PUBLIC RECORD

Dates: 02/11/2026 - 16/11/2026

Doctor:	Dr Balvinder MEHAT
GMC reference number:	2932198
Primary medical qualification:	MB ChB 1984 University of Bristol

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

Summary of outcome

No action (warning not considered)

Tribunal:

Legally Qualified Chair	Mrs Stacey Patel
Lay Tribunal Member:	Mrs Hannah De Merode
Registrant Tribunal Member:	Dr Patricia Moultrie

Tribunal Clerk:	Mr Joel Taylor-Garratt

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Ghazan Mahmood, Counsel, instructed by Weightmans
GMC Representative:	Mr Alan Taylor, 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.

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection 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 - 16/11/2026

Background

1. Dr Mehat qualified in 1984 from Bristol University. Prior to the events which are the subject of the hearing, Dr Mehat had worked as the Senior Partner at Bakersfield Medical Centre ('the Practice') since 1990, qualifying to perform minor surgery in 2005. At the time of the events, Dr Mehat was still practising as a Senior Partner, performing non-therapeutic circumcision since 2006.

2. The allegations that have led to Dr Mehat's hearing relate to his conduct. It is alleged by the General Medical Council (GMC) that Dr Mehat performed a non-therapeutic circumcision on Patient A without having established if his father, Mr B, had parental responsibility for the child and therefore needed to consent to the procedure. It is further alleged that, after the procedure, Dr Mehat inappropriately provided to Patient A's mother, Ms C, two pre-prepared disclaimer forms and a pre-prepared statement, all relating to the information she provided the Practice, which he asked her to sign and date.

3. The initial concerns were raised with the GMC on 27 October 2022 by Mr B. Dr Mehat also self referred to the GMC on 10 November 2022.

The Outcome of Applications made during the Facts Stage

4. The Tribunal granted an application from both parties to hear various witness' evidence via video link and also for the hearing to convert to remote means after day 5. These applications were not opposed by any party.

5. The Tribunal granted in part Dr Mehat's application, made pursuant to Rule 17(2)(g) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), that there was no case to answer in respect of several paragraphs of the Allegation. The Tribunal's full decision on the application is included at Annex A.

The Allegation and the Doctor's Response

6. The Allegation made against Dr Mehat is as follows:

That being registered under the Medical Act 1983 (as amended):

1. Between 17 October 2022 and 08 December 2022, you were responsible for the care of Patient A (a child aged 7 years) in relation to a non-therapeutic male circumcision ('the procedure') you carried out on him. Admitted and found proved

2. At all material times:

   a. Patient A was vulnerable due to his age; Admitted and found proved

   b. you knew that Patient A was vulnerable due to his age. Admitted and found proved

3. At all material times Mr B (Patient A's father) had parental responsibility for Patient A. Admitted and found proved

4. On 19 October 2022, at your place of work you carried out the procedure on Patient A, and you failed to:

   a. make sufficient enquiries to satisfy yourself as to whether or not Mr B had parental responsibility for Patient A to determine if you required his consent to the procedure; To be determined

   b. ~~include Patient A in the decision-making process for the procedure.~~ Removed following a successful Rule 17(2)(g) application

5. On 24 October 2022, five days after the procedure, at your place of work you provided to Ms C (Patient A's mother) a pre-prepared disclaimer form ('form D') for the procedure which you asked her to sign and date. **Admitted and found proved**

6. 0n 08 December 2022, at your place of work you provided to Ms C:

   a. a pre-prepared witness statement in her name regarding the procedure which you asked her to sign and date; **To be determined**

   b. a pre-prepared disclaimer form for the procedure which:

      i. you asked her to sign; **Admitted and found proved**
      ii. had been backdated to 19 October 2022. **Admitted and found proved**

7. Your conduct at paragraphs 5 and 6 was inappropriate and/or unprofessional. **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 Admitted Facts

7. At the outset of these proceedings, through his Counsel, Mr Mahmood, Dr Mehat made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

8. In light of Dr Mehat's response to the Allegation made against him, the Tribunal is required to determine whether Dr Mehat made sufficient enquiries as to Mr B's parental responsibility, whether he provided Ms C with a pre-prepared witness statement on 8 December 2022 and whether it was inappropriate and/or unprofessional to have provided that statement and the two pre-prepared disclaimer forms.

Witness Evidence

9. The Tribunal received oral evidence on behalf of the GMC from the following witnesses:

- Mr B, Patient A's father, in person on 3 November 2026. His witness statement was dated 15 May 2025;
- Ms C, Patient A's mother, by video link on 4 November 2026. Her witness statements were dated 31 January 2025 and 13 August 2026.

