of which could properly be regarded in isolation as calling into question Dr Dutta's fitness to practise.

86. The wording of the AR's own decision reflects this. In a section that preceded the passage I have quoted, the AR summarised the allegations as follows:

> "The complainant has raised a number of concerns about the standard of treatment provided by Dr Dutta to the complainant. … Prior to [the] surgery the complainant was worried she was too thin to have implants put under her skin, but Dr Dutta allegedly assured her that she had enough breast tissue for this and went ahead …
>
> ….
>
> Dr Dutta later performed a scan of the patient's breasts on 25 August 2010 and reported nothing was wrong…"

The AR then went on to consider, individually, allegation (i), and to dismiss it on the basis that Dr Dutta's registration history showed that he was not suspended from practice.

87. Turning to the reasoning quoted above, and the words of Rule 4(5), it cannot be said that things that were alleged to have happened in August 2010, following the post-operative scan, were "the most recent events giving rise to the allegation" in paragraph (a), that Dr Dutta failed to provide appropriate pre-operative advice. Nor, obviously, can the alleged events of August 2010 be "events giving rise to" the allegation that Dr Dutta offered the patient a financial incentive in 2009. On the face of the reasoning set out above, the AR proceeded on the erroneous basis that where a patient makes a number of related allegations all concerned with a single "course of treatment", the term "allegation" should be given some composite meaning, and the 5-year rule applied to the whole. That is wrong in law.

88. I am comforted to note that my analysis is consistent with the Aide Memoire. Paragraph 7 states that the identification of "the most recent events giving rise to the allegation" and their date, is not straightforward where impaired fitness to practise is alleged to arise from a series of separate but linked events. One category of case discussed in this context is one where there is a "single composite allegation made at the same time by the same person/body of identical and persistent misconduct", such as sexual assault. At the other end of the scale, "various quite distinct allegations may be made in relation to discrete incidents involving the same practitioner". The Aide Memoire recognises that there is a wide variety of factual circumstances in between, and offers the advice that "as a rule of thumb, the Registrar should seek to identify the extent to which the alleged events are linked by common features and ought reasonably to be regarded as a composite whole". A footnote to this passage says this:

> "Occasionally, but not often, a single complaint document contains more than one distinct allegation. The Registrar needs to be aware of this possibility and to pinpoint the allegation in question before applying rule 4(5)."

That is a task which was carried out by the author of the Allegation Information. It was also a task the AR carried out in the first part of the decision reasoning, where the allegations were identified separately. But the AR failed to carry through that analysis when it came to the application of Rule 4(5), with the consequence that the decision reached was wrong in law.

89. For completeness, I would add that in my judgment the AR was also largely wrong about the other end of the relevant timescale: the date when the allegation was "first made or first [came] to the GMC's attention". The Aide Memoire deals with this aspect of the Rule at paragraph 6. It suggests this is usually a straightforward matter, as "typically, the allegation is made by an aggrieved patient", though there may be cases where an allegation "comes to the GMC's attention more passively: for example, through media coverage". There is no doubt that the 2015 Statement would count for this purpose. Patient A was clearly complaining then about Dr Dutta. But the AR fixed on the 2014 Conversation as the relevant date. In my judgment, that is an artificial and unreal approach, such that the decision on this point was wrong in law also.

90. The only evidence as to what was said in 2014 is an internal handwritten note, made by an unknown representative of the GMC, dated 24 Sept 2014. It evidently records things reported by a police officer about what Patient A had said to the officer about Dr Dutta and Dr B. Understandably, given that this is a report to and by the police, it focuses on the allegations of sexual assault by Dr B, and the trauma experienced by Patient A. There is incidental reference to the surgery undertaken by Dr Dutta having "gone wrong". But the GMC did not see this as an allegation of unfitness to practise. It took no action at the time, or for over a year after that: see [6(1)-(2)] above. The GMC saw the 2014 Conversation as a report of a complaint about Dr B. This is reflected in the first paragraph of the Referral Decision (emphasis added):

> "In 2014, the GMC received *a complaint from [Patient A] in relation to [Dr B].* However, as part of the open investigation w*e have since received further information which has raised concerns about the conduct and treatment of Dr Dutta.* Therefore, *in June 2016, an internal triage request was sent* to Triage to allow us to consider the allegations about Dr Dutta."

Put another way, allegations of unfitness to practise were not made to the GMC nor did they "come to the attention" of the GMC in September 2014. It was not until further information was provided that the GMC identified such allegations. It was evidently the 2015 Statement and the CQC referral of November 2015 that contained the relevant information, or were the prompt.

91. Further, although the record does suggest that in the 2014 Conversation the patient was complaining of the treatment given by Dr Dutta and its consequences, including food intolerance and allergies, the note contains nothing about any offer of a discount for swift surgery. It cannot be said that allegations (a) or (b) were "first made" in September 2014, or that they first came to the GMC's attention at that time. The same is true when it comes to the allegations of dishonest misrepresentation in respect of the PIP implants.

92. It follows that the Five-Year Decision must be quashed, and so must the Referral Decision, in relation to the 2009 Charges. The case will have to be remitted for reconsideration of impairment and sanction, based on the other charges that were admitted or found proved.