PUBLIC RECORD

Dates: 13/11/2023 - 24/11/2023
11/12/2023 - 13/12/2023

Medical Practitioner's name: Dr Neill GARRARD

GMC reference number: 6159385

Primary medical qualification: MB BS 2007 University of London

Type of case
New - Misconduct

Outcome on facts
No facts found proved

Outcome on impairment
Consideration of impairment not reached

Summary of outcome
Case concluded

Tribunal:

Legally Qualified Chair	Mr David Raff
Lay Tribunal Member:	Mrs Amanda Webster
Medical Tribunal Member:	Dr Joanne Topping

Tribunal Clerk:	Miss Emma Saunders Ms Fiona Johnston (16/11/2023)

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Michael Rawlinson, Counsel, instructed by Weightmans
GMC Representative:	Mr Christopher Hamlet, Counsel

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.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote

and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 13/12/2023

Background

1. Dr Garrard qualified in 2007 and undertook his foundation training at King's College Hospital NHS Foundation Trust, Queen Mary's Hospital and Croydon University Hospital. He subsequently worked as a Locum Registrar at Croydon before a post at Lister Hospital from August 2015. Dr Garrard undertook locum work at various hospitals and was appointed as a Forensic Medical Examiner for the UK Border Force in September 2018. Dr Garrard started work as a Locum Senior Clinical Fellow at Crawley Hospital from March 2019 until the start of the Covid-19 pandemic. He also worked at Lewisham and Greenwich NHS Trust as a CESR (Certificate of Entry into the Specialist Register) Fellow at Lewisham Hospital from May 2019 to December 2022. Dr Garrard continued to take locum shifts at various hospitals, including shifts at the Royal Hampshire County Hospital in Winchester, from January 2020. Dr Garrard is an associate of the Royal College of Emergency Medicine and obtained further qualifications, including a masters in Criminology and Criminal Justice in 2014 and a postgraduate certificate in Clinical Education in 2018.

2. The allegations that have led to Dr Garrard's hearing relate to his conduct in respect of the care of Patient A on 27 March 2021 and Patient B on 27 December 2021. It is alleged (amongst other things) by the General Medical Council (GMC) that Dr Garrard behaved in a sexually motivated way towards these patients.

3. Patient A was treated by Dr Garrard in the Accident and Emergency department at the Royal Hampshire County Hospital, Winchester. Patient A was taking medications, including co-codamol, pregabalin, duloxetine and diazepam, to relieve symptoms of functional neurological disorder (FND). She had been taken to hospital by ambulance suffering from a severe headache/migraine and two witnessed episodes of loss of consciousness. Patient A was administered oral morphine by the paramedics and received oxygen while at hospital. It is alleged by the GMC that Dr Garrard, in four or five visits to her hospital bed in the early morning, touched Patient A in an inappropriate way, including touching her breasts and squeezing her nipple, and chanted to her in a hypnotic way.

4. The initial concerns were raised with the GMC on 28 March 2021, when Patient A's husband filed a GMC online complaint form on her behalf. Patient A had made an immediate complaint at the time to staff at the hospital and to the Police. Dr Garrard was interviewed by the Police under caution and subsequently a decision by the Police to take no further action was made. Dr Garrard denies any inappropriate conduct took place.

5. Patient B was treated by Dr Garrard at Lewisham Hospital. Patient B had been experiencing a number of symptoms including anxiety, loss of balance, elevated heart rate and sleepwalking over the Christmas period. She had received a Covid-19 booster vaccine on 21 December 2021. Patient B had, five weeks previously, been prescribed antidepressants and a family member was concerned that her symptoms were interfering with the medication and encouraged her to contact 111. Patient B attended the Urgent Care Centre by appointment following the call she made to the NHS 111 service, when the doctor on the call had advised that she attend the hospital. It is alleged by the GMC that, during consultations with Dr Garrard, he asked Patient B to remove her clothes when it was not clinically indicated, made inappropriate comments, spoke to her in a hypnotic way, asked her to buy him a coffee, and asked her to wait at a bus stop where he would pick her up after his shift and take her home.

6. After speaking with her boyfriend the following day, Patient B wrote an email to the hospital the following evening and was contacted by the Deputy Chief Nurse about the complaint and the options for pursuing it. Patient B decided not to report the incident to the Police as she felt it was being dealt with appropriately at the hospital level.

7. Patient B called her General Practitioner (GP) Practice on 29 December 2021 to check about staying on the same dose of antidepressants and told the GP about her experience.

8. A Trust investigation was carried out and she gave interviews on 23 February 2022 and 17 June 2022. Patient B was contacted by the GMC on 23 May 2022 to provide a statement for these proceedings. Dr Garrard self-reported the allegation to the GMC and denies any inappropriate conduct took place.

The Outcome of Applications made during the Facts Stage

9. On 13 November 2023 the Tribunal granted Dr Garrard's application, made pursuant to Rule 34(1) of the Rules, for the admission of a supplemental report dated 8 November

2023 from Professor D, an expert on behalf of Dr Garrard. The Tribunal's full decision on the application, as handed down on 14 November 2023, is included at Annex A.

10. On 15 November 2023 the Tribunal granted Dr Garrard's application, made pursuant to Rule 34(1) of the Rules, for the admission of a letter from his legal representatives dated 3 May 2022 and notes of a meeting on 17 June 2022 regarding the Trust's Maintaining High Professional Standards (MHPS) process. The Tribunal determined to admit this evidence. It concluded that the evidence was relevant to the issues under consideration in respect of Dr Garrard and it was fair that this evidence be put to Patient B during her oral evidence.

11. On 20 November 2023 the Tribunal granted the GMC's application, made pursuant to Rule 34(1) of the Rules, for the admission of the evidence of Dr C, an expert on behalf of the GMC. The Tribunal's full decision on the application is included at Annex B. The Tribunal also agreed the admission - as requested by those on behalf of Dr Garrard - of an article regarding opioid-induced hallucinations.

12. On 20 November 2023 it became apparent that there were two versions of Professor D's supplemental report. The Tribunal had been provided with the version dated 8 November 2023, in accordance with its decision at Annex A. A version dated 6 November 2023, which did not contain a number of amendments which were reflected in the version of 8 November 2023, had been provided to the GMC but was not before the Tribunal. Following discussions, the Tribunal determined that it was fair and relevant for the 6 November 2023 report to be admitted too. The differences between the reports was explored during Professor D's oral evidence.

The Allegation and the Doctor's Response

13. The Allegation made against Dr Garrard is as follows:

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

1. On or around 27 March 2021, whilst treating Patient A in the Accident and Emergency department at Royal Hampshire County Hospital, you:

a. dug your fingers into Patient A's shoulder;
To be determined

b. squeezed Patient A's fingers;
To be determined

c. touched Patient A's breasts on one or more occasion;
To be determined

d. squeezed Patient A's nipple on one or more occasion;
To be determined

e. chanted to Patient A in a hypnotic way;
To be determined

f. said to Patient A:

i. 'you will lust for me' or words to that effect;
To be determined

ii. 'you'll want to kiss me' or words to that effect;
To be determined

2. Your actions as described at paragraph 1a-d above amount to inappropriate physical contact with Patient A.
To be determined

3. On or around 27 December 2021, whilst treating Patient B at Lewisham Hospital, you:

a. asked Patient B to remove her:

i. vest on one or more occasion;
To be determined

ii. bra on one or more occasion;
To be determined

iii. trousers;
To be determined

iv. underwear;
To be determined

when it was not clinically indicated;

b. told Patient B:

i. to go to a nearby garage to buy some water for herself and some coffee for you;
To be determined

ii. that Patient B's boyfriend was causing her sleepwalking and anxiety and that Patient B was not to trust him or her parents;
To be determined

iii. that no one understood Patient B and her symptoms apart from you;
To be determined

iv. to wait at the bus stop and that you would pick Patient B up after your shift and take her home;
To be determined

c. spoke to Patient B on one or more occasion in a hypnotic way.
To be determined

4. Your actions set out at:

a. paragraphs 1a-e and 2 were carried out without Patient A's consent;
To be determined

b. paragraph 3c were carried out without Patient B's consent;
To be determined

c. paragraphs 1, 2, 3a, 3b ii-iv and 3c were sexually motivated.
To be determined

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

Witness Evidence

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

- Ms E, Healthcare Assistant, who gave evidence on 13 November 2023. Her witness statement was dated 8 August 2023. Ms E was present at the Royal Hampshire County Hospital and involved in the care of Patient A;
- Patient A, who gave evidence on 14 November 2023. Her witness statements were dated 22 July 2022 and 11 July 2023;

- Patient B, who gave evidence on 15 November 2023. Her witness statements were dated 5 July 2022 and 30 June 2023.

15. The Tribunal also received evidence on behalf of the GMC in the form of a witness statement from Mr F, Deputy Director of Finance at Lewisham and Greenwich NHS Trust, who was not called to give oral evidence. His witness statement was dated 18 September 2023. Mr F chaired the relevant Trust's *'Maintaining High Professional Standards in the Modern NHS Policy'* disciplinary hearing in respect of Dr Garrard that was held on 30 September 2022.

16. Dr Garrard provided his own witness statement dated 16 October 2023 and also gave oral evidence at the hearing on 21 November 2023.