10. Dr Mehat provided his own witness statement, dated 22 October 2026, and also gave oral evidence at the hearing.

11. In addition, the Tribunal received evidence from the following witnesses on Dr Mehat's behalf:

- Ms D, Practice Manager at the Practice, via video link on 11 November 2026. Her witness statement was dated 22 October 2026;
- Ms E, Healthcare Assistant at the Practice, via video link on 11 November 2026. Her witness statement was dated 21 October 2026.

Expert Witness Evidence

12. The Tribunal also received evidence from an expert witness, Dr F, who was called by the GMC and provided a report dated 15 September 2025, to which he added an addendum on 29 May 2026. Dr F also gave oral evidence at the hearing. Dr F is a Consultant Paediatric Surgeon and his evidence was directed at assisting the Tribunal in understanding whether Dr Mehat inappropriately conducted the procedure without Mr B's consent, whether Patient A should have been involved in discussions and whether it was inappropriate for Dr Mehat to ask Ms C to sign the pre-prepared disclaimer forms and the witness statement.

Documentary Evidence

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

- Correspondence between the Practice and Mr B regarding his complaints about the procedure;
- ID documents of Ms C and Patient A, including his birth certificate;
- The consent form for the procedure, signed by Ms C;
- The disclaimer forms, the statement signed by Ms C on 8 December 2022 and associated email chains;
- Metadata of the 8 December statement;

- XXX regarding Mr B's parental responsibility;
- Letters written by Ms C, dated 9 and 14 December 2022.

The Tribunal's Approach

14. In reaching its decision on the facts, the Tribunal will apply the civil standard of proof. This means that the Tribunal must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged. The burden of proof rests with the GMC and it is for the GMC to prove the case that it is presenting against the doctor. There is no burden on the doctor to prove or disprove anything.

15. The Tribunal will approach fact finding by firstly identifying agreed facts and evidence. To reach a decision on the disputed facts, the Tribunal will assess the evidence in the round. It will consider what conclusions and inferences can be drawn from the documentary evidence. The Tribunal will then consider the available oral evidence and subject that evidence to critical scrutiny against the agreed facts and documentary evidence to consider a witness's reliability and credibility. The Tribunal should not decide reliability and credibility based on the demeanour of a witness alone.

16. Paragraph 4 of the Allegation includes the word 'failed', which implies that there was a duty upon Dr Mehat. The Tribunal must first establish what that duty was and then whether Dr Mehat failed to uphold it. The Tribunal must consider what is a reasonable duty and standard to be expected of a doctor.

17. There is no heightened standard of proof in certain classes of case. It is not correct that the more serious the nature of the allegations made, the higher the standard of proof required.

The Tribunal's Analysis of the Evidence and Findings

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

Paragraph 4(a)

19. The Tribunal first considered what obligation or duty there was upon Dr Mehat to establish whether Mr B had parental responsibility for Patient A and where that duty was

derived from. The Tribunal had been referred to BMA and GMC guidance on the subject of consent and parental responsibility in circumcisions, provided by Dr F.

20. The BMA guidance, *Non-therapeutic male circumcision (NTMC) of children – practical guidance for doctors,* states that non-therapeutic circumcision should not be undertaken against the wishes of a parent, unlike in other treatments where one parent's consent may be sufficient. It says that *'…where a child has two parents with parental responsibility, doctors considering circumcising a child must satisfy themselves that both have the necessary parental authority and have given valid consent. Where a child has only one parent, obviously that person can give their consent alone.'* This guidance also quotes GMC guidance that says *'you should get consent from all those with parental responsibility.'*

21. Further BMA guidance, *The law and ethics of male circumcision: guidance for doctors,* also states that *'The BMA and GMC have long recommended that consent should be sought from both parents.'*

22. The Tribunal considered that this guidance meant it was not controversial that there was a duty on Dr Mehat to seek consent from anyone with parental responsibility before performing the procedure.

23. The Tribunal then set out to establish what Dr Mehat knew at the relevant times.

24. The Tribunal considered the evidence of Mr B. However, as he himself had stated that he was not aware the procedure was taking place on 19 October 2022, the Tribunal was not assisted by his evidence.

25. On 17 October 2022, Ms C first had a telephone consultation with the Practice ahead of the procedure on 19 October 2022. The Tribunal noted that there were discrepancies in Ms C's statements about what occurred in this appointment, including who she spoke to. In her initial statement, she said that she had spoken to reception/admin staff *'…to my recollection, not with Dr Mehat.'* However, in her second statement, she stated that Dr Mehat explained the procedure itself and asked her to bring in Patient A's birth certificate but did not discuss Patient A's father or ask for her marriage certificate. In oral evidence, Ms C said that she could not remember who she spoke to or if they discussed parental responsibility.

