Neutral Citation Number: [2020] EWHC 2518 (Admin)

Case No CO/4728/2019

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/09/2020

Before :

MRS JUSTICE FOSTER

- -

Between :

THE GENERAL MEDICAL COUNCIL	**Appellant**
- and -	
DR RAIED HARIS	**Respondent**

- -
- -

Ms Jenni Richards QC (instructed by **GMC Legal**) for the **Appellant**
Mr James Leonard (instructed by **RadcliffesLeBrasseur LLP**) for the **Respondent**

Hearing dates: 29 April 2020

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

....

Covid-19 Protocol: This Judgment was handed down by the Judge remotely by circulation to the parties' representatives by email and release to Bailii. The date and time for hand-down is deemed to be Tuesday 22nd September 2020 at 3pm.

Mrs Justice Foster :

INTRODUCTION

1. This is the appeal of the General Medical Council ("the GMC") under section 40A of the Medical Act 1983 ("the 1983 Act") against a decision of the Medical Practitioners Tribunal ("the Tribunal") made on 6 November 2019. By that decision the Tribunal determined that Dr Raied Haris was guilty of misconduct, that his fitness to practice was impaired, and that conditions should be imposed upon his registration for a period of 12 months.

2. The hearing of the allegations of fact took place between 14 January 2019 and 18 January 2019; the Tribunal reconvened on 24 January 2019 to give its Determination on the Facts. After that date it adjourned for Dr Haris to undergo further medical examination in order to assist the Tribunal to determine the issues of misconduct and in particular, impairment. Two doctors reported and their written evidence was considered by the Tribunal at the adjourned hearing on 31 October 2019. Between 4 and 6 November 2019 it gave its conclusions on impairment and sanction.

3. This is the public version of the judgment, a private version of which, containing certain medical details, has been distributed to the parties.

4. Dr Haris qualified MBChB from the University of Manchester in 2008 completing his Foundation Training in Burley and Blackburn in 2010 and beginning his GP Training in 2011. He qualified as a GP in August 2014 and has worked predominately since then in the Out of Hours Service (FCMS and PDS) and at walk-in centres (at FCMS/PDS/Accrington) in the north of England.

5. The allegations made against him in the proceedings before the Tribunal arose from his work as a GP. Patient A alleged that Dr Haris had undertaken a non-clinically indicated, intimate examination without informed consent on 23 February 2017 whilst working as a locum GP in the out of hours service in Morecambe. Patient B alleged effectively the same, in a separate incident on 5 March 2017, whilst Dr Haris was working as the GP in the Minor Injuries Unit at Leeds General Infirmary.

6. Dr Haris made several written statements and gave oral evidence to the Tribunal denying that the physical acts which formed the substance of the allegations had ever happened. He strongly challenged the veracity of the witnesses and their supporting evidence in sustained cross-examination through his counsel.

7. The Tribunal however, accepted in strong terms the evidence of two complainants as to what happened at the relevant times, rejecting Dr Haris' account. His evidence was characterised by the Tribunal as at various times defensive, evasive, and contradictory. They also found he had failed in certain consequential clinical requirements such as wearing gloves for vaginal examinations.

8. Although regarding Patient A the Tribunal found it established that, (in circumstances where it was not clinically indicated and without her informed consent) the Respondent, without gloves, had pulled down her underwear exposing her pubic region, pressed above her pubic area and put a finger on each of the lips of her vagina

and pulled them apart, staring at her pubic area, they went on to find that Dr Haris' actions were not sexually motivated.

9. With respect to Patient B, the Tribunal found that the Respondent's actions were not sexually motivated although he had caressed the cheeks of her buttocks for some seconds, inserted his finger between her legs, touching her vagina and, parting the lips of it, had held his finger there for a number of seconds. Further he had fondled her left breast, without gloves. There was no informed consent for the vagina and breast examinations and in no case were such examinations clinically indicated.
10. It was not argued in either instance that the touching had occurred but had been accidental.

11. No mention of any intimate examination was made in patient A's notes. In respect of Patient B, Dr Haris specifically recorded in his clinical notes that he had *not* conducted an intimate examination.

12. Patient A had been accompanied by her mother in the consultation and it was she who made a complaint the next day on behalf of her daughter. Patient B who had been accompanied by her husband, herself made a complaint the following day and also complained to the police.