Expert Witness Evidence

17. The Tribunal also received evidence from four expert witnesses, as listed below. The following experts on behalf of the GMC:

- Mr G, Senior Consultant in Emergency Medicine at University Hospitals of Morecombe Bay NHS Foundation Trust, gave evidence on 16 November 2023. His expert reports were dated 27 September 2022 and 10 August 2023. He provided evidence to assist the Tribunal in respect of the care provided to Patient A and the standards expected of a reasonably competent Senior Clinical Fellow in Emergency Medicine.

- Mr H, Lead Consultant in Emergency Medicine at the Princess Elizabeth Hospital in Guernsey, gave evidence on 17 November 2023. His expert reports were dated 24 August 2022 and 17 July 2023. He provided evidence to assist the Tribunal in respect of the care provided to Patient B and the standards expected of a reasonably competent Emergency Medicine Clinical Fellow.

- Dr C, Consultant in Emergency Medicine and Intensive Care and Clinical Toxicologist, gave evidence on 20 November 2023. His report was dated 16 November 2023. He provided evidence to assist the Tribunal in respect of Serotonin Syndrome and Sertraline regarding Patient B, in response to the evidence of Professor D.

18. The following expert on behalf of Dr Garrard:

- Professor D, Fellow of the Royal College of Psychiatrists and the Academy of Medical Sciences, and Professor of Psychopharmacology in the University of Oxford. He gave evidence on 21 and 22 November 2023. Professor D's expert reports were dated 4 June 2022, 6 November 2023 and 8 November 2023. He provided evidence to assist the Tribunal in respect of Serotonin Syndrome and Sertraline regarding Patient B.

19. Two articles were produced during the expert evidence, namely: an article entitled *"Opioid-induced Hallucinations: A Review of the Literature, Pathophysiology, Diagnosis, and Treatment"* and an article *entitled "Functional Auditory Hallucinations in a Case of Serotonin Syndrome"*.

Documentary Evidence

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

- Patient A's medical records for 26 to 27 March 2021;
- Handwritten recollection of events by Ms E on 27 March 2021;
- Screenshots of text messages between Patient A and an army welfare officer on 27 March 2021;
- The online referral form completed on Patient A's behalf on 28 March 2021;
- Transcript of Patient A's interview with the Police on 1 April 2021;
- Police record of interview with Patient A;
- Summary of Patient A's amendments to Police record of interview;
- Dr Garrard's witness statement to the Police regarding Patient A dated 30 April 2021;
- Police statement of Ms E dated 6 May 2021;
- Sketch of section of the Emergency Department at the Royal Hampshire County Hospital;
- Extracts from the British National Formulary (BNF) in relation to Morphine, Diazepam, Pregabalin and Duloxetine;
- Patient B's medical records from Lewisham Hospital on 27 December 2021;
- Screenshots of text messages between Patient B and a friend on 27 December 2021, and between Patient B and her boyfriend;
- Patient B's email to Lewisham Patient Advice and Liaison Service (PALS) on 28 December 2021;

- Interview notes of the Trust interviews with Patient B on 23 February 2022 and 17 June 2022;
- Extracts of Patient B's GP records from 1 October 2021 to 31 March 2022;
- Dr Garrard's timesheet for 27 and 28 December 2021;
- Sketch plan of the layout of the Urgent Care Centre at Lewisham Hospital;
- Map of Lewisham Council controlled parking zones.

The Tribunal's Approach

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

22. The Legally Qualified Chair (LQC) addressed the issue of the impact of the seriousness of the allegations and any impact that might have on the standard of proof. The current state of the law on this point was confirmed in *Byrne v GMC* [2021] EWHC 2237 (Admin). The LQC stated that this confirmed the principle that there was only one standard of proof in civil and regulatory cases; and that was proof that the fact in issue more probably occurred than not. The LQC stated, however, that the inherent probability of the relevant conduct having occurred was a matter which could be taken into account when weighing the probabilities, and in deciding whether the event or conduct occurred; this goes to the quality of evidence.

23. The LQC drew the Tribunal's attention to the cases of *R (Dutta) v GMC* [2020] EWHC 1974 (Admin), *Khan v GMC* [2021] EWHC 374 Admin, and *Joseph v GMC* [2022] EWHC 3345. The LQC summarised some of the salient points from those cases. In *Dutta*, the LQC said that the Judge stated that the Tribunal had made a fundamental error in assessing a witness's credibility based largely, if not exclusively, on her demeanour when giving evidence. The Judge went on to quote approvingly from a number of other authorities to the following effect:

> *"We believe memories to be more faithful than they are. Two common errors are to suppose (1), that the stronger and more vivid the recollection, the more likely it is to be accurate; (2) the more confident another person is in their recollection, the more likely it is to be accurate.*
>
> *...*

Events can come to be recalled as memories, which did not happen at all, or which happened to somebody else.

...

The best approach from a judge is to base factual findings on inferences drawn from the documentary evidence and known or probable facts.

...

Oral testimony does serve a useful purpose but its value lies largely... in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny, and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events."

24. The LQC stated that key principles derived from *Khan* included:

- The Tribunal should not assess a witness's credibility exclusively on their demeanour when giving evidence;
- Tribunals should consider all the evidence before them before coming to a conclusion about a witness's credibility. This could include, amongst other things, conflicts of evidence with another witness, denials of the allegations, and reasons why they could not be true;
- It is open to Tribunals not to rule out the whole of a witness's evidence based on credibility; credibility can be divisible.

25. The LQC stated that, in *Joseph*, the Court held that in cases involving sexual misconduct where there was no other direct available evidence (i.e. where it was one person's word against the other's) it may be reasonable for the Tribunal to take into account some aspects of a witness's demeanour. The Tribunal should, in assessing truthfulness, consider the consistency over time and under cross-examination. The LQC stated that the Tribunal should note any general discrepancies and give reasons for its evaluation and conclusions in relation to them, including reference to any discrepancies within another witness's account.

Good character

26. The LQC stated that Dr Garrard is of good character; he has no previous disciplinary matters proved against him. The LQC stated that good character was not a defence to the Allegation but it was relevant to the Tribunal's consideration of the case in two ways:

27. Firstly, Dr Garrard gave evidence. His good character supported his credibility and was a positive feature of Dr Garrard, which the Tribunal should take into account when considering whether it accepted his evidence. Secondly, the fact that Dr Garrard is of good character and has no previous disciplinary findings against him may make it less likely that he acted as was now alleged against him.

28. What weight should be given to Dr Garrard's good character, on the facts of this particular case, was a decision for the Tribunal to make. In making that assessment, the Tribunal was entitled to take into account everything it had been told about him.

Allegations of sexual misconduct and assessment of witnesses

29. The LQC advised that, whilst intended for use within the criminal jurisdiction where different rules apply in relation to the burden of proof and admissibility of evidence, it was reasonable to apply the same principles in assessing witnesses' evidence as set out in the guidance issued in the Crown Court Compendium. It assisted in countering the risk of stereotypes and assumptions about sexual behaviour and reactions to non-consensual conduct.

30. So far as the making of complaints in sexual misconduct cases is concerned, in the case of *D* [2008] EWCA Crim 2557, the Court of Appeal accepted that a judge may give appropriate directions to counter the risk of stereotypes and assumptions about sexual behaviour and reactions to non-consensual sexual conduct. In short, these were that:

(i) experience shows that people react differently to the trauma of a serious sexual assault, that there is no one classic response;

(ii) some may complain immediately whilst others feel shame and shock and not complain for some time; and

(iii) a late complaint does not necessarily mean it is a false complaint.

31. The LQC reminded the Tribunal that it should bear in mind that there may be good reasons why a victim of sexual misconduct may not complain, or may delay in complaining, about a sexual offence.

32. In summary, stereotypes of a 'complainant', an 'assailant' or views as to what an appropriate or inappropriate reaction was should be avoided. The LQC stated that the Tribunal should approach its decision making without any preformed assumptions. It should exercise caution against stereotypical images of how a complainant or an alleged perpetrator of a sexual offence ought to have behaved at the time or ought to appear when giving evidence and should judge the evidence on its intrinsic merits. Some people may show emotion or distress and may cry but other people will seem very calm or unemotional.

33. The LQC stated that, to decide this point, the Tribunal should look at all of the circumstances including any reason that the patient gave for not having complained at the time. Different people react to particular situations in different ways. Some, if they have experienced something of the kind alleged in this case, may tell someone about it straightaway, whilst others may not be able to do so, whether out of shame, shock, confusion or fear of getting into trouble, or not being believed. The LQC stated that, in this case, the Tribunal should consider the circumstances of Patients A and B, and it should consider whether or not there were matters that would have impacted on whether they complained at the time.

34. The fact that a complaint was not made at the time did not necessarily mean that it must be untrue, any more than the fact that a complaint was made immediately means that it must be true. It was for the Tribunal to decide whether or not the evidence of Patients A and B was accurate.

Sexual motivation

35. If the Tribunal finds certain of the actions alleged in paragraphs 1, 2, 3(a), 3(b)(ii) to (iv) and 3(c) proved, then it must go on to consider whether those actions were sexually motivated. This was the allegation set out in paragraph 4(c).

36. The LQC stated that sexual motivation was an allegation of specific intent. In *Basson v GMC* [2018] EWHC 505 (Admin), the High Court defined acting with sexual motivation as conduct either in pursuit of sexual gratification or in pursuit of a future sexual relationship.