26. Ms C's statement of 8 December 2022, which she signed and affirmed in evidence was true, stated:

'I had a telephone consultation with Dr B Mehat on the 17th October 2022 when Dr Mehat explained the procedure and pre-procedural requirements e.g. consent from all those with parental responsibility. He enquired about whether the child's father was named on the birth certificate and whether he had parental responsibility. To this I replied that no father was not named on the birth certificate and the father did not have parental responsibility.'

27. In cross examination, Ms C was inconsistent on a number of areas. She was asked if Dr Mehat had asked on 17 October if she was married, to which she answered that he might have but she couldn't remember.

28. On 19 October 2022, Ms C attended the Practice with Patient A for the procedure. She provided Patient A's birth certificate, which did not include a father's name, and signed the consent form for the procedure without mentioning Mr B. The Tribunal noted that the consent form included declarations that *'all those with parental responsibility are aware of the procedure above to be carried out without any disagreement or disputes.'* In cross examination, Ms C confirmed that she understood the content of the consent form and signed it accordingly.

29. In her second statement, Ms C stated that Dr Mehat asked about Patient A's father for the first time on 19 October, to which she answered that he was very active in his life. This was contradictory to her first witness statement, where she stated there was no conversation about the father. Ms C also said in oral evidence that she signed the consent form because she did not believe that Mr B had parental responsibility for Patient A. However, in cross examination she said that she could not remember staff asking her about Patient A's father or if she told Dr Mehat that he was not involved in Patient A's life. She did not recall if she was asked about her marital status but said it was possible she had been and merely forgot. At one point in her evidence, she agreed that she had been asked about her marital status on 19 October.

30. The Tribunal considered that Ms C had given significantly conflicting evidence about what had been discussed on 17 and 19 October 2022 relating to her marital status and Mr B's parental responsibility.

31. The Tribunal considered that the consent form was the most significant contemporaneous document. Ms C had signed it without including details of Mr B and had given evidence that she understood the form and that the information was true. The Tribunal also noted that Ms C had signed the two disclaimers on 24 October and 8

December, which she maintained in oral evidence were accurate, both of which affirmed that the information she had given on 19 October was accurate. The Tribunal noted that, by 8 December 2022, Ms C had XXX which had affirmed Mr B's parental responsibility and that she knew that. Despite this, Ms C still declared on the disclaimer of 8 December 2022 that no person other than herself had ever had parental responsibility for Patient A.

32. The Tribunal further noted the statement of 8 December, signed and affirmed in evidence by Ms C as true, that stated *'Dr Mehat took every step to ensure that there was no other person with parental responsibility for Patient A.'* At no point in her statements, letters to the Practice or in oral evidence at the hearing did Ms C claim that the content of this statement was untrue.

33. The Tribunal considered that, overall, the contemporaneous records indicated that Dr Mehat did make enquiries. The Tribunal's general assessment of Ms C's evidence was that she was unreliable and not a credible witness. She had repeatedly changed her evidence, often being unable to recall significant details. The Tribunal took into account the passage of time and the pressure of cross examination but considered that this was not sufficient to account for the major inconsistencies in her evidence, nor would it explain the conflicts between her different statements. The Tribunal considered that there was a question of how truthfully Ms C completed the consent and disclaimer forms – even if the Tribunal accepted she did not know on 19 October that Mr B had parental responsibility, she knew this had been affirmed XXX by 8 December and yet she still declared in her 8 December disclaimer that no other person ever had parental responsibility from Patient A.

34. The Tribunal considered that, in light of the evidence, it was fair to conclude that Dr Mehat made at least some enquiries on 19 October as to who had parental responsibility for Patient A, and Ms C's marital status. It now had to decide if these enquiries were sufficient.

35. Dr Mehat's evidence was that he discussed parental responsibility and Ms C's marital status on 17 October 2022 and was told that she was not married and no-one else had parental responsibility. Dr Mehat was consistent in his oral evidence and under cross examination. Ms D's evidence and that of Ms E was also consistent throughout cross examination and with that of Dr Mehat. The Tribunal considered that Ms D and Ms E both had close relationships with Dr Mehat but that there was no evidence that either had attended to support Dr Mehat inappropriately and the Tribunal considered that there was no reason to doubt their credibility.

36. The Tribunal considered that Dr Mehat's evidence was credible and reliable, supported by contemporaneous documentation. The Tribunal was satisfied that he had made enquiries about who had parental responsibility for Patient A and was told directly that Ms C was the only one. She had signed the consent form, provided a birth certificate without a father's name and told Dr Mehat that she was not married.

37. The Tribunal noted the question of whether Dr Mehat should have done more to establish parental responsibility in light of Patient A being a XXX child with XXX different from that of his mother. The Tribunal considered that a 7 year old child would not be able to answer questions about his parents' marital status or on parental responsibility. The Tribunal also noted that Dr F had not stated that this should have been done.

