PUBLIC RECORD

Dates: 10/06/2024 - 13/06/2024

Medical Practitioner's name:	Dr Aravinden RATNAKUMAR
GMC reference number:	7659572
Primary medical qualification:	MB BS 2019 Kings College London

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment not found proved	Consideration of impairment not reached

Summary of outcome

Case concluded
IOT order revoked

Tribunal:

Legally Qualified Chair	Mrs Aaminah Khan
Lay Tribunal Member:	Mr Martyn Green
Medical Tribunal Member:	Mr Ian Crighton

Tribunal Clerk:	Mr John Poole

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Andrew Hockton, Counsel, instructed by the MPS
GMC Representative:	Ms Fiona McNeill, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 13/06/2024

Background

1. Dr Ratnakumar qualified as a doctor in 2019 from Kings College London and is currently training to become a General Practitioner ('GP'), having started a GP training programme in August 2021. At the time of the events which form the subject of this hearing, Dr Ratnakumar was a GP trainee employed by the Royal Surrey NHS Foundation Trust ('the Trust') and was working at the Woodbridge Hill Surgery ('the Surgery') in Guildford.

2. The allegation that has led to Dr Ratnakumar's hearing can be summarised as follows. On 9 May 2022, Dr Ratnakumar consulted with Patient A and during a chest examination is alleged to have inappropriately cupped her breasts underneath her clothing, moved his hand down over Patient A's breasts, and touched and/or pushed in Patient A's nipples. It is the GMC's case that Dr Ratnakumar's conduct was not clinically indicated, carried out without Patient A's consent, and was sexually motivated. It is also alleged that Dr Ratnakumar failed to record in Patient A's medical notes that he had undertaken an examination of Patient A's stomach.

3. The initial concerns were raised by Patient A in two emails sent by her to the Surgery on 20 September 2022. At the time of the events Patient A was 21 years old. The Surgery conducted an internal investigation which involved interviews with both Patient A and Dr Ratnakumar. The matter was also referred to the Royal Surrey Country Hospital and to the police. In November 2022 following an investigation, the police decided to take no further action. The Trust referred Dr Ratnakumar to the GMC on 15 December 2022.

The Outcome of Applications Made during the Facts Stage

4. The Tribunal granted an application made on behalf of Dr Ratnakumar by Mr Andrew Hockton, Counsel, to admit into evidence a bundle of testimonial evidence in accordance with Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'). The Tribunal's full decision on the application is included at Annex A.

The Allegation and the Doctor's Response

5. The Allegation made against Dr Ratnakumar is as follows:

1. On 9 May 2022, you consulted with Patient A and you inappropriately:

a. cupped Patient A's breasts underneath her clothing; To be determined

b. moved your hand down over Patient A's breasts; To be determined

c. touched and or/pushed in Patient A's nipples, using your fingers. To be determined

2. Your conduct as described at paragraph 1 above was:

a. not clinically indicated; To be determined

b. carried out without Patient A's consent; To be determined

c. sexually motivated. To be determined

3. You failed to record in Patient A's medical records that you had undertaken an examination of Patient A's stomach. To be determined

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. To be determined

The Facts to be Determined

6. In light of Dr Ratnakumar's response to the Allegation made against him, the Tribunal is required to determine the entirety of the Allegation.

Witness Evidence

7. The Tribunal received evidence on behalf of the GMC from Patient A, via video-link. She provided a witness statement to the GMC dated 1 June 2023, and an undated supplemental statement.

8. Dr Ratnakumar provided his own witness statement, dated 18 April 2024, and gave oral evidence.

9. The Tribunal also received testimonial evidence in support of Dr Ratnakumar, including from Dr B, who is Dr Ratnakumar's educational supervisor and GP trainer, who also gave oral evidence to the Tribunal via video-link.

Expert Witness Evidence

10. The Tribunal also received evidence from Dr C, a GP Principal and expert witness on GP practice. He provided a report dated 1 July 2023 and also an undated supplemental report.

11. In summary, Dr C's evidence was that if there was an examination of Patient A's breasts in the way she described, it was not clinically indicated, would have required consent as it would have been an intimate examination, and Dr Ratnakumar's conduct would have fallen seriously below the standard expected. However, Dr C's opinion was that if the chest examination took place as described by Dr Ratnakumar (limited to listening to the back of the chest), then a chaperone would not have been required, as that would not be an intimate examination and Dr Ratnakumar's conduct would not have fallen below the standards expected.