BEFORE THE TRIBUNAL

The Allegations

13. A point is taken on Dr Haris' behalf about the wording of the pleadings and so I set out the Allegations as drafted and found:

1. "In February 2017, during your consultation with **Patient A** you:

a. undertook a vaginal examination that was not clinically indicated;
Determined and found proved

b. pulled down Patient A's underwear;
Determined and found proved

c. leaned against Patient A's side as you examined her;
Determined and found proved

d. thrusted your pelvis against Patient A's side as you were examining her;
Not Proved

e. stared at Patient A's pubic area;
Determined and found proved

f. failed to:
i. wear gloves during the vaginal examination;
Determined and found proved

ii. tell Patient A to pull up her underwear;
Not proved

iii. obtain informed consent for the vaginal examination;
Determined and found proved

iv. record obtaining informed consent from Patient A for the vaginal examination;
Determined and found proved

v. record that you had undertaken a vaginal examination.
Determined and found proved

2. On 5 March 2017, during your consultation with **Patient B** you:

a. undertook non-clinically indicated examinations of Patient B's:

i. buttocks;
Determined and found proved

ii. vagina;
Determined and found proved

iii. breast;
Determined and found proved

b. attempted to undertake a second examination of Patient B's chest or breast without a chaperone present;
Not proved

c. failed to wear gloves during the vaginal examination on Patient B;
Determined and found proved

d. undertook, without the presence of a chaperone, an examination of Patient B's vagina;
Determined and found Proved

e. failed to ask Patient B if she required a chaperone to be present for the:

i. second chest examination you attempted;
Not proved

ii. vaginal examination;
Determined and found proved

f. failed to obtain informed consent for the examination you undertook of Patient B's:

i. vagina;

Determined and found proved

ii. breast.
Determined and found proved

3. Your record keeping was inadequate in that you failed to record:

a. that you had undertaken an examination of Patient B's:

i. vagina;
Determined and found proved

ii. breast;
Determined and found proved

iii. buttocks;
Not proved

b. obtaining informed consent for the examination you undertook of Patient B's:

i. vagina;
Determined and found proved

4. Your conduct described at paragraphs 1a-f(ii), 2a-d, above was sexually motivated.
Not Proved"

14. Expert evidence was called by the GMC to the effect that none of the challenged touching was clinically indicated, nor indeed did Dr Haris assert that it was. As stated, his case was it just had not happened. The Tribunal also heard live evidence from Patients A and B, Patient B's husband, and certain staff at the surgical sites.

15. Dr Haris made several written statements including one at a late stage before the hearing seeking to refute the allegations. In the later statement he disclaimed any interest in sex whatsoever and described himself as asexual. He also relied on written statements from his sister and a friend of his to the effect that they had not known him to show any interest in sex.

16. Mr Haris' team called a Dr Vandenabeele, psychiatrist, in support of the doctor's denials.

17. The Opinion section of Dr Vandenabeele's Report, based upon a consultation on 14 December 2018, said the following:

Opinion

"14.1 I understand that in the past Dr Haris had been provided with counselling for his addiction to computers and technology. He did not

report any other pre-existing history of mental health difficulties and, as far as I am aware, he has never been given a psychiatric diagnosis.

14.2 Based on the information provided to me by Dr Haris it appears that he has a long history of struggling with social interactions. I also understand that he has difficulties understanding the impact of his actions upon others and equally it seems that from an emotional perspective he struggles to understand other people. It also seems there is a history that may indicate some rigidity in his behaviours and thinking patterns and him becoming preoccupied with certain activities for prolonged periods of time. Some of these features were also apparent at the time of my examination.

14.3 it is not my view that Dr Haris is suffering from a functional mental illness, such as a mood disorder or a psychotic illness, and it is also not my view that based upon the information available he has a history of such an illness.

14.4 I note that Dr Haris has described himself as asexual and based upon the information he gave me it seems that he has not had any sexual experiences. He also stated that he does not have any interest in sexual relationships. I consider it likely that this can be understood in a context of a history… He told me he got engaged earlier this year, but I also understand that this engagement had been arranged for him and he appeared rather ambivalent about the engagement; it is my view this can be explained by the …
14.5 Whilst Dr Haris indicated his social contacts with women have been very limited, upon further exploration it seems that his relationships with any other people (both male and female) have been limited. This again can in my view be explained by...

14.6 I have been asked to comment upon the fact that Dr Haris did not inform his legal team as to his sexual preferences or indeed the lack thereof until 22 November 2018. When I discussed this with Dr Haris, he stated that he had not disclosed this prior to this date as he had not specifically been asked about this prior to this date.

18. In cross-examination it is recorded:

Q Only two questions, Doctor, if I may? You talked about the impact of … in forming social relationships and can one imply from that potentially sexual relationships as well?
A That is correct.

Q Would it be right to say that those who find themselves displaying … it is not inconsistent with that they are going to have sexual urges or sexual feelings?
A They may have sexual urges and sexual feelings, but they would struggle really to express those, and using an awkward

> word now but almost materialise them in the context of interpersonal relationships."