38. In light of the above, the Tribunal concluded that Dr Mehat had made enquiries about parental responsibility and that the GMC had failed to prove that these were insufficient. As such, it determined that paragraph 4(a) of the Allegation was not proved.

Paragraph 6(a)

39. The Tribunal then went on to consider if Dr Mehat had provided a pre-prepared statement for Ms C to sign on 8 December 2022.

40. The Tribunal considered the evidence of Mr B. However, as he was not present on this date, his evidence did not assist the Tribunal in determining whether Dr Mehat provided a pre-prepared statement to Ms C.

41. The Tribunal noted that Ms C, in her first GMC statement, had said that this statement had already been drafted for her to sign. In her oral evidence, she said that the content of the statement was true. She said in oral evidence that she could not recall dictating the statement but accepted that might have happened. She said *'I don't believe the statement was not my dictation, I can remember the statement was ready…it's possible I dictated it.'* Also: *'they presented the statement to me, I don't know if I dictated parts of it.'* The Tribunal considered that, at various times in her evidence, Ms C had accepted that she may have dictated the statement, at least in part. Ms C was also unclear about who specifically it was that provided that statement for her signature.

42. The Tribunal considered that it was unable to conclude that it was Dr Mehat who provided the statement to Ms C.

43. The Tribunal noted that Ms C's oral evidence contradicted her previous evidence that this was a typed statement that was merely provided to her to sign. Ms C had clearly stated that she had spoken on the phone to the Practice about these issues in the days prior to 8 December. Her oral evidence was that there were several conversations beforehand. In all her evidence, Ms C accepted that the contents of the statement were true and that the details must have come from her, possibly from her dictation.

44. The Tribunal had regard to the letters from Ms C dated 9 and 14 December. It noted that the 9 December letter was of unknown provenance. In neither of these letters did Ms C take issue with the content of her 8 December statement, only with how it was prepared. The Tribunal also considered that there was no indication in the emails themselves that Ms C was unhappy with the statement or of any tension. They appeared to reflect a cordial mutual discussion about the exchange of documents.

45. Dr Mehat's evidence was that Ms C was invited into the Practice to discuss the information she had previously provided as part of a fact finding exercise to confirm what information she had given. His evidence, supported by that of Ms D and Ms E, was that they had this discussion and Ms C began to dictate a statement with Ms E present. Ms E then attended to patients while Ms C and Ms D went to a different room to type up the statement.

46. The Tribunal was not satisfied that the statement was pre-prepared for Ms C to sign. The metadata provided supported the fact that the statement document was worked on at a time of day and for a period of time that was consistent with the account put forward by Ms D. The Tribunal considered that Ms C had been involved in the statement's creation, providing details and dictating at least some parts. As such, the Tribunal determined that this paragraph of the Allegation was not proved.

Paragraph 7

47. The Tribunal moved on to consider whether the provision of the disclaimer forms was inappropriate or unprofessional. It noted that, having found paragraph 6(a) not proved, this paragraph only could only relate to paragraphs 5 and 6(b) – namely the disclaimer forms of 24 October and 8 December 2022.

48. The Tribunal considered that Ms C had been called back to the Practice on 24 October and 8 December 2022 in order to document what information she had provided in relation to the procedure. These were not enhanced consent forms, as Ms C described them, but rather disclaimers. The Tribunal noted that Dr Mehat was facing a complaint

from Mr B about him having performed the procedure on Patient A without his consent and had learned that the situation was not how he had previously believed, namely that Ms C did not have sole parental responsibility for Patient A.

49. The Tribunal considered that there was no indication on either of these forms that they were intended to mislead or provide retrospective consent, these were for Ms C to affirm the information she had provided. The Tribunal noted that Ms C did not dispute the content of these documents. The Tribunal considered that, whilst this may not have been best practice, it was not necessarily inappropriate or unprofessional for a doctor to try and document the information they had received in an evolving situation.

50. The Tribunal noted that Dr Mehat had acknowledged not following the protocol set down by the Practice but considered that this was an internal document to aid their process, it was not a protocol set down by any external professional body.

51. The Tribunal bore in mind it should consider what other, reasonable practitioners would do in the circumstances. Dr F, whilst a highly experienced clinician, had accepted he did not have knowledge of GP records and documentation and that the forms were not misleading. His main criticism was that they were *'a bit late'* and that the 8 December form would have been *'much better to have been obtained prior to the procedure.'*

52. The Tribunal concluded that the disclaimer forms were not misleading and that the misdating of the 8 December form was a genuine error. Had this information been provided on 19 October, it would have been detrimental to Dr Mehat's case as it confirmed that Ms C was married, which establishes parental responsibility.