Documentary Evidence

12. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:

- Police Witness Statement of Patient A, dated 3 November 2022
- Patient A's emails to the surgery, 20 September 2022
- The surgery's meeting notes from meetings with Patient A regarding her complaint on 21 September 2022 and 5 October 2022
- The surgery's meeting notes from a meeting with Dr Ratnakumar on 28 September 2022
- Letter to Dr Ratnakumar dated 28 October 2022 – summary of meeting on 21 October 2022
- Letter to Dr Ratnakumar dated 14 November 2022 – summary of meeting on 4 November 2022
- Various correspondence with the Trust, Surgery and Practitioner Performance Advice
- Surrey Police – Crime Report – occurrence enquiry log report
- Dr Ratnakumar's prepared statement to Surrey Police, dated 23 November 2022
- Medical Records of Patient A (relevant extracts)
- Photographs of Dr Ratnakumar dated 9 May 2022 (the day of the consultation with Patient A)

The Tribunal's Approach

13. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Ratnakumar does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.

14. The LQC referred the Tribunal to the case of *Byrne v General Medical Council [2021] EWHC 2237 (Admin) (10 August 2021)*. She advised that the Tribunal has to weigh the inherent improbability of the practitioner acting as alleged against the relative improbability of the witness fabricating the allegations. She drew the Tribunal's attention to the following part of *Byrne* where it was advised*:*

> *'The inherent probability or improbability of an event is a matter which can be taken into account when weighing the probabilities and in deciding whether the event occurred. Where an event is inherently improbable, it may take better evidence to persuade the judge that it has happened. This goes to the quality of evidence…'*

15. The LQC advised that where possible, factual findings should be based on objective facts, as shown by contemporaneous documents. However, corroborating documentary evidence is not always required or available. Where the case turns upon which oral account to accept, the approach of first considering documentary evidence before assessing the credibility of a witness's oral account has less significance and the Tribunal can, in those circumstances, place substantial reliance on oral evidence (*Byrne v General Medical Council* [2021] EWHC 2237 (Admin)).

16. When considering credibility, the LQC reminded the Tribunal of the guidance given in the case of *Dutta v GMC [2020] EWHC 1974 (Admin)* where tribunals were warned against assessing credibility either solely or largely based on demeanour, as this can lead to errors. It was advised that the stronger or more vivid a person's recollection is, does not make it more accurate. And the more confident a person is, does not make their account more accurate; a confident witness can have a false memory of an event. The LQC advised that the Tribunal should consider all of the evidence before coming to conclusions on credibility. Furthermore, credibility can also be divisible, and it is open to the Tribunal to accept some parts of a witness's evidence but to reject others.

17. The LQC advised that the Tribunal should also bear in mind when considering the issue of any delay in reporting a complaint that it may take several months or years for victims of sexual abuse to come to terms with what has happened to them. She observed that this was a point that came up in the case of *Roy* v *General Medical Council [2023] EWHC 2659 (Admin)*, where the High Court stated that it needs to be appreciated by Tribunals.

18. In regard to the allegation of sexual motivation, the LQC reminded the Tribunal of the case of *Basson v GMC* [2018] EWHC 505 where it was described that:

> *'A sexual motive means that the conduct was done either in pursuit of sexual gratification, or in pursuit of a future sexual relationship'.*

19. The Tribunal was reminded that sexual motivation can be inferred from the circumstances. The LQC referred the Tribunal of the case of *Haris v General Medical Council [2021] EWCA Civ 763*, where it was held that the best evidence of sexual motivation can be the behaviour itself and it might be appropriate to draw an inference of sexual

motivation which can be in some cases an irresistible inference if the only way that the behaviour could be perceived was overtly sexual and in the absence of any other plausible innocent explanation.

20. The LQC advised that Dr Ratnakumar is of good character. She advised that good character evidence was relevant at the fact stage as Dr Ratnakumar's credibility is an issue. The Tribunal was provided with a testimonial bundle and heard oral evidence from a testimonial witness in support of Dr Ratnakumar. The LQC advised that what weight to attach to the good character evidence is a matter for the Tribunal. Good character is not a defence, but it is an important factor that is capable of assisting the doctor in two ways. Firstly, in considering whether his evidence is credible and, secondly, how likely it is that he acted as alleged.