37. The LQC stated that allegations of sexual motivation in the regulatory context were particularly serious. For that reason, any Tribunal would wish to seek cogent evidence before it concluded that a case of sexual motivation was made out. Sexual motivation requires a specific intent on the part of the doctor. It is not the same as carelessness, recklessness, or

negligence. It is important not to equate inappropriate conduct with sexually motivated conduct and the Tribunal should address the important question as to whether there could be any other explanation for inappropriate conduct. However, the key indispensable ingredient of motivation related to the individual's state of mind. The state of an individual's state of mind was not something that could be proved by direct observation. It could be proved only by inference or deduction from the surrounding evidence.

38. The LQC stated that 'sexual' was defined in section 78 of the Sexual Offences Act 2003. This states that:

> *"touching or any other activity is sexual if a reasonable person would consider that -*
> *(a) whatever its circumstances or any person's purpose in relation to it, it is because of its nature sexual, or*
> *(b) because of its nature it may be sexual and because of its circumstances or the purpose of any person in relation to it (or both) it is sexual."*

39. The LQC advised that sexual motivation was, as it were, in its own box and the Tribunal must regard it in that way. There was no direct evidence of motive, other than the perception of events of Patients A and B, but it may be possible to prove sexual motivation by way of inference. The Tribunal must be satisfied on the balance of probabilities that sexual motivation should be inferred from all of the circumstances.

40. The LQC stated that, when considering sexual motivation, the Tribunal should make a deduction from all of the facts and circumstances of the case and looking at the material in the round. However, the best evidence of a sexual motivation could be the behaviour itself. The LQC stated that if there was no plausible, alternative explanation as to why the doctor engaged in conduct or actions of an overtly sexual nature, then it was entitled to conclude that the motivation was sexual. In *Haris v GMC* [2021] EWCA Civ 763; *GMC v Haris* [2020] EWHC 2518 (Admin), it was said that such a motivation could be inferred from:

> *"a. The fact that the touching was of the sexual organs;*
> *b. The absence of a clinical justification;*
> *c. The absence of any other plausible reason for the touching."*

Expert evidence

41. The LQC stated that the Tribunal was also provided with the reports of expert witnesses and heard oral evidence from them. He stated that expert evidence was permitted to provide the Tribunal with information and opinion, which was within the witness's expertise but which was likely to be, or may be outside its experience and knowledge. The LQC stated that it was important that the Tribunal should see it in its proper perspective, which was that it was before the Tribunal as part of the evidence as a whole to assist in relation to any particular aspect of the evidence to which it related. The Tribunal should reach any conclusions in respect of this evidence on the basis of its own observations. The LQC stated that, in considering the expert evidence, the Tribunal should attach such weight to it as it considered appropriate in making a determination on the denied factual allegations.

42. The LQC stated that the Tribunal should bear in mind that, having given the matter careful consideration, it did not have to accept the evidence of an expert, even where that evidence was unchallenged. It was for the Tribunal to decide whose evidence and whose opinions it accepted, if any. However, if the Tribunal did not accept a significant element of any of the expert evidence it should give reasons for its decision.

Cross admissibility

43. The LQC gave advice on cross admissibility, i.e. in what circumstances the evidence of misconduct alleged in one part of the Allegation may be admissible in support of the allegation of misconduct in a second part of the Allegation.

44. The LQC referred to the case of *R v BQC* [2021] EWCA Crim 1944 where the Court of Appeal Criminal Division helpfully summarised the position set out in the leading case of *R v Freeman* [2008] EWCA 1863. It said that:

> *"there are two main ways in which evidence of an offence charged on one count may be admissible in support of the allegation of an offence charged on another count. One is that if the jury are sure that the conduct charged on one count took place, they may treat that conduct as showing a propensity to commit a particular type of offence or to behave in a particular way, so as to provide support for a conclusion of guilt on another count. That may apply to different counts relating to a single complainant, as well as to those involving different complainants. The other way in which evidence of one offence may be cross admissible in support of another arises where there is more*

than one complainant. In such a case it may rebut coincidence because of the unlikelihood that separate and independent complainants would have made similar but untrue allegations against the defendant. Sometimes the evidence may be cross-admissible on both bases."

45. The LQC stressed the following points:

- it was for the Tribunal to determine whether each separate paragraph of the Allegation had been proved on the balance of probabilities.

- The Tribunal should reach a conclusion on each paragraph separately but it was entitled, in determining whether each paragraph was found proved, to have regard to relevant evidence in regard to any other paragraph. It may consider the evidence in the round.

- Propensity, if found, was only one relevant factor and could not be regarded as a satisfactory substitute for direct evidence.

Reasonable inferences

46. The LQC stated that the Tribunal can draw reasonable inferences from the facts. However, it must not speculate and, in particular, must not speculate about what other evidence there might have been.

The Tribunal's Analysis of the Evidence and Findings

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

Analysis regarding Patient A

48. As detailed above, Patient A was suffering from a severe headache/migraine and had experienced two witnessed episodes of loss of consciousness on the evening of 26 March 2021. At this time, Patient A would normally take daily medications, namely co-codamol, duloxetine, pregabalin, diazepam, and bisacodyl to relieve symptoms of FND. Within her GMC witness statement, Patient A reported that she had not taken her regular medications

that morning due to having a migraine and said that she had taken two paracetamol and one naproxen that morning, before further paracetamol in the afternoon.

49. Paramedics attended Patient A at her home at 21:53, following a call at 20:36. Within a Patient Clinical Report form, the paramedics recorded that Patient A had felt a squeezing sensation in her head that had caused her to lose consciousness for 30 seconds, and they witnessed another episode lasting around 15 seconds. The paramedics recorded:

> *"Pt states this does not feel like her normal migraines... pt has ongoing short term memory loss but today this has worsened, pt feels muddled... Pt diagnosed with functional neurological disorder in September, felt she was managing okay but has recently noticed that she is struggling to cope mentally, spoke to GP monday who adv. pt to lower pregabalin. Pt has suicidal ideology, would throw herself out of window."*

50. The paramedics administered oral morphine and took Patient A to hospital by ambulance. Patient A was taken to the Accident and Emergency department at the Royal Hampshire County Hospital, with the arrival listed by the paramedics as 22:30. Patient A was seen by Dr Garrard, received oxygen to help with a severe headache, and stayed overnight.

<u>The hospital environment - busy hospital/Bay 13/call bell/curtain</u>

51. It was common ground that the Accident and Emergency department was busy at the time in question. Patient A was placed in Bay 13 in a smaller area to which there was allocated one nurse and one healthcare assistant. The Tribunal was told, in addition, that there would be around 13 nurses for the total area. It is unknown exactly how many doctors were allocated to the Emergency department. However, Dr Garrard, in his witness statement, indicated that during Covid the usual complement of one registrar and two SHOs had increased to five to six doctors.

52. Dr Garrard provided a diagram (not to scale) of the area in question, which includes Bay 13, a number of other bays, a nurses station and a PPE store. The accuracy of this diagram was not challenged by the GMC. The diagram showed Bay 13 had a bed which appeared to be against one wall, a diagonal entrance with a curtain and two other bays that attached to each side of the Bay with solid walls. The Tribunal has not been provided with any photographs of Bay 13 or the immediate area.

53. Within the online GMC referral form, completed by Patient A's husband based on information told to him by Patient A, it was stated that Dr Garrard had moved to the left and right of her when he was chanting to her and carrying out the inappropriate conduct alleged in the Allegation. The Tribunal noted that Patient A said that Dr Garrard approached her from both sides of the bed. The diagram provided appeared to show the bed in Bay 13 as against the wall. While the diagram was not challenged by the GMC, it was difficult for the Tribunal to know the accuracy of the bed position. If the bed was in the position suggested, then it appeared unlikely that Dr Garrard would have been able to stand at both sides of Patient A as she suggested.

54. The Tribunal was told that there were two curtains across Bay 13, a transparent plastic curtain due to Covid-19 precautions, and a blue privacy one.

55. Within her first GMC witness statement, Patient A stated that the blue curtain was fully across the whole time that she was there. In a supplemental witness statement, Patient A stated *"I was unable to see clearly out of the cubical as the curtain was partly drawn. I could only see through a clear section of the curtain as it wasn't drawn fully"*.

56. Ms E, a healthcare assistant present in this area of the Accident and Emergency department that night, stated that she was looking after the patients in beds 11 to 14 with a nurse. Within her GMC statement, she stated that she did not know Dr Garrard well and that this night was the first and only time they had met. Ms E conducted observations of Patient A at 11.30pm and 12.30am, after arrival. She stated that Dr Garrard saw Patient A at around 1.30am, and that the curtain of Patient A's bay was slightly open so she could look through to check on the patient throughout the night. Ms E stated that she checked on Patient A throughout the night but did not conduct full observations as she was under instruction from Dr Garrard not to wake the patient. Ms E said that she would usually check a patient hourly, that she only quietly poked her head in through the gap in the curtain and did not enter the bay.

57. Patient A stated that she did not directly look at Dr Garrard's face with her eyes open, that he told her to close her eyes the first time he saw her, and that she had later squinted through her eyelashes to make out his outline when he was outside the bay, below the bottom of the blue curtain.

58. Within his witness statement for the Police dated 30 April 2021, and reiterated in his statement for these proceedings, Dr Garrard stated that, when he saw Patient A for the first

time, he recalled that the curtain was drawn and the lights were off. He said that he introduced himself to Patient A and that she told him that the lights were off as they were causing her pain. Dr Garrard stated that there was sufficient light in the room for him to proceed with an examination of the patient. He stated that, after the assessments, he placed a nasal cannula (for oxygen) on Patient A's face and closed the curtain behind him when he exited.