53. Whilst having these forms completed prior to the procedure may have been best practice, and in line with the Practice's protocol, the Tribunal considered that it was not inappropriate or unprofessional for them to have been completed at a later date. Therefore, the Tribunal determined that this paragraph of the Allegation was not proved.

The Tribunal's Overall Determination on the Facts

54. The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

1. Between 17 October 2022 and 08 December 2022, you were responsible for the care of Patient A (a child aged 7 years) in relation to a non-therapeutic male

circumcision ('the procedure') you carried out on him. **Admitted and found proved**

2. At all material times:

   a. Patient A was vulnerable due to his age; **Admitted and found proved**

   b. you knew that Patient A was vulnerable due to his age. **Admitted and found proved**

3. At all material times Mr B (Patient A's father) had parental responsibility for Patient A. **Admitted and found proved**

4. On 19 October 2022, at your place of work you carried out the procedure on Patient A, and you failed to:

   a. make sufficient enquiries to satisfy yourself as to whether or not Mr B had parental responsibility for Patient A to determine if you required his consent to the procedure; **Determined and found not proved**

   b. ~~include Patient A in the decision-making process for the procedure.~~ **Removed following a successful Rule 17(2)(g) application**

5. On 24 October 2022, five days after the procedure, at your place of work you provided to Ms C (Patient A's mother) a pre-prepared disclaimer form ('form D') for the procedure which you asked her to sign and date. **Admitted and found proved**

6. 0n 08 December 2022, at your place of work you provided to Ms C:

   a. a pre-prepared witness statement in her name regarding the procedure which you asked her to sign and date; **Determined and found not proved**

   b. a pre-prepared disclaimer form for the procedure which:

      i. you asked her to sign; **Admitted and found proved**
      ii. had been backdated to 19 October 2022. **Admitted and found proved**

7. Your conduct at paragraphs 5 and 6 was inappropriate and/or unprofessional. **Determined and found not proved**

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

Determination on Impairment - 16/11/2026

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Mehat's fitness to practise is impaired by reason of misconduct.

The evidence

2. The Tribunal has reviewed its findings of fact and in addition, the Tribunal received further evidence as follows.

3. Dr Mehat provided his own witness statement dated 16 November 2026.

4. The Tribunal also received in support of Dr Mehat a number of testimonials from patients, friends and colleagues.

5. The Tribunal also received Dr Mehat's reflections and evidence of CPD courses that he had completed.

Submissions

Submissions on behalf of the GMC

6. Mr Taylor indicated to the Tribunal that he had no submissions to make on behalf of the GMC.

Submissions on behalf of Dr Mehat

7. Mr Mahmood referred the Tribunal to the relevant guidance and case law and reminded the Tribunal of the two stage process that it must follow. He submitted that, in order to consider impairment, the Tribunal must first find that Dr Mehat's actions amounted to serious professional misconduct. He said that for an action to amount to misconduct, it must be a serious breach of professional standards and be such that fellow professionals would describe it as 'deplorable'.

8. Mr Mahmood submitted that the actions found proved in this case were only those to which Dr Mehat had admitted and that the Tribunal's considerations must be limited to

those facts. He said that the admitted facts amounted to performing a circumcision on a patient for whom Mr B had parental responsibility, but that Dr Mehat was not aware of that fact, having been misled by Ms C. He had also provided disclaimer forms to Ms C for her signature, which the Tribunal had found was not inappropriate or unprofessional.

9. Mr Mahmood submitted that Dr Mehat's actions did not amount to misconduct. However, if the Tribunal found that his actions did amount to misconduct, and so went on to consider impairment, Mr Mahmood submitted it must take into account the passage of time, Dr Mehat's efforts to remediate and the particular circumstances of the case, including that Dr Mehat had been misled by Ms C. He also reminded the Tribunal that it had found Dr Mehat had not failed to make sufficient enquiries regarding parental responsibility and consent.

10. Mr Mahmood said that Dr Mehat had taken on board the issues of this case and had made adjustments to his practise in response. He submitted that Dr Mehat's fitness to practise was not currently impaired.

The relevant legal principles

11. There is no burden or standard of proof at this stage of the proceedings and the decision of impairment is a matter for the Tribunal's judgment alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

12. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious, and then whether the finding of that misconduct, which was serious, poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

13. To assess whether Dr Mehat poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal follow the steps set out in the *MPTS Guidance for Tribunals (Section three: MPT Hearings > Part B > Stage 2: Impairment > Steps 2(a) to (e)* ('the Guidance'). It will consider:

- where on the spectrum of seriousness the allegation lies, based on the facts found proved the impact of any relevant context known about Dr Mehat and/or their working environment, and
- how Dr Mehat has responded to the allegations.

