

## PUBLIC RECORD

**Dates:** 02/02/2026 - 20/02/2026  
08/06/2026 - 09/06/2026

**Doctor:** Dr Matthew JONES  
**GMC reference number:** 7017606  
**Primary medical qualification:** MB ChB 2009 University of Liverpool

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

### Summary of outcome

Erasure  
Immediate order imposed

### Tribunal:

Legally Qualified Chair:	Mrs Nessa Sharkett
Lay Tribunal Member:	Mr Darren Shenton
Registrant Tribunal Member:	Dr Pavan Rao

Tribunal Clerk:	Ms Ciara Fogarty (02/02/2026 - 20/02/2026) Miss Emma Saunders (08/06/2026 - 09/06/2026)
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### Attendance and Representation:

Doctor:	Present, represented (02/02/2026 - 20/02/2026) Not present, represented (08/06/2026 - 09/06/2026)
Doctor's Representative:	Ms Vivienne Tanchel, Counsel, instructed by the MDDUS
GMC Representative:	Mr Ian Brook, Counsel (02/02/2026 - 20/02/2026) Mr Martin Mensah, Counsel (08/06/2026 - 09/06/2026)

### **Attendance of Press / Public**

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

### **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 - 19/02/2026**

1. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential.

### **Background**

2. Dr Jones qualified in 2009 from the University of Liverpool and has been a General Practitioner since August 2014. At the time of the events which are the subject of this hearing, Dr Jones worked as a partner at Academy Medical Centre in Forfar for approximately three years, before moving in January 2018 to a different partnership at The Blue Practice, Crieff Medical Centre. He is currently employed as a salaried GP in a practice in Liverpool.

3. XXX

4. The allegations that have led to Dr Jones's hearing relate to his conduct. It is alleged by the GMC that in January and December 2015, Dr Jones consulted with Patient A and Patient B respectively and undertook examinations which were not clinically indicated and which were sexually motivated. It is also alleged that Patient B was vulnerable due to her mental health. It is further alleged that, in June 2019, Dr Jones engaged in sexual behaviour at St Margaret's Hospital in that he took one or more inappropriate photographs of himself on his personal mobile phone in and outside the residential room of the Hospital.

### **The Outcome of Applications made during the Facts Stage**

5. The Tribunal granted the GMC's application, made pursuant to Rule 34(1) of the Rules of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), for the admission of hearsay evidence of Mr C. The Tribunal's full decision on the application is included at Annex A.

6. The Tribunal granted the GMC's application, made pursuant to Rule 35(4) of the Rules of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), for the anonymisation of three witnesses: Patient A, Patient B and Mr C. The Tribunal's full decision on the application is included at Annex B.

### The Allegation and the Doctor's Response

7. The Allegation made against Dr Jones is as follows:

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

#### Patient A

1. On 12 January 2015, you consulted with Patient A at the Academy Medical Centre in relation to abdominal pain and you:

- a. undertook an examination of Patient A where you:
  - i. placed your right hand under:
    1. the waistband of Patient A's trousers;  
**Admitted and found proved**
    2. Patient A's underwear;  
**Admitted and found proved**
  - ii. rubbed/touched Patient A's pubic hair with your finger(s);  
**To be determined**
  - iii. moved your right hand down towards the opening of Patient A's vagina;  
**To be determined**
  - iv. rubbed the opening of Patient A's vagina with your hand;  
**To be determined**
  - v. pressed your body and/or erect penis against Patient A's arm and/or upper thigh area.

**To be determined**

**Patient B**

2. On 6 December 2015 you consulted with Patient B at her home address in relation to a suspected urinary tract infection and:

a. during the initial visit you:

i. asked Patient B to pull her pyjama bottoms down, or words to that effect;

**To be determined**

ii. undertook an examination of Patient B where you:

1. touched and/or rubbed her clitoris with your left hand in a circular motion for a prolonged period of time;

**To be determined**

2. touched Patient B's vulva;

**To be determined**

b. during the second visit you:

i. asked Patient B to pull her pyjama bottoms down, or words to that effect;

**To be determined**

ii. undertook an examination of Patient B where you:

1. touched and/or rubbed her clitoris with your left hand in a circular motion;

**To be determined**

2. touched Patient B's vulva.

**To be determined**

3. At all material times Patient B was vulnerable due to her mental health.

**To be determined**

4. Your actions as set out at paragraph(s):

(a) 1ai-v, 2ai, 2aii, 2bi and 2bii were not clinically indicated;

**To be determined**

(b) 1 and 2 were sexually motivated.

**To be determined**

### St Margaret's Hospital

5. On or around 20 June 2019 you engaged in sexual behaviour at St Margaret's Hospital ('the Hospital'), in that you took one or more photographs on your personal mobile telephone of you:

a. standing naked with your erect penis in front of a vaginal sex toy in the residential room ('the Room') at the Hospital;

**Admitted and found proved**

b. standing partially naked with your flaccid penis in your hand on the landing outside of the Room;

**Admitted and found proved**

c. standing naked with your erect penis in your hand on the landing outside of the Room.

**Admitted and found proved**

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**

8. At the outset of these proceedings, through his Counsel Ms Tanchel, Dr Jones made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the '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**

9. In light of Dr Jones's response to the Allegation, the Tribunal is required to determine whether Dr Jones carried out the actions alleged and not admitted in relation to Patient A on 12 January 2015 and Patient B on 6 December 2015, including whether he engaged in inappropriate physical contact during clinical examinations, whether any such contact was clinically indicated, whether Patient B was vulnerable at the material time due to her mental health, and whether his actions in respect of Patients A and B were sexually motivated

### **Witness Evidence**

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

- Patient A, via video link. Her witness statement was dated 1 November 2022 and a supplemental report was dated 9 July 2025;
- Patient B, via video link. Her witness statement was dated 17 October 2022 and a supplemental report was dated 12 August 2025;
- Dr D via video link. Her witness statement was dated 17 November 2023 and a supplemental report was dated 6 November 2024;
- Mr E, via video link. His witness statement was dated 14 September 2025;

11. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- DC F, Police Sergeant in the Contact, Command & Control (C3) Division at Police Scotland. His witness statement was dated 15 December 2025.
- Ms G, Practice Manager. Her witness statement was dated 24 October 2023 and a supplemental report was dated 5 November 2024, Ms G had been scheduled to attend to give oral evidence but as there were to be no questions from the defence she was no longer required.
- The written statements of Mr C admitted on the application of the GMC as hearsay evidence.

12. Dr Jones provided his own witness statement dated 8 December 2025 and also gave oral evidence at the hearing.

### Expert Witness Evidence

13. The Tribunal received reports from two Experts.

- Dr H, General Practitioner. who was instructed on behalf of the GMC. Dr H prepared an expert report dated 17 May 2023 and a supplemental report dated 27 August 2025.
- Dr I, GP via video link, who was instructed on behalf of Dr Jones. Dr I provided an expert report in December 2025.
- A joint expert report of Dr H and Dr I dated 14-15 January 2026.

14. The Tribunal considered the joint expert report of Dr H and Dr I. The experts agreed that there were clear factual disputes between the accounts of Patient A and Patient B and

the account of Dr Jones, and that those disputes were matters for the Tribunal to determine. The experts were in agreement that, if the patients' accounts were accepted, the examinations described were not clinically indicated, were undertaken without explicit consent, and without the offer or presence of a chaperone, and that such conduct would have been seriously below the standard expected of a reasonably competent general practitioner. The experts further agreed that locating the pubic bone was not a required component of a routine abdominal examination and that any examination extending into the pubic or vulval area would have required clear clinical justification together with explicit consent and the offer of a chaperone. The experts agreed that the issue of sexual motivation was not a matter for expert opinion and was properly a matter for the Tribunal.

### Documentary Evidence

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

- Police Statement from Patient A dated 12 September 2019;
- Transcript of the High Court Scotland evidence of Patient A dated 18 March 2021;
- Police statements of Patient B dated 9 December 2015 and 14 October 2019;
- Transcript of the High Court Scotland evidence of Patient B;
- Police statement of Ms G dated 10 September 2019 and 30 September 2019;
- Police statement of Dr D dated 11 December 2015;
- Police statement of Mr E dated 11 December 2015;
- Police statements from the following:
  - DC F dated 15 September 2019;
  - DC J dated 6 September 2019;
  - DC K dated 29 November 2019;
  - Ms L dated 15 March 2021;
  - Ms M dated 12 September 2019;
  - Ms N dated 4 October 2019
- Joint reports of DC K and Ms O (Forensic Computer Analyst) dated 23 October 2019 and 31 October 2019;
- Images recovered from Dr Jones' mobile phone;

### Cross-Admissibility

16. The GMC invited the Tribunal to consider cross-admissibility of the evidence of Patient A and Patient B. Mr Brook submitted that the evidence relating to Patient A and

Patient B was admissible in respect of the other as evidence of propensity and to rebut coincidence. He relied upon the principles set out in *Professional Standards Authority for Health and Social Care v General Medical Council (Garrard)* [2025] EWHC 318 (Admin), the MPTS Appeals Circular A05/25, and the Crown Court Compendium (October 2025, Part I, Chapter 13).

17. Mr Brook submitted that the test for cross-admissibility was whether the evidence was relevant to a matter in issue, which depended upon whether there was sufficient connection and similarity between the allegations. He submitted that the Tribunal was entitled to consider the allegations together where the similarities went beyond mere coincidence and revealed a pattern of behaviour.

18. It was submitted that the allegations shared striking similarities. In each case the complainant was female and attended for an abdominal examination in circumstances of vulnerability. In each case Dr Jones was said to have abused the position of trust inherent in the doctor–patient relationship and exploited the power imbalance between clinician and patient. In each case Dr Jones was alleged to have utilised the apparent legitimacy of abdominal palpation as a means of progressing his hand to the genital area, and to have rubbed intimate genital structures which could not plausibly form part of a clinically indicated abdominal examination.

19. Mr Brook submitted that the similarities extended not merely to context but to method, namely the movement of Dr Jones’ hand from an area where palpation might ordinarily occur to an area where it plainly should not, and the act of rubbing rather than incidental contact. He submitted that such similarities were capable of demonstrating a sexual interest in the complainants and a propensity to engage in boundary-violating conduct under the guise of clinical care.

20. In addressing coincidence, Mr Brook submitted that it was inherently implausible that two unrelated patients, unknown to one another and separated by time and location, would independently give accounts of strikingly similar inappropriate genital contact during abdominal examinations if such conduct had not occurred. He submitted that there was no suggestion of collusion or prior knowledge between the complainants, and that the absence of any connection between them strengthened, rather than weakened, the probative value of their respective accounts.

21. Mr Brook further submitted that the Tribunal was entitled to consider whether Dr Jones’ admitted sexual behaviour in a clinical setting, namely the taking of explicit photographs at St Margaret’s Hospital, formed part of a broader pattern of sexual disinhibition and disregard for professional boundaries. He submitted that this evidence was

capable of supporting an inference of propensity towards sexualised conduct in inappropriate settings, and was relevant to rebut any suggestion that the alleged conduct during examinations was accidental, inadvertent, or misunderstood.

22. It was submitted that sexual motivation was ultimately a matter for the Tribunal, but that cross-admissibility assisted the Tribunal in assessing whether the allegations disclosed a consistent pattern inconsistent with coincidence or innocent explanation. Mr Brook submitted that, even affording Dr Jones the benefit of a good character direction, good character was not a bar to a finding of propensity where the evidence justified it, and was not a passport to findings of not proved.

23. On behalf of Dr Jones, Ms Tanchel submitted that the GMC's application on cross-admissibility was misconceived and procedurally unfair. She relied on *PSA v GMC (Garrard)* as establishing a refined and specific approach to cross-admissibility in regulatory proceedings, which were not criminal proceedings and were governed by the MPTS Rules. She submitted that, contrary to the GMC's position, *Garrard* made clear that, for the purposes of propensity, the first allegation in time must be found proved before it could be relied upon as cross-admissible, irrespective of Crown Court practice.

24. Ms Tanchel rejected the GMC's submission that cross-admissibility was not a legal argument. She submitted that the issue plainly involved a legal question as to the scope of the Tribunal's powers and the manner in which evidence could properly be used. She emphasised that the defence was entitled to respond to any such legal application and that this was the purpose of the GMC making it. She submitted that it was wrong to suggest that the defence ought simply to have anticipated the argument; the Rules required legal issues to be identified in advance through case management, and there was no concept of ambush in these proceedings.

25. Ms Tanchel submitted that, while she accepted that legal arguments could arise during the course of a hearing, the GMC could not sidestep the procedural framework governing fairness by characterising the issue as something other than a legal submission. She submitted that the Tribunal itself appeared troubled by the application, which underlined its legal significance.

26. She further submitted that it was not for the defence to speculate in advance as to how cross-examination might develop or what issues might arise had notice been given. The opportunity to address the matter fully had been denied to Dr Jones, even if only to a limited extent, and the Tribunal would need to consider whether that denial affected fairness. That was ultimately a matter for the Tribunal, but it reinforced the defence objection to the GMC's approach.

27. In addressing the GMC's reliance on Crown Court practice, Ms Tanchel submitted that while it was accepted that decisions on cross-admissibility were often taken after the evidence had been heard, this did not relieve the prosecuting authority of the obligation to identify and signal such an application. She rejected the contention that the issue was not legal in nature, submitting that arguments concerning propensity, coincidence, and the proper use of evidence were quintessentially legal submissions requiring notice.

28. Finally, Ms Tanchel submitted that the GMC was impermissibly seeking to extend the concept of cross-admissibility to matters which did not fall within the gateway, including the admitted matters at allegations 5 (a), (b) and (c). She submitted that those matters were not capable of being cross-admissible in the manner suggested and that the GMC's approach amounted to an attempt to "shoe-horn" them into the doctrine. She concluded that whether cross-admissibility applied at all was a matter for the Tribunal, but the defence position had been clearly stated.

#### The Law in relation to cross admissibility

29. The Tribunal first considered whether it should consider Mr Brooks' invitation to cross admit evidence or whether on the basis of Ms Tanchel's objections it should not. The Tribunal had regard to Rule 34 which deals with the admission of evidence in these proceedings. However, it noted that this was evidence that was already before the Tribunal, albeit each related to different allegations. The Tribunal noted that Ms Tanchel had confirmed that it was not the case of the defence that there was collusion between Patient A and Patient B. She did suggest that the evidence of Patient A may have been contaminated by the number of times she had recounted her account relying on around eight occasions where she had spoken to family, the surgery and the police. The Tribunal noted that it was clear from the allegations as pleaded that the core of the allegations relating to Patient A and Patient B were similar. It found that the evidence was relevant and that it would be in the interests of justice to consider whether or not it met the test for cross admissibility. It was unable to establish any prejudice to Dr Jones when it was not his case that the two witnesses had colluded with each other.

30. The LQC gave advice to the Tribunal in relation to the correct approach when considering cross admissibility. The Tribunal had particular regard to the decision in *Professional Standards Authority for Health and Social Care v General Medical Council (Garrard)* in which Mr Justice Macdonald acknowledged that the subject of cross-admissibility is substantially informed by jurisprudence from the criminal jurisdiction. The Tribunal was referred to the established principles that apply when considering the question of cross-admissibility as follows:

31. Evidence from one allegation may be cross admissible to another allegation in the same proceedings where:

- (a) It may establish propensity to commit that kind of conduct and/or
- (b) It may rebut coincidence

There is a difference between the two and a Tribunal must be clear of the basis on which cross admissibility is deemed appropriate, but it can be both. If the application is made on only one ground the Tribunal need not give a direction on both.

32. The legal tests are different depending on which ground is relied upon. However, for evidence in respect of one allegation to be cross admissible against another allegation, the evidence must of course be relevant to the matter to be determined. Whether the evidence will be considered to be relevant will depend on whether there is a sufficient connection and similarity between the facts of the allegations. This is a matter on which the Tribunal will be required to make a finding that there is a sufficient connection and similarity between the facts of the allegations it is required to determine. The Tribunal is reminded of the case of *PSA v GMC & Garrard* where the Tribunal fell into error when it applied too high a threshold to this test, i.e. to “*insufficiently similar to find a pattern*” and “*very substantial differences*”. The Judge said that the case law simply requires the fact finder to consider whether there is sufficient connection and similarity between the facts of the allegations

33. Once the test of sufficient connection and similarity is determined the Tribunal then needs to consider the basis on which it is asked to apply the cross admissible evidence. The question of whether the evidence in fact establishes propensity or rebuts coincidence falls to be decided by the Tribunal. How that is achieved differs depending on the ground under which the evidence has been admitted.

34. Where evidence is cross admitted to establish propensity, the Tribunal can find that the relevant propensity has been established by being satisfied to the relevant standard of proof that conduct of the kind relied on was committed on one or more occasions (see *Adams* [2019] EWCA Crim 1363 at [14], relying on *Freeman*). In a case where there are only two similar allegations, this will require the fact finder to be satisfied to the relevant standard that the first allegation is found proven before then deciding whether the facts found proven show a propensity to conduct of a relevant kind, before it is able to rely on that conduct to deduce propensity from the second allegation (see *R v Mitchell* [2016] UKSC at [43]).