59. Patient A said that she did not have a call bell. She said there was a bell on the wall and the bed was far away, in circumstances where she could not walk at this time due to her FND. In her oral evidence, Ms E stated that Patient A had been handed a call bell as part of her normal practice and that Patient A could have used it if needed. The Tribunal noted the conflict in evidence, but was also conscious that Patient A may not have felt able to use the call bell even if she had had one close to her. Indeed, in her interview with the Police, Patient A said that she did not shout for help as she thought Dr Garrard would be there.

Medication

60. Within her GMC witness statement, Patient A stated that, at this time, she would normally take daily medications, namely co-codamol, duloxetine, pregabalin, diazepam, and bisacodyl to relieve symptoms of FND. Patient A reported that she had not taken her regular medications on the morning of 26 March 2021 due to having a migraine and said that she had taken two paracetamol and one naproxen that morning, before further paracetamol in the afternoon.

61. Within Dr Garrard's notes in Patient A's medical records listed at 1.30am, it stated that Patient A had a known history of migraine, had been diagnosed with FND in September, and was on pregabalin, diazepam and co-codamol regularly. The *"Impression"* was described as *"Medication overuse headache"* and the *"Plan"* was *"High flow nasal cannula (oxygen) 6 litres, Observe"*.

62. In Patient A's interview with the Police on 1 April 2021, she said that, at about 5pm on the evening she was admitted to hospital, she had taken 100mg of pregabalin. She also said that she had taken two co-codamol (which the Tribunal noted is an opioid) *"which are 30/500 which are quite strong"*. She said that she tried to have less pregabalin as sometimes a side effect of the drug was that it caused a headache. Within her oral evidence to the Tribunal, Patient A stated that she had taken paracetamol and naproxen; she stated that she had not taken co-codamol on the day in question.

63. The Tribunal considered whether it was likely that Patient A had taken co-codamol and pregabalin on the date of her admission to hospital. It took the view that Patient A's recollection at the time of the Police interview was more likely to be accurate as it was much closer in time to the events than her GMC witness statement and her oral evidence. Accordingly, the Tribunal was satisfied that, on the balance of probabilities, Patient A had taken co-codamol and pregabalin on the date in question.

Medication - Oral morphine

64. The Tribunal also considered the oral morphine that was administered to Patient A by the paramedics, and any effect or impact of this - in combination with and in addition to the other medication - on Patient A.

65. The Tribunal had regard to the evidence of Mr G, GMC expert. In his report dated 27 September 2022, he stated that the ambulance records had indicated that Patient A was given 10mg of morphine sulphate in oral solution at 2132 hours. Mr G said that the side effects of morphine included *"arrhythmias, confusion, constipation, dizziness, drowsiness, dry mouth, euphoric mood, flushing, hallucination, headache, hyperhidrosis, miosis, nausea".*

66. Dr Garrard stated, in oral evidence, that the paramedic notes would often be separate from the patient notes in the Accident and Emergency department and so he was originally unaware that Patient A had been administered morphine. Within his witness statement prepared for these proceedings, Dr Garrard stated that it was also necessary to appreciate the length of time it took from the ingestion of drugs until the drug had its maximal effects and the time it takes for that effect to wear off. He provided a table that stated that morphine had a half-life of 2-4 hours and pregabalin had a half-life of 6.3 hours.

67. In oral evidence to the Tribunal, Mr G stated that oral morphine was a potent opiate and as she was given it between 9.15-10.30pm, it would have been at its peak effectiveness in terms of side effects at the point of being seen and assessed by Dr Garrard at 1-1.30am. He stated that morphine can have a synergistic effect when taken in conjunction with an opioid such as co-codamol. He said that morphine could cause hallucinations although he had not personally observed it causing tactile hallucinations. He further stated that diazepam (the effects of which would likely continue for up to 48 hours), pregabalin, co-codamol and morphine could all have contributed to drowsiness in the patient.

68. As set out above, the Tribunal has concluded that on 26 March 2021, on the balance of probabilities, Patient A took 100mg of pregabalin and two co-codamol 30/500 that had been prescribed for her FND. Further, there would have been continued effects from her prescribed diazepam despite its omission on 26 March 2021. In addition, she had been administered oral morphine by the paramedics. The Tribunal was of the view that, given the expert evidence, this combination could have altered Patient A's perception during the morning at issue.

Stressful time?

69. Patient A was asked by Dr Garrard's legal representatives if the time period in question was a stressful one. Patient A said it was not. They later asked this question again as there had been mention in the Police interview of her brother having been recently diagnosed with cancer. Patient A maintained that it was not a particularly stressful period apart from the fact that she was recently disabled, but apart from that she has always lived a happy life.

Was Patient A asleep?

70. While the Tribunal did not think that this point was determinative in respect of its decision, it was mindful of the evidence of Ms E and Dr Garrard that Patient A appeared to be asleep for most of the early morning. Patient A says that she would have looked asleep on occasion but that she did not sleep. This ran contrary to the evidence of Ms E who stated that Patient A had described herself as *"going back to sleep"* after one of the alleged interactions with Dr Garrard.

71. Patient A said that she had her eyes shut when Dr Garrard entered Bay 13. Within her GMC statement, she said that she only looked at Dr Garrard the first time he entered the bay and that he told her to keep her eyes closed and to relax. Patient A said that she occasionally opened her eyes to observe her surroundings, or to squint and observe what was happening in the corridor beneath the curtain. Patient A said that she did not ever directly look at Dr Garrard's face with her eyes open. She said that she was able to squint through her eyelashes and make out his outline when he was outside the bay, below the bottom of the blue curtain.

72. Patient A stated that anyone looking through the clear plastic curtain during the night might have got the impression that she was asleep as she kept her eyes closed to deal with

her light sensitivity. In her supplementary statement dated 11 July 2023, Patient A stated that this was because her eyes were shut and she was lying on her back. She said she could only see through a clear section of the curtain as it wasn't drawn fully.

73. Within his witness statement for the police dated 30 April 2021, and reiterated in his statement for these proceedings, Dr Garrard stated that Patient A had closed her eyes at the end of his first visit and that he did not attempt to wake her during his subsequent visits to check on her. Dr Garrard stated that he waited in the room long enough to satisfy himself that she was moving naturally during sleep and not unconscious. He stated that Patient A was connected to a cardiac monitor, including a blood pressure cuff on her left arm where the machine was taking hourly readings. Dr Garrard stated that he had not needed to touch the patient at all during the subsequent visits.

74. The Tribunal was assisted by the evidence of Ms E in this regard. She did not know Patient A or Dr Garrard, and therefore would appear to have no motive to support one witness's version as against another. Ms E reported that she saw Patient A's chest moving such that she appeared to be asleep at the various points that she checked on her. Ms E's evidence within her GMC witness statement was that she had checked on Patient A regularly after Dr Garrard saw the Patient at 1.30am but did not conduct full observations as she was under instruction from Dr Garrard not to wake her. She stated:

> *"I only quietly poked my head in through the gap in the curtain and did not enter the bay. Patient A appeared as if she was asleep each time I did check on her. I would check Patient A was breathing by looking at whether her chest was moving up or down and the status of the monitor. I could see Patient A was breathing and wasn't fidgety. She appeared settled. I can't confirm if Patient A had her eyes closed or if she was on her side on some of the occasions I checked in on her. I didn't make a note of these checks on Patient A's records as I didn't take any vitals... to avoid waking her."*

In oral evidence, Ms E stated that she had poked her head through the curtain to check at various points and that Patient A had appeared asleep.

75. Within her GMC witness statement, Patient A stated that she had spoken to the nurse and healthcare assistant after she made her complaint and said they had told her that they had only observed her through the clear Perspex curtain from the ward and had not physically entered Bay 13.

76. Within her interview to the Police, Patient A said that, on the third visit to Bay 13, Dr Garrard had told her to *"stay sound asleep"*, and *"each time he came in he's wiggling my arms, and he tests - he squeezes my finger"*. The implication was that Dr Garrard was pressing her nail bed or squeezing her finger to see if she was awake - and that he was acting inappropriately thinking that she was asleep or hypnotised. The Tribunal noted that a person could make it clear that they were awake if they felt such an action, but appreciated that someone might freeze and not make a sound or indication that they were awake.

77. Taking into account all the evidence and in particular the expert evidence as to the potential effect of the combination of the morphine, co-codamol and diazepam (which would still, in line with the expert evidence, have been in her system if she had taken it the previous day), the Tribunal formed the view that Patient A was likely to have been asleep or drifting in and out of sleep at certain points that morning and did not realise that she had been sleeping. The combination of drugs may have caused confusion and/or misperception. The Tribunal found Ms E's evidence to be persuasive. She was an independent, experienced healthcare assistant who checked on Patient A a number of times and reported that she believed her to be asleep.

Dr Garrard's visits to Patient A

78. Within his witness statement for the police dated 30 April 2021, Dr Garrard stated that he first saw the patient around 1am and then checked on her three or four times between 1.30 and 4.30am. He stated that Ms E also checked on Patient A during this time. Within his witness statement for these proceedings, Dr Garrard stated that he had checked on Patient A three or four times between 1 and 4am. He stated that the reason he checked was to see if the patient had improved in order to discharge them and to ensure they had not deteriorated. He stated that he did not attempt to wake the patient after the first occasion when he completed the assessments and examinations.