19. The reasoning of the Tribunal as to its finding under Allegation 4 and the absence of any sexual motivation was expressed in the Determination on Facts in the following terms:

> "109. The Tribunal notes the LQC's advice on this issue. The burden is on the GMC to demonstrate that Dr Haris' conduct described at paragraphs 1 a-f (ii) and 2 a–d above was sexually motivated. It notes the dictionary definition of sexual as "of, relating to, or characterised by sex or sexuality". It further notes that for an act to be sexually motivated it needs more than for the complainant/subject of that act to perceive it as a sexual act.
>
> 110. In addition, it noted that there are two questions for the Tribunal to ask itself, the first being "was the act overtly sexual or reasonably able to be perceived as such"? The Tribunal noted that the observations of the High Court in *Basson v General Medical Council* [2018] EWHC 505 (Admin): "the state of a person's mind is not something that can be proved by direct observation. It can only be proved from inference or deduction from the surrounding evidence" might be of assistance to it. The Tribunal has only considered the question of whether Dr Haris' actions were sexually motivated. It considers that it is not required to make any alternative finding as to what his motivation was and has not speculated what Dr Haris' motivation could have been.
>
> 111. The Tribunal is of the opinion that, in the absence of any clinical necessity, undertaking a vaginal examination of Patient A, which included parting the vaginal lips, and staring at her pubic area, together with the other actions described by Patient A, **are at the very least reasonably able to be perceived as overtly sexual and therefore that the first criteria [sic] is satisfied insofar as Patient A is concerned. In relation to Patient B, caressing and/or manipulating her buttocks, touching her vaginal lips and parting them, and stroking Patient B's left breast, in the absence of any clinical indication, could also be reasonably able to be perceived as overtly sexual**. Accordingly, the first criterion that needs to be established to prove sexual motivation is also established insofar as it relates to Patient B.
>
> 112. The second question for the Tribunal to consider is "was the act carried out for the doctor's own sexual gratification"? **The Tribunal has found that the GMC has proved that the doctor's actions were able to be perceived as such but the doctor has put forward a potential explanation that, if he did such actions, they were not for his own sexual gratification, since he had, and has, no interest in sexual matters at all. The Tribunal concludes that the weight of evidence on this point is in the doctor's favour.** Two people who have known him for almost all his life have confirmed that he has

> never exhibited any interest in sexual matters and that he has not been interested in forming intimate relationships with women. Dr Vandenabeele has diagnosed… He has noted Dr Haris' lack of sexual interest and states in his report "I consider it likely that this can be understood in a context of a history of… **Looking at all this evidence in the round and balancing it against the inferences that can be drawn from his actions in relation to Patients A and B, the Tribunal is led to the conclusion that the doctor was not sexually motivated when carrying out these actions.** The Tribunal therefore finds that the GMC has failed to discharge the burden of proof upon it and therefore finds allegation 4 not proved."

20. The emphasised passages are those that are specifically criticised in this appeal.

21. The Tribunal then adjourned again indicating they wished for further medical evidence on the presence and effect of… That evidence was provided by two psychiatrists, Dr Singh and Dr Vincenti.

IMPAIRMENT and SANCTION

22. Following their further examinations and reports Dr Haris conceded the GMC's submission that professional misconduct had been made out and that it was serious. He also conceded that his fitness to practice was impaired. On 6 November 2019 the Tribunal reconvened and concluded the same. Dr Haris did not give live evidence at the hearing but submitted materials to the Tribunal as evidence of his remediation and his insight.

23. The Tribunal in its sanction consideration concluded that Dr Haris had demonstrated "a significant degree of insight", that he had exhibited remorse and had apologised, finding that his remediation was "well-advanced". Its evaluative decision in the circumstances was that its obligations with regard to the public interest were satisfied by imposing conditions (and not suspension as urged by the GMC) upon Dr Haris' registration.

24. The Tribunal's reasoning in support of their conclusions as to impairment and insight contained the following:

> 17. Dr Singh indicated that 'under pressure Dr Haris could become more focused and possible rigid in his clinical approach due to a need to be thorough which would mean that he could struggle to use a 'common sense approach' and would be likely to follow a systematic approach to a clinical examination whether the situation warrants it or not due the perception of the higher risk created by the assessment being taken in an out of hours/A & E setting.' He also indicated that 'when faced with uncertainty in terms of clinical presentation in an emergency setting Dr Haris would be likely to struggle to read his patients emotions and would also be likely to struggle to adopt a flexible approach depending on the need of the situation. There is therefore a possibility that patients could be subject to a more intrusive

> examination than warranted, especially if the contact were to take place in an unscheduled setting like out of hours/A & E were the situation could appear as high risk due to the setting of the clinical presentation'. Dr Singh made the following recommendations, first that Dr Haris should seek daytime work to minimise the high-risk interactions inherent in out of hours/A & E working and, second, that Dr Haris be subject to a period of medical supervision to support him obtaining and using specialist help to develop a better understanding of and modification of his social interaction patterns.
>
> 18. …. When answering the question 'How will the … explain some of Dr Haris' behaviour…?' Dr Singh confirmed that… Further, in answer to the question 'whether such a condition might provide an explanation of Dr Haris' actions [as] found proved, or any motive for carrying them out?'. Dr Singh confirmed that he had not been able to identify any sexual motivation or drive but that one possible explanation would be that Dr Haris dissociated himself from the actions which he did not record. However, Dr Singh indicated that this was pure conjecture on his part."