35. It is clear that whether the evidence cross admitted is capable of demonstrating a propensity to a particular type of conduct, it is necessary to first find the first allegation

proved to the relevant standard including the nature of the conduct relied on, before moving on to rely on that evidence as demonstrating a propensity to the type of conduct alleged in another allegation. When considering the weight to be attached to cross admitted evidence that demonstrates propensity the Tribunal had regard to the case of Richards [2018] EWCA Crim 23742016/03384/C4 & 2016/05363/C4. The Tribunal reminded itself that propensity can only provide some support for the prosecution case on a particular charge. The Tribunal must be careful to ensure that it does not make a finding based wholly or mainly on the ground of propensity.

36. In this case the GMC invites the Tribunal to consider the cross admissible evidence as showing both propensity and rebuttal of coincidence. In applying the test to rebut coincidence the Tribunal reminds itself that once the evidence has passed the gateway of sufficient connection and similarity, there is no requirement to find one allegation proved before relying on the cross admissible evidence in support of the other allegation. The Tribunal must also

- Ensure that where collusion or contamination of the evidence is raised as an explanation for the similarity of the complainant's evidence, that there is no reliable evidence to support that contention before going on to carry out the exercise of;
- assessing the strength of the argument that the allegations are unlikely to be a coincidence. It must also acknowledge that the fact that more than one person making allegations of the same or similar nature reduces the likelihood of there being an innocent explanation for them
- When carrying out the exercise the Tribunal must not look at each allegation in turn but rather it must look at the evidence and allegations in the round.

37. The Tribunal does not approach the allegations sequentially. Instead, the Tribunal must consider the evidence holistically and assess whether the similarities between the allegations are such that they are unlikely to be coincidental. In undertaking this exercise, the Tribunal must consider and address any explanation advanced by the defence, including allegations of collusion or contamination, and ensure that there is no reliable evidential basis for such explanations before placing weight on the similarities.

38. The Tribunal is reminded that, when considering rebuttal of coincidence, the fact that more than one person has made allegations of a similar nature may reduce the likelihood of an innocent explanation. However, the Tribunal is reminded that this does not relieve the Tribunal of the obligation to consider the evidence in the round. The Tribunal may recognise that the evidence relating to one allegation may appear stronger when considered alongside evidence relating to another, but it must then decide what weight, if any, should properly be attached to that combined consideration when determining each allegation.

39. The Tribunal should consider Chapter 13 of the Crown Court Compendium and ask; (5), how likely it is that two (or more) people would independently of each other make similar accusations and yet both be lying/mistaken. If the jury thought this unlikely, they could, if they thought it right, treat the evidence of each of the complainants as mutually supportive (6) When deciding how much support, if any, the evidence of one complainant gives to another, the jury should take into account how similar their accusations are since the jury might take the view that the closer the similarities the more likely it is that the complainants are telling the truth. (Crown Court Compendium Chapter 13)

40. The GMC invited the Tribunal to treat the evidence of Patient A and Patient B as cross admissible both as to demonstrating propensity for conduct of a particular nature and to rebut coincidence. Whilst Mr Brook invited the Tribunal to consider the admissions of Dr Jones in allegation 5b and 5c he confirmed in oral submissions that he does not invite the Tribunal to cross admit the evidence of these pictures and the circumstances in which they were taken.

41. The Tribunal considered that the correct starting point was whether the evidence in question was relevant to an issue it was required to determine and whether there was sufficient connection and similarity between the allegations.

42. The Tribunal had regard to the similarities relied on by the GMC and the differences relied on by Ms Tanchel in support of her submission that the relevant facts and evidence relating to Patient A and Patient B did not meet the test to engage cross admissibility. The Tribunal found that the sufficient connection and similarity test was met, because:

- (a) both were females who saw Dr Jones in his professional capacity as a medical practitioner
- (b) both presented with symptoms indicating the need for an abdominal examination
- (c) both attended alone. A chaperone was not present and neither was offered one
- (d) both complained of inappropriate touching of a sexual nature during the course of the examination.

43. The allegation against Dr Jones by Patient A is sufficiently similar in nature to that made by Patient B as are the issues to be determined by the Tribunal. The evidence of both is therefore relevant to an issue to be determined by the Tribunal.

44. Having determined that the evidence is cross admissible the Tribunal then went on to consider whether it was sufficient to rebut coincidence.

45. The Tribunal had regard to the fact that both Patients complaints arose in a clinical setting whilst being seen by Dr Jones. Patient A was a patient at the surgery where Dr Jones worked. Her complaint was 12 January 2015. The complaint brought by Patient B about Dr Jones was while he was working as an Out of Hours doctor for NHS24, almost 11 months later on 6 December 2015. Dr Jones admitted seeing and examining Patient A on 12 January 2015 and carrying out one examination of Patient B on 6 December 2015. Both patients complained of an examination that went further than that of an abdominal examination and that it extended into the genital/vulval area of each patient, each describing a similar type of touch and movement by the Doctor when examining them. Neither patient was accompanied during the examination by anyone else and no chaperone was offered.

46. There is no evidence, or suggestion that these two patients knew each other. Nor was there any evidence that their own evidence had been contaminated by other people who may have spoken to either of them. Having regard to the evidence in the round, and in the absence of an innocent explanation the Tribunal find that the evidence of Patient A and Patient B is sufficient to rebut an explanation of coincidence that these two individuals bring complaints of a sufficiently similar nature. The Tribunal find that it would be able to rely on this evidence in support of the allegations, depending on its findings as to the extent of the similarities when making its finding of facts in respect of each allegation.

### **The Tribunal's Approach**

47. 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.

48. 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' reliability and credibility. The Tribunal should not decide reliability and credibility based on the demeanour of a witness alone.

49. The Tribunal was advised that its approach to fact-finding was governed by the MPTS Guidance (the 'MPTS Guidance') which came into effect on 24 November 2025. The Tribunal was further reminded that its decisions must also satisfy the overarching objective.

50. The Tribunal reminded itself that when considering the cross admissibility of the evidence relied upon, it must have regard to the relevant test and weight to be attached in respect of propensity, and the approach to be taken when considering the weight to attach in rebuttal of coincidence is a matter for the Tribunal having regard to all the similarities of the case and the evidence in the round.

51. The Tribunal was advised that submissions were not evidence but could be of assistance to the Tribunal in directing it to relevant parts of the evidence. It was entitled to take into account the absence of any previous complaints or findings against Dr Jones when assessing the inherent probability of events, but this did not alter the standard of proof.

52. The Tribunal was advised that it must assess credibility and reliability with care, recognising that inconsistencies or gaps in recollection did not necessarily mean a witness was dishonest, particularly given the passage of time. It must not determine credibility on the basis of demeanour alone and should be mindful of the fluid nature of memory.

53. The Tribunal was advised that it must consider all of the evidence in the round, ordinarily beginning with documentary and other objective evidence, and addressing both material that supported the allegations and material that pointed away from them, giving reasons where evidence was rejected. It was not bound by expert opinion but must give it proper consideration and, if departing from it, provide clear and cogent reasons.

### **The Tribunal's Analysis of the Evidence and Findings**

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

55. As these allegations arise from clinical examinations that Dr Jones undertook on each patient the Tribunal first considered the description of how an abdominal examination should be undertaken as set out in the witness evidence of Dr Jones and the agreed evidence of both Experts as to what is the accepted approach in practice. The Tribunal noted that there was an agreed note contained within the bundle which sets out agreed facts between the Prosecutor and Counsel for Dr Jones in the criminal proceedings in Scotland. In particular it makes mention of what was agreed in respect of an abdominal examination. Ms Tanchel submitted that it was untenable that the GMC sought to rely on this document when the Experts instructed in this case both reached a different opinion to the Expert instructed in the High Court in Scotland. The Tribunal did not find that the brief reference made in the note set out a definitive opinion of that Expert in respect of locating the pubic bone. The Tribunal has

not had sight of the report prepared by that Expert, the note itself is hearsay evidence and it had not had an opportunity to question the Expert that had been instructed. The very brief mention in the agreed note between Counsel was not a complete explanation of the Expert's opinion and contained insufficient information of a differing opinion to that of the Expert reports prepared for this hearing. The Tribunal did not agree that this note placed the GMC in difficulty for the reasons set out above. In any event it placed no reliance on the content of the agreed note in respect of the abdominal examination or at all. The note was hearsay, prepared by counsel in a different hearing, in a different jurisdiction.

56. The explanation of the relevant part of Dr Jones' explanation of an abdominal examination is set out as follows;

*12. I will explain precisely what the examination entails to the patient, to ensure their understanding is correct before proceeding. I go into as much specific detail as possible. I begin by explaining to the patient the position I would need them to lie in, flat on their back on the examination couch and check whether this is something they could manage for a few minutes. I explain the examination would require uncovering their abdomen, by lifting any upper clothing to the lower ribs and by moving down any lower clothing onto the hips to expose the lower abdomen. I would then start by having a look at the abdomen, followed by feeling the abdomen with the hand to cover all the areas, starting away from the point of pain, at times asking them to breath in time with feeling. That I may need to tap on the abdomen and finishing by listening to the sounds the bowels make. I would then check the patients understanding, by asking them to relay what I have just explained and clarify any uncertainties before gaining the patients verbal explicit consent to proceed. I advise them that if they want me to stop at any time, to let me know.*

*13. I start my examinations by inviting the patient to lay on the examination couch and once comfortable to adjust their own clothing to the positions as described above. I would begin by inspecting the abdomen from a distance, looking for any scars (or other skin changes), masses or asymmetry for example. I would then confirm consent again by asking to now place a hand on the abdomen. I would begin palpation from the point away from the area of complaint, proceeding in a systemic fashion, to cover all nine quadrants of the abdomen. The superior aspect is the inferior edges of the lowest ribs, and the inferior aspect is the superior border of the pubic symphysis. With specific palpation for the liver and spleen with patient inspiration and examination of the renal angles posteriorly and anteriorly for the kidneys. If clinically indicated, I may then percuss the abdomen to identify any changes in density between air, fluid or solid masses, and then a listen with the stethoscope for bowel sounds. Once the examination is complete, I would advise the patient and thank them, giving them time and*

*privacy to re-adjust their clothing and when they are ready to join me back seated to discuss the findings.*

57. In evidence Dr Jones also explained that he had previously understood that it was necessary to locate the pubic bone when carrying out an abdominal examination in order to locate the boundaries of the same. In his statement he says that he no longer does this.

58. The Tribunal had the benefit of the opinions of two Experts who had been instructed in this case. Dr H for the GMC and Dr I for Dr Jones. In their joint report they agreed that it was not necessary to locate the pubic bone when carrying out a properly conducted abdominal examination. The experts agree that the boundary of an abdominal examination extends to the anterior aspect of the pubis symphysis but this is something that is located with the side of the hand or finger when palpating the lower abdomen. A properly conducted abdominal examination goes no lower than that. In evidence Dr Jones agreed with this opinion.

#### Patient A

#### Paragraph 1(a) (ii)

59. The Tribunal considered paragraph 1(a)(ii) of the Allegation.

60. The Tribunal first had regard to the nature and extent of an abdominal examination as set out above. Dr Jones does not deny that Patient A attended an appointment with him at his practice on 12 January 2015. He further does not deny that he carried out a clinical examination of her abdomen when she presented with symptoms which he says were indicative of the need for an examination of her abdomen. Dr Jones also admitted that he placed his right hand under the waistband of Patient A's trousers and Patient A's underwear. It is alleged that when doing this he rubbed/touched Patient A's pubic hair with his fingers.

61. The Tribunal considered Dr Jones' account that the pubic hair can cover an area above the superior rim of the pubic symphysis and that he may have touched Patient A's pubic hair inadvertently while palpating her abdomen. He denied rubbing it but accepted that his actions may have been interpreted as rubbing. However, he maintained that he was palpating rather than rubbing. He denied intentionally rubbing Patient A's pubic hair.

62. The Tribunal considered the evidence that Dr Jones placed his right hand inside Patient A's trousers and underwear. In oral evidence Dr Jones accepted that he should not have done this and should have asked Patient A to adjust her own clothing. The Tribunal noted that this was a departure from his stated practice that in conducting an abdominal

examination he would first inspect the abdomen for any scars or masses. He could not explain why he had done this and accepted that it was an error. The Tribunal noted that the agreed opinion of the experts was that the symptoms with which Patient A presented did not indicate a clinical need to examine the lower part of Patient A's abdomen.

63. The Tribunal also noted that when asked during the High Court proceedings in Scotland if Patient A was right when she said he was rubbing her pubic hair during his examination of her, Dr Jones' response was that she was. He denied however going lower than the pubic bone.

64. The Tribunal considered Patient A's evidence, the most contemporaneous of which was her account to Ms G immediately after the consultation with Dr Jones. Ms G the practice manager of the surgery saw her when she returned soon after with Mr C to complain about her examination. Ms G records in her note of 12 January 2015 that;

*"Patient A explained that she had just been to see Dr Jones who had conducted an abdominal examination. She stated that he had asked her consent to do this and she had agreed but during the examination she began to feel uncomfortable as she felt that Dr Jones kept going lower and lower and "touched down low". She felt that he was pushing himself on her and she felt male part against her. She also stated that he may have been aroused but could not confirm this as she was too upset at this point. Patient A felt that the examination went on longer than was necessary. She did not say anything to Dr Jones at the time as she just wanted to get out of the room."*

Ms G had spoken to Dr Jones about the matter, but he had reported that the examination had been fairly straightforward. Having spoken to other partners in the practice and taken advice from a medical defence union, she wrote to Patient A on 26 January 2016. In that letter to Patient A, she acknowledged Patient A's distress and her reference to the proximity of Dr Jones' body to her and her belief that he may have been aroused. Ms G explained what an abdominal examination entailed and how this may have led her to feel that it was more than she expected. She had spoken to Dr Jones who did not consider anything other than a normal examination had taken place but that if she wanted to discuss it further with her she could.

65. The Tribunal had regard to the letter written by Ms G and her other accounts given to the police. The Tribunal accepted Patient A's explanation that *"she felt had not been believed and that there was no point in taking it further as it was her word against that of Dr Jones"*. For the same reason, although she considered going to the police she did not do so. It was only in September 2019 when she was approached by the police that she gave her first

statement. Her evidence to the police is consistent with her GMC witness statement which records:

*“Dr Jones examined me by placing his hand on my stomach area. He then moved his hand towards down the sides of my stomach, to my lower stomach and then under my pants up to the opening of my vagina and was rubbing this area. It lasted one to two minutes and I don’t remember any conversation.*

*After Dr Jones removed his hand from this area, I cannot recall much of the conversation as I froze but I think he just went over what he was going to prescribe me. I don’t recall Dr Jones’ diagnosing me or what the prescription was.....*

*When I reported the incident in 2015, I informed the Surgery and wrote a statement for their investigation. I didn’t go to the Police but I consented to the Surgery informing the Police, however I didn’t receive any further information of my complaint, so I just wanted to remove what happened from my mind”*

66. In 2021 Patient A gave evidence in criminal proceedings brought against Dr Jones in the High Court in Scotland where he was found not guilty of the charges against him. During her evidence before the High Court Patient A gave evidence which was largely consistent with the previous accounts she had given. She was able to consistently recall events of the day and when she was unable to do so said that she could not. She described the examination, the points at which she “felt uncomfortable”, and when she “froze”.

67. Her evidence to the High Court in Scotland in relation to the touching of her pubic hair and vaginal area included the following:

*I think I just said to you that what I understood you to have told us a few moments ago was that this doctor’s hand remained just at the start of your pubic hair for a few seconds and you described that his hand was rubbing you. Is that right?*

*A Yes, correct.*

*Q After a few seconds it went moving from side to side again. Is that right?*

*A Yes.*

*Q Whereabouts on your body was the hand touching after the point you’ve described he was rubbing your pubic hair?*

*A Further down towards the opening of my vagina.*

*Q All right. At that point, when the doctor’s hand moved further down, can you describe the way that the doctor was touching you at that point?*

*A Again with the rubbing and ever so slight prodding once in a while.*

*Q How long did the doctor touch you in that area for in the manner that you’ve described?*

*A It felt like a long time but I would say probably only ten to 15 seconds, maybe.*

*Q After the ten to 15 seconds that you estimate, what did the doctor do with his hand at that point?*

*A He just took it away very quickly.*

*Q All right. Did he touch you again in that area?*

*A No. No*

In further questioning about the incident she answers as follows:

*You were asked a number of questions about the positioning of your trousers and where the doctor examined relative to your trousers and your belly button and so forth, and there was mention made of him examining near your pubic bone. Is that right? Do you remember that?*

*A Yes.*

*Q All right. I just want to clarify, at the point when the doctor's hand was lowest, how far would you say it was from the entrance to your vagina?*

*A I'm struggling to know what you mean by entrance of the vagina.*

*Q All right. At the part that the doctor's hand was at its lowest, I think you'd mentioned relative to pubic hair area. Was the doctor's hand touching your pubic hair at any point?*

*A Yes.*

*Q In a direct line from your belly button downwards, if you consider the first area of your vagina below your belly button as a relative point, where was his hand in relation to that?*

*A On that point.*

*Q On it?*

*A Yes.*

*Q You mentioned in questions a moment ago an answer about him staying in the one area for a period of time. What area were you describing when you said that?*

*A That area there.*

*Q All right. When the doctor was touching you in that area, you described a variety of different types of touch and examination. How would you describe the touch in that area at the entrance to your vagina below your belly button?*

*A I would describe it as rubbing.*

*Q The only other matter that I want to ask you about is the letter that you received, and my learned friend made clear to you that we have another document, notes, where [Ms G] took a note of what you told her and I understand it not to be disputed that you told her that the doctor had in fact made contact with you by pushing himself on you. Do you agree with that, that you had told [Ms G] that?*

*A Yes.*

*Q When she wrote to you, the words that she used, and I think you were referred to this particular paragraph, were: "I am sorry that you were upset because you felt Dr Adam took too long or pressed too hard on you during the examination to the point where you felt his*

*body was very close to yours and that he may have been aroused.” Now, is it accurate to say that his body felt very close to yours?*

A Yes.