14. The Tribunal had regard to the case of *Roylance v GMC (No.2) [2000] 1 AC 311:*

'Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which will qualify. The professional misconduct must be serious.'

15. The Tribunal noted the case of *Nandi v General Medical Council [2004] EWHC 2317 (Admin) (04 October 2004):*

'31 [misconduct is observed] as "a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious". The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners. It is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree.'

16. The Tribunal had regard to the test for impairment that was set out by Dame Janet Smith, as cited in the case of *CHRE v Grant and NMC, [2011] EWHC 927 (Admin):*

'a) Whether the registrant has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;

b) Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;

c) Whether the registrant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession.

d) Whether the registrant has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

Also:

'74 In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

The Tribunal's determination on impairment

Is there a legal basis for considering impairment?

17. The Tribunal considered that there had been no findings that could be considered to be in breach of the standards set out GMP. It also bore in mind the submissions of both parties and considered that the facts found proved were merely of a factual nature and did not involve any culpability on the part of Dr Mehat.

18. The Tribunal had regard to the three limbs of public protection: maintaining the health, safety and well-being of the public; maintaining public confidence; and upholding proper professional standards. It concluded that none of the limbs were engaged.

19. The Tribunal found that none of the facts found proved would be considered deplorable by fellow members of the profession and did not amount to misconduct, therefore not engaging any of the legal grounds for impairment. Accordingly, the Tribunal determined there was no legal basis for considering Dr Mehat's fitness to practise.

20. The Tribunal has therefore determined that Dr Mehat's fitness to practise is not impaired by reason of misconduct.

21. The interim order is hereby revoked.

22. That concludes the case.

ANNEX A – 10/11/2026

Submission of No Case to Answer

1. On day six of the hearing, Mr Mahmood, on behalf of Dr Mehat, made a submission of no case to answer in respect of the following paragraphs of the Allegation:

> *4 On 19 October 2022, at your place of work you carried out the procedure on Patient A, and you failed to:*
>
> *a. make sufficient enquiries to satisfy yourself as to whether or not Mr B had parental responsibility for Patient A to determine if you required his consent to the procedure;*
>
> *b. include Patient A in the decision-making process for the procedure.*
>
> …
>
> *6 0n 08 December 2022, at your place of work you provided to Ms C:*
>
> *a. a pre-prepared witness statement in her name regarding the procedure which you asked her to sign and date;*
>
> …
>
> *7 Your conduct at paragraphs 5 and 6 was inappropriate and/or unprofessional.*

2. Mr Mahmood's application on paragraph 7 was only in relation paragraphs 5 and 6(a) of the Allegation.

Submissions

3. Both parties provided detailed written submissions to the Tribunal, which they supplemented orally.

4. Mr Mahmood submitted that the GMC had failed to produce sufficient evidence that the above paragraphs of the Allegation were capable of being found proved and that there was no case to answer regarding these paragraphs.

5. Mr Mahmood submitted that the GMC had produced no evidence at all in relation to paragraph 4(b) and that the evidence in relation to the other paragraphs was insufficient

for the allegation to be capable of being found proved. He said that there was no evidence Dr Mehat had not involved Patient A in the decision-making process, merely that there was no documentary evidence that he had done so. Mr Mahmood submitted that this was not sufficient for a Tribunal to be able to find paragraph 4(b) of the Allegation proved.

6. Mr Mahmood submitted that the Tribunal should consider the specific wording of the Allegation carefully and that its considerations must be limited to only those issues contained within. He also submitted that Mr B's evidence was his own opinions and could not assist the Tribunal with its findings of fact as he was not present during the procedure or at any of the conversations between Ms C and Dr Mehat.

7. Mr Mahmood submitted that Ms C was the only witness to speak to paragraph 4 of the Allegation and that her evidence was wholly unreliable, having been contradictory throughout. He said that she had given multiple accounts of events but had also stated that all of her evidence and statements were true, as was the content of her consent forms, disclosure forms and the statement of 8 December 2022. She had given evidence that the witness statement of 8 December had been produced with her providing details of information and also possibly her dictation.

8. Mr Mahmood also submitted that, in the expert evidence of Dr F, he had only offered his own opinion but not provided a range of objective views from within the profession. He reminded the Tribunal that Dr F had not given a reason for that being omitted from his report.

9. Mr Mahmood submitted that, in the context of this case, parental responsibility was established either by Mr B being named on Patient A's birth certificate or if he was married to Ms C at the time of the procedure, which he was. Ms C had told Dr Mehat that she was not married and that Patient A's father had no parental responsibility.