….

The Tribunals decision on the Health Assessors' evidence

> 28. …The Tribunal also finds Dr Singh's argument credible and logical that, practising in isolation was likely to increase the stress upon Dr Haris which led him to adopt formulaic and potentially inappropriate examination procedures. The Tribunal finds that it is at least plausible that this could be an explanation for him conducting inappropriate intimate examinations on both patients.
>
> 29. The Tribunal noted Mr Grey's argument and agrees that it does not have to seek an explanation for Dr Haris' actions. However, the Tribunal does consider that Dr Singh's evidence provides a possible explanation for those actions and it appears to be one which chimes with Dr Haris in that, having accepted the possibility of it contributing to his failings, he has taken steps to address that possibility. The point the Tribunal would make is that Dr Haris' positive reaction to that potential diagnosis and the information that it might have provided an explanation for his actions is entirely relevant to the question of remediation and current impairment."

THIS APPEAL

25. Ms Jenni Richards QC on behalf of the GMC takes three essential points on this appeal.
    a. the tribunal was wrong to find that there was no sexual motivation to the Respondent's conduct particularly in circumstances where there was no reasonable alternative explanation for the Respondent's behaviour.

b. Even if, contrary to her first submission, the Tribunal had been entitled to find that there was no sexual motivation, the sanction imposed by the Tribunal was in any event insufficient to protect the public and the sanction of suspension should be substituted for the conditions which were imposed.
c. The Tribunal fell into error in being satisfied so readily that the risk of repetition by Dr Haris was low. On the Tribunal's findings there was no explanation as to why the Respondent had acted as he did; it was therefore illogical and unreasonable to be satisfied as to risk. They therefore failed to take into account, when assessing risk and/or considering the overarching public interest objective, the absence of any real explanation for the respondent's conduct – other than that of sexual motivation which they had rejected.

26. The jurisprudential background against which the issues fall to be determined has been the subject of a considerable body of authority and was not in dispute before me. The essential foundations are as follows.

LEGAL FRAMEWORK

Statute

27. Section 1(1A) of the 1983 Act provides that in exercising its functions the over-arching objective of the GMC must be to protect the public. By section 1(1B), this involves the pursuit of three objectives: (a) to protect, promote and maintain the health, safety and well-being of the public; (b) to promote and maintain public confidence in the medical profession; and (c) to promote and maintain proper professional standards and conduct for members of that profession.

28. It is well-established that a tribunal hearing follows a three-stage process, first hearing evidence and making findings of fact, second, after submissions, making a determination as to whether those facts amount to misconduct and whether the practitioner's ability to practice is impaired. Thereafter, if a finding of impairment is made the tribunal may impose sanctions whether conditions, suspension or erasure. Without a finding of impairment, a warning may be given. A practitioner may appeal where he or she is dissatisfied with a direction given for erasure, suspension or in respect of conditions. By section 40A the GMC may also appeal.

29. The relevant parts of section 40A of the Act provide as follows:

> …
>
> *(3) The General Council may appeal against a relevant decision to the relevant court if they consider that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.*
>
> *(4) Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient—*
>
> *(a) to protect the health, safety and well-being of the public;*
> *(b) to maintain public confidence in the medical profession; and*

> *(c) to maintain proper professional standards and conduct for members of that profession.*
>
> *(5) The General Council may not bring an appeal under this section after the end of the period of 28 days beginning with the day on which notification of the relevant decision was served on the person to whom the decision relates.*
>
> *(6) On an appeal under this section, the court may—*
>
> *(a) dismiss the appeal;*
> *(b) allow the appeal and quash the relevant decision;*
> *(c) substitute for the relevant decision any other decision which could have been made by the Tribunal; or*
> *(d) remit the case to the MPTS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court, and may make such order as to costs (or, in Scotland, expenses) as it thinks fit.*

Case law

30. The principles governing the exercise of the Section 40A appellate power were recently set out by the Divisional Court *GMC v Jagjivan* [2017] EWHC 1247 (Admin):

"…

In summary:

> i) Proceedings under section 40A of the 1983 Act are appeals and are governed by CPR Part 52. A court will allow an appeal under CPR Part 52.21(3) if it is 'wrong' or 'unjust because of a serious procedural or other irregularity in the proceedings in the lower court'.
>
> ii) It is not appropriate to add any qualification to the test in CPR Part 52 that decisions are 'clearly wrong': see *Fatnani* at paragraph 21 and *Meadow* at paragraphs 125 to 128.
>
> iii) The court will correct material errors of fact and of law: see *Fatnani* at paragraph 20. Any appeal court must however be extremely cautious about upsetting a conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of the witnesses, who the Tribunal, unlike the appellate court, has had the advantage of seeing and hearing (see *Assicurazioni Generali SpA v Arab Insurance Group (Practice Note) [2002] EWCA Civ 1642; [2003] 1 WLR 577* , at paragraphs 15 to 17, cited with approval in *Datec Electronics Holdings Ltd v United Parcels Service Ltd [2007] UKHL 23, [2007] 1 WLR 1325* at paragraph 46, and *Southall* at paragraph 47).