21. The LQC reminded the Tribunal of the case of *Sawati v GMC [2022] EWHC 283 (Admin)* which also dealt with good character and reiterated principles including the significance of good character evidence and that it should not be overstated and detract from the primary focus of the evidence.

The Tribunal's Analysis of the Evidence and Findings

22. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

Paragraph 1

23. The Tribunal considered whether on 9 May 2022, Dr Ratnakumar consulted with Patient A and inappropriately cupped her breasts underneath her clothing; moved his hand down over her breasts; and touched and or/pushed in Patient A's nipples, using his fingers.

24. Patient A's evidence was that on 7 May 2022 she had become quite ill with tonsillitis but due to it being a weekend she was unable to obtain an appointment and so called the Surgery on the morning of Monday 9 May 2022. She was offered a lunchtime appointment to be seen face to face.

25. The Tribunal had regard to the note of the telephone call in Patient A's medical records at 09:01 on 9 May 2022. The Tribunal had heard evidence that this had been made by a paramedic with whom Patient A had spoken to over the phone prior to her consultation with Dr Ratnakumar. The presenting problem recorded was '*Upper respiratory infection (Flare Up)'* rather than tonsillitis. It also recorded a number of symptoms in the history taken, including a productive cough.

26. Patient A had no recollection of any discussion with a paramedic and had thought she had only spoken with a receptionist who had booked the appointment for her later that day. Patient A also had no memory of having a cough and stated when questioned that she stood

by her evidence that she did not have a cough. She believed that the appointment was only for her tonsils and glands to be checked.

27. In her GMC witness statement, Patient A said that she told Dr Ratnakumar that she was suffering with tonsillitis and advised him of her symptoms. She stated that he asked to conduct an examination of her throat and tonsils to which she consented. She stated that Dr Ratnakumar confirmed that her tonsils were red and that she had tonsilitis. Patient A stated that Dr Ratnakumar asked to conduct a chest examination to check her breathing and to rule out anything further associated with the tonsillitis.

28. Patient A stated that Dr Ratnakumar did not provide her with any further information about what the chest examination would entail nor explain if any instruments would be used. She said that he asked if she wished to have a chaperone present whilst conducting the chest examination and that she confirmed she did. She stated that Dr Ratnakumar left the consultation but returned after a short time and advised there were no chaperones available but they could wait. She stated that he asked if he could proceed with the chest examination in the absence of a chaperone. Patient A stated:

> *'…At this point, I did feel quite uncomfortable, but I did not want to be an inconvenience, so I just said yes. Dr Ratnakumar did not provide me with any alternate options, and I felt I had to proceed with the examination.*
>
> *My understanding of the chest examination was that Dr Ratnakumar would listen to the very top of my chest area with a stethoscope. I also thought he may listen to the back of my chest as he specifically stated he wished to check my breathing. I did not ask any questions as I had previously had a chest examination conducted by other doctors without any issues.*
>
> *Prior to conducting the chest examination, Dr Ratnakumar did not provide an explanation of what he would be doing as part of the examination. I recall that it was a very warm day, and I was wearing a maxi dress which had a low slit in the leg. I would describe the dress as a light, breezy sundress. It had a button positioned round the back of the neck. Due to the warm weather, I was not wearing a bra. Dr Ratnakumar asked if he could unbutton the dress to gain access to my back area.*
>
> *I recall that Dr Ratnakumar had asked me to stand, and he had positioned himself directly behind me. I felt that he was extremely close to me, and he proceeded to undo the button at the back of my dress. He proceeded to place both his hands inside my dress onto the back of my ribs. I believed he listened to my breathing for approximately 10 seconds, and he did not utilise any instruments, only his hands.*
>
> *He then proceeded to move both his hands from my back to the front of my ribs, just underneath my breasts. He did not inform me that he intended to move his hands and he was still positioned directly behind me which made me feel extremely uncomfortable. I recall that he did not say anything to me apart from asking me to*

breath [sic] *in and out. I recall that on the next breath, he turned his palms upwards and positioned his hands directly underneath my breasts. I became panicked and was too shocked to say anything. Dr Ratnakumar then proceeded to take hold of my breasts so both his hands were completely covering them. Dr Ratnakumar had stopped asking me to breathe in and out and the room was silent. I recall being conscious of how close behind me he was stood, and I could feel his legs against mine which made me feel quite scared.*