79. Within his oral evidence to the Tribunal, Dr Garrard stated that he always checks on patients himself. He said that he was a locum and, apart from a few senior members of staff, all of the other staff were unfamiliar to him. Dr Garrard was asked if he could not trust the nursing staff to conduct the observations of Patient A. He said that it was not a question of trust, that he expected them to do their jobs but that he did not know them and therefore he was not going to assume without checking himself. The Tribunal found this to be a plausible explanation as to why Dr Garrard entered the bay on a number of occasions.

80. In Patient A's GMC witness statement, she said that she was not certain during the first two or so times of Dr Garrard entering the bay if there was a medical reason for him touching her body. She said that it was only on the third or fourth time, when, on her evidence, Dr Garrard lifted up her top and squeezed her nipple, that she realised what was happening and became really alarmed. She said that each time Dr Garrard entered the bay she was torn as she did not know what to do. Patient A said that she was shocked and did not know what to do so decided not to do or say anything that might provoke Dr Garrard.

81. The Tribunal had regard to the evidence that there was a short distance and an unobstructed view between the nurses station and the entrance to Bay 13. Ms E saw Dr Garrard going into the bay to check on Patient A at least once. In her oral evidence, Ms E told the Tribunal that the curtain was open a bit when she checked on Patient A and that it would have been fully closed if someone had gone in to examine the patient. Ms E stated that there were a lot of people around at the time as it was a busy shift and that one would have been able to hear someone talking in Bay 13 if one were at the nurses station, which was close by Bay 13. In her evidence, Patient A acknowledged that she *"was able to hear what was happening on the ward, including the next bays and the nurses station"*.

82. The Tribunal noted that it appeared that there was a clear expectation that Dr Garrard could have been interrupted at any point when with Patient A throughout the early morning. Ms E saw him go in at least once and others may have too. The Tribunal found it plausible that, while Dr Garrard was in the bay, someone would have been able to 'pop their head in' to speak to Dr Garrard or check on the patient themselves. Indeed, as the senior doctor of the department on duty that evening, it would have been highly likely that junior doctors and/or nurses would wish to consult with him.

83. The Tribunal noted that Patient A asked Ms E who had undone her gown. Ms E told Patient A that she had tied it loosely. In oral evidence, Ms E said that it was her usual practice to tie gowns loosely around the neck as she worried that they could tighten if the patient fell asleep or moved. She said that she did not always wrap it around the back of the patient unless they were getting up to mobilise, which Patient A could not do. Ms E was asked if the gowns could come undone by the patient moving around and said that they could.

84. The Tribunal noted that Patient A had woken up asking who had undone her gown and so clearly did not have a memory of anyone doing so. She then appeared to have concluded quickly that it must have been Dr Garrard who had been in and untied it. However, the Tribunal found Ms E's evidence to be persuasive that she would have tied the gown

around Patient A's neck loosely and that it could have come undone of its own accord. The Tribunal found this to be the likely explanation, on the balance of probabilities, especially given the lack of recollection by Patient A and the account of Ms E.

Patient A not recalling the examination

85. Within Dr Garrard's entry within Patient A's medical records at 1.30am on 27 March 2021, he recorded the history he took, results of examinations he undertook and assessment conclusions. This included an examination of the chest and abdomen.

86. Within Dr Garrard's witness statement that he completed for these proceedings, he stated that he had taken a history from Patent A that included details of her headache, and reference to her FND and the medication she was taking. He said that he undertook an examination and spoke to the patient throughout; he described it as a *"running commentary"*. This included an eye examination to look for signs of anaemia or jaundice, a respiratory examination requiring him to listen to Patient A's chest, an abdominal examination, and a cranial nerve examination. He stated that this last one was to exclude some serious causes of headaches, such as bleeds in the brain.

87. In her oral evidence, Patient A was taken through the notes that Dr Garrard made on the first occasion he saw her. Dr Garrard's legal representatives put to Patient A that Dr Garrard had examined her and shone a light in her eyes as part of those examinations. Patient A said that Dr Garrard had falsified this record. However, it was suggested on behalf of Dr Garrard that the information recorded in the note could only have come directly from Patient A. She told the Tribunal that Dr Garrard had not examined her, had not asked her the questions, and did not get the information from her.

88. The Tribunal noted that Patient A did not have a memory of the examinations and assessment undertaken by Dr Garrard. Her evidence was that Dr Garrard had made up that initial record in her medical notes and, in her view, had already decided the first time he saw her that he was going to assault her. The Tribunal did not find this explanation to be plausible. Dr Garrard did not have the information from the paramedics and so it was unclear where else he would have obtained the information about Patient A. On the evidence before it, the Tribunal did not find that the 1.30am record was a fabrication.

Previous complaints

89. Dr Garrard's representatives raised the issue that there had been two previous complaints against the hospital in question about the care Patient A had received. One was an informal complaint about advice concerning the use of a wheelchair and the other concerned a complaint raised about her treatment by a paramedic involved in her care. The Tribunal agreed with Mr Hamlet's submission that neither matter raised any suggestion by Patient A of inappropriate conduct by a doctor. The Tribunal concluded that it would be wrong to draw any link between those matters and this complaint.

Hypnosis

90. Within her GMC witness statement, Patient A stated that Dr Garrard had chanted to her each time that he entered Bay 13.

91. In Patient A's oral evidence, she said that she had not been hypnotised. When asked about the chanting, Patient A said that Dr Garrard had been breathing heavily, sexually chanted, and made reference to lust and *"you'll want to kiss me"*.

92. Dr Garrard said that he may have spoken in a soft tone of voice but denied that he had spoken or chanted in a hypnotic manner. He said that he would not have been able to speak too softly as it was a busy ward and he would not have been able to have been heard if he had spoken too quietly.

93. The Tribunal noted Patient A's oral evidence that she had not been hypnotised. Whilst Patient A alleged that Dr Garrard had chanted in a repetitious manner to her, even on her own evidence the Tribunal had insufficient to conclude, on the balance of probabilities, that this amounted to chanting in a hypnotic way.

Conclusion of analysis regarding Patient A

94. Dr Garrard's representatives did not suggest that Patient A had fabricated or dishonestly concocted the allegations against him. The Tribunal endorsed that view. It was also mindful that a victim of sexual assault may well be shocked and may not clearly remember everything that had happened to them, particularly in the light of the passage of time.

95. However, in the light of its analysis of the evidence set out above, the Tribunal concluded that it was not satisfied, on the balance of probabilities, that the events had occurred as described by Patient A for the following reasons:

- The combination of morphine together with the other medications she had taken may well have led to her perceiving events as having occurred when they did not. This was in the context of her presenting to the paramedics as feeling *"muddled"*, suffering short term memory loss and a suggestion of suicidal ideology.
- Linked to the preceding point, Patient A may well have been asleep or drifting in and out of sleep at the relevant times and this may, again, have altered her perceptions of what had happened to her.
- The position of the bay where Patient A was situated was such that any such conduct might well have been capable of being seen and/or heard. Furthermore, other doctors, nurses or healthcare assistants could have walked in at any time.
- It was entirely plausible that Dr Garrard could have entered the bay on several occasions to check on Patient A for good medical reasons.
- Whilst not determinative, the Tribunal noted that there were a number of conflicts in her various versions of events giving rise to concerns as to the reliability of Patient A's recollection. Moreover, Patient A seemed to have no recollection or a different recollection of certain events which the Tribunal had found had occurred. This included the call bell being on her bed as opposed to being on the wall as clearly stated by Ms E, and the Tribunal's finding that, contrary to Patient A's evidence, Dr Garrard did indeed examine her on first encountering her at 1.30am.

96. Accordingly, the Tribunal came to the following conclusions.

Paragraph 1

1. On or around 27 March 2021, whilst treating Patient A in the Accident and Emergency department at Royal Hampshire County Hospital, you:

a. dug your fingers into Patient A's shoulder;

b. squeezed Patient A's fingers;

c. touched Patient A's breasts on one or more occasion;

d. squeezed Patient A's nipple on one or more occasion;

e. chanted to Patient A in a hypnotic way;

f. said to Patient A:

i. 'you will lust for me' or words to that effect;

ii. 'you'll want to kiss me' or words to that effect;

97. In the light of its analysis above and in particular the summary analysis contained in paragraph 95 (and further in relation to sub-paragraph e: in paragraph 93) and also the analysis contained in paragraph 155 below, the Tribunal was not satisfied in the case of each sub-paragraph of paragraph 1 that the GMC had discharged the burden upon it to the required standard, to show that it was more likely than not that Dr Garrard carried out any of the actions set out in the sub-paragraphs of paragraph 1. Accordingly, the Tribunal found each of the sub-paragraphs of paragraph 1 of the Allegation not proved.

Paragraph 2

98. The Tribunal has found all of paragraph 1 not proved. As such, paragraph 2 of the Allegation is not proved in its entirety.

Analysis regarding Patient B

99. Patient B called the NHS 111 service on 27 December 2021. She reported that she could not remember what happened the previous night, and that her mother had seen her fall over and hurt her arms and legs. It was noted that Patient B had started a new medication five weeks prior, namely Sertraline 50mg tablets. Patient B was referred to the Emergency department at Lewisham Hospital.

100. The assessment section in the 111 report stated that Patient B had her Covid-19 booster injection on 21 December 2021, that she did not have a fever, and her symptoms had started on 24 December 2021. It stated:

> *"3 nights of disorientation, was unsure if dreamt last night woke up- fell down steps- 5-6- has mild bruises."*

Further, it stated that Patient B's balance was slightly off and that she'd had a slight tremor since starting the Sertraline. The diagnosis that was recorded was *"check re obs to exclude serotonin syndrome"*.