Q Was it in fact making contact?

A Yes.

Q That was his groin area. Is that right?

A Yes.

Q The note that seems to have been taken by [Ms G] in that regard was:

*“She [and that’s a reference to you] felt that he was pushing himself on her and she felt male part against her. She also stated that he may have been aroused but could not confirm this as she was too upset at this point.”*

Did [Ms G] try to clarify with you what you meant when you said that he may have been aroused?

A Not that I recall, no.

68. Mr C was unable to attend to give evidence at the Tribunal and his evidence was admitted as hearsay. The Tribunal noted that his account is that he took Patient A to the surgery for her appointment that day and waited in the car while she went in for the appointment. When she came out she was distressed and told him that the examination she had had was inappropriate and made reference to what she said of the state of Dr Jones’ arousal during that examination. This largely accords with the uncontested evidence of Ms G that has been placed before this Tribunal. Whilst much has been made of the degree of distress recorded as being experienced by Ms A. The Tribunal is satisfied that Patient A was distressed when she came out of the examination and that the reason she gave for her distress was because of her experience during that examination with Dr Jones.

69. In Ms G’s statement to the police in 2019 she suggests *“the patient was a young patient who maybe didn’t know what to expect.”* Patient A however was a XXX year old woman, who whilst she accepted may have had little experience of abdominal examinations at that time, her evidence was that she was expecting to be examined on that day and she had been prepared for this.

70. The Tribunal had regard to what Patient A told the police about the examination in 2015 in which she explained her reaction to Dr Jones going under the waistband of her trousers and then going under her pants the waistband of which was lower still to the waistband of her trousers. She says:

*“My whole body then tensed up and I’m pretty sure that the doctor would have noticed this as soon as the doctor put his hand in my pants I noticed a change in his actions. He went from*

*prodding my stomach to gently rubbing me with his fingertips and he occasionally prod. He still went from side to side rubbing me and worked his hand downwards.”*

71. The Tribunal accepted that parts of an abdominal palpation could feel like a rubbing action particularly when pressure was applied to feel deeper under the skin. However, the Tribunal was satisfied that the examination of Patient A had not been conducted in an appropriate way as is first demonstrated by Dr Jones’ admission that he did not prepare Patient A for the examination as would be his usual practice by asking her to adjust her own clothes. Instead, he placed his hand both under the waistband of her trousers and underwear which was lower still to the trousers. This would have missed out entirely the observation part of the examination described by Dr Jones and set out above.

72. The Tribunal also had regard for the consistent accounts given by Ms A throughout and contrasted these with the evidence recorded by Ms G who recorded what Dr Jones had told her at the time. The Tribunal noted that she records being told that he did ask Patient A to adjust her clothes, albeit it he also adjusted her trousers further and noticed nothing different in Patient A either during or after the examination. The Tribunal accepted that Patient A was upset when she left the surgery and that this was evident to Ms G when she spoke with her not long after. Whilst Patient A may have had little experience of clinical examinations of her abdomen at that stage, the Tribunal noted that she was XXX years old and had been in a relationship with her partner for four years. In addition, her evidence was that she was expecting an abdominal examination on that day.

73. The Tribunal accepted that pubic hair may in some patients extend higher than the superior ridge of the symphysis pubis. The evidence of Patient A was that Dr Jones was rubbing parts of her pubic hair in an area that she described in her own words and which the Tribunal identified as being lower than the superior ridge of the pubic symphysis. The Tribunal noted that Patient A’s account of the core allegation had remained consistent, notwithstanding changes in her vocabulary over time. The Tribunal considered that the evolution of her language reflected increased maturity and confidence rather than fabrication. The Tribunal also had regard to her evident distress that was recorded by Ms G, the perception of that distress by her boyfriend, and the fact that she returned immediately to the surgery to make a complaint.

74. Having regard to the evidence in the round and the consistent account of Patient A the Tribunal accepted that during the course of the examination as described by her Dr Jones rubbed Patient A’s pubic hair with his fingers, rather than an unintentional or accidental contact during the course of an abdominal examination.

75. Accordingly, for the reasons set out above the Tribunal determined that paragraph 1(a)(ii) of the Allegation was proved.

Paragraph 1(a)(iii)

76. The Tribunal considered paragraph 1(a)(iii) of the Allegation.

77. During the course of oral evidence the Tribunal asked Patient A to explain what she meant by ‘the opening of her vagina’. She described this as the last piece of skin which is covered by pubic hair, before you reach the vagina. She was also asked to describe what she meant by this area when giving evidence before the High Court in Scotland as set out above. The Tribunal having regard to the description given before the High Court and that given to the Tribunal, was satisfied that it understood the anatomical area referred to by Patient A, which was illustrated in the diagrams contained within the expert’s reports and explained by Dr I in questions from the Tribunal.

78. The Tribunal had regard to the evidence that Dr Jones accepted that, in the course of an abdominal examination, it would be usual to come into contact with the superior aspect of the pubis symphysis with the side of the hand or finger. The Tribunal noted that this was the point at which the mons pubis begins to form and that any movement beyond that point would be outside the accepted boundaries of an abdominal examination.

79. The Tribunal considered Patient A’s evidence, including her police statement, in which she described Dr Jones moving his hand down towards the opening of her vagina. The Tribunal noted that Patient A stated that Dr Jones spent a few seconds moving his hand in this area. The Tribunal accepted that Patient A’s description was her attempt to convey the nature and location of the touching as she experienced it.

80. The Tribunal considered that there was some discrepancy in terminology between references to the vagina and the precise anatomical location of the touching. However, it was satisfied that this did not amount to an inconsistency. In oral evidence Patient A explained that when the examination took place in 2015 she would not have known to use the vocabulary she later used when she referred to the area as vaginal rather than the reference to ‘down lower’ in her earlier account. The Tribunal accepted that Patient A’s later account, including that given to the police in 2019, was more detailed and reflected increased clarity in describing events, rather than a change in substance of her account.

81. The Tribunal found that Patient A had not sought to embellish her account over time and whilst there have been minor inconsistencies relating to an exact timing of how long the examination took or how distressed she had been, the Tribunal did not find these

inconsistencies to be material to her account. It considered that the account of her distress by others was subjective and as perceived by them. In respect of the duration of the examination or particular aspect of the same, the Tribunal considered that this too, in the absence of a clock, was the perception of Ms A. The Tribunal found that the core of Patient A's account had remained the same. The Tribunal found that Patient A never departed from the core of her account, namely that Dr Jones' hand moved beyond the superior aspect of the pubic bone and downwards towards her vaginal area. The Tribunal considered her to be a credible and reliable witness who gave a calm and measured account and was willing to concede matters where appropriate or say when she was unable to remember or recall an aspect of the event.

82. Dr Jones denies Patient A's account of what happened. The Tribunal noted that Dr Jones did not advance an alternative explanation as to how Patient A might have perceived his hand moving downwards towards her vaginal opening if this had not occurred. The Tribunal noted however that the burden of proving the allegation was on the GMC and the doctor did not need to prove anything. To consider otherwise would reverse the burden of proof, a point that the Tribunal was alert to.

83. The Tribunal also had regard throughout its decision making process to the fact that the Dr Jones was of previous good character and that this was a factor that should be considered when considering both his credibility and the inherent probability or improbability of the alleged conduct occurring.

84. The Tribunal noted that paragraph 1(a)(iii) of the Allegation was widely drafted. Having sought clarification from Patient A and the evidence she gave to the High Court in Scotland, it interpreted it as encompassing movement of the hand from the superior aspect of the pubis symphysis over the mons pubis towards the vaginal opening. The Tribunal had regard to the clear and consistent evidence of Patient A and determined that on the balance of probabilities her account of the examination had more likely than not taken place.

85. Accordingly, the Tribunal determined that paragraph 1(a)(iii) of the Allegation was proved.

#### Paragraph 1(a)(iv)

86. The Tribunal considered paragraph 1(a)(iv) of the Allegation.

87. As set out above the Tribunal had regard to Patient A's evidence of what she meant by the "*opening of her vagina*". Patient A had explained that by this phrase she meant the last piece of skin immediately before the vaginal opening. The Tribunal noted that Patient A did

not use anatomical terminology such as the clitoris and accepted that her description for the reasons previously set out.

88. The Tribunal noted that the GMC did not provide a formal definition of where the opening of the vagina began. It also noted that there were anatomical diagrams available within the expert evidence. However, the Tribunal was satisfied that it was not required to resolve a precise anatomical boundary in order to determine this allegation. It accepted that Patient A's explanation of what she meant by the opening of her vagina was clear and sufficient for the purposes of fact-finding.

89. Dr Jones denies the allegation and maintains his position that he conducted an appropriate abdominal examination on Patient A.

90. The Tribunal had regard to Patient A's evidence in the High Court in Scotland in which she described Dr Jones moving his hand further down to the opening of her vagina. During part of that evidence which is set out more extensively above, the transcript records:

*“Q Whereabouts on your body was the hand touching after the point you’ve described he was rubbing your pubic hair?”*

*A Further down towards the opening of my vagina.”*

91. The Tribunal noted that Patient A stated that Dr Jones rubbed this area for a short period. The Tribunal also noted Patient A's evidence that, at this stage of the examination, she had the impression that Dr Jones had an erection, which she associated with the nature of the contact he was having with her.

92. The Tribunal considered the evidence of this allegation in the round, having regard to the departure from Dr Jones' usual practice of asking the patient to adjust their own clothing before an examination and instead putting his hand under Patient A's clothing and underwear. Adopting this approach also resulted in Dr Jones missing out that part of the examination where he says he would first observe the abdomen.

93. The Tribunal noted that the evidence of Dr Jones was not that he adjusted the clothing of Patient A but rather he admitted that he had placed his hand under the waistband of her trousers and underwear. It would not have been possible therefore to have conducted an observation of the abdomen which remained covered by her clothing. The Tribunal also had regard to the oral evidence of Dr Jones who said that it is the way he explains the procedure to patients that has changed since 2015 and not that the manner in which he carries out an abdominal examination save for the fact that he no longer particularly identifies the boundary of the abdomen by deliberately locating the pubic bone.

94. During the course of all its deliberations the Tribunal had regard to the passage of time since these events had taken place, the fluidity of memory and the number of accounts that Patient A had provided about her account. It was satisfied that throughout Patient A had stayed loyal to the core account of what happened to her during the examination by Dr Jones on 12 January 2015. The Tribunal found that Patient A's account of this part of the examination had not changed over time, it had not been embellished nor had it been inconsistent with any other account she had given.

95. Having regard to all the evidence in the round and in particular the circumstances of the manner in which this examination had been conducted, the Tribunal found that on the balance of probabilities, Dr Jones had more likely than not acted in the manner alleged during the course of the examination of Patient A on 12 January 2015.

96. Accordingly, the Tribunal determined that paragraph 1(a)(iv) of the Allegation was proved.

Paragraph 1(a)(v)

97. The Tribunal considered paragraph 1(a)(v) of the Allegation.

98. Patient A's evidence is that during the course of the abdominal examination Dr Jones performed on her on 12 January 2015, she felt Dr Jones' body pushed on her side and that he was in a state of arousal at the time.

99. Dr Jones denies that he had an erection or was in any state of arousal. He does however accept, as do the Experts, that during the course of an abdominal examination it would be necessary to lean over a patient which would result in a feeling that the examiners body may be pressing against a patient. Dr Jones accepted in evidence that he may have pressed his body against Patient A in this way. Dr Jones denied that he had an erection and denied any sexual intent. He relied upon the explanation that incidental body contact was inevitable during close physical examinations and that there were innocent alternative explanations for such contact.

100. The Tribunal considered Patient A's account that she felt Dr Jones press his body against her and that she observed, through his trousers, a bulge which she believed to be an erect penis. Patient A described this in her oral evidence and in her witness statements. She maintained in cross-examination that she was sure about what she experienced.

101. The Tribunal considered the contemporaneous hearsay evidence of Mr C, and had particular regard to the following in his witness statement,

*“After the appointment, she came back to the car in tears. Patient A told me that Dr Jones was examining her stomach and then he went further down than she was comfortable with and that he was aroused at the time.”*

102. The Tribunal noted Ms G’s contemporaneous notes of meeting with Patient A prepared by Ms G on 12 January 2015 at approx. 4pm:

*“Patient A explained that she had just been to see Dr A who had conducted an abdominal examination. She stated that he had asked her consent to do this and she had agreed but during the examination she began to feel uncomfortable as she felt that Dr A kept going lower and lower and “touched down low”. She felt that he was pushing himself on her and she felt male part against her. She also stated that he may have been aroused but could not confirm this as she was too upset at this point.”*

103. The Tribunal noted that immediately after the consultation Patient A left the consulting room, went directly to the car where her boyfriend was waiting. It noted she had been sufficiently distressed to return immediately to the surgery, with her boyfriend, to make a complaint. The Tribunal considered that this contemporaneous conduct was consistent with Patient A having experienced something she found concerning during the examination.

104. The Tribunal took into account that Patient A did not pursue the matter further at the time and that she was approached by the police some four years later in 2019. The Tribunal again had regard to the fact that the events occurred some time ago but noted that Patient A’s account of the core allegation had remained consistent, notwithstanding some variation in her estimate of the duration of the examination.

105. The Tribunal had regard to the particular circumstances in which this examination took place. It considered that the manner in which Dr Jones placed his hand under the waistband of the trousers and underwear of Patient A was unprofessional and not in keeping with expected clinical standards. It further noted the opinion of the experts that the need to examine the lower part of the abdomen was not clinically indicated. It was also a deviation from Dr Jones’ asserted practice. It considered the accounts given and recorded by Patient A and Ms G. Patient A has remained consistent in her account. In oral evidence she did not agree with what Ms G had recorded in her letter but explained that she did not challenge this because she felt that she was just not being believed and that it was essentially her word against that of Dr Jones. In contrast the evidence of Ms G is not as consistent. In her note of the meeting with Patient A she records that Patient A said Dr Jones may have been aroused but that she had been unable to confirm that as she was so upset at this point. Her letter of response to Patient A’s complaint of 26 January 2016 makes a passing reference to Patient A’s report of Dr Jones being aroused during the examination. In her statement to the police in

September 2019, she makes no reference to the possibility of Dr Jones being aroused. In her witness statement to the GMC of October 2023, however she states that Patient A said, *“that during the abdominal examination she felt that Dr Jones became aroused and she felt it against her body”*

106. The Tribunal accept that Ms G was acting in her capacity as the practice manager of the surgery at which Dr Jones was a partner. The Tribunal is not aware of the extent of the investigation that was carried out by Ms G into the allegation but according to the evidence of Patient A in the High Court in Scotland, she was not asked for any further clarification of her complaint after the meeting with her on 12 January 2015, immediately after the alleged assault when she was by everyone’s account upset.

107. As set out above the Tribunal has found Patient A to be a consistent and reliable witness. The core of her account has not changed over the considerable length of time that has passed since these events. The Tribunal find that the manner in which this examination took place was a departure from the expected clinical standard. The Tribunal had regard to its findings of fact as set out above and found that the examination involved Dr Jones putting his hand under the waistband of Patient A’s trousers and underwear whilst moving his hand down towards her vagina and briefly rubbing the area just before her vagina. In such circumstances the Tribunal find it entirely plausible for such actions to have aroused a male in the manner described by Patient A. For these reasons the Tribunal find that it is more likely than not that during the course of the examination conducted by Dr Jones, he pressed his body and erect penis against areas of Patient A.

108. Accordingly, the Tribunal determined that paragraph 1(a)(v) of the Allegation was proved.

109. Having found all paragraphs of this allegation proved, the Tribunal went on to consider whether the conduct found proved showed conduct of a particular nature that could be relied upon to strengthen evidence in other allegations, which alleged the same type of conduct.