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

v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standards in the profession and sanctions, with diffidence: see *Fatnani* at paragraph 16; and *Khan v General Pharmaceutical Council [2016] UKSC 64; [2017] 1 WLR 169* , at paragraph 36.

vi) However there may be matters, such as dishonesty or sexual misconduct, where the court "is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal …": see *Council for the Regulation of Healthcare Professionals v GMC and Southall [2005] EWHC 579 (Admin); [2005] Lloyd's Rep. Med 365* at paragraph 11, and *Khan* at paragraph 36(c). As Lord Millett observed in *Ghosh v GMC [2001] UKPC 29; [2001] 1 WLR 1915* and 1923G, the appellate court "will afford an appropriate measure of respect of the judgment in the committee … but the [appellate court] will not defer to the committee's judgment more than is warranted by the circumstances".

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

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

31. The Divisional Court also stated in paragraph [39]:

" … the well-settled principles developed in relation to section 40 appeals (in cases including: *Meadow v General Medical Council [2006] EWCA Civ 1390; [2007] QB 462* ; *Fatnani and Raschid v General Medical Council [2007] EWCA Civ 46; [2007] 1 WLR 1460* ; and *Southall v General Medical Council [2010] EWCA Civ 407; [2010] 2 FLR 1550*) as appropriately modified, can be applied to section 40A appeals."

32. The GMC's case on sanction and public protection also centres on the absence of any explanation as to *why* the Respondent had acted as he did. Sexual motivation had been rejected and no plausible alternative reason was, they say, put forward. In the public interest the Tribunal was required to be satisfied as to risk and, says the GMC, could not be on the available materials. This led to failing to appreciate the persistent risk

presented by Dr Haris, absent a plausible rationale as to why he did what he did, and thus to an inadequate sanction.

33. Accordingly, deductions from facts and evaluation/judgement are at the centre of the Appellant's case and the principles explained at paragraph 30 (iii) – (vi) above, and in *Bawa-Garba v GMC* [2018] EWCA Civ 1879 are helpful. The latter case concerned a challenge to an evaluative decision. The Court of Appeal reiterated that this court may interfere both where there is an error of principle when carrying out the evaluation, or where the decision is beyond the bounds of what could properly and reasonably be decided by a tribunal.

34. In the case of *Jagivan*, the Tribunal had similarly accepted the patient's account that Dr Jagjivan had talked about getting excited, pointing to her nipples and vagina and suggesting she could put pressure to get excited but then did not find that the conduct was sexually motivated. The Division Court concluded the decision was "wrong and unsustainable" [judgment, paragraph 44]:

    > " … notwithstanding the fact that Dr Jagjivan had not been seen to have acted in any similar manner before and what Dr Jagjivan himself said about his sexuality and that he was not sexually attracted to patient A, there could be no motivation other than a sexual one for making statements to a partially dressed patient about intimate body parts and the stimulation of her vagina."

35. The case of *Basson v General Medical Council* [2018] EWHC 5050 (Admin) was a case where sexual motivation was found by the tribunal and challenged on appeal. Mostyn J said:

    > "13. The issue, indeed, the only issue for the tribunal, in terms of its primary determination, was the state of mind of the appellant. It was alleged that the appellant did what he did and said what he said with a sexual motive. This, the appellant vehemently denied.
    >
    > 14. The tribunal decided that what the appellant did and said was done with a sexual motive. A sexual motive means that the conduct was done either in pursuit of sexual gratification or in pursuit of a future sexual relationship. The tribunal did not, in fact stipulate explicitly what the appellant's sexual motive was; inferentially they found that he behaved in the way that he did for sexual gratification.
    >
    > 15. In reaching its decision, the tribunal was at pains to state that it treated the appellant as a witness of honesty. It accepted his evidence that he could not remember the events in question. It reached its conclusion on the basis of all the evidence before it, including the admissions made by the appellant. The appellant appeals against that finding. He says that it represents an indelible stain on his character.

    …

    > "17. … The question for me is whether the tribunal's finding was legitimately made. In *Edgington v Fitzmaurice* (1885) 29 Ch D 459, Bowen LJ famously said that the state of a man's mind is as much a fact as the state of his digestion. Therefore, in civil proceedings that fact, the state of the man's mind, is to be proved in the usual way by the

> necessary body of evidence on the balance of probabilities. An appellate challenge to a finding of fact is always highly demanding. However, the state of a person's mind is not something that can be proved by direct observation. It can only be proved by inference or deduction from the surrounding evidence. It has been said that the appellate challenge, where the disputed fact has been proved by inference or deduction, is less stringent than where the challenge is to a concrete finding of fact. In other cases, however, it has been said that the standard is the same.
>
> 18. I am prepared to accept that in a regulatory appeal the appellate challenge to a finding of fact derived from inference or deduction is less stringent than a challenge to a concrete finding of fact. Generally speaking, a finding of fact, whether one of a primary concrete nature or one made on the basis of inference or deduction, can only be challenged on appeal where it can be said that the finding is wholly contrary to the weight of the evidence or that there was some fault in the decision- making process that renders the finding unsafe.