101. Patient B made her way to the Emergency department and was seen by Dr Garrard.

102. Within his witness statement prepared for these proceedings, Dr Garrard stated that he saw Patient B at approximately 1940 hours. He made a note of what Patient B reported including that she had been on Sertraline for about five weeks due to anxiety and depression, that she had been sleepwalking for a few days and had noticed a new tremor. Dr Garrard stated that he took a set of observations including blood pressure, and examinations including eye, respiratory, abdominal, and cranial nerve examinations. The medical records indicated that Patient B's blood pressure and pulse rate were both found to be elevated. Dr Garrard further stated that he placed a cannula in Patient B's arm and took a set of bloods. Dr Garrard said that he reviewed Patient B around 2110 hours and undertook a repeat set of observations. He discussed the next steps for managing Patient B's anxiety symptoms, including speaking to her GP. Dr Garrard gave Patient B safety netting advice and discharged her.

103. Patient B stated that, during the initial consultation, Dr Garrard asked her to take off her hoodie so he could take her blood pressure, which she did. In her witness statement Patient B also said that Dr Garrard asked her to get him a specific coffee from a local garage. In the follow up consultation, Patient B stated that Dr Garrard asked her to take her hoodie off again to take her blood pressure again, which she did. She stated that Dr Garrard then proceeded to undertake what she understood to be a neurological exam, in asking her to touch her nose with her finger and repeating this several times. Patient B stated that Dr Garrard then asked her to take her vest and sports bra off. She said that thought it was odd but that it might be part of the neurological examination. Patient B stated that Dr Garrard asked her to do this several times; she thinks it was three times in total. She said she was asked to go and wait in the waiting room again and was asked to provide a urine sample. Patient B said that she was asked to go into the consultation room again, that Dr Garrard asked her to close her eyes and then started speaking to her in a different tone. She stated that he made a double-clicking noise with his fingers and said that it was her boyfriend who was causing her sleepwalking and not to trust him. Patient B referred to Dr Garrard saying that, on leaving the hospital, she should meet him at a specific bus stop and said that it was in this consultation that Dr Garrard asked her to take off her trousers and underwear. She said that he then asked her to put them back on, and that she assumed that he was alarmed to see that she was on her period. Patient B said that Dr Garrard said that she was ok to go and that the tests had come back ok. She then left the hospital and walked home.

104. Patient B spoke with her boyfriend when he arrived home the next day on 28 December 2021. She said that he asked her if she was ok and agreed with her that she should report the behaviour to the hospital. Patient B wrote an email to Lewisham PALS to report Dr Garrard's behaviour on that same day.

105. Within Patient B's medical records, the GP makes a record on 29 December 2021 that Patient B had reported that she'd had vivid dreams for two to three nights, and that since starting Sertraline she'd had shakes, diarrhoea, nausea and a tremor. The note also reported:

> *"seen in A&E... patient has appropriately reported Dr to PALS because of these behaviours - asked her to go to shop for water and by (sic) him a coffee, asked for her to remove bra for BP, asked her to take off her bottoms as part of examination".*

Serotonin Syndrome/side effects of Sertraline

106. There was various expert evidence before the Tribunal as to whether Patient B was suffering from Serotonin Syndrome caused by her prescription of Sertraline or (even if she were not suffering from Serotonin Syndrome) whether she was suffering from the side effects of Sertraline at the time of the events in question.

107. Within his report dated 16 November 2023, Dr C, expert on behalf of the GMC, stated that he was of the opinion that Patient B did not suffer from Serotonin Syndrome on 27 December 2021 as she did not fulfil the diagnostic criteria which he preferred. Dr C stated that Serotonin Syndrome was a dangerous syndrome commonly encountered in patients who had been started on drugs affecting the amount of Serotonin in the nervous system. He stated that the classic signs and symptoms included altered mental status, agitation, tremor and incoordination, and that the onset was usually rapid as in hours or days after exposure. Dr C stated that there were various diagnostic criteria for the diagnosis of Serotonin Syndrome, including the Sternbach Criteria and Hunter's Criteria. He said that, in his view, the Hunter Criteria were superior to the Sternbach Criteria in that they registered fewer false positives. He went on to state that Patient B did not fulfil the Hunter Criteria for diagnosis. Dr C was of the opinion that Patient B did not suffer from Serotonin Syndrome on 27 December 2021.

108. However, Dr C stated that Patient B did suffer from a multitude of medication related side effects which were in keeping with the side effects of Sertraline. He stated that the fact

that Patient B had suffered from a multitude of medication related side effects related to Sertraline raised the possibility that, even though he was of the opinion that she did not suffer from Serotonin Syndrome, those side effects she experienced may have altered her mental state on 27 December 2021.

109. There was reference within Patient B's medical records to sleepwalking and memory loss. Within her oral evidence, Patient B said that this was memory loss within the context of her sleepwalking and not memory loss generally. There was also a reference on 8 February 2022 to Patient B reporting to her GP that she had had vivid dreams, sleepwalking and one episode of auditory hallucinations - by that point all improved following her ceasing to take Sertraline. Within her oral evidence, Patient B accepted that all the other elements of the GP notes were accurate but denied that she had suffered auditory hallucinations. However, the Tribunal was satisfied that the GP would not have included reference to auditory hallucinations other than as a result of what Patient B had told her. Accordingly, the Tribunal was satisfied that it was more likely than not that Patient B had told the GP that she had suffered from such hallucinations.

110. Within his report, Dr C was asked to give an opinion on whether Patient B's mental state was impacted in any way on 27 December 2021. He stated that it was possible that Patient B's mental state was affected by Sertraline. Dr C made reference to the GP record of the auditory hallucination. With reference to the question regarding impact on mental state, he stated that it was not possible to say how likely this would have been, other than that it was possible.

111. In his oral evidence, Dr C agreed that both Serotonin Syndrome and the side effects of Sertraline could lead to altered mental state including hallucinations and confusion. He did not demur from the suggestion of Dr Garrard's Counsel that, whether Patient B was suffering from Serotonin Syndrome or the side effects of Sertraline, could be viewed as a matter of labelling and might make no difference to the evaluation of whether it was possible that Patient B might have perceived events to have occurred that did not actually happen.

112. The Tribunal also had regard to the evidence of Professor D, on Dr Garrard's behalf. Professor D produced his initial report on 4 June 2022 and then two further reports on 6 and 8 November 2023 based on the receipt of Patient B's medical records.

113. Within his reports, Professor D stated that Sertraline was a widely prescribed first-line pharmacological treatment for depression, and that the adverse effects were principally due

to increased serotonin function in the central nervous system and peripherally. Professor D stated that common side effects of Sertraline included nausea, insomnia, fatigue, anxiety, and tremor. He referred to a note in the GP records on 18 December 2021 that, after four weeks on Sertraline, Patient B had reported no major side effects. However, the entry on 29 December 2021 noted previous complaints of shaking, diarrhoea, nausea and tremor.

114. In terms of Serotonin Syndrome, Professor D referred to the Sternbach and Hunter's Criteria. He stated that there was no specific laboratory test for Serotonin Syndrome and that the diagnosis was made on clinical grounds. Professor D stated that the Sternbach Criteria covered a wider range of symptoms. He stated that Patient B experienced a tremor, problems with balance, diarrhoea and a mild fever. Professor D opined that he believed that Patient B did meet the Sternbach Criteria for Serotonin Syndrome on 27 December 2021.

115. Professor D stated that, in his opinion and on the balance of probabilities, Patient B was experiencing Serotonin Syndrome when she was assessed by Dr Garrard on 27 December 2021. Professor D stated that Dr Garrard did not report any abnormalities in Patient B's mental state, but that detailed examinations of mental state would often have a low priority in busy Accident and Emergency departments where the overriding concern was a patient's immediate medical safety. Professor D stated that Patient B had described several symptoms that could be relevant to mental state abnormalities including memory loss, disorientation, and sleepwalking. He also made reference to the note in the GP records of an episode of auditory hallucinations. Professor D opined that, taken together, the symptoms were consistent with Patient B experiencing an abnormal mental state around 27 December 2021. He stated that it was therefore possible that, when assessed by Dr Garrard, Patient B may have had an abnormal mental state that could have affected her perception of Dr Garrard's speech and actions.

116. The Tribunal was clear that, while there was disagreement in the expert evidence as to whether Patient B had been suffering from Serotonin Syndrome or the side effects of Sertraline, it was clear that they agreed that she was suffering from one or the other. There were significant debilitating side effects of the medication that Patient B was suffering from on 27 December 2021, ranging from very common to rare. These included insomnia, anxiety, agitation, nightmares, sleepwalking, dizziness, tremor, tachycardia, yawning, diarrhoea, possible balance issues, and one reported episode of auditory hallucinations. Dr C and Professor D were at one that it was a possibility that Patient B could have perceived events as having happened which did not in fact occur. Further, Professor D stated that it was possible that a person's memory could comprise of a mix of fantasy and reality. He was also asked to

comment on how a person, who had recovered from a confusional state where they had mixed fantasy and reality, would recall the distorted memory. He said that they would likely remember the distorted memory as being accurate and consistent. Dr C was asked about this and felt that this was outside of his field of expertise and should be addressed by a psychiatrist. Professor D, who is a psychiatrist, felt able to comment on this aspect.