110. Mr Brook’s submissions dealt somewhat globally with the issue of cross admissibility of evidence. In relation to propensity Mr Brook clearly suggested that Dr Jones had a propensity to take risks for sexual gratification. However, the Tribunal has not made any findings of that nature. He also submitted that Dr Jones takes advantage of vulnerable female patients, abusing a legitimate arena for the conduct of clinical examinations and his position as a doctor. The Tribunal did not find that age alone was capable of rendering Patient A as vulnerable at the relevant time. The Tribunal did find conduct that amounted to an abuse of Dr Jones’ position as a doctor and that his conduct also involved taking advantage of

legitimate settings to carry out inappropriate examinations of a sexual nature on female patients.

Patient B

Paragraph 2(a)(ii)(1)

111. The Tribunal considered paragraph 2(a)(ii)(1) of the Allegation.

112. The Tribunal noted that Dr Jones attended Patient B's home address in response to a phone call she had made to NHS24 on 6 December 2015, requesting assistance in respect of pain she was experiencing due to a suspected kidney infection. The out of hours record of that visit documents his arrival at 12.54 and departure at 13.21. It is not disputed that an examination took place, or that prior to the examination Dr Jones had asked Patient B to pull her pyjama bottoms down or words to that effect. Patient B did as requested and her evidence to the police on 9 December 2015 was that she had pulled them down far enough to show her bladder and groin area. She said that *"I pulled them down to just below my vagina and top up to show my stomach but not my boobs"*. In the High Court of Scotland she had described that further as *"Just past my bottom basically"*.

113. Patient B gave evidence to the police that during the course of this examination Dr Jones had examined her with one hand whilst rubbing her clitoris with the other in a circular movement. Patient B has remained consistent in her account that she was lying in a position where the left side of her body was closest to Dr Jones. The Tribunal accepted that Patient B has been confused about which hand Dr Jones had used to carry out the examination or touch her clitoris from the first account that she gave to the police just three days after the visit. The Tribunal noted that up to just before the start of this hearing some 10 years later Patient B had remained confused and asked for her evidence to record that Dr Jones had been touching her clitoris with his right hand and examining her with his left. Patient B has also given different accounts of the length of time it is alleged that Dr Jones was touching her clitoris. Patient B told this Tribunal that she had not been looking at a clock so was unable to give a precise time. The Tribunal noted that her first account to her police was that it lasted for 4-5 minutes which was the evidence she gave to the GMC in October 2022. In 2021 before the High Court in Scotland she had estimated the time as being between 5-10 minutes and told the Court that his touching had lasted *"all the time he was pressing on my stomach and my groin and side, the whole time he was doing that he was playing about with my clitoris, it was like he was trying to turn me on that's how it felt"*.

114. The Tribunal accepted that Patient B was not watching the clock and that her estimate of time had been her perception of the time over which the touching is said to have occurred.

115. The Tribunal noted that the wording of this allegation was that Dr Jones had touched and/or rubbed [her] clitoris with his left hand in a circular motion for a prolonged period of time. The question then for the Tribunal was whether the GMC had proved the allegation as drafted, including the specific elements of the Allegation particularly that it had occurred for a prolonged period of time.

116. The Tribunal considered the objective evidence of the out of hours record of the duration of the visit with Patient B as set out above.

117. The Tribunal accepted that during the course of an examination that had taken place there was sufficient opportunity for inappropriate touching to have occurred. However, this alone was not sufficient to make a finding that it had in accordance with the allegation as drafted.

118. In her first statement to the police on 9 December 2015, Patient B corrected herself as to the hand with which Dr Jones had touched her clitoris and confirmed that it had been his left hand. The Tribunal did not consider that this amounted to an inconsistency on the part of Patient B but was merely a correction of her recollection during the course of one interview. It is unclear as to why on 3 February 2026, Patient B has asked to change her evidence of this event to say that he was touching her clitoris with his right hand whilst examining her with the left. Dr Jones accepts the evidence of Patient B that during the course of the examination that she was lying with the left side of her body closest to Dr Jones, it seems unlikely that he would have been touching her clitoris with his right hand whilst examining her abdomen with his left as this would have involved him crossing his arms over to do so.

119. The Tribunal had regard to the ordinary meaning of the words ‘prolonged period of time’ which it identified as meaning lasting longer than usual or expected, or continuing for a long time.

120. The Tribunal had regard to the fact that Patient B’s evidence of her perception of time has been fluid. The Tribunal considered all her evidence about time and her recollection of the same in the round. It found with the passage of time her perception of the time involved varied. The Tribunal also found that as a witness Patient B had poor recollection and at times was intransigent in her belief on particular matters as set out below. The Tribunal also noted broader concerns about the reliability of her evidence, including inconsistencies and a

tendency to embellish aspects of her account. It therefore approached her evidence on duration with caution.

121. The Tribunal had regard to the cross admitted evidence that it could rely on to support a finding that it was unlikely that two people unknown to each other would both be lying about what Dr Jones had done whilst carrying out examinations on them. The Tribunal found that in respect of this particular paragraph, there was insufficient evidence to support a finding that on the balance of probabilities Dr Jones had rubbed Patient B's clitoris in the manner described for a prolonged period of time.

122. Accordingly, the Tribunal determined that paragraph 2(a)(ii)(1) of the Allegation was not proved.

#### Paragraph 2(a)(ii)(2)

123. The Tribunal considered paragraph 2(a)(ii)(2) of the Allegation.

124. The Tribunal considered Patient B's account of the examination by Dr Jones on 6 December 2015. Whilst there had been a number of inconsistencies in Patient B's evidence overall, the core of her account in respect of the examination remained the same throughout. The Tribunal had regard to the fact that Patient B was not a medical practitioner and would therefore not be as familiar with the terminology relating to female genitalia. Patient B was consistent in her evidence that in conducting the examination Dr Jones' hands had extended beyond the top of her pubic bone and into the pubic/vulval area, even when other aspects of her evidence had varied.

125. Dr I had explained to the Tribunal the anatomical location of extent of what is known as the vulva, which included the clitoris. She also explained that while it was theoretically possible to touch the clitoris without touching the vulva, such contact would be unlikely in the circumstances described. The Tribunal accepted that, if Dr Jones' hand moved downwards as described by Patient B, contact with the vulva was more likely than not to have occurred.

126. The Tribunal acknowledged that Patient B was an unreliable witness in certain respects but this did not mean that the Tribunal was required to reject all of her evidence. She had remained consistent about the area of her body that had been examined and the Tribunal was satisfied on the balance of probabilities that this had extended to touching her vulva. The Tribunal considered that her account was supported by the cross admitted evidence of Patient A to enable the Tribunal to reach a conclusion that it was not simply a coincidence that sufficiently similar allegations were brought by two women who were

unknown to each other. The circumstances and conduct complained of were of significant similarity which the Tribunal found strengthened a finding that Patient B was less likely to be lying about the conduct of this examination.

127. For the reasons set out above and on the balance of probabilities, the Tribunal determined that it was more likely than not that Dr Jones touched Patient B's vulva during the course of the examination he carried out on her during his initial visit on 6 December 2015.

128. Accordingly, the Tribunal determined that paragraph 2(a)(ii)(2) of the Allegation was proved.

Paragraph 2(b)(i)

129. The Tribunal considered paragraph 2(b)(i) and 2(b)(ii) of the Allegation together.

130. The Tribunal noted that it was not disputed that Dr Jones returned to Patient B's home address later that day. What is disputed is the allegation that when Dr Jones returned on his second visit he carried out an examination of Patient B in the manner described at paragraph 2(b)(ii). The Tribunal therefore needed to first determine whether or not, on the balance of probabilities a second examination took place as alleged or at all.

131. The Tribunal has had careful regard to its findings of fact in relation to paragraph 2(a) including the fact that an examination of an identical nature was alleged. The significant difference between the two allegations is that in the former Dr Jones accepts that he carried out an examination of Patient B when he attended on the first visit of 6 December 2015 but categorically denies that he carried out any kind of physical examination on the second. The first examination is recorded in the out of hours record as:

*Examination .....*

*Abdomen soft, tender supra-pubic, left loin and renal angle*

*Guarding + BS normal*

The section for recording an examination on the out of hours report on the second visit has not been completed. The out of hours report records that:

*History: Issue with medication from previous call, prescription delivered but not medication as requested/ Collected Rx myself from Montrose Boots with addition of oramorph bottle to replace.*

*Examination:*

*Diagnosis Medication*

*Treatment Delivered to patient next time I was passing property*

132. The Tribunal accepted the evidence, which was corroborated on the whole by Mr E the out of hours driver, that the antibiotics that Patient B needed were not in the van so Dr Jones asked another doctor at Arbroath MIU to write a prescription and then give it to another driver that was in the same location. Dr Jones made this request so that the driver could then be instructed to take the prescription to be dispensed and for the driver to take the medication to Patient B. Unfortunately, the driver took only the paper prescription to Patient B and she was unable to go to the chemist herself due to her pain and she had no-one else to do it for her. Whilst Patient B has given inconsistent accounts about whether the driver came to her home at all the Tribunal is entirely satisfied that there is reliable evidence that this account is the correct one.

133. Mr E the driver who was working with Dr Jones on 6 December 2016 was also able to confirm that the driver let Dr Jones know what had happened about the prescription. He told the Tribunal that Dr Jones was annoyed that the medication had not been taken to Patient B and said that he would get it himself. This accords with Dr Jones' account of what had occurred.

134. When Dr Jones returned to the property he got out of the van to take the medication to Patient B. As before Patient B did not answer the door which remained unlocked, and when Dr Jones shouted up that it was the doctor she shouted for him to come up.

135. Dr Jones states that when he arrived upstairs in the flat he found Patient B in her pyjamas but this time she was not on the sofa but in the kitchen. He recalls that she may have been making a cup of tea. It is his evidence that he told Patient B that he had been able to get her some oramorph as well as her antibiotics and placed the same on the kitchen worktop. He then had a chat with her about her pain and the medication and left. Patient B does not agree with this account and alleges that on Dr Jones' return she was laid on the sofa as before and that he examined her once again in exactly the way she described she had been examined during the first visit, including lowering her own pyjamas bottoms in the manner described.

136. Patient B has given a number of accounts of what happened after Dr Jones had given her the injection of morphine on 6 December 2015 and left the house. Although she had spoken to Dr D on 8 December 2015 to complain about the conduct of Dr Jones during his

visits of 6 December 2015, her first formal account was given to the police on 9 December 2015. In that statement it is recorded that she told the police that she had previously been examined by Dr Jones for kidney problems at a different address. She also confirmed that whilst she could not recall the date on which this occurred she did confirm that she had no concerns about the manner in which that examination had taken place. In the statement she confirmed that she recognised Dr Jones when he arrived at her flat and that they both acknowledged they had seen each other before. When Dr Jones had arrived at her flat she said that she was laid on the sofa and he knelt down at the side of the sofa and said “*your kidney again?*” to which she had replied “*yeah*”.

137. In her evidence before the High Court in Scotland in March 2021, Patient B gave pre-recorded evidence under affirmation that she could not remember having seen Dr Jones before he attended her flat on 6 December 2015. When in cross examination she was shown her written evidence to the police on 9 December 2015, just three days after the visit, she responded to the effect that she didn’t remember him on the day but afterwards remembered seeing him at a different address, but on the 6 December 2015, she could not remember if she had seen him before. It is clear to the Tribunal that if it was the case that Patient B had only remembered that she had previously seen Dr Jones after the examination on 6 December 2015, then her evidence to the police on the 9 December 2015 about that fact that they had met before and the references to it ‘being her kidney again’ and her response, would not have been in her police statement.

138. The Tribunal found that this was one of a number of accounts that had been given by Patient B where, having given a subsequent and inconsistent account of events, she was adamant that the account she was giving was correct. In most cases she only conceded the point when presented with a written record of her previous testimony but on occasion as set out below even when presented with previous testimony she sought to justify her evidence.

139. The Tribunal found that it was significant that a number of these inconsistencies related to events following the administration of the morphine injection during the first of the visits by Dr Jones on 6 December 2015.

140. The Tribunal has attempted where possible to list these in the order in which they occurred on that day. The first related to the administration of the injection of morphine. In her evidence to the police Patient B had said that she had asked Dr Jones whether the injection would be given in her bottom and he had replied that it could be given either in her bottom or arm. She told the police that she then pulled up the sleeve of her pyjamas for the injection which he then gave and told her “*that should work quite quickly*”.

141. In evidence to the High Court in Scotland Patient B told the Court that the injection had been in her bottom and that she disagreed that it had been in her arm. She had said to the Court that she could remember being asked to turn on her right side so that the injection could be given in her bottom and that she could not remember ever receiving an injection of morphine into her arm as it had always been given in her bottom. When taken to her statement to the police she accepted that she had told them this but that she had been in pain when the injection had been given and she reiterated that morphine had always previously been given in her bottom.

142. In her statement to the police of 9 December 2015, it is recorded that Patient B had said that after Dr Jones had left she made a 'cuppy', had a sleep and then called her friend. She had told her friend that she had been examined, had had her observations done, had been given an injection of morphine and was waiting on her antibiotics. She told the police that while she was on the phone to her friend the driver arrived and she shouted for him to come up. She had told the driver that the written prescription was no good and he went out to make a call. She had stayed on the phone to her friend and when he returned after a couple of minutes he told her that Matt would come around later with the antibiotics. She had asked who Matt was and he had told her it was Dr Jones. She told the police that she did not know what time Dr Jones came back to her house because *"the morphine had knocked her a bit"*.

143. The Tribunal had regard to the approximate timing of the administration of the morphine which was between 12.56 when Dr Jones arrived at 12.56 and 13.21. The driver had informed Dr Jones no later than 13.41 that he had not delivered the antibiotics to Patient B which was 20 minutes after Dr Jones had left her flat. The Tribunal noted that in the intervening period Patient B had made a cup of tea, had a sleep and had a phone call with her friend.

144. In her evidence to the High Court in Scotland Patient B said she could not remember a driver coming back and nor did she know that Dr Jones would be returning. She said that Counsel was wrong to suggest that she knew that Dr Jones was coming back. When she was taken to the police statement of 9 December 2015 which recorded that which is set out above, she accepted that the driver must have visited but that she could not remember because *"she had had morphine"*.

145. In respect of her denial of knowledge of Dr Jones' intention to return with antibiotics. When it was put to her in the High Court in Scotland that in light of her statement to the police, she must have known that Dr Jones was coming back she responded by saying *"but I didn't know what time"*. Patient B adopted a similar stance when replying to questions before this Tribunal and when challenged about her knowledge of Dr Jones' intention to come back

she told this Tribunal that she was just told a doctor would be coming back and, she did not know it would be Dr Jones. She also said that she had not known that “Matt” was Dr Jones, which is inconsistent with her account to the police as above, and that she did not know when or what time he was coming back.

146. When asked why she had not raised any of her concerns about Dr Jones or ask that a different doctor bring the medications, Patient B was adamant that it would have been inappropriate to do this as he was a driver. She was also robust in her response to the question of why she had not asked when she could expect Dr Jones to return with her antibiotics, and told the Tribunal that she had not asked this as he was a driver not a doctor.

147. The Tribunal noted that even when faced with the documentary record that she had been told who it was that was coming back to the house with her medication she remained adamant that she did not know that it was going to be Dr Jones who was coming back.

148. As set out above Dr Jones said that when he returned to the home of Patient B he found her in the kitchen and, having chatted with her left her medication on the kitchen top. The Tribunal has been shown documentary evidence of the medication that was dispensed by Boots Montrose for Patient B of the antibiotics and oramorph.

149. In her police statement of 9 December 2015 Patient B said that when Dr Jones returned she was on the sofa in the same position. Dr Jones had told her that he had brought her antibiotics and put them on the floor. He had said to her that because it was him coming back she was also getting oramorph as drivers were not allowed to carry controlled drugs.

150. Her evidence in the High Court in Scotland was that she did not get the antibiotics she had requested and that he had only got the oramorph. Dr Jones had told her how much to take and when and to keep the bottle in the refrigerator.

151. In her witness statement to the police she recorded that she had been left with the oramorph and antibiotics and Dr Jones told her to ring the out of hours if needed. It is recorded in the police statement that Dr Jones had been in the house for about 10 minutes and after he had left she later went to bed.

152. In her witness statement to the GMC of October 2022 Patient B also refers to Dr Jones bringing antibiotics and oramorph on his return and that he had left them on the kitchen worktop which is consistent with the account of Dr Jones.

153. The Tribunal also noted that the entry in Patient B's medical records of her appointment with Dr D records that the driver had brought only a prescription not the antibiotics and that the GP had come back with antibiotics and oramorph.

154. The Tribunal has also been shown a copy of the dispensing note of the medicines that were dispensed by Boots Montrose for Patient B on 6 December 2015. It also showed that they were dispensed on behalf of Tayside Out of Hours, for whom Dr Jones was working on that day. The document showed that both the antibiotics and the oramorph had been dispensed in the name of Patient B.

155. Notwithstanding the above Patient B remained robust in her denial that Dr Jones had not brought the antibiotics for her and told this Tribunal that the antibiotic that she says she took on the day following the examination was one that she had left from a previous prescription.