….

> 24. In my judgment, the finding made by the tribunal was one that was available on the evidence before it; indeed, I would go further and say it would have been arguably wrong for the tribunal to have reached any other conclusion on the controversial question than the one that it did."

NO FINDING OF SEXUAL MOTIVATION

36. Ms Richards QC, who did not appear below, submits that the Tribunal was wrong to find that there was no sexual motivation to the Respondent's conduct, in particular in circumstances where there was no reasonable alternative explanation for what Dr Haris did. She refers to the case of Jagjivan (above) arguing that the present is just such as case and that there is no reasonable alternative to a sexual motivation to Dr Haris' actions in touching Patient A and Patient B. As she put it in her skeleton argument the Tribunal ignored "the fact that the best evidence as to the Respondent's motivation was the way in which he had behaved towards the patients."

37. The argument for the GMC before me was that in effect, when it came to deciding what the likeliest inference from the facts was as to Dr Haris' motivation, the Tribunal appears to have put out of their minds the overwhelmingly sexual character of his acts.

38. For Dr Haris Mr Leonard, who, similarly, did not appear before the Tribunal, argued it was quite possible to conceive of non-sexual motivation and the pleading of the allegations had done so. The GMC had pleaded the actions of Dr Haris were "examinations" of Patients A and B which left open the interpretation that although the "examinations" were not "clinically *indicated*" they could properly be described as "clinically *motivated*". Accordingly, it was incorrect to assert that there was no other possible motivation save for sexual motivation as argued by the GMC.

39. This analysis was of a piece he said with the further allegations of a failure to wear gloves, obtain proper consent or complete accurate records which reflected the possibility of an analysis related to clinical activity. Nothing in the wording of the allegations made them illogical in the absence of sexual motivation nor were the findings at stage 2, based on the health assessments, to be seen as illogical in the absence of sexual motivation. The framer of the allegations had contemplated a scenario in which the physical acts underlying the allegations were made out without sexual motivation being also proven.

40. Mr Leonard argued in this appeal a number of the points that had been prayed in aid at stage 1 of the case below as to the unlikelihood of the events occurring at all, and therefore, he submitted, the unlikelihood of their sexual nature - including the room size and layout and the presence of others in the course of his touching of their sexual parts.

41. This was different from other cases such as *Basson*, he submitted, where the activity was described as "inappropriately touched the patient". Moreover, the character of the acts was to be distinguished from those in *Basson* and *Jagjivan*. In *Basson* the touching was accompanied by comments on the shortness of the Patient's skirt and in *Jagjivan* by statements to a partially dressed patient about intimate body parts and stimulating her vagina. He argued the Appellant's submission has the effect of reversing the burden of proof such that it was for the Respondent to establish an alternative explanation.

42. In answer to Ms Richards' submission that the Tribunal had erred in finding a "potential explanation" for the acts had been put forward, Mr Leonard submitted that even if the Tribunal had indeed said in its Fact Determination [in paragraph [112] above] that the Registrant '…has put forward a potential explanation…' that was not strictly what had occurred, taking into account the way in which the Allegations were drafted, and exchanges with Counsel about the burden of proof and including the evidence as to the Respondent's lack of interest in sexual matters. Rather the Tribunal was in fact saying that the GMC had not proved the examinations were sexually motivated.

STAGES 2 and 3 of the HEARING

43. Alternatively, Mr Leonard makes reference to materials that were not in fact in front of the Tribunal when the Allegation 4 decision as to no sexual motivation was made. He says the Tribunal may indeed have understood there to be an explanation. He points to a passage in the consideration many months later of Dr Haris' claimed remediation and insight to the effect that there was

> "a possibility that patients could be subjected to a more intrusive examination than warranted, especially if the contact were to take place in an unscheduled setting like out of hours/A & E where the situation could appear as high risk because of the setting of the clinical presentation."

citing in the Determination on Sanction, an expert report obtained from Dr Singh for the purpose.

44. The Tribunal's later finding, derived from the evidence provided for stage 2 by Drs Singh and Vincenti indeed appears to characterise the touching of Patient and A and B's vaginas and Patient B's breasts and buttocks as in some way a product of a too careful (yet innocent) clinical examination. This appears to have led the Tribunal to the following findings when dealing with the second and third stages.

> "The Tribunal also finds Dr Singh's argument credible and logical that, practicing in isolation was likely to increase the stress upon Dr Haris which lead him to adopt formulaic and potentially inappropriate examination procedures. The Tribunal finds that it is at least plausible that this could be an explanation for him conducting inappropriate intimate examinations on both patients."