117. The Tribunal noted the evidence that Serotonin Syndrome or the side effects of Sertraline would normally (although not always) materialise sooner than five weeks after the patient commencing the medication. However, in this case it was clear that the symptoms such as sleepwalking and vivid dreams, had only occurred in the days immediately preceding the events in question. It was also clear from the evidence that the side effects subsequently resolved following cessation of her taking Sertraline.

118. The Tribunal had regard to Mr Hamlet's submissions on behalf of the GMC that Patient B's account was interspersed with accurate recollections of events that, in his submission, broadly accorded with Dr Garrard's own account - the initial assessment, the discussion about fluids and going to the garage, providing the coffee, the urine sample, the follow up observations, the discussion of the blood test results. However, in the Tribunal's view and as set out further below, recollections of the details of those conversations varied substantially and therefore it was not satisfied that Patient B's account of the matters alleged was interspersed with uncontested recollections of other conversations.

119. As to the possibility of Patient B imagining a conversation or actions that did not happen, the experts agreed that it was possible but could not give a view on the likelihood of this having happened.

Text messages

120. Patient B sent a number of text messages to her friend and to her boyfriend on and around 27 December 2021. Patient B disclosed the messages to her friend at an early stage. In her oral evidence, Patient B explained that she had location sharing on with a number of close friends and that one had noticed that she was at the hospital. There were a number of messages, including:

> *"I'm ok, thanks. The doctor made me go to the garage to get myself water and him a coffee. Waiting on my blood results.*
> *...*

Oh yea so the conclusion was bad anxiety and sleepwalking. I presented with a very high heart rate and blood pressure but it eventually went down... keep taking the meds... I don't agree with the med bit so will contact my gp.
Also the doctor was really weird and wanted me to wait at the bus stop so he could drop me home. I said no twice and walked home.
He also insinuated my partner was causing my anxiety and to avoid him."

121. The Tribunal noted that there was no mention of talking off her clothes or any of the sexual allegations in the text messages. There was however mention of the coffee and asking Patient B to wait at the bus stop. Patient B was asked about this in her oral evidence. She explained that she did not want her friend rushing to the hospital and did not want her boyfriend to feel the need to rush back from visiting his parents when he was due back on 28 December 2021 in any event.

122. It became apparent during Patient B's oral evidence that she had also exchanged relevant text messages at the time in question with her boyfriend. She read out parts of the messages and these were later provided in redacted form to the parties and Tribunal.

123. Within the messages with her boyfriend which were the subject of the later disclosure, Patient B told him that 111 was making her go to the hospital (18:30), that she was anxious and that the [111] doctor thought that she might have Serotonin Syndrome (19:09). She subsequently said that she had been told at the hospital that she was not suffering from Serotonin Syndrome and that she was getting some bloods taken (19:56). Patient B told her boyfriend that she was fine, that she had a thing in her arm, and that the doctor had made her go to the garage to get some water and a coffee for him *"That's weird right"* (20:28). She then said she was free, that they had basically just said anxiety and sleepwalking and that she was going to speak to her GP (21:22).

124. When asked why she had not disclosed the messages to her boyfriend earlier, Patient B said that they were a mirror or duplication of the texts with her friend. The Tribunal noted however that, unlike the text exchange with her boyfriend, the texts with the friend did not refer to the 111 potential diagnosis of Serotonin Syndrome. The Tribunal noted that Patient B could have lied and said that there were no messages with her boyfriend and she read out extracts when asked and provided the messages afterwards. The Tribunal agreed that the messages with the boyfriend should have been disclosed much earlier but was of the view that this was a genuine mistake on Patient B's part and did not believe that she had sought to

mislead the Tribunal. The Tribunal did not consider the late disclosure to be an indication of dishonesty.

125. The Tribunal's overall conclusion on the text messages was that they did demonstrate consistency with certain of Patient B's allegations. However, Dr Garrard's case was that Patient B's perception of her interactions with him was at variance with the reality. The key question therefore was whether the events had occurred. If they were not proved on the balance of probabilities to have occurred the text messages would only be viewed as repeating Patient B's perception without providing support that the facts as alleged did indeed occur.

Coffee

126. Within her GMC witness statement, Patient B said that Dr Garrard had told her to go for a walk and get some water from the local garage. She stated that Dr Garrard *"also asked me to get him a coffee from the garage"*. Patient B stated that she could not remember the exact coffee that Dr Garrard asked for. She stated that Dr Garrard had explained *"how the coffee machine works, and where to find the garage... he did not give me any money for the coffee"*. Patient B stated that she thought it was weird that Dr Garrard requested for her to get him a coffee but that *"no major alarm bells were ringing for me at this point"*.

127. Patient B referred to the text messages that she had sent to her friend and boyfriend, which included reference to the doctor making her get a coffee for him and her saying *"That's weird right"*.

128. Patient B said that she went back to Dr Garrard's consultation room and knocked on his door. She said he opened the door but not fully as she thought he might have been with another patient. Patient B said that she gave him the coffee and he thanked her. She said that she went back to the waiting area and awaited her blood test results.

129. Within his witness statement prepared for these proceedings, Dr Garrard denied that he asked Patient B for a coffee. He stated that there was tea and coffee provided at the hospital for staff members. Dr Garrard stated that, sometime later when he was with another patient, there was a knock at the door, which he expected to be one of his colleagues. Dr Garrard stated that he opened the door and Patient B was standing outside she said *"I got this for you"* and handed him a cup of coffee. He was with another patient and said thank you and carried on with that consultation. Dr Garrard stated: *"With the benefit of hindsight, I*

realise now that this was an unusual interaction and that I could have handed her care over to another doctor at this point, but as it was a very busy shift, I did not consider the matter further". Dr Garrard stated that he left the coffee on the side of the counter in the consultation and that he did not drink it. XXX.

130. In Patient B's oral evidence to the Tribunal, she said that Dr Garrard did not outright ask her for a coffee. Patient B said that Dr Garrard hinted about wanting a coffee and implied that a coffee would be gratefully received, and told her where the coffee machine was and how to use it.

131. The Tribunal noted Patient B's view that the hinting and suggesting was the same as telling her to get him a coffee. The Tribunal did not agree that this amounted to the same thing. The Tribunal was of the view that, even based on Patient B's own oral evidence, she had not been *"told"* to get him a coffee.

Cannula/fluids

132. Within her GMC witness statement, Patient B said that Dr Garrard said that she needed to wait for her blood results. She said that she must have needed her hydration levels increasing as Dr Garrard had asked her if she would prefer an IV drip or to have some water. Patient B said that she would rather have an IV drip. She stated that Dr Garrard then appeared to change his mind in giving her the option and said he thought it would be best if she went for a walk and get some water from the local garage.

133. There was also reference to the cannula in Patient B's messages to her boyfriend. Patient B told her boyfriend that she was *"Fine. Got a thing in my arm. The doctor made me go to the garage to get some water and a coffee for him. That's weird right"* (20:28).

134. Within his witness statement prepared for these proceedings, Dr Garrard stated that he placed the cannula in Patient B's arm and took a set of bloods. He said he explained to Patient B that he would like to give her intravenous fluids through her cannula. Dr Garrard said that Patient B declined and said she would rather take oral fluids and asked if there were any shops nearby. As the in-hospital newsagents had already closed, he explained that the only place nearby was the garage opposite.

135. The Tribunal was unclear why Dr Garrard would put a cannula in if he did not intend to give Patient B intravenous fluids. It found it more likely than not that Patient B expressed a

preference not to have them and said she would get some water instead. This was an example of a conversation where there was little or no correlation between the accounts of Patient B and Dr Garrard.

136. The Tribunal returned to Mr Hamlet's submissions that Patient B's account was interspersed with accurate recollections of events that broadly accorded with Dr Garrard's own account - the initial assessment, the discussion about fluids and going to the garage, providing the coffee, the urine sample, the follow up observations, the discussion of the blood test results. The Tribunal was of the view, in respect of the coffee, cannula and the IV fluids, that there was little consensus between Patient B and Dr Garrard as to what had occurred and been said. Whilst there was some accord as to the overall subject matter of certain conversations that both agree happened, there were, in respect of almost every interaction, substantial differences of recollection as to what happened and what was said. Apart from the time that Patient B arrived and left the hospital, the Tribunal found limited correlation between the accounts of Patient B and Dr Garrard as to the interactions that they had.

Bus stop

137. Within her GMC witness statement, Patient B said that at some point when Dr Garrard had asked her to close her eyes, he had said that she should wait for him at the bus stop and that he would pick her up after he had finished his shift and take her home. Patient B stated that Dr Garrard explained where the bus stop was. She said that she remembered declining with her eyes still closed and that she only lived a short distance away and so would be fine going home by herself. Patient B said that Dr Garrard made a double-clicking noise with his fingers again and asked her to open her eyes. She stated that Dr Garrard went on to speak about something unrelated as if he had not mentioned the bus stop. Patient B stated that she found Dr Garrard asking her to wait at the bus stop the most concerning out of all the behaviours as for everything else she felt they may have been part of the examinations he was undertaking, but there was no medical reason why he would ask her to wait for him at the bus stop. Patient B stated that Dr Garrard asked her to close her eyes again and was more insistent on her waiting for him at the bus stop. She repeated that she only lived a short distance away and did not need him to drive her home.