156. Patient B has alleged that on his return of the afternoon on 6 December 2015 Dr Jones told Patient B that he needed to examine her again. Prior to doing so he had asked her to pull down her pyjama trousers and lift up her top and had then carried out an examination in exactly the same manner as described in the first examination. Her account of how long this examination took has varied between 1 to 1.5 minutes in her statement to the police to between 5 and 10 minutes in her evidence before the High Court in Scotland. The Tribunal also noted that Patient B told Dr D that Dr Jones had examined her a second time when he returned with the medications.

157. The Tribunal has also had regard to the inaccurate recording of time during which this second visit took place, and the fact that Dr Jones had failed to address this in his witness statement. It noted that in as far as it was able to tell from the transcripts before it, the issue was not one that was raised in the High Court proceedings in Scotland. It was obvious to the Tribunal that the arrival time of 16.12 and finish at 16.13 could not have been accurate especially in light of the fact that his driver that day, Mr E had given evidence that he had estimated that Dr Jones had been in the home of Patient B for 10-15 minutes and had apologised when he had returned to the van because he had taken so long. He had explained to Mr E that this had been because he had been chatting to Patient B.

158. Dr Jones explained to the Tribunal that the time entry on the out of hours record was incorrect and that although he is unable to say definitively, he thinks that this was probably because he had failed to press the button on the system when he had arrived at the address of Patient B. He explained that once this button was pressed a large "A" would appear on the screen and the next step would then be to press the button again to record the note of the visit and the system would then record the finish time and close the record. He told the

Tribunal that the absence of the “A” would have been a reminder to him that he had failed to register the call when he arrived. Dr Jones explained that when he arrived upstairs he had chatted with Patient B and had not simply left the medication. He estimated that he had probably been in the home of Patient B for 5-10 minutes.

159. The Tribunal further noted that Mr E had reported no change in the behaviour or demeanour of Dr Jones when he returned to the van and they had continued to the next visit before finishing their shift at around 5:40pm.

160. In considering this evidence the Tribunal has had regard to the lapse in time since the alleged events took place. It has also had regard to the fluidity of memory and the evidence of the experts in respect of the potential for the effects of morphine, to create a distortion in perception and memory of a patient who had received the same. This would be especially so if as Patient B has suggested in her evidence that she has the tolerance of a child to drugs.

161. The Tribunal has also considered the likelihood of Patient B lying about Dr Jones carrying out a second examination and whether the evidence that had been cross admitted to rebut coincidence had any relevance to our analysis on this occasion. Dr Jones gave evidence that there could be occasions when a second examination was required but there had been no indication for one on this visit.

162. Looked at in the round the Tribunal found that Patient B’s recollection of events after Dr Jones had administered morphine to Patient B during the first visit, was unreliable. The Tribunal do not find that Patient B was not credible but rather that she was unable to recollect the events of that time with a reliable degree of consistency or accuracy. She was intransigent in her belief of matters that could be objectively proved to be wrong for example the provision of the antibiotics, where she went as far as to say that Dr D had inaccurately recorded what she had told her during her appointment of 8 December 2015. She has also referenced her lack of memory of events that occurred to be attributable to the morphine she had been given.

163. The Tribunal accepted the evidence of Dr Jones in relation to his explanation of the time he spent in the home of Patient B and the inaccurate record of time in the system.

164. For the reasons set out above the Tribunal do not find that there is sufficient evidence on which it is able to rely to make a finding that it was more likely than not that a second examination was conducted by Dr Jones that day. The Tribunal considered that in addition to the considerable inconsistencies in her evidence following the administration of morphine, her memory of the second visit may have become conflated by the effect of the morphine and the experience of the previous visit. In light of its findings the Tribunal did not consider

that this was an allegation in which it would be appropriate to rely on the cross admissible evidence to rebut coincidence. The Tribunal found that whilst the allegation relating to the nature of the examination was identical to the allegation relating to the first examination, there was a striking difference between the two in that in this allegation it was necessary to show that an examination had taken place on the second visit before going on to look at the nature of it. There was a lack of any reliable evidence to support this and the Tribunal reminded itself that cross-admissibility could not be used to prove the occurrence of an event in the absence of sufficiently reliable primary evidence.

165. Having considered the evidence in the round, it was not satisfied that the GMC had discharged that burden in relation to this allegation.

166. Accordingly, the Tribunal determined that paragraph 2(b)(i) of the Allegation was not proved.

167. As the Tribunal has not found to the requisite standard that Dr Jones carried out a second examination on Patient B on the afternoon of 6 December 2015, it follows that there is no evidence to support the allegations relating to paragraphs 2(b)(i) 2b(ii) (1) and (2) and the Tribunal find them not proved.

#### Paragraph 3

168. The Tribunal considered paragraph 3 of the Allegation.

169. The Tribunal had regard to Dr Jones' evidence. In cross-examination, Dr Jones accepted that at the time of his attendance he knew that Patient B was vulnerable due to her mental health. The Tribunal also considered Patient B's presentation, her circumstances at the time of the events in question, and the broader context of her medical history.

170. The Tribunal was satisfied that Patient B's mental health difficulties rendered her vulnerable by reason of her mental health at the material times.

171. Accordingly, the Tribunal determined that paragraph 3 of the Allegation was proved.

#### Paragraph 4

172. The Tribunal considered paragraph 4 of the Allegation and noted that, as originally drafted, it did not accurately reflect the relevant charges arising from the factual particulars set out elsewhere in the Allegation.

173. The Tribunal reconvened to hear submissions from the parties on the amendment proposed by the Tribunal. After some discussion both parties agreed that the amendment would provide clarity and would not result in prejudice or unfairness to either party. The Tribunal was satisfied that paragraph 4 required amendment in order to ensure accuracy, clarity, and consistency with the underlying factual allegations.

174. Accordingly, the Tribunal amended paragraph 4 of the Allegation to read as follows:

Your actions set out at paragraph(s):

(a) 1(a)(i)(1) and (2), 1(a)(ii)–(v) and 2(a)(i), 2(a)(ii)(1) and (2), 2(b)(i), and 2(b)(ii)(1) and (2), were not clinically indicated;

(b) 1(a)(i)(1) and (2), 2(a)(ii)(1) and (2), and 2(b)(ii)(1) and (2), were sexually motivated.

175. The Tribunal was satisfied that this amendment did not alter the substance of the case against Dr Jones, nor did it cause any unfairness. Rather, it ensured that paragraph 4 accurately reflected the scope and nature of the allegations as particularised and considered by the Tribunal at the fact-finding stage

176. The Tribunal considered paragraph 4(a) of the Allegation, namely whether Dr Jones' actions, as set out at paragraphs 1(a)(i)(1) and (2), 1(a)(ii)–(v), 2(a)(i), 2(a)(ii)(1) and (2), 2(b)(i), and 2(b)(ii)(1) and (2), were not clinically indicated.

177. In respect of paragraph 4 the Expert witnesses had set out the circumstances where facts found proven in relation to the Allegation would not be clinically indicated.

178. The Tribunal had regard to its findings of the facts found proved as set out above. It accepted the findings of the expert witnesses when determining whether or not that this allegation was found proved. It found that the examinations carried out by Dr Jones on Patient A and Patient B went beyond that of an abdominal examination and were not clinically indicated on the basis that, in respect of

- (a) Patient A, her presenting symptoms did not indicate a clinical need for Dr Jones to;
  - a. Place his hand under the waistband of Patient A's trousers or underwear
  - b. Rub/touch Patient A's pubic hair
  - c. Move his right hand down towards the opening of her vagina
  - d. Rub the opening of Patient A's vagina with his hand.
  - e. Press his body/erect penis against Patient A's arm and/or upper thigh
- (b) Patient B, her presenting symptoms did not indicate a clinical need for Dr Jones to
  - a. Touch her vulva

179. The Tribunal had regard to the Experts opinion that there may be circumstances where the request to pull pyjama bottom down may be appropriate but considered the request would be disproportionate where the patient was not wearing underwear. The experts were of the view that this could potentially amount to an intimate examination if the lower abdomen or vulva was touched and would require the consent of the patient and the offer of a chaperone. The Tribunal found that the examination that Dr Jones had carried out on Patient B was an intimate examination by reason of the fact that his examination was found to extend to the lower abdomen and vulva and that it was not clinically indicated.

180. It had not found proved that Dr Jones touched or rubbed Patient B's clitoris for a prolonged period of time. That allegation therefore did not fall to be considered for the purposes of clinical indication.

181. In relation to the second visit involving Patient B, the Tribunal had not found proved that any examination took place and had not found proved the allegations at paragraphs 2(b)(ii)(1) or 2(b)(ii)(2). Those allegations therefore did not fall to be considered for the purposes of sexual motivation.

182. Accordingly, the Tribunal determined that paragraph 4(a) of the Allegation was proved in respect of paragraphs 1(a)(i)(1) and (2), 1(a)(ii)–(v), and 2(a)(ii)(2), and was not proved in respect of paragraphs 2(a)(i), 2(a)(ii)(1), 2(b)(i), 2(b)(ii)(1), and 2(b)(ii)(2).

183. The Tribunal considered paragraph 4(b) of the Allegation, namely whether Dr Jones' actions, as set out at paragraphs 1(a)(i)(1) and (2), 2(a)(ii)(1) and (2), and 2(b)(ii)(1) and (2), were sexually motivated.

184. Before determining whether or not the actions of Dr Jones which the Tribunal had found proved was sexually motivated, the Tribunal reminded itself of the guidance of *Basson and the GMC* [2018] EWCA Civ 763. It also reminded itself that Dr Jones has no previous convictions or regulatory findings against him. It further reminded itself that before an inference of sexual motivation can properly be drawn the Tribunal had to be able to safely exclude, as less than probable, other possible explanations for his conduct. In relation to Patient A, the Tribunal had found proved that Dr Jones placed his hand inside Patient A's clothing and underwear, touched her pubic hair, moved his hand down towards the opening of her vagina, rubbed the opening of her vagina, and pressed his body and erect penis against her. It considered all the circumstances of this examination in the round and had regard to the relevant opinions of the expert witnesses. The Tribunal was satisfied that there was no clinical indication for this conduct. It further considered that the presence of an erection, together with the nature and location of the touching, supported a finding that these actions

were sexually motivated. The Tribunal determined that there was no plausible explanation for the conduct of Dr Jones and therefore found his actions to be sexually motivated.

185. In relation to Patient B the Tribunal had not found proved that Dr Jones touched or rubbed Patient B's clitoris for a prolonged period of time at paragraph 2(a)(ii)(1). That part of the allegation therefore did not fall to be considered for the purposes of sexual motivation.

186. However, the Tribunal had found proved that Dr Jones touched Patient B's vulva during the first visit at paragraph 2(a)(ii)(2). In reaching its decision on whether or not the conduct of Dr Jones was sexually motivated the Tribunal considered all the circumstances of this examination and had regard to the opinions of the expert witnesses. The Tribunal was satisfied that there was no clinical indication for an examination of the type carried out by Dr Jones. The Tribunal determined, as it had above, that given the nature of the examination there was no plausible explanation for Dr Jones' conduct other than it was sexually motivated.

187. The Tribunal had regard to the joint report in which the two Experts had set out the relevant areas to these allegations on which they were agreed. The Tribunal also had regard to a number of professional diagrams and extracts from medical textbooks which illustrated the female anatomy and the procedure undertaken when carrying out an abdominal examination. During the course of oral evidence the Experts had assisted the Tribunal with areas on which it had asked for clarity of their

188. Accordingly, the Tribunal determined that paragraph 4(b) of the Allegation was proved in respect of paragraphs 1(a)(i)(1) and (2) and 2(a)(ii)(2), and was not proved in respect of paragraphs 2(a)(ii)(1), 2(b)(ii)(1), and 2(b)(ii)(2).

### **The Tribunal's Overall Determination on the Facts**

189. The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1993 (as amended):

#### **Patient A**

1. On 12 January 2015, you consulted with Patient A at the Academy Medical Centre in relation to abdominal pain and you:
  - a. undertook an examination of Patient A where you:
    - i. placed your right hand under:

1. the waistband of Patient A's trousers;

**Admitted and found proved**

2. Patient A's underwear;

**Admitted and found proved**

ii. rubbed/touched Patient A's pubic hair with your finger(s);

**Determined and found proved**

iii. moved your right hand down towards the opening of Patient A's vagina;

**Determined and found proved**

iv. rubbed the opening of Patient A's vagina with your hand;

**Determined and found proved**

v. pressed your body and/or erect penis against Patient A's arm and/or upper thigh area.

**Determined and found proved**

### **Patient B**

2. On 6 December 2015 you consulted with Patient B at her home address in relation to a suspected urinary tract infection and:

a. during the initial visit you:

i. asked Patient B to pull her pyjama bottoms down, or words to that effect;

**Admitted and found proved**

ii. undertook an examination of Patient B where you:

1. touched and/or rubbed her clitoris with your left hand in a circular motion for a prolonged period of time;

**Not proved**

2. touched Patient B's vulva;

**Determined and found proved**

b. during the second visit you:

i. asked Patient B to pull her pyjama bottoms down, or words to that effect;

**Not proved**

- ii. undertook an examination of Patient B where you:
  - 1. touched and/or rubbed her clitoris with your left hand in a circular motion;  
**Not proved**
  - 2. touched Patient B's vulva.  
**Not proved**

3. At all material times Patient B was vulnerable due to her mental health.

**Determined and found proved**

- 4. Your actions as set out at paragraph(s):
  - (a) 1(a)(i)(1) and (2), 1(a)(ii)–(v) and 2(a)(i), 2(a)(ii)(1) and (2), 2(b)(i), and 2(b)(ii)(1) and (2), were not clinically indicated;  
**Amended under Rule 17(6) Determined and proved in relation to 1(a)(i)(1) and (2), 1(a)(ii)–(v) and 2(a)(i), 2(a)(ii)(2)**
  - (b) 1(a)(i)(1) and (2), 2(a)(ii)(1) and (2), and 2(b)(ii)(1) and (2), were sexually motivated. **Amended under Rule 17(6) Determined and proved in relation to 1(a)(i)(1) and (2), 1(a)(ii)–(v) and 2(a)(i), 2(a)(ii)(2)**

**St Margaret's Hospital**

- 5. On or around 20 June 2019 you engaged in sexual behaviour at St Margaret's Hospital ('the Hospital'), in that you took one or more photographs on your personal mobile telephone of you:
  - a. standing naked with your erect penis in front of a vaginal sex toy in the residential room ('the Room') at the Hospital;  
**Admitted and found proved**
  - b. standing partially naked with your flaccid penis in your hand on the landing outside of the Room;  
**Admitted and found proved**
  - c. standing naked with your erect penis in your hand on the landing outside of the Room.  
**Admitted and found 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 - 08/06/2026

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 Jones' fitness to practise is impaired by reason of misconduct.

### The evidence

2. The Tribunal has reviewed its findings of fact.

### Submissions

#### Submissions on behalf of the GMC

3. Mr Brook, Counsel, submitted that Dr Jones' fitness to practise is impaired due to his misconduct and all three limbs of public protection were engaged in this case.

4. Mr Brook reminded the Tribunal of the principles in *Meadow v GMC* [2006] EWCA Civ 1390 and *Roylance v GMC* [1999] UKPC 16 (24 March 1999), submitting that serious professional misconduct is conduct which would be regarded as deplorable by fellow practitioners. He submitted that the findings in relation to Patients A and B fall squarely within that definition, as sexual misconduct during the course of clinical consultations is plainly serious and would properly be regarded as deplorable by fellow practitioners.

5. Turning to paragraphs 5(b) and 5(c) of the Allegation, Mr Brook submitted that the conduct on the stairwell also falls within the definition of serious professional misconduct. He reminded the Tribunal of the factual context that Dr Jones had been on duty at a sister hospital, accommodation was not available there, and he made arrangements to stay in accommodation at another hospital due to the distance of his journey home. Mr Brook submitted that, notwithstanding that context, Dr Jones posed on a stairwell within the accommodation building in a state of undress and sexual arousal and took photographs of himself. He reminded the Tribunal that this was not within the privacy of a room but on a stairwell used for passage up and down within that part of the building. Although the photographs were deleted and the Tribunal heard Dr Jones's evidence about why he had taken them, Mr Brook submitted that the deliberate decision to photograph himself in that

location rendered the conduct serious. He submitted that fellow practitioners would find such behaviour deplorable.

6. In relation to paragraph 5(a) of the Allegation, Mr Brook submitted that the position is different. He referred the Tribunal to the discussion during the hearing as to whether conduct within the privacy of a room, albeit hospital accommodation, might properly fall within the ambit of serious professional misconduct. Mr Brook submitted that it might be said that what Dr Jones did in private is a matter for him. He submitted that, if pressed, the GMC might be prepared to concede that the conduct inside the room, taken in isolation, may not amount to serious professional misconduct. However, he submitted that it remained relevant evidence, as Dr Jones chose not only to photograph himself in private but also deliberately photographed himself outside the room on the stairwell.

7. Mr Brook then turned to impairment. He reminded the Tribunal of the structured approach to impairment and submitted that the question is whether Dr Jones' fitness to practise is currently impaired by reason of his misconduct.