Dr Ratnakumar then proceeded to move his hands down over my breasts and left two fingers covering each of my nipples and was slowly pushing them in. I would approximate that the feeling of my nipples lasted for approximately 10 seconds. He then finally withdrew his hands from the back of my dress. I recall that this whole encounter felt like it went on for a long time but in reality, I would approximate that it was less than a minute…'

29. The Tribunal noted that Patient A went on to state that:

'As soon as I closed the door and left the consultation, I knew what Dr Ratnakumar had done was not right and I felt extremely uncomfortable and violated. I proceeded to walk out of the surgery to find my dad who was waiting in the car. On the way to the car, I called my boyfriend at the time and told him that I had been seen by the doctor, but the consultation felt very strange.

When I got in the car with my dad, I did not say anything immediately to him. It was only when we arrived [XXX], and it was playing on my mind that I casually mentioned to him that the doctor was strange, and he stroked my arm when he was conducting a stomach examination. My dad did seem concerned but suggested that maybe the doctor was attempting to comfort me.

It took me months to come to terms with what had happened and realise that I needed to do something. It felt like it had not happened to me, and I had ignored it rather than let it sink in..'

30. Patient A also gave evidence regarding an abdominal examination, during which she described that her arm was stroked by Dr Ratnakumar, which took place towards the end of the consultation, after she had mentioned IBS symptoms. In her oral evidence she also stated that in addition to telling her boyfriend at the time and her dad that the consultation seemed strange, she said she had also discussed her concerns with a friend she had bumped into in Tesco. In addition, Patient A later discussed the consultation with four XXX friends and her mother prior to making the written complaint.

31. The Tribunal had regard to the most contemporary evidence available regarding what occurred in the consultation which was Dr Ratnakumar's contemporaneous note in Patient A's medical record made on 9 May 2022. Dr Ratnakumar recorded the problem as *'Pharyngitis'*, and noted a history of a recent sore throat since Saturday, previous episodes of

a sore throat and that antibiotics had not been found to be helpful. He also noted *'considering looking into private care for tonsillectomy.'* In his entry by Examination, Dr Ratnakumar recorded:

> *'…No increased WOB, chest clear from back, not examined at front. Good ROM at neck in all planes of movement*
>
> *No cervical lymph nodes palpable. She has felt her own axillary area- no lymph nodes*
>
> *Throat clear, no exudate present.'*

32. The Tribunal considered that this was a clear and detailed note of the consultation and that the note supports that a chest examination, from the back, took place. Further, Dr Ratnakumar's note of the consultation contained no reference to IBS symptoms or of an abdominal examination taking place.

33. The Tribunal had regard Dr Ratnakumar's evidence. In his witness statement he stated: *'I categorically deny that at any time during the consultation with Patient A that I made any contact with Patient A's breasts. This did not happen…'*

34. Dr Ratnakumar relied on the medical notes of the consultation which he made at the time, his normal practice and the other documentary evidence available. He stated that whilst he had no memory of the consultation, he did *'recall having a conversation about tonsillectomy with a patient although I cannot be sure if it was with Patient A'.* He added that:

> *'I had consulted with approximately 700 patients in General Practice (and more patients at the local hospice) between when this patient was seen and when the complaint was made. This appears to be a clinically unremarkable consultation about a cough, fever and sore throat, which are extremely common symptoms in general practice. I have therefore primarily based my statement on the contemporaneous medical records which were made at the time of the consultation and my usual practice..'*

35. Dr Ratnakumar also stated that:

> *'As I was new into my training, I was assiduous in making sure I took accurate notes of all the consultations I had with patients… I was one month into my training post as a GP Registrar, and I would meet with a GP at the end of every morning and afternoon to talk through and review the medical notes for the patients from that session. I would also meet weekly with my Educational Supervisor and Trainer, who was [Dr B], and we would go through patients and medical notes from the week.*
>
> *Within those meetings we would often discuss the consultations which I had and whether there were any questions/queries or follow up points which I would wish to discuss. I would also go through the notes I made for consultations I had carried out. It*

was precisely because of this close supervision, that my mindset was always to ensure that as much detail as possible was included within the notes to accurately reflect the consultation that I had had with a patient…'