45. Carefully and persuasively as they were advanced, I reject the submissions of Mr Leonard on each of the grounds of appeal which he seeks to meet.

46. The claimed sustainability of the non-sexual conclusion is not in my judgement fortified by the pleadings. That places too much emphasis on what were merely allegations inserted to cover the (obviously culpable) failures to wear gloves or obtain consent. To differentiate between clinically "indicated" and clinically "motivated" is I am afraid sophistry in this context. However, the manner in which the matter was pleaded may well not have assisted clarity for the Tribunal, about which I say more below.

47. In the present case it is in my judgement clear beyond argument that the intimate touching of Patients A and B was sexual and that answering a question as to the motivation of the toucher, the only available answer, is yes, the motivation must have been sexual. This is another way of saying the only reasonable inference from the facts is that the behaviour was sexual. This derives from;
    a. The fact that the touching was of the sexual organs
    b. The absence of a clinical justification
    c. The absence of any other plausible reason for the touching.

48. The absence of any suggestion of accident and the absence of any consent gives further colour to the acts.

49. The only rational conclusion from the facts at Stage 1, taking into account Dr Vandenbeele's views, was that the motivation for the touching was sexual. The issue before the Tribunal was a question of fact for which, in the face of Dr Haris' denial of sexual motivation, they were required to make a deduction from all the facts and circumstances of the case. It was a corollary – and a powerful one- of their findings on Allegations 1 to 3 and that the patients were telling the truth, that Dr Haris was lying.

50. There was no alternative reason given at all at the hearing at which the finding was made. The tribunal said they were not "required to" make a positive finding, but this,

with respect misses the point: an assessment of all relevant factors was necessary to make the deduction. This factor, as Ms Richards submits, reinforces the conclusion that the motivation was sexual.

51. The over-complication of the decision-making process may have led to the Tribunal's error. They became muddled as to what they had to ask themselves and concerned unnecessarily with the burden of proof and/or evidential burdens. It remained for the GMC to show it was more likely than not, looking at the material in the round, that the motivation was sexual. This was, on these facts, overwhelmingly the likeliest deduction to be made.

52. At the later stages of the hearing, when exploring the extent of remediation and insight, the Tribunal "noted" that the Respondent's behaviour was "distressing" and the actions "could also be perceived as an abuse of his position of trust" (in paragraph 12 of the Sanction Determination). The Tribunal appear to have been driven by the earlier finding of no sexual motivation into what in my judgement is a gross mischaracterisation of what took place. The acts in question cannot reasonably be described, as the Tribunal accepted, as "formulaic and potentially inappropriate examination procedures". This was deliberate, unconsented, touching of a woman's sexual parts: in other words what was, absent clinical indication, a sexual assault in all but name. Moreover, it took place within a therapeutic relationship and therefore in circumstances of significant power imbalance between the perpetrator and the victim. The Tribunal's purported analysis seriously undermines the gravity of the findings on counts 1 to 3 and cannot be sustained.

53. The "explanation" proffered in a written statement from Dr Haris (he did not give live evidence at the later parts of the hearing) was that he had always striven to provide the best care possible and to treat patients with dignity and respect ensuring that he obtained consent for all examinations. He referred to consultation style and stated that possibly "in both Patient A and Patient B's cases, I was more thorough than they expected" or "clumsiness and miscommunication may also have been a factor in these complaints". In my judgement this does not serve to reassure as to either insight or risk.

54. Ms Richards submitted that the material filed after the Tribunal's Stage 1 determination did not at all demonstrate that Dr Haris understood the gravity of his behaviour. He had drafted a Reflective Statement focused on lack of obtaining consent rather than the fact that he had carried out "examinations" that should never have been undertaken. Ms Richards argued that the weight attached by the Tribunal to the Respondent's level of insight and to the steps taken in respect of remediation was manifestly excessive and wrong. I agree.

55. Whilst of course it is the case that a registrant who does not accept factual findings against him is not prohibited from showing that he has insight into the position, it is nonetheless recognised as a difficult exercise (see for example Lewis J in *Blakeley v GMC* [2019] EWHC 905 (Admin) and per Yip J in *Yusuff v General Medical Council* [2018] EWHC 13 (Admin)). The responses of Dr Haris nonetheless cannot be described as an insightful response to the factual findings; in my judgement they are inconsistent with them. It was not within the bounds of reasonable findings in the circumstances of this case for the Tribunal to decide as they did with regard to insight

and remediation. I am unpersuaded by Mr Leonard's arguments to the contrary even recognising as I must, the Tribunal's specialist nature in this area and the quality of judgement implicit in their conclusions. The sanction of conditions imposed on Dr Haris was plainly wrong because, even absent a finding of sexual motivation behind the actions of Dr Haris, they constituted serious and distressing, uninvited intimate intrusion upon 2 patients.