8. Mr Brook referred the Tribunal to paragraphs 81 and 86 of Good Medical Practice ('GMP') (2013 edition). He submitted that paragraph 81 requires doctors to ensure that their conduct justifies patients' trust in them and the public's trust in the profession. He submitted that paragraph 86 makes clear that doctors must not act in a sexual way towards patients.

9. Mr Brook submitted that the misconduct involving Patients A and B falls at the higher end of the spectrum of seriousness. He submitted that sexual misconduct is inherently serious, is capable of causing serious physical, emotional and/or psychological harm, and represents a fundamental breach of trust.

10. Mr Brook submitted that patients must have confidence that doctors will behave professionally, particularly during consultations. Sexual misconduct arising within professional practice results in a breakdown of trust and undermines public confidence. He submitted that it also undermines the doctor's integrity and constitutes a significant breach of professional standards, thereby engaging both the public confidence and professional standards limbs of the overarching objective.

11. Mr Brook referred the Tribunal to the new Guidance for MPTS Tribunals (Section three: MPT Hearings > Part B > Stage 2: Impairment > Step 2) ('the Guidance').

12. Mr Brook first addressed Step 2b, seriousness. He submitted that in terms of the nature of the allegations, the misconduct involving Patients A and B, namely sexual assaults committed during non-intimate abdominal examinations, falls at the higher end of the spectrum. He submitted that sexual misconduct within clinical practice represents a fundamental breach of trust, undermines public confidence and professional standards, and is identified in paragraph 31 of the Guidance as conduct likely to fall at the higher end of seriousness. He submitted that the starting point when assessing current and ongoing risk is therefore high.

13. Mr Brook referred the Tribunal to the features which may increase seriousness at paragraphs 34 to 36. He submitted that the conduct was repeated. He reminded the Tribunal that it had found Patient B to be vulnerable by reason of mental health. He submitted that the conduct was premeditated, involved taking advantage of opportunity, was predatory in nature, constituted an abuse of professional position, and demonstrated a reckless disregard for professional standards.

14. Mr Brook then turned to Step 2c, relevant context about the doctor and or the workplace. He submitted that there is no contextual factor relating to Dr Jones' working environment, role, experience or personal circumstances which mitigates the assessment of current and ongoing risk to public protection.

15. Mr Brook then addressed Step 2d, the doctor's response. He submitted that there has been a lack of sufficient insight and remediation. He referred the Tribunal to paragraph 94, which provides that a lack of insight may increase the level of current and ongoing risk to public protection. He also referred the Tribunal to paragraph 109, in particular the third bullet point, which recognises that cases at the higher end of seriousness and capable of damaging public confidence may be more difficult to remediate.

16. Mr Brook acknowledged that there has been no repetition since 2015. However, he reminded the Tribunal that from October 2019 to May 2021 there had been an interim order of suspension on Dr Jones' practice and thereafter he had been subject to conditions which remain in place. He submitted that the absence of repetition must be viewed in that context. He referred the Tribunal to paragraphs 115 and 127 in that regard.

17. Mr Brook then turned to Step 2e, the current and ongoing risk posed and the elements of public protection. Having considered where the case lies on the spectrum of seriousness, the absence of mitigating context, and Dr Jones's response, he submitted that

Dr Jones poses a current and ongoing risk to public protection. He submitted that the level of risk is high and that restrictive action is required. He submitted that impairment is necessary 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.

18. He therefore invited the Tribunal to make a finding of current impairment.

#### Submissions on behalf of Dr Jones

19. On behalf of Dr Jones, Ms Tanchel, Counsel, made no submissions in relation to misconduct or impairment.

#### **The relevant legal principles**

20. The Tribunal received legal advice from the Legally Qualified Chair as set out below.

21. 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 legal basis advanced by the GMC is misconduct. 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.

22. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved are sufficiently serious as to amount to misconduct, and whether as a result of that misconduct the doctor's fitness to practise is currently impaired in that he poses a current and ongoing risk to public protection requiring restrictive action.

23. In respect of misconduct, paragraph 11 of 'Part B: stage 2 - impairment' of the Guidance provides a description of what may constitute misconduct.

24. The Tribunal was further reminded that misconduct has been defined by the Privy Council in the case of *Roylance v GMC (No 2)*[2000] 1 AC 311 as “a word of general effect involving some act or omission which falls short of what would be proper in the circumstances”. In that case the Privy Council went on to say that “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”.

25. The relevant standards to be applied to this case are set out in the 2013 version of GMP. The Tribunal should ask itself how far short of those standards the doctor’s conduct has fallen. Seriousness must be given its proper weight: is it conduct which would be regarded as deplorable by fellow practitioners (*Nandi v GMC [2004] EWCH 2317 (Admin)* at paragraph 31 which was approved by *Meadow v GMC [2007] QB 462* at paragraph 200).

26. To assess whether Dr Jones poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal 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 Jones and/or his working environment, and
- how Dr Jones has responded to the allegations.

27. The Tribunal was reminded that whilst there is no statutory definition of impairment, the guidance provided by Dame Janet Smith in the Fifth Shipman report as adopted by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 927 (Admin)* (‘Grant’) would be of assistance in its consideration of impairment. The Tribunal is reminded it may wish to consider whether its findings show that the doctor’s fitness to practise is impaired in the sense that he:

*“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;*

*and/or has in the past or is likely in the future to bring the medical profession into disrepute;*

*and/or has in the past breached and /or is liable in the future to breach one of the fundamental tenets of the medical profession...”*

## The Tribunal’s determination on impairment

### Misconduct

28. In determining whether the facts found proved amounted to serious misconduct, the Tribunal considered its findings of fact in relation to Patients A and B. The Tribunal found that Dr Jones carried out examinations of a sexual nature which were not clinically indicated and for which he did not obtain consent. The Tribunal found that his conduct in respect of both examinations was sexually motivated. In relation to Patient B, the Tribunal found that she was vulnerable due to her mental health. These examinations were carried out during the course of Dr Jones’ clinical practice, in one instance within a surgery setting and the other while working as a medical practitioner for NHS24 Out of Hours Service at Patient B’s home.

29. The Tribunal determined that, in relation to Patient A, Dr Jones placed his hand under her trousers and underwear, rubbed or touched her pubic hair, moved his hand towards and rubbed the opening of her vagina, and pressed his body and erect penis against her. In relation to Patient B, the Tribunal found that Dr Jones asked her to pull her pyjama bottoms down and touched her vulva during an examination which was not clinically indicated and was sexually motivated.

30. The Tribunal had regard to GMP and the paragraphs relevant to this case. The Tribunal was of the view that Dr Jones’ behaviour was a clear departure of the principles contained in paragraphs 1 and 65:

*“1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.*

*65. You must make sure that your conduct justifies your patients’ trust in you and the public’s trust in the profession.”*

31. The Tribunal was satisfied that these actions represented a serious abuse of Dr Jones’ professional position. Patients are entitled to expect that examinations are clinically justified, conducted with proper consent and carried out in a professional manner. The conduct found proved fell seriously below the standards expected of a registered medical practitioner.

32. The Tribunal considered the overarching objective and the need for doctors to justify patient and public trust in the profession. The Tribunal concluded that Dr Jones’ conduct represented a fundamental breach of that obligation. The misconduct engaged all three limbs of the overarching objective, namely the protection of the public, the maintenance of public confidence in the medical profession and the upholding of proper professional standards and conduct.

33. In relation to the photographs taken at St Margaret’s Hospital, the Tribunal distinguished between those taken within the residential room and those taken on the landing outside the room. The Tribunal accepted that the residential accommodation was a private space where Dr Jones would ordinarily not expect to be interrupted. The Tribunal did not consider that paragraph 5(a) of the Allegation, taken in isolation, reached the threshold of serious misconduct.

34. However, the Tribunal found that the photographs taken on the landing outside the room were on hospital premises in an area accessible to others within the building. The Tribunal concluded that paragraphs 5(b) and 5(c) amounted to serious misconduct. Such behaviour on hospital premises brought the profession into disrepute and fell seriously below the standards expected of a doctor.

35. Taking all matters together, the Tribunal concluded that Dr Jones’ conduct found proved in relation to Patients A and B, and in respect of paragraphs 5(b) and 5(c), fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct.

Is there a legal basis for considering impairment?

36. Having found that the facts found proved amount to misconduct, the Tribunal went on to consider, whether as a result of that misconduct Dr Jones’ practice is currently impaired. The Tribunal was satisfied that having found Dr Jones’ actions amounted to misconduct, there was a legal basis for a finding of impairment.

37. The Tribunal had regard to paragraph 6 of the MPTS guidance which states;

*“6. An MPT can only assess whether a doctor is fit to practise where there is a legal basis for doing so. There are six legal bases which are known as the grounds for impairment. These are:*

- *misconduct*
- *deficient professional performance*
- *a conviction or caution*
- *adverse physical or mental health*
- *not having the necessary knowledge of English and*
- *a determination.”*

38. The Tribunal considered each of the three steps set out in Steps 2(b) - 2(d) of the Guidance in turn.

Where on the spectrum of seriousness does the allegation lie?

39. The Tribunal reminded itself that a finding of impairment requires a finding that Dr Jones poses a current ongoing risk to public protection. In order to assess this the Tribunal first considered where on the spectrum of seriousness the allegation lies. In doing so it had regard to its finding as set out above. The Tribunal had regard to the period of time which had passed since these incidents. However, all allegations of sexual misconduct are serious and can have a significant and harmful impact and pose a high level of risk to public protection.

40. The Tribunal had regard to the General Introduction section of the Guidance and specifically the section headed ‘*Case Type 1: sexual misconduct*’. Paragraph 63 sets out how the three parts of public protection might be engaged in a sexual misconduct case:

*“Whilst a range of behaviour can be seen, the nature of the departure from the professional standards usually means these concerns or allegations fall at the higher end of the spectrum of seriousness. Even a single incident of sexual misconduct can have a significant harmful impact and pose a high level of risk to public protection.”*

41. The Tribunal had regard to paragraph 31 of the Guidance, which identifies sexual assault and sexually motivated conduct as matters likely to fall at the higher end of the spectrum of seriousness.

*“Allegations usually falling at the higher end of the spectrum of seriousness  
31. Allegations that are likely to fall at the higher end of the spectrum of seriousness  
include, but are not limited to:*

- *sexual assault, indecency or sexual harassment”*

42. The Tribunal considered that the misconduct found in this case involved sexually motivated examinations of two patients during consultations, conduct which was not clinically indicated and for which no proper consent was obtained. The Tribunal reminded itself that one of the patients was found to be vulnerable due to her mental health.

43. The Tribunal also considered paragraph 34 of the Guidance, which sets out features that may increase the seriousness of the allegation such that it moves up the spectrum of seriousness. It had regard to the non-exhaustive list of such features set out in paragraph 26 and considered that several such features were present:

- The conduct was repeated;
- The conduct involved the exploitation of two patients in a clinical setting, one of which was vulnerable by reason of her poor mental health;
- Whilst there was no evidence of premeditation, the conduct was opportunistic and predatory, as defined at paragraph 36 of the Guidance;
- It involved an abuse of Dr Jones' professional position; and
- A reckless disregard for patient safety and professional standards.

44. Having regard to paragraph 42 of the Guidance, the Tribunal reminded itself that the starting point fell at the higher end of the spectrum of seriousness. The Tribunal found that there are features in this case as set out above that increase the seriousness of the conduct and, therefore, it follows that the allegation must rest at the higher end of seriousness when assessing the current and ongoing risk which Dr Jones poses to public protection.

45. The Tribunal had regard to paragraph 44 of the Guidance:

*“44. In all cases where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current and ongoing risk to public protection will be high. Evidence of relevant context known about the doctor and/or their working environment and evidence of how the doctor has responded to the concern that decrease risk, will usually have less impact and carry less weight. This is because the risk to public protection arising from allegations at the higher end of the spectrum of seriousness are generally more difficult to mitigate and address.”*

What is the impact of any relevant context known about Dr Jones and/or their working environment?

46. The Tribunal considered whether there was any relevant context that impacted on Dr Jones' behaviour. In doing so it had regard to paragraph 45 of the Guidance. Dr Jones suggested in oral evidence that his relative inexperience of practicing as a GP not long after qualifying at the time might provide some explanation for the manner in which he carried out examinations. The Tribunal rejected that explanation at the facts stage and did not accept that his length of time since qualification or role as a GP provided any mitigation for the sexually motivated conduct found proved.

47. The Tribunal identified no working environment factors that contributed to or explained the misconduct. No personal circumstances were advanced which assisted the Tribunal in its assessment of risk. The Tribunal therefore concluded that there was no relevant contextual factor which decreased the level of risk.

How has Dr Jones responded to the allegations?

48. The Tribunal had regard to paragraph 74 of the Guidance and considered whether Dr Jones had shown insight, taken steps to remediate and kept his knowledge and skills up to date. It also noted paragraph 81 of the Guidance, which reads:

*“To demonstrate insight, and insight which is genuine, the doctor will need to show they understand what happened and accept how they could have acted differently. This involves showing, where relevant, that they have:*

- *considered the allegation, understanding what went wrong and accept they should have acted differently*
- *fully understood the impact or potential impact of their behaviour, performance, or health condition*
- *empathy for any individual affected, for example by apologising*
- *taken, or are taking, steps to remediate and to identify how they will act differently in the future to avoid similar issues arising*
- *sought appropriate support for a health condition and are seeking and/or following treatment and advice and/or are engaging with local support and any steps put in place to manage any risks to patients*
- *complied with the professional duty of candour*
- *co-operated with earlier investigations into the allegation (if they had the opportunity to do so) and engaged with the GMC's investigation, and/or*
- *self-referred to their employer and/or the GMC.”*

49. The Tribunal noted that Dr Jones denied the misconduct found proved. Following the findings of fact, he made no submissions and provided no further documentation for the Tribunal to consider in relation to insight or remediation. The Tribunal considered that Dr Jones has cooperated with these regulatory proceedings and set out an explanation of his practice when carrying out abdominal examinations in his witness statement, acknowledging that he may not have sufficiently explained what he was doing to patients at the time of the allegations. He had stated in his witness statement that he had reflected on the way he carries out abdominal examinations, but during oral evidence was unable to describe any meaningful process of reflection or change in practice. The Tribunal also recognised that he had apologised to Patient A through Ms G but noted that the apology related to how she had felt on that day not on what he had done. The Tribunal acknowledged that Dr Jones has a right to advance a robust defence to an allegation but that did not preclude providing some evidence of insight or acknowledgement of harm experienced by Patient A and Patient B.

50. The Tribunal noted that it was provided with no evidence demonstrating insight into his conduct or its impact on Patients A and B. There was no evidence of targeted training, supervision, mentoring or other steps taken to address professional boundaries. In accordance with paragraph 93 of the Guidance, the Tribunal considered that Dr Jones' failure to demonstrate insight increased the level of current and ongoing risk to public protection.

51. The Tribunal recognised that most misconduct is capable of remediation. However, it had regard to paragraph 109 of the Guidance:

*“109. Cases involving the following features can be more difficult to remediate:*

- *there is a high risk of harm to patients due to the doctor's deliberate, reckless, persistent, or repeated behaviour*
- *the nature of, or circumstances giving rise to, the allegation suggests there is an underlying issue with the doctor's attitude, and*
- *the allegation falls at the higher end of the spectrum of seriousness and is capable of damaging public confidence in the professions.”*

The Tribunal considered that this case fell within that category.

52. The Tribunal noted that the misconduct dated back to 2015 and that Dr Jones has continued to practise, subject to restrictions that have been in place since October 2019, as set out above. It accepted that no concerns have been raised regarding his general clinical competence whilst he has remained in practice and on that basis the Tribunal accepted that

his clinical knowledge and skills were up to date. However, no evidence was provided to demonstrate how he has addressed the specific boundary and attitudinal concerns arising from this case. The Tribunal could find no evidence that Dr Jones had undertaken any meaningful remediation since these events took place in 2015 and found that the absence of repetition in circumstances where he has been subject to investigation and restrictions did not, in the Tribunal's view, demonstrate remediation.

Tribunal's decision as to whether Dr Jones poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

53. The Tribunal next had to consider, overall, whether Dr Jones poses any current and ongoing risk to public protection which may require restrictive action on his registration and make its decision on impairment.

54. The Tribunal determined that the misconduct falls at the higher end of the spectrum of seriousness and that there were no working environment, role and experience, or personal factors present which may have reduced the risk. It further noted that there was no evidence of insight or remediation. The Tribunal determined that the starting point for assessing the current and ongoing risk to public protection was high.

55. The Tribunal reviewed its conclusions at Steps 2(a) to (d) above. Having regard to its findings of fact, the Tribunal determined that all three parts of public protection are engaged.

56. In relation to the first limb of the overarching objective, the Tribunal concluded that there remains a risk to patient safety in circumstances where sexually motivated conduct towards patients has not been acknowledged or addressed.