36. In his witness statement, Dr Ratnakumar stated that considering Patient A's symptoms of a cough with sputum and fever, he needed to conduct an examination of her lungs. He stated that in light of what Patient A stated she was wearing, he would have needed to request a chaperone present so that he could conduct an examination of the front and back of her chest, however, with no chaperone present:

'I can see that I suggested as an appropriate alternative, that I would examine Patient A from the back only and not the front. This is again clearly documented within Patient A's medical records as I have documented "chest clear from the back, not examined from the front". I have made a conscious effort not to examine the front of the chest and to clearly document this at the time. This would be an effective way of completing a clinically conclusive examination without unnecessarily exposing the patient from the front or asking her to remove clothing to reveal intimate areas…'

37. The Tribunal noted that Patient A was adamant in her evidence that Dr Ratnakumar did not use a stethoscope and that he listened to her breathing from behind her back without its use. However, the Tribunal considered that it was unlikely that a doctor who made a note *'chest clear from back'* would have done so without having used a stethoscope, and Dr C's evidence was that he would assume a stethoscope was used from the note made by Dr Ratnakumar.

38. The Tribunal considered the two contrasting accounts given by both Patient A and Dr Ratnakumar as to what was said during this appointment, which involved a careful consideration of the credibility and reliability of their evidence. The Tribunal noted that Patient A first put her account of events in writing via the complaint to the Surgery in her two emails sent on 20 September 2022, some four and half months after the consultation on 9 May 2022. Patient A had given evidence that she did not report it earlier as she had tried to forget it and was having CBT treatment for other issues, which she successfully resolved. However, she then started to have recurring nightmares, where she would relive the consultation, in about September 2022.

39. The Tribunal was mindful, as per the case of *Roy,* that it can take time before victims of sexual abuse come to terms with what has happened. As such, the Tribunal did not consider this lapse of time to be unusual. However, given the time that had elapsed since the consultation when Patient A came to write her first account of it, this would inevitably in the Tribunal's view have an affect upon her recollection of events, which would not be as fresh in her mind as it would have been had she written an account sooner. In addition, in the Tribunal's view there were other intervening events, between the consultation and Patient A's first written account of it, which may have had an impact on her recollection, in particular a similar consultation at the surgery, with a different male GP, just over a month later on 14 June 2022, which she was unable to recall.

40. The Tribunal noted that since making the initial complaint, Patient A has had to give her account of events on several occasions, to the surgery, the police, the GMC and to the Tribunal. Whilst there may be some variations in the details between these accounts, the Tribunal was of the view some degree of variation is to be expected when a witness is retelling an account in different contexts. In addition, it was the view of the Tribunal that Patient A has not wavered from her core account. In her oral evidence she stated that *'If it didn't happen, why am I here? Why am I having nightmares?'.*

41. The Tribunal considered that Patient A did her best to assist the Tribunal with her evidence. The Tribunal formed the view that Patient A was not being untruthful or seeking to mislead the Tribunal in any way, nor had she any motive to do so. However, there were several instances where the evidence of Patient A was clearly incorrect. For example, Patient A had given a clear description of Dr Ratnakumar in her police witness statement, detailing the colour of his shirt, that he was clean shaven, his style of glasses and hair. The Tribunal was provided with a photograph of Dr Ratnakumar taken that day after work, and considered that the description given by Patient A was markedly different to Dr Ratnakumar's appearance that day.

42. Furthermore, the Tribunal noted that Patient A was unwilling to make concessions in her evidence even where contemporaneous documents may show otherwise. For example, when Patient A was asked about the fact that the paramedic had recorded that she had a productive cough, which she did not accept was correct. In oral evidence Patient A also stated that her recall of the consultation was a '*blur*' and like a '*dream*', commenting that it was as if the incident had happened to someone else. The Tribunal found these comments concerning when considering the quality and reliability of Patient A's evidence and recollection. The Tribunal was also mindful that there had been discussions between Patient A and her friends and family members about the consultation on several occasions prior to her writing her first account on 20 September 2022, which may have had an impact upon her recollection or perception of events.