56. The problems in this case essentially began in the Tribunal's difficulty with making findings under Allegation 4 and, although not germane to my decision in this case, I make some observations about the way in which the case was initially pleaded. I did not hear submissions on this, unsurprisingly as it was not in the interests of either side to advance arguments on the subject and these observations do not qualify or inform my findings set out above on the case as it was pleaded.

57. It may be that a different form of allegation might assist a tribunal and diminish the risk of over-complication of the task they face where the essential charge, albeit in a wholly different context, is one of sexual assault. The regulatory context is of course different, particularly the medical sphere in which touching may be apparently sexual in character but entirely justified in certain circumstances by clinical need. The standard of proof is of course also different. The criminal offence is described thus in the Sexual Offences Act 2003 s 3

1) A person (A) commits an offence if—
(a) he intentionally touches another person (B)
(b) the touching is sexual,
(c) B does not consent to the touching, and
(d) A does not reasonably believe that B consents

58. As to "sexual" in subsection (1)(b), section 78 of the 2003 Act provides two ways to determine whether the touching is sexual thus:

78 "Sexual"

> For the purposes of this Part …. touching or any other activity is sexual if a reasonable person would consider that—
> (a) whatever its circumstances or any person's purpose in relation to it, it is because of its nature sexual, **or**
> (b) because of its nature it **may** be sexual **and** because of its circumstances or the purpose of any person in relation to it (or both) it is sexual." [My emphasis].

59. Section 3 excludes from the offence unintentional and also consensual touching. As to the sexual character, section 78(a) contemplates a category of act that is, whatever the circumstances, sexual. Section 78(b) excludes from the offence that category of act that may appear to be sexual but by reason of the circumstances is in truth, not. An act that was clinically indicated, although it might appear sexual, would be excluded under s78(b). Of course, there are significant differences in the context and the analogy is not exact, but it does seem to me that pleading "sexual motivation" is unhelpful. Similarly, to look for "sexual gratification" may be misleading and overcomplicating. It is irrelevant to the actions which the GMC would wish to

proscribe whether or not the perpetrator was sexually "gratified" at all - whether before, after or during the act in question. Gratification, as with "pursuit of a relationship" are, *pace* the analysis of Mostyn J in *Basson*, not helpful in my judgement in promoting the public interests at stake here. These criteria set the bar too high and I respectfully disagree that they represent the law.

60. It may well be that the Tribunal here were seeking to base themselves on a version of the section 78 approach- accepting that the actions "may" be sexual and asking what the context told them about the true character of what was done, but they were distracted by notions of gratification (which appear elsewhere in the criminal law). Had the touching been pleaded as being "sexual", and had the Tribunal asked themselves whether in all the circumstances, which includes the absence of accident (cf. section 3(1)(a)), absence of consent (cf. section 3(1)(c)) and any clinical or other proper justification (cf. section 78(b)), then it seems to me impossible they would have reached any conclusion other than that the touching was sexual.

Disposal

61. On behalf of Dr Haris it is submitted that if I were to accede to the submissions of the Appellant, all findings of fact made at Stage 1 should be quashed and the matter remitted to the MPTS for a full re-hearing on all issues of fact because it would not be appropriate to simply substitute a finding of sexual motivation in the absence of hearing particularly as the evidence of Dr Singh is relevant to sexual motivation at Stage 1 and was not available at the time.

62. I decline to take that course, which would in the circumstances be unnecessary and also disproportionately burdensome to the victims. I have read the material parts of the transcript and am sure that I am able to draw the conclusion clearly that the Tribunal's only available conclusion is that Allegation 4 was made out.

63. Further, I quash for the reasons given, essentially those advanced-on behalf of the GMC, the Tribunal's findings as to remediation, risk and sanction.

64. After careful consideration I conclude I should remit the matter of sanction to the Tribunal to decide. This will give Dr Haris and the Tribunal an opportunity to consider the true position, namely in light of the replaced finding on Allegation 4 and to explore the issues of risk and remediation and the public interest in that context.

SUMMARY of CONCLUSIONS

65. The Tribunal fell plainly into error in this case. The only reasonable deduction from the facts available to them was that Allegation 4 as to sexual motivation was made out.

66. The Tribunal's conclusions as to risk, remediation and sanction cannot stand and the matter will be remitted to a tribunal to decide again the question of sanction in this case.

ORDER

Before Mrs Justice Foster, sitting at the Royal Courts of Justice, the Strand, London, on 22 September 2020
UPON handing down judgment in the above matter remotely
IT IS ORDERED THAT:-

1. The appeal is allowed.

2. The decisions of the Medical Practitioners Tribunal in respect of sexual motivation, risk, remediation and sanction are quashed.

3. There shall be substituted a finding that Allegation 4 as to sexual motivation is proved.

4. This matter shall be remitted to the Medical Practitioners Tribunal Service for them to arrange for a Medical Practitioners Tribunal to decide the question of sanction.

5. The Respondent shall pay the Appellant's costs of and occasioned by the appeal in the agreed sum of £14,442.80.

20 September 2020

The Honourable Mrs Justice Foster