57. In relation to the second limb, the Tribunal concluded that Dr Jones' actions undermined public trust and confidence in the medical profession and brought the profession into disrepute. It found that his conduct breached fundamental tenets of the profession and constituted a serious departure from the standards expected of doctors. The Tribunal concluded that the misconduct was of such a serious nature that a finding of impairment is necessary to maintain public confidence in the profession.

58. In respect of the third limb, the Tribunal reminded itself of its earlier conclusion that Dr Jones' conduct represented a serious departure from the standards of conduct expected of medical practitioners. The Tribunal considered that a finding of impairment is required to

send a clear message to the profession and the public that this type of conduct is wholly unacceptable.

59. For the reasons set out above the Tribunal was satisfied that all three limbs of the overarching objective are engaged. Public confidence in the profession and the need to uphold proper professional standards would be undermined if a finding of impairment were not made.

60. The Tribunal has therefore determined that Dr Jones' fitness to practise is impaired by reason of misconduct, as there is a current and ongoing high risk to all three limbs of public protection.

#### **Determination on Sanction - 09/06/2026**

1. Having determined that Dr Jones' fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

2. As of 8 June 2026, the GMC was represented by Mr Martin Mensah, Counsel. Dr Jones was not present but continued to be represented by Ms Tanchel, Counsel.

3. All references to the Guidance in this determination are to 'Section three: MPT hearings', 'Part C: stage three - sanction' of the Guidance for MPTS Tribunals.

#### **The evidence**

4. The Tribunal has reviewed its findings at the facts and impairment stages and taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction. The Tribunal received no further evidence at this stage.

#### **Submissions**

##### Submissions on behalf of the GMC

5. Mr Mensah stated that the decision as to the appropriate sanction to impose in this case was a matter for the Tribunal exercising its own independent judgement. He submitted

that the proportionate regulatory response to protect the public in this case would be for Dr Jones' name to be erased from the medical register.

6. Mr Mensah invited the Tribunal to remind itself of its earlier conclusions at the facts and impairment stages and took the Tribunal to relevant paragraphs of the impairment determination. This included reference to Dr Jones' actions and the Tribunal's conclusions that they represented a serious abuse of Dr Jones' professional position, and that the conduct was opportunistic and predatory, and showed a reckless disregard for patient safety and professional standards. Mr Mensah stated that he had highlighted those elements to make the point that the Tribunal's decision on sanction has to remain consistent with those findings and to have regard to the current and ongoing risk to public protection, which is high.

7. Mr Mensah referred to the sanctions banding referenced within the Guidance. He stated that this case involves sexual misconduct and the Tribunal has found there to be a higher level of risk to public protection. Mr Mensah stated that the appropriate banding is: *"Suspension 12 months to Erasure"*.

8. Mr Mensah submitted that there has been a lack of insight and remediation shown by Dr Jones, including no evidence to demonstrate how Dr Jones has addressed the boundary and attitudinal concerns arising from this case. He submitted that this inevitably leads to a conclusion that there may be a risk of repetition of similar conduct by Dr Jones, which has a direct impact upon the level of current and ongoing risk to public protection.

9. Mr Mensah referred to the relevant paragraphs of the Guidance in relation to suspension. He submitted that the GMC's conclusion was that suspension did not meet the seriousness of the conduct in this case. Mr Mensah stated that this allegation of sexual misconduct was at the higher end of the spectrum of seriousness. He submitted that, in light of the overall assessment of risk, the sanction of suspension would be inadequate and Dr Jones' conduct is incompatible with continued registration. Mr Mensah submitted that erasure was the most proportionate response and the least restrictive action required in order to address the risk posed by Dr Jones.

#### Submissions on behalf of Dr Jones

10. Ms Tanchel made no submissions in relation to sanction.

### The Tribunal's determination on sanction

11. In reaching the decision, the Tribunal has regard to its earlier findings at both the facts and impairment stages to ensure that its decision remains consistent with its previous decisions and its finding of the current level of ongoing risk in respect of each part of public protection. The Legally Qualified Chair (LQC) reminded the Tribunal that the Guidance cautions against “double counting” evidence that has previously informed its earlier decision on impairment and has therefore already been taken into account.

12. The LQC stated that the Tribunal does not have any new evidence before it to consider today but, if it had, it would have considered if it was capable of further increasing or decreasing the level of current and ongoing risk. The LQC stated that the Tribunal must also have regard to the submissions made by the parties, and it was noted that Dr Jones had taken the decision not to make any submissions on sanction through Ms Tanchel. The LQC stated that submissions are not evidence, although they may include evidence already before the Tribunal that a party may wish the Tribunal to have regard to.

13. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own independent judgement and any decision should be proportionate, transparent and fair. The Tribunal has borne in mind that, while restrictive action is not put in place to punish or discipline a doctor, a sanction may have a punitive effect, yet still remain necessary if required to protect the public. The LQC reminded the Tribunal that it is important to consider the impact of restrictive actions and ensure that any sanction imposed is proportionate and no more than is needed to protect the public and uphold the overarching objective.

14. The Tribunal had regard to the Guidance in relation to sanctions bandings for some case types commonly seen at a hearing. As referred to by Mr Mensah above, this Tribunal has found there to be a higher level of risk to public protection and so, in relation to a sexual misconduct case, the relevant sanctions banding to be considered is “*Suspension 12 months to Erasure*”.

### No action

15. In reaching its decision as to the appropriate sanction, if any, to impose in Dr Jones' case, the Tribunal first considered whether to conclude the case by taking no action.

16. The Tribunal had regard to paragraph 13 of the Guidance:

*“Where a doctor’s fitness to practise is impaired, it will usually be necessary for the MPT to restrict the doctor’s registration to achieve public protection. But there may be exceptional circumstances to justify an MPT taking no action. Exceptional circumstances are unusual, special, or uncommon, so such cases are likely to be very rare.”*

17. The Tribunal determined that, given the serious nature of the Tribunal’s findings at the facts and impairment stages, it would be neither sufficient, appropriate nor in the public interest to conclude this case by taking no action. The Tribunal was unable to identify any exceptional circumstances such that taking no action would be appropriate. In any event, the Tribunal determined that the seriousness of the misconduct found and the high level of current and ongoing risk was such that taking no action would be insufficient in terms of ensuring public protection.

### Conditions

18. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Jones’ registration.

19. The Tribunal was mindful that conditions are suitable for those cases where the doctor’s behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, and is currently incompatible with unrestricted registration. This means the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting their registration for a period of time, with the aim they should be able to safely return to unrestricted practice in the future. The Tribunal appreciated that any conditions imposed should be appropriate, workable, and measurable.

20. The Tribunal had regard to paragraph 23 of the Guidance:

*“Conditions are likely to be workable where:*

- a. the doctor has shown insight*
- b. time is needed for the doctor to take steps to address the findings (remediate), for example through retraining, study, supervision and/or seeking medical treatment*
- c. the doctor is willing to remediate, and*

*d. the MPT is satisfied the doctor will comply with them.”*

The Tribunal determined that during the facts stage of the hearing Dr Jones had not demonstrated insight into his actions. The findings made by this Tribunal were handed down on 19 February 2026. Since that time the Tribunal has not received any further information from Dr Jones in relation to the development of insight into the conduct found proved. The Tribunal was of the view that Dr Jones has not shown that he is willing to remediate his conduct and consequently it determined that to impose conditions to afford Dr Jones time to remediate was not appropriate.

21. The Tribunal also had regard to paragraph 30 of the Guidance:

*“Conditions are unlikely to be a proportionate response in cases where the nature of the allegations about the doctor’s behaviour fall at the higher end of the spectrum of seriousness and/or suggest an underlying problem with their attitude.”*

In all the circumstances, the Tribunal determined that the imposition of conditions on Dr Jones’ registration would be inappropriate and insufficient. The Tribunal concluded that conditions would not adequately address the seriousness of its findings or the high level of current and ongoing risk that it has identified.

## Suspension

22. The Tribunal then went on to consider whether suspending Dr Jones’ registration would be appropriate and proportionate.

23. A period of suspension restricts a doctor’s registration and prevents them from practising during the period it is in force. The Tribunal had regard to paragraph 41 of the Guidance:

*“Suspension is for those cases where the doctor’s behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is currently incompatible with unrestricted registration. This means the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting their registration for a period, with the aim they should be able to safely return to unrestricted practice in the future.”*

24. The Tribunal also had regard to paragraph 45 of the Guidance:

*“Suspension may be proportionate in cases where some, or all, of the following factors are present:*

- a. conditions are not appropriate, measurable and/or workable*
- b. the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or*
- c. the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.”*

The Tribunal has found that conditions would not be appropriate, measurable or workable and that the high current and ongoing risk to public protection was such that it could not be managed with conditions. The Tribunal determined that it was necessary to restrict Dr Jones’ ability to practise as a doctor. Given the seriousness of the misconduct found and the lack of insight and remediation shown, the Tribunal determined it was not appropriate or sufficient in terms of public protection to impose a period of suspension on Dr Jones’ registration.

### **Erasure**

25. The Tribunal considered whether it would be appropriate and necessary to erase Dr Jones’ name from the medical register.

26. The Tribunal had regard to paragraphs 55 and 56 of the Guidance:

*“55. Erasure is action available for those cases where a doctor’s behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is incompatible with continued registration at this point in time. It means the level of current and ongoing risk the doctor poses to public protection is so significant that they should not be allowed to practise.*

*56. Erasure takes away a doctor’s registration which means they are no longer entitled to practise in the UK at all, or anywhere else where they are required to hold GMC registration. It is used to protect the public in the most serious cases. It also has a*

*deterrent effect as it sends a signal to the individual doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor.”*

27. The Tribunal also took account of paragraph 57 of the Guidance:

*“Erasure may be the proportionate response where:*

*a. conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public*

*b. the doctor’s behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place*

*c. the doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and/or*

*d. the seriousness of the facts found proven and/or impact of any relevant context that increased the current and ongoing risk to public protection mean the effect of the doctor continuing to hold registration is such that it will undermine public confidence in the profession.”*

For the reasons set out above, the Tribunal has found that conditions would not be appropriate, measurable or workable and suspension was not sufficient to protect the public. It has found that Dr Jones’ behaviour caused serious harm and the risk of harm could not be mitigated sufficiently through conditions or suspension. The Tribunal determined that the seriousness of the facts found proved and the current and ongoing high risk to public protection meant that the effect of Dr Jones’ continuing to hold registration would undermine public confidence in the profession.

28. With regard to paragraph 55 of the Guidance, as quoted above, the Tribunal determined that the level of current and ongoing risk that Dr Jones’ poses to public protection is so significant that he should not be allowed to practise; his actions were fundamentally incompatible with continued registration. The Tribunal therefore directs that Dr Jones’ name be erased from the medical register.

**Determination on Immediate Order - 09/06/2026**

1. Having determined to erase Dr Jones’ name from the medical register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Jones’ registration should be subject to an immediate order.

## Submissions

### Submissions on behalf of the GMC

2. Mr Mensah submitted that an immediate order was necessary to protect members of the public and was otherwise in the public interest. He submitted that, based on the facts found proved, the seriousness of the proved Allegation and the level of current and ongoing risk to public protection posed by Dr Jones, an immediate order would be proportionate.
3. Mr Mensah invited the Tribunal to revoke the current interim order.

### Submissions on behalf of Dr Jones

4. Ms Tanchel made no submissions in relation to immediate order.

## The Tribunal’s Determination

5. The Tribunal had regard to *the ‘Immediate and interim orders following sanction’* section within ‘Section three: MPT hearings’, ‘Part C: stage three - sanction’ of the Guidance. This included paragraph 79:

*“The MPT may impose an immediate order where it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor... Where the MPT has imposed a sanction of suspension or erasure, it may impose an immediate order of suspension”*

6. The Tribunal had regard to the seriousness of its findings, the high risk of repetition, and the high level of current and ongoing risk to public protection that it has found in this case. In all the circumstances, the Tribunal determined to impose an immediate order of suspension on Dr Jones’ registration. It determined that an immediate order was necessary to protect members of the public and is in the public interest.

7. This means that Dr Jones' registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.
8. The interim order currently in place on Dr Jones' registration is hereby revoked.
9. That concludes this case.

ANNEX A - 19/02/2026

### Application to admit witness evidence as hearsay evidence under Rule 34

1. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 (the Rules), to sit in private when the matters under consideration were confidential.
2. At the outset of the hearing, during the preliminary stage, Mr Brook on behalf of the GMC submitted that the Tribunal should admit the evidence of Mr C as hearsay pursuant to Rule 34(1) of the Rules and the MPTS Circular dated 12 June 2024 which gives guidance on the admission of hearsay evidence and consideration of weight to be attached to the same.
3. Mr Brook explained that Mr C was a GMC witness who had provided a witness statement dated 22 November 2023 and a supplementary statement dated 23 February 2024. His evidence related to the complaint made by Patient A and the events that followed the alleged incident. This included the complainant's account of the incident, her demeanour, and the steps that were taken immediately after the alleged event took place.
4. Mr Brook told the Tribunal that Mr C was unable to attend the hearing in person or give evidence remotely because throughout the duration of the hearing he was working offshore in Turkmenistan. Mr Brook explained that because of the nature of Mr C's work, he had been unable to confirm his dates of unavailability at the time the hearing was listed. Mr Brook referred the Tribunal to correspondence from Mr C and a letter of confirmation from his employer indicating that he would be working XXX, where telephone and internet connectivity were severely limited and unreliable. As a result, it had not been possible to arrange for Mr C to give evidence by video or telephone link.
5. Mr Brook submitted that the GMC had made reasonable efforts to secure Mr C's attendance, including exploring whether remote evidence would be possible by attempting to do test calls with him and maintaining contact with him in the period leading up to the hearing. Despite those efforts, no reliable means of communication could be identified.
6. Mr Brook reminded the Tribunal that Rule 34 confers a broad discretion to admit hearsay evidence where it is fair and relevant to do so. He submitted that there was a genuine and unavoidable reason for Mr C's non-attendance and that this was a matter the Tribunal could properly take into account when assessing admissibility.

7. It was further submitted that Mr C's evidence was not the sole or decisive evidence relied upon by the GMC.
8. On behalf of Dr Jones, Ms Tanchel, Counsel, opposed the application. She submitted that admitting the evidence of Mr C as hearsay was unfair in the circumstances of the case. She reminded the Tribunal that the allegations were serious and Dr Jones disputed the factual account relied on by the GMC.
9. Ms Tanchel submitted that Mr C's evidence was not peripheral, his statements addressed matters relied upon by the GMC in support of the allegations, including the complainants account immediately following the alleged incident and subsequent events. She submitted that Dr Jones was therefore deprived of the opportunity to test that evidence through cross-examination.
10. Ms Tanchel referred the Tribunal to correspondence within the bundle which demonstrated that the GMC had been aware for a significant period that Mr C worked XXX and that his availability was uncertain. It was submitted that, notwithstanding this knowledge, the GMC had not taken adequate steps to ensure that the hearing was listed at a time when Mr C would be available to attend or to give evidence remotely.
11. Ms Tanchel submitted that the difficulties said to arise in relation to remote attendance were not exceptional and that no independent evidence had been provided to demonstrate that all reasonable alternatives had been exhausted. She submitted that there are limitations in connectivity but it has not been established by the GMC that remote evidence was not impossible in any circumstances.
12. Ms Tanchel referred the Tribunal to the principles set out in *Thorneycroft v NMC [2014] EWHC 1565(Admin)* and *NMC v Ogbonna [2010] EWCA Civ 1216*, and reminded the Tribunal that fairness was a threshold issue to be determined at the point of admissibility, rather than being deferred to weight. She submitted that the inability to cross examine a witness whose evidence was relied upon by the GMC gave rise to prejudice for Dr Jones.
13. Ms Tanchel submitted that, in light of the seriousness of the allegations and the potential consequences for Dr Jones, the Tribunal should exercise caution before departing from the usual position that witnesses should give evidence orally. She invited the Tribunal to conclude that admitting Mr C's evidence as hearsay would undermine the fairness of the proceedings.

### The Tribunal's Approach

14. The Tribunal was advised that, as a preliminary matter, it should first consider whether the statements and transcripts of the evidence of Mr C it has been invited to admit into evidence, amounted to hearsay evidence. The Tribunal was reminded that hearsay is defined in CPR 6 as *“a statement made, otherwise than by a person while giving oral evidence in proceedings, which is tendered as evidence of the matters stated”*. It was explained that hearsay may arise where one party requires a witness to attend for cross-examination but that witness refuses or is unable to attend. The Tribunal was advised that this approach is analogous to the definition contained within sections 114 and 115 of the Criminal Justice Act 2003, namely that hearsay is a representation of fact or opinion made by a person otherwise than in oral evidence in the proceedings in question, when tendered as evidence of any matter stated therein.

15. The Tribunal was advised that it should next identify the circumstances in which it was being asked to admit the evidence, including the reason for the witness's absence and the nature of the material sought to be relied upon.