43. The Tribunal also considered it significant that Patient A had a consultation on 14 June 2022 with another doctor at which there was a chest and heart examination. The expert witness, Dr C, was asked in his evidence what a heart examination would ordinarily involve and he stated that it 'inevitably' involves some contact with the breasts. Furthermore, in this consultation, it was recorded in the GP notes that Patient A had raised IBS symptoms in this appointment. However, Patient A had no recollection of this consultation when asked.

44. Overall, the Tribunal did not consider Patient A's account to be reliable and considered that she may have misremembered or confused parts of the consultation.

45. The Tribunal considered that although Dr Ratnakumar was unable to give his recollection of the consultation, the contemporary evidence of the GP records supports his account. It bore in mind his good character, and the testimonial evidence before it, which spoke highly of Dr Ratnakumar's character and the standard of his record keeping. The Tribunal was mindful that good character was relevant to his credibility and also the

likelihood that he would have acted as alleged. The Tribunal also considered the inherent improbability of Dr Ratnakumar acting as alleged by Patient A, particularly as he was a trainee GP working under supervision. The Tribunal concluded that it was not satisfied that Patient A's account was reliable and the GMC had not discharged the burden upon it, on the balance of probabilities, to prove that it was more likely than not that Dr Ratnakumar had acted as alleged at paragraph 1a -c of the Allegation.

46. Accordingly, the Tribunal found paragraphs 1 a – c not proved.

Paragraph 2

47. Given that the Tribunal found paragraph 1 not proved, it follows that paragraph 2 is not proved.

Paragraph 3

48. The Tribunal considered whether Dr Ratnakumar failed to record in Patient A's medical records that he had undertaken an examination of her stomach.

49. In Patient A's witness statement, she stated that:

> *'After the chest examination, Dr Ratnakumar moved from behind me and sat down in his chair. He did not proceed to make any notes on the computer documenting the examination. I recall that I remained stood up and he asked me whether I had any other additional medical problems I wished to discuss. I was in a complete state of shock and panic and did not know what do. I thought that if I just spoke about my medical concerns, he would leave me alone.*
>
> *I told Dr Ratnakumar that I suffered with IBS, and he proposed to conduct an examination of my stomach. He did not provide me with any information of what the stomach examination would entail or why it was necessary to conduct such an examination. Dr Ratnakumar directed me to lie on the bed and I recall that I felt conscious of wearing a dress that had an open slit. I proceeded to adjust my dress to ensure that my legs were fully covered.*
>
> *I recall that Dr Ratnakumar proceeded to place his hands on my stomach over the top of my dress. He slowly moved his hands around my stomach area. I have suffered with IBS for a number of years and as such have had several stomach examinations. The examination that Dr Ratnakumar conducted on my stomach was completely different to examinations I have previously had. He was not properly feeling my stomach and was not asking me to breathe in and out. Dr Ratnakumar was performing a stroking motion over my stomach area as opposed to pushing and feeling different parts of my stomach.*

Whilst this examination was ongoing, I felt extremely uncomfortable and shaky. I recall that as a result of panic I was talking excessively about my stomach and IBS. Dr Ratnakumar was staring at me sympathetically, but it was as if he was not listening to what I was saying and was completely zoned out. I recall being terrified of him moving his hands lower than my stomach and I felt vulnerable and as if I mentally had to prepare myself for something worse to happen.

He proceeded to move his hands from my stomach to my right arm. He began stroking and caressing my arm whilst attempting to stare into my eyes. I found this extremely uncomfortable, and he was behaving very strangely. He was stroking the top of my right arm, just below my shoulder. I would approximate that he was stroking my arm for approximately 10 seconds, but it felt so much longer. I proceeded to sit up to indicate that the examination was over. If I had not have done so, I believe Dr Ratnakumar would have continued to stroke my stomach and arm in an inappropriate manner. I felt unsafe led down on the bed and just wanted the examination to be over..;

50. Dr Ratnakumar stated that he:

'did not conduct an abdominal examination on Patient A. Had I performed an abdominal examination I would have documented this in Patient A's medical notes.'

51. The Tribunal considered that the contemporary medical note supports Dr Ratnakumar's account. There was no record of IBS symptoms nor of an examination of the abdomen, which the Tribunal considered would have more likely than not have been recorded had they arisen in this consultation. It determined that there was no contemporary evidence to support that an examination of the stomach took place.