10. Mr Mahmood said that the wording of paragraph 4(a) imposed a duty upon Dr Mehat to satisfy himself whether or not Mr B had parental responsibility over Patient A and that the GMC was required to prove what enquiries were made and that they were insufficient. The GMC say that Dr Mehat could have done more, including asking Patient A, but Mr Mahmood submitted Dr F had withdrawn his criticism of Dr Mehat in this regard and agreed that sufficient enquiries were made in relation to parental responsibility.

11. Mr Mahmood submitted that the evidence showed Dr Mehat told Ms C that consent was required from both parents and asked about the presence and involvement of a second parent. He asked Ms C if she was married and she told him no.

12. Mr Mahmood submitted that the GMC had produced insufficient evidence to prove that Dr Mehat's actions at paragraphs 5 and 6(a) were inappropriate or unprofessional. He said that the words were vague and reminded the Tribunal that Dr F had said it was unusual for disclaimer forms to be completed after the event but would only be inappropriate if they were completed retrospectively. Mr Mahmood submitted that these forms were not retrospective and were not intended to conceal anything.

13. On behalf of the GMC, Mr Taylor submitted that to agree to this application would have the consequence of not hearing evidence on the points from Dr Mehat and that this should not be taken lightly. He said that there was no inherent weakness in the evidence. He said that the documentary evidence was strong and that, despite Ms C not being as clear as she may have been, Mr Mahmood's submission on her credibility was an exaggeration.

14. Mr Taylor submitted that, where there was some evidence before the Tribunal but that it needed an assessment of the credibility of a witness, then the case should continue. He said that this was an assessment that should be made at the close of the facts stage when determining whether an allegation *should* be proved, not whether it *could* be proved. He said that the Tribunal could, in due course, decide whether it accepts some, none or all of a given witness' evidence.

15. Mr Taylor submitted that it is common for complainants and witnesses to be inconsistent or confused in giving their evidence. He said that the passage of time was relevant as Ms C was being asked to recall conversations and forms from 4 years ago. He also said that the context of giving evidence should be kept in mind as Ms C may have been feeling pressure under cross-examination and that she was being accused of being in the wrong.

16. Mr Taylor reminded the Tribunal that the role of an expert witness was to give their opinion on areas that were outside the Tribunal's expertise and that it was a matter for the Tribunal how much weight it gave that opinion.

17. Mr Taylor submitted that it was a matter for the Tribunal's judgement whether Dr Mehat took sufficient steps to establish whether Mr B had parental responsibility. He also submitted that the absence of evidence of Dr Mehat involving Patient A in the discussion should be taken as evidence that the discussion did not occur. He said that there was a

clear duty for Dr Mehat to involve Patient A in the discussions, which came from the GMC and BMA guidance referred to by Dr F.

18. Mr Taylor told the Tribunal that the witness statement of 8 December 2022 clearly did not come from Ms C, she was called into the surgery to sign the statement. He said that, whilst Ms C had surely provided some details, it was not plausible that she had come into the surgery and dictated the statement. He submitted that the statement was pre-prepared in Ms C's name, even if it was made using details she provided.

Legal Principles

19. The LQC reminded the Tribunal that the burden of proof rests on the GMC and that Dr Mehat does not have to prove anything.

20. The Tribunal should have regard to Rule 17(2)(g) which states:

> *'the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld'.*

21. The purpose at this stage is not to make findings of fact, but to determine whether sufficient evidence, taken at its highest, has been presented by the GMC, such that the Tribunal could properly find the relevant paragraphs proved. The Tribunal's decision is not whether the facts *should* be found proved but whether or not they *could* be proved, based on the evidence so far adduced.

22. The relevant approach when considering a submission of no case to answer was laid down by Lord Lane CJ in the case of *R v Galbraith (1981) 1 WLR 1039*. It was confirmed as the appropriate test for regulatory proceedings in the case of *General Medical Council v Udoye [2021] EWHC 1511 (Admin).* The Galbraith test states that a case should not be left to the jury if there is no evidence or insufficient evidence to support a conviction. The test sets out:

> *'(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The Judge will of course stop the case.*
>
> *(2) The difficulty arises where there is some evidence but it is of a tenuous character, or example because of inherent weakness or vagueness or because it is inconsistent with*

other evidence, (a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made to stop the case, (b) Where however the prosecution evidence is such that its strength or weakness depends on the view taken of a witness's reliability, or other matters that are generally speaking within the province of the jury, and where, on one possible view of the facts, there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the Judge should allow the matter to be tried by the jury.'

23. The Tribunal was also reminded that their role was not to make findings of fact and to limit their deliberations to establish if there was sufficient evidence for the case to proceed on all or any of the allegations. The Tribunal was referred to the case of *R (on the application of Dr Alan Tutin) v General Medical Council [2009] EWHC 553 (Admin*) to consider each allegation still in dispute separately and the case of *McLennan v General Medical Council (2020) CSIH 12*, the Tribunal's role at this stage was not to determine whether the facts should be proved, but whether they could be proved on the evidence adduced thus far.