16. The Tribunal was advised that it had the power to consider the application under Rule 34(1) of the Rules, which confers a broad discretion to admit evidence where it is fair and relevant to do so. By way of context, the Tribunal was reminded that in criminal proceedings the starting point is that hearsay evidence is inadmissible, subject to statutory exceptions, agreement of the parties, or where the court determines that admission is in the interests of justice under section 114 of the Criminal Justice Act 2003. Section 116 of the Criminal Justice Act 2003 sets out circumstances in which a witness is treated as unavailable, including where the witness is deceased, unfit to give evidence by reason of bodily or mental condition, outside the United Kingdom and it is not practicable to secure their attendance, cannot be found despite reasonable steps, or is absent through fear. The Tribunal was advised that reluctance alone is not sufficient to justify admission.

17. The Tribunal was advised that it must consider whether the transcripts constituted relevant evidence for the purposes of the proceedings. If the evidence was found to be relevant, the Tribunal was advised that it must then go on to consider whether it would be fair to admit it.

18. The Tribunal was advised that guidance on the approach to fairness in hearsay applications is provided by the case law, in particular *Bonhoeffer v General Medical Council [2011] EWHC 1585 (Admin)*. The Tribunal was advised that Bonhoeffer concerned allegations of sexual assault where the GMC sought to rely on a transcript of a police interview with a witness who was willing to give evidence but was not called. The transcript was the sole and decisive evidence. The Tribunal admitted the evidence on the basis of its public interest duties, including protection of patients and maintenance of public confidence. On appeal, the decision was overturned. The High Court held that in disciplinary proceedings involving serious allegations amounting to criminal offences, with grave potential consequences for the doctor, there must be compelling reasons to deprive the doctor of the opportunity to cross-examine a witness whose evidence is critical. The Tribunal was advised that the court emphasised that “*the more serious the allegation, the greater the importance of ensuring that the accused doctor is afforded fair and proper procedural safeguards. There is no public interest in a wrong result*”.

19. The Tribunal was further advised on the decision in *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)*, which considered and applied the principles in *Bonhoeffer*. In *Thorneycroft*, two key witnesses did not attend the hearing and their statements were admitted. On appeal, the decision was quashed due to material procedural errors. The Tribunal was advised that the High Court reiterated that the admission of hearsay should not be regarded as routine, that fairness is a threshold issue for admissibility rather than weight, and that while the absence of a witness may be reflected in the weight attached to the evidence, this will not always be sufficient to address concerns of unfairness.

20. The Tribunal was advised that the relevant principles emerging from the authorities include that the existence or absence of a good and cogent reason for non-attendance is an important factor but is not determinative; that where evidence is sole or decisive, particular care is required; and that the Tribunal must consider the issues in the case, the other evidence available, and the potential consequences of admitting the evidence. The Tribunal must be satisfied either that the evidence is demonstrably reliable or that there are sufficient counter-balancing measures to test its reliability.

21. The Tribunal was advised that further relevant factors identified in *Bonhoeffer* and *Thorneycroft* include whether the evidence is sole or decisive, the nature and extent of the challenge to the evidence, whether there is any suggestion of motive to fabricate, the seriousness of the allegations and their potential impact on the practitioner, whether there is a good reason for the witness’s absence, whether reasonable steps were taken to secure

attendance, and whether the respondent had adequate notice that hearsay evidence would be relied upon.

22. The Tribunal was advised that both *Bonhoeffer* and *Thorneycroft* remain good law. However, the Tribunal was also advised of the more recent decision in *Mansary v Nursing and Midwifery Council*, in which the admission of hearsay evidence was upheld on appeal. In that case, the panel expressly acknowledged that the hearsay evidence was decisive and applied a heightened degree of scrutiny before admitting it. The Tribunal was advised that the appellate court confirmed that there is no blanket prohibition on hearsay evidence in regulatory proceedings, provided the panel applies the *Thorneycroft* principles, carefully evaluates the quality of the evidence, and ensures that appropriate safeguards are in place to minimise unfairness arising from the inability to cross-examine the witness.

23. The Tribunal was advised that the key distinction in *Mansary* was that the panel had recognised the decisive nature of the hearsay evidence and had tested it rigorously before admitting it, thereby satisfying the requirements of fairness.

#### The Tribunal's determination

24. The Tribunal first considered whether the evidence amounted to hearsay. It determined that the transcripts from the high court ruling and written statements relied upon were statements made otherwise than by a person giving oral evidence in these proceedings and were tendered as evidence of the matters stated. It therefore determined that the evidence amounted to hearsay.

25. The Tribunal considered the circumstances in which the application was made. It noted that Mr C had informed the GMC that he did not know when he would be able to give evidence and that he was working overseas. The Tribunal noted that Mr C had communicated difficulties with attendance to the GMC and that these difficulties were confirmed by his employer, who explained the challenges of communication when working XXX. The Tribunal noted that the GMC took steps to confirm the veracity of Mr C's explanation and received permission to contact his employer who confirmed the same along with an explanation of the challenges of communication when working XXX.

26. The Tribunal determined that the evidence was relevant. Mr C's evidence as it related to matters immediately following the alleged incident, including the demeanour of Patient A and the steps taken thereafter. The Tribunal noted that the extent of the evidence Mr C

could provide was limited as he did not accompany Patient A when she saw Dr Jones and had not witnessed the alleged event. His evidence was confined to observations and actions taken in the immediate aftermath.

27. The Tribunal then considered whether it would be fair to admit the evidence. In doing so, it had regard to the guidance in *Bonhoeffer v General Medical Council [2011] EWHC 1585 (Admin)* and *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)*.

28. The Tribunal acknowledged that the allegations were serious and that, in accordance with *Bonhoeffer*, the seriousness of the charge and the potential consequences for Dr Jones were important factors. The Tribunal determined that it also had to balance its broader duty to protect the public and to uphold professional standards.

29. The Tribunal considered whether Mr C's evidence was the sole or decisive evidence in the case. It determined that it was not. The Tribunal noted that Ms G who was timetabled to appear as a GMC witness, would be giving evidence on matters overlapping with Mr C's account. The Tribunal further noted that Patient A would give evidence and that there would therefore be an opportunity to challenge the substance of the account relied upon by the GMC, albeit not through direct cross-examination of Mr C.

30. The Tribunal considered the reason for Mr C's non-attendance. It accepted that there was a good reason for his absence, namely that he was outside the United Kingdom working XXX and that it was not practicable to secure his attendance. The Tribunal noted that while the GMC might have been more robust at an earlier stage, including in exploring potential future availability or proposing alternative listing arrangements, the evidence showed that at the relevant time Mr C himself did not know when he would be available. The Tribunal did not consider that a postponement of the hearing would have been appropriate or proportionate in the circumstances and noted the importance of the hearing proceeding expeditiously.

31. The Tribunal was satisfied that the GMC had taken reasonable steps to secure Mr C's attendance. These included maintaining communication with him, contacting his employer, and attempting to establish whether remote attendance was possible. The Tribunal accepted that those efforts had been unsuccessful through no fault of the GMC.

32. The Tribunal considered Ms Tanchel's submission that Mr C, as the partner and now husband of Patient A, might have a reason to fabricate his evidence. The Tribunal noted that

this contention was advanced in a theoretical sense only. There was nothing before the Tribunal to indicate that Mr C had any motive to lie or to make something up and at the time of the alleged event they were not married. While the Tribunal accepted that his evidence was not wholly independent, it did not consider that this alone justified exclusion.

33. The Tribunal also noted that Mr C had previously made statements to the police and the GMC and had given evidence in criminal proceedings in the High Court in 2021, where his evidence was subject to cross-examination under oath. The Tribunal considered that this was a relevant factor when assessing fairness and reliability.

34. The Tribunal further noted that the events described by Mr C were contemporaneous, occurring within a short period following the alleged incident, albeit more than ten years ago. The Tribunal determined that it would be appropriate to assess consistency and inconsistency between Mr C's evidence and that of Ms G and Patient A when considering weight.

35. Having balanced all relevant factors, including the seriousness of the allegations, the relevance of the evidence, the good reason for non-attendance, the steps taken by the GMC, and the fact that the evidence was not sole or decisive, the Tribunal determined that it would be fair to admit Mr C's evidence as hearsay.

36. The Tribunal determined that the evidence should be admitted.

## ANNEX B - 19/02/2026

### Application for anonymity

1. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 (the Rules), to sit in private when the matters under consideration were confidential.

### Submissions on behalf of the GMC

2. Mr Brook submitted an application made by the GMC for the anonymity of the three witnesses, Patient A, Patient B, and Mr C for the duration of the hearing.

3. The application was made pursuant to Rule 36 of the Fitness to Practise Rules, in particular Rule 36(1)(e) and Rule 36(3)(d)(i) and Mr Brooke invited the Tribunal to infer that the quality of the evidence of Patient A and Patient B would likely be adversely affected if such an order were not made.
4. Mr Brook submitted that both Patient A and Patient B had been spoken to prior to the application and had confirmed that they wished to be anonymised in these proceedings. He submitted that the consequences and impact of the alleged conduct upon each of them were set out within their respective witness statements, and that these matters supported the inference available to the Tribunal under Rule 36(3)(d)(i).
5. Mr Brook further submitted that, if anonymisation were granted in respect of Patient A, the Tribunal was invited also to anonymise Mr C, pursuant to Rule 35(4), by reason of his relationship with Patient A. He submitted that, absent such an order, there would arise a risk of jigsaw identification of Patient A.
6. For completeness, Mr Brook submitted that the Tribunal had been informed that evidence in the related proceedings before the High Court of Justiciary in Scotland had been heard in closed session, and that documentation from the Scottish court system and relevant statutory provisions had been provided to the defence the previous day.
7. He submitted that, whilst criminal proceedings in England and Wales are ordinarily conducted in public, complainants in particular cases involving allegations of sexual assault benefit from lifelong statutory anonymity, unless waived. He submitted that, although Scotland did not have equivalent legislation at the material time, it was his understanding that such provisions had since received Royal Assent, albeit not yet fully implemented.
8. Mr Brook submitted that, in light of the manner in which complainants in sexual matters are treated, and applying the provisions of the Fitness to Practise Rules to which he had referred, the Tribunal was invited to grant anonymisation in respect of Patient A, Patient B, and Mr C. He indicated that he was content to assist the Tribunal further if required.

#### Submissions on behalf of Dr Jones

9. Ms Tanchel, counsel, on behalf of Dr Jones submitted that she approached the application with a degree of ambivalence. She accepted that her opposition was not a strong one and emphasised that she was anxious not to waste the Tribunal's time, nor to give rise to

any inference that Dr Jones was seeking to create difficulty for the witnesses. She submitted that her position arose from her obligation to be a stickler for process and the law, and that, particularly in respect of Mr C, she was not satisfied that the application had been faithful to the legal principles.

10. Ms Tanchel submitted that the principle of open justice could only be departed from where it was in the interests of justice to do so, or where there had been a material change of circumstances. She accepted that Patient A and Patient B had been identified as vulnerable witnesses, and did not go behind that assessment, but submitted that vulnerability did not of itself automatically entitle a witness to anonymity, rather giving rise to a discretion to consider appropriate measures.

11. In respect of Mr C, Ms Tanchel relied on *Lou v Solicitors Regulation Authority [2022] EWHC 1729 (Admin)*, submitting that anonymisation could not be imposed without good reason. She submitted that Mr C was not giving live evidence, and that witnesses were anonymised in any documents released in any event. Accordingly, the assertion that Mr C could be linked to Patient A by way of jigsaw identification was not accepted in her submission.

12. Turning to Patient A and Patient B, Ms Tanchel submitted that the issue required a balancing exercise between competing rights under Articles 8 and 10 of the Human Rights Act 1998. She relied on *London Borough of Camden v AM [2020] EWCA Civ 1468* and *In re S [2005] 1 AC 593*, submitting that neither right had precedence, that an intense focus on the comparative importance of the rights engaged was required, and that a proportionality assessment must be undertaken.

13. She cited the authorities of *Nursing and Midwifery Council v D [2018] EWHC 498 (Admin)* and *MXM v General Medical Council [2022] EWHC 81 (Admin)* in discharge of her professional obligation to assist the Tribunal, notwithstanding that they did not support her position.

14. Ms Tanchel submitted that her concern was to ensure that the Tribunal conducted its own balancing exercise, and did not proceed on the basis that anonymisation should follow simply because proceedings in Scotland had been conducted in closed session, noting that this was a different jurisdiction.

### The Tribunal's Approach

15. The Tribunal was advised that Rule 35 governs the manner in which witnesses are ordinarily required to give evidence. Rule 35(4) expressly provides that, upon the application of a party, the Committee or Panel may agree that the identity of a witness should not be revealed in public. This confers a discretionary power to direct non-publication where the Tribunal considers it appropriate to do so.

16. The Tribunal was advised that Rule 36 makes provision for vulnerable witnesses. Rule 36(1) defines categories of vulnerable witnesses, which include any witness who complains of intimidation. Where the quality of a witness's evidence is likely to be adversely affected as a result of vulnerability, the Tribunal may, subject to the advice of the LQC and after hearing representations from the parties, adopt such measures as it considers desirable to enable it to receive the evidence. The Tribunal was reminded that the purpose of these provisions is to ensure that evidence can be received fairly and effectively while protecting witnesses whose ability to give evidence may be compromised. The Tribunal was reminded that a previous case management decision had been made that both Patient A and Patient B should be treated as vulnerable witnesses. Consequently the Tribunal could not go behind that decision unless there had been a material change in circumstances or it would be in the interests of justice to do so. The Tribunal had not been informed that there had been any change in circumstances since the decision which had only recently been made and it was not invited to revoke the same on the basis that it would be in the interests of justice to do so.

17. The Tribunal was advised that non-publication of a witness's identity is a discrete protective measure available under Rule 35(4) and Rule 36(3)(d). It does not prevent the registrant from knowing the identity of the witness for the purposes of the proceedings but restricts public disclosure in order to protect the witness from unnecessary distress, intimidation or adverse consequences. The Tribunal must balance the principle of open justice against the need to protect witnesses and ensure the proper administration of justice.

18. The Tribunal was reminded that any decision to direct non-publication must be proportionate and justified by reference to the circumstances of the individual witness. The Tribunal should consider whether there is evidence that the quality of the witness's evidence is likely to be adversely affected, and whether non-publication is necessary and appropriate to protect the witness while maintaining procedural fairness.

#### The Relevant Legal Principles

19. The Legally Qualified Chair (LQC) drew attention to relevant legal principles, and Rule 35(4) of the Rules which states:

*‘The Committee or Tribunal may, upon the application of a party, agree that the identity of a witness should not be revealed in public.’*

20. In determining the application for anonymisation, the Tribunal was referred to the relevant MPTS Circular and guidance, which confirms that anonymity at MPTS hearings is not automatic. The guidance notes, that where individuals are alleged victims of sexual offences, anonymity is more likely to be appropriate, as such witnesses may properly be regarded as vulnerable. The LQC emphasised that this guidance does not create a presumption in favour of anonymity, but is a factor to which the Tribunal may properly have regard when exercising its discretion in a fact-specific and proportionate manner

21. The vulnerability provisions are set out in Rule 36 of the Rules in respect of ‘vulnerable witnesses’ and have already been determined, as indicated by a case manager.

22. The Tribunal was reminded that, pursuant to Rule 35, the question of whether to grant anonymity is a matter for the Tribunal’s discretion. The LQC advised that anonymity constitutes a departure from the principle of open justice, which is a fundamental feature of disciplinary proceedings. There is a general public interest in the identities of those involved in such proceedings being known.

23. The Tribunal was advised that it must consider the relevant Rules, guidance and case law, and exercise its discretion in deciding whether anonymity should be granted.

24. The Tribunal was further advised that applications for anonymity are case-specific and must be determined on a witness-by-witness basis, rather than as a single, collective application.

25. The Tribunal was advised that the Tribunal is required to carry out a balancing exercise, having regard to the principle of open justice and the interests of justice and fairness to Dr Jones.

#### The Tribunal’s determination

26. The Tribunal had regard to the serious and confidential nature of the allegations. The Tribunal noted that both Patient A and Patient B had expressly stated that they wished to be anonymised in these proceedings.

27. The Tribunal acknowledged that Patient A and Patient B had been identified as being vulnerable witnesses, and that granting anonymity was consistent with the overarching objective, including the need to protect vulnerable witnesses and to ensure that the quality of their evidence was not adversely affected.

28. In relation to Patient A, the Tribunal considered the risk of jigsaw identification arising from the fact that Mr C is her husband. The Tribunal noted that it was not an unreasonable assumption that Patient A and Mr C would share the same marital surname and there was evidence that the surname of Patient A had changed, although the name to which she had changed had been redacted in the documents before the Tribunal. The Tribunal further considered that Mr C's occupation, his XXX work, the community in which he lived, and the identification of the area of surgery created a real risk that Patient A could be identified if Mr C were not anonymised. The Tribunal also noted that Patient A continued to live in the same area as Mr C.

29. The Tribunal determined that anonymisation of Mr C was necessary to prevent jigsaw identification of Patient A, and that the fact of his marital relationship with Patient A was sufficient to justify anonymisation.

30. The Tribunal determined that anonymity should be granted in respect of Patient A, Patient B, and Mr C.

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