52. As set out above, the Tribunal had concerns regarding the reliability of Patient A's account. It also bore in mind Dr Ratnakumar's good character and evidence relating to his record keeping. He was new in his training and he was assiduous in making sure he took accurate notes of all his consultations with patients. The Tribunal determined that it was inherently unlikely that he conducted an examination of the stomach and made no note of it.

53. Accordingly, the Tribunal found paragraph 3 not proved.

The Tribunal's Overall Determination on the Facts

54. The Tribunal has determined the facts as follows:

1. On 9 May 2022, you consulted with Patient A and you inappropriately:

    a. cupped Patient A's breasts underneath her clothing; **Not proved**

b. moved your hand down over Patient A's breasts; Not proved

c. touched and or/pushed in Patient A's nipples, using your fingers. Not proved

2. Your conduct as described at paragraph 1 above was:

a. not clinically indicated; Not proved

b. carried out without Patient A's consent; Not proved

c. sexually motivated. Not proved

3. You failed to record in Patient A's medical records that you had undertaken an examination of Patient A's stomach. Not proved

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. Consideration of impairment not reached

55. As the Tribunal found none of the facts proved, it did not proceed to stage 2.

56. The Tribunal determined to revoke the interim order with immediate effect.

57. That concludes the case.

ANNEX A – 13/06/2024

Application to admit character evidence

Submissions on behalf of Dr Ratnakumar

1. On Day 2 of the hearing, Mr Hockton, on behalf of Dr Ratnakumar, made an application to admit into evidence a bundle of documents containing testimonial evidence and patient feedback evidence.

2. Mr Hockton submitted that the evidence was admissible as it goes to the central issues which the Tribunal need to consider at the fact-finding stage. He submitted that it was relevant to Dr Ratnakumar's credibility and whether he acted in the way alleged. He submitted that the evidence supports Dr Ratnakumar's professionalism and integrity.

3. Mr Hockton submitted that he had never come across a case involving allegations of this sort where character evidence was not adduced on behalf of the medical practitioner, either in a criminal context or regulatory context. He submitted that it was important to have proper regard to the issue of character.

4. Mr Hockton reminded the Tribunal of Rule 31 of the Rules which imposes the requirement of fairness and relevance in relation to the admissibility of evidence. He submitted that it was both fair and relevant to admit the evidence at Stage 1, and that if the Tribunal decided not to, 'the horse would have bolted' by Stage 2, given the serious nature of the allegation. He submitted that it would be unfair not to admit the evidence at this stage.

GMC submissions

5. On behalf of the GMC, Ms McNeill submitted that there is a stark contrast in the evidence regarding what happened on 9 May 2022. She submitted that what may or not be glowing references for Dr Ratnakumar would not assist the Tribunal at this stage. She invited the Tribunal to refuse the application. She submitted however that they may become relevant at a later stage depending on the Tribunal's determination on the facts.

The Relevant Legal Principles

6. The Tribunal had regard to Rule 34(1) which states that:

> '*…a Tribunal may admit any such evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.*'

7. The LQC advised that a good character direction will be made in this case, and that in the case of *Sawati v GMC [2022] EWHC 283 (Admin),* it was reiterated that cogent evidence of positive good character is relevant to the consideration of dishonesty because it goes to

issues such as credibility; how reasonable it is to believe or disbelieve what an individual says, and the propensity and probability that they conducted themselves as alleged.

8. The LQC also directed the Tribunal to the case of *Wisson v Health Professions Council (2013) EWHC 1036* which reiterated that good character can be material when considering the credibility of the individual in question, where there is a dispute, and is not necessarily limited to dishonesty cases. The LQC advised that it was for the Tribunal to decide what weight to attached to good character evidence.

Tribunal's Decision

9. The Tribunal determined that the evidence was relevant to Dr Ratnakumar's good character and his propensity to act as alleged, which the Tribunal must consider in determining the Allegation.

10. The Tribunal was mindful that good character evidence was not determinative and it was a matter for the Tribunal to determine how much weight to attach it.

11. The Tribunal determined that it was relevant and fair to admit the documentation into evidence in accordance with Rule 34(1) of the Rules.

12. Accordingly, the Tribunal granted Mr Hockton's application.