24. Finally, the Tribunal was reminded of *R (on the Application of David Husband) v General Dental Council [2019] EWHC 2210 (Admin)* and the need to exercise care in how much detail is provided in any reasons given for a decision at no case to answer stage, to avoid giving a premature indication of how the Tribunal is considering the evidence at this stage.

The Tribunal's decision

25. The Tribunal took each paragraph of the Allegation in order. It bore in mind that Mr Mahmood's submission was on the second limb of *Galbraith* for all of the paragraphs except paragraph 4(b) – that there was some evidence but that it was not sufficient for the Tribunal to be able to find the allegations proved.

Paragraph 4(a)

26. The Tribunal considered that the evidence of Ms C was the most significant in determining this paragraph of the Allegation. The Tribunal bore in mind that Ms C had given various, conflicting accounts around the events and had stated that all the forms she completed were true. The Tribunal considered that there was a question of credibility and reliability around her evidence. However, the Tribunal considered that there was evidence available that went to the issue in question. As such, the credibility of

Ms C's evidence would need to be tested and measured against the documentary evidence.

27. The Tribunal, having found that there was some evidence in relation to paragraph 4(a), did not accept that the evidence was inherently weak, vague, tenuous or inconsistent. Ms C gave oral evidence that is potentially supported by the documentary evidence but this assessment should be carried out in full at the conclusion of the facts stage. The Tribunal would also need to consider the evidence of Dr F, as his acceptance that sufficient enquiries were made was based on which evidence the Tribunal accepted. In addition, the consent and disclosure forms signed by Ms C, also needed to be considered in the round. The Tribunal considered that the Allegation was capable of being logically probative and that therefore there was still a case to answer.

Paragraph 4(b)

28. The Tribunal reminded itself that Mr Mahmood's position in relation to this paragraph was that there was no evidence at all – the first limb of *Galbraith*. It reminded itself that it was for the GMC to prove its case. The Tribunal bore in mind that it had not been provided with the clinical records from Patient A's procedure or the consultations. Ms C did not give evidence, either orally or in her witness statements, as to whether Patient A was involved in the discussions at all. There is also no evidence from Patient A himself, nor Mr B on this point.

29. The Tribunal bore in mind that Dr F gave evidence that his criticism of Dr Mehat was based solely on the absence of a record that he included Patient A in the discussions.

30. The GMC's case was that Dr Mehat failed to include Patient A in the discussions because it had not been documented that he did so. The Tribunal did not agree that an absence of a record was sufficient evidence that the conversation did not happen.

31. The Tribunal considered that there was no evidence Dr Mehat did not include Patient A in the discussions, there was only a lack of documentation, which did not form part of the Allegation. It bore in mind that Ms C was not asked any questions on this issue and that Dr F accepted there was no other evidence to suggest the conversation did not happen other than that it was not documented.

32. The Tribunal concluded that the absence of documentary evidence was not evidence that an event did not happen. As such, the Tribunal granted Mr Mahmood's application in relation to paragraph 4(b) of the Allegation.

Paragraph 6(a)

33. The Tribunal considered that, as with paragraph 4(a) above, Ms C's evidence was key to this issue and would require evaluating and comparing to the documentary evidence. The Tribunal considered that *'pre-prepared'* was a vague term and it would be for the Tribunal to make an assessment at the facts stage of what this meant. The Tribunal considered that there was some documentary evidence that could potentially go to this point including the emails between Ms C and the Practice discussing statements. The Tribunal also noted that Ms C has suggested there was some coercion, both in her witness statement and in the documentary evidence, which is matter requiring further consideration by the Tribunal.

34. For the same reasons as set out above in relation to paragraph 4(a), the Tribunal considered that there was some evidence in relation to this paragraph of the Allegation that was logically probative and must be assessed in full. As such, the Tribunal determined that there was a case to answer.

Paragraph 7

35. The Tribunal noted that the key words in this paragraph of the Allegation were *'inappropriate and/or unprofessional'*. The Tribunal considered that it had received some evidence relating to professional standards from Dr F although it had not been directed towards any specific professional standard that this paragraph of the Allegation should be assessed against. The Tribunal also noted that the practice's own protocol was before it in evidence and there is some evidence to suggest that this was not complied with.

36. As above, the Tribunal considered that further analysis of Ms C's evidence would be necessary but that there was evidence from her that could potentially lead to this being found proved. The Tribunal also reminded itself of the issue of coercion in writing the statement on 8 December 2022; if this were to be found proved, this could be evidence of unprofessional and/or inappropriate behaviour. As such, the Tribunal determined that there was a case to answer.