138. Within his statement prepared for these proceedings, Dr Garrard stated that he had not travelled to work by car on the day in question. He explained that the hospital sat within a series of Controlled Parking Zones that prohibited parking unless you had a valid permit.

Dr Garrard stated that he did not have a staff parking permit and that the nearest available street parking was about a 20 minute walk from the hospital. Dr Garrard also stated that the bus stop sat on a 'red route' where stopping (including dropping off or picking up) was prohibited. He stated that it therefore would not have been possible for him to pick Patient B up from the bus stop without incurring a fine.

139. In addition, Dr Garrard stated that his shift that day ended at 22:00 and enclosed his timesheet. He said that he likely left the hospital at around 22:15 hours. From Patient B's text messages, it appears she left the hospital at around 9.30pm and walked home. The Tribunal noted that there would have been a 45 minute waiting period between when Patient B and then Dr Garrard left the hospital.

140. In the light of Dr Garrard's unchallenged evidence as to the impracticality of the bus stop arrangements alleged by Patient B and its overall view as to the possibility of Patient B's perception of events being flawed as a result of Serotonin Syndrome or Sertraline side effects (as to which see further paragraph 152 below), the Tribunal was not satisfied on the balance of probabilities that the bus stop conversation took place as alleged by Patient B.

Hypnosis

141. Within her GMC witness statement, Patient B stated that Dr Garrard had asked her to close her eyes and then started speaking to her in a different tone of voice, which she could only describe as a more soothing tone. Patient B stated that Dr Garrard then made a double-clicking noise, which she presumed was with his fingers, and asked her to open her eyes. His tone of voice would then change to what she considered to be 'normal' and he would talk about something unrelated to what he was saying she had her eyes closed. Patient B stated that Dr Garrard asked her to close her eyes a number of times, including when he told her that she was not to trust her boyfriend and about the bus stop. She stated that it was while Dr Garrard was speaking in a soothing voice that he asked her to take off her trousers and underwear.

142. In Patient B's oral evidence, she said that she did not believe that Dr Garrard had spoken to her hypnotically. She said that Dr Garrard had used a soothing voice, that there was no chanting, and that she did not think that she had been hypnotised.

143. Within his statement prepared for these proceedings, Dr Garrard stated that he did not discuss Patient B's partner, save for her confirming there was a safe place to discharge

her to. He stated that he did not tell Patient B that nobody understood her symptoms except him and she was not asked to (and did not) remove any item of clothing except her outer jacket. Dr Garrard stated that he did not speak to Patient B in a hypnotic way.

144. The Tribunal determined that even on Patient B's own evidence, there was insufficient evidence to persuade it that Dr Garrard had spoken in a hypnotic way. She had alleged neither that she was hypnotised nor that Dr Garrard attempted to hypnotise her. It had regard to the description of Dr Garrard using a soothing voice but the use of a soothing voice was not necessarily inappropriate behaviour on the part of a doctor.

GMC investigation

145. The Tribunal also had regard to a letter that the GMC sent to the relevant Responsible Officer at the Royal Hampshire County Hospital on 13 December 2021, some two weeks prior to the events involving Patient B. The letter set out that the GMC was investigating the concerns regarding Patient A and was requesting the Trust outcome and patient medical records. The letter stated that Dr Garrard knew the GMC was contacting them. The Tribunal noted that the police investigation had been dropped in May 2021 but that, following the conclusion of the Trust investigation, the GMC commenced its own investigation. The Tribunal considered that it would have been unlikely that Dr Garrard would have brought further potential scrutiny upon himself at a time when he clearly knew the GMC was investigating him. In the Tribunal's view this was not, of itself, determinative but it did view it as a factor to take into account in terms of the overall picture before it.

CCTV

146. There was mention of there being CCTV in the areas of Patient B's consultation and the waiting areas. The Tribunal noted that Dr Garrard had emailed the relevant person at the Trust to ask them to retain the CCTV footage.

147. Within his statement prepared for these proceedings, Dr Garrard stated that he was aware of there being CCTV in the general area. He stated that he had been working a shift on 25 July 2021 when a patient had assaulted him. He said that the patient was arrested and subsequently convicted of criminal damage. Dr Garrard stated that his presence at Court had not been required as the CCTV footage alone sufficed as evidence.

148. Within the notes of a Trust investigatory meeting with Dr Garrard on 8 February 2022, Dr Garrard stated that he was subsequently informed that CCTV had never been installed in the relevant room where he saw Patient B as the room used to be a paediatric triage room.

149. Dr Garrard stated that he asked for the remaining waiting room CCTV footage to be retained to identify when the consultation was interrupted and to document his movements within the department. Ultimately, no CCTV was obtained and there is no such evidence before this Tribunal. The Tribunal was unsure why this was not followed up further by Dr Garrard. In oral evidence, he said he had provided the information to his legal representatives.

150. The Tribunal was of the view that the main point was that it had no CCTV footage before it to assist it in its deliberations. It was unwilling to speculate as to what it may or may not have shown.

Conclusion of analysis regarding Patient B

151. The Tribunal considered all of the various parts of its analysis and of all of the evidence before it.

152. The Tribunal found Patient B to be broadly consistent in her evidence and had no reason to doubt her honesty and wish to assist the Tribunal. However, the Tribunal noted, in accordance with the evidence of Professor D, that the fact that a witness who had been in a confusional state is consistent in their recollection does not mean that the recollection is necessarily correct. On the evidence before it, whether due to Serotonin Syndrome or the side effects of Sertraline, Patient B was suffering from significant mental state changes at the relevant time, including sleep/wake disturbances, vivid dreams, sleepwalking, disorientation, amnesia and anxiety. The experts were agreed that it was possible that either of these conditions could have resulted in Patient B giving an account which she believed to be true when that was not in fact what had occurred. Further, Professor D had confirmed that it was possible that Patient B would recall this as accurate. In the light of the expert evidence and the serious symptoms from which Patient B was suffering due to her medication, the Tribunal was unable to conclude that the events as described by Patient B had, on the balance of probabilities, occurred.

Cross-admissibility/coincidence

153. The Tribunal noted and gave careful consideration to the point raised by Mr Hamlet of the alleged similarities between the accounts of Patients A and B. He referred first to the hypnosis allegations. The Tribunal has considered these above. It has found on Patient B's own evidence that whilst she said that Dr Garrard had used a soothing voice, there was no chanting and she was not hypnotised. Patient A likewise said that she had not been hypnotised, and when asked about the chanting that she referred to in her witness statement, she alleged that Dr Garrard had been breathing heavily and had sexually chanted, making reference to lust and *"you'll want to kiss me"*. Having found neither allegation of speaking or chanting in a hypnotic way to have been proved, it would not be correct to conclude that either allegation supported the credibility of the other. There were also significant differences in the descriptions of how Dr Garrard was alleged to have spoken or chanted. Furthermore, the content of the alleged wording used by Dr Garrard was very different in the case of Patient A and Patient B. In the case of Patient A, the alleged wording was of a clear sexual nature. In the case of Patient B, the alleged wording related to the ability to trust other people such as her parents and boyfriend, and the causes of her symptoms.

154. More generally, Mr Hamlet submitted that it was wholly unlikely, as was suggested, that two independent patients separated by time and location would make similar allegations against Dr Garrard as a product of a rare or uncommon side effect of their medication. He stated that the allegations of chanting and soft speaking, that were accompanied by the touching of breasts in Patient A's case and the removal of clothing in Patient B's case, were too similar to be attributed to coincidence.

155. In its overall examination of all of the evidence before it, the Tribunal found the two allegations to be insufficiently similar to find a pattern. The Tribunal acknowledged that Dr Garrard was alleged to have said and done something inappropriate and sexually motivated in both instances but there was nothing sufficiently distinctive to link what was allegedly said and done to Patient A and then to Patient B. Moreover, there was significant and credible expert evidence as to the effect of different medications in the two cases and very substantial differences in the accounts of Patients A and B.

156. Accordingly, the Tribunal came to the following conclusions.

Paragraph 3

3. On or around 27 December 2021, whilst treating Patient B at Lewisham Hospital, you:

a. asked Patient B to remove her:

i. vest on one or more occasion;

ii. bra on one or more occasion;

iii. trousers;

iv. underwear;

when it was not clinically indicated;

b. told Patient B:

i. to go to a nearby garage to buy some water for herself and some coffee for you;

ii. that Patient B's boyfriend was causing her sleepwalking and anxiety and that Patient B was not to trust him or her parents;

iii. that no one understood Patient B and her symptoms apart from you;

iv. to wait at the bus stop and that you would pick Patient B up after your shift and take her home;

c. spoke to Patient B on one or more occasion in a hypnotic way.

157. In the light of its analysis above and in particular the analysis comprised in paragraphs 152 and 155 (and further:

in relation to sub-paragraph b(i): paragraph 131,
in relation to sub-paragraph b(iv): paragraph 140,
in relation to sub-paragraph c: paragraph 144),

the Tribunal was not satisfied in the case of each sub-paragraph of paragraph 3 that the GMC had discharged the burden upon it to the required standard, to show that it was more likely than not that Dr Garrard carried out any of the actions set out in the sub-paragraphs of paragraph 3. Accordingly, the Tribunal found each of the sub-paragraphs of paragraph 3 of the Allegation not proved.

Paragraph 4

158. The Tribunal has found all of paragraphs 1 to 3 not proved. As such, paragraph 4 of the Allegation is not proved in its entirety.

The Tribunal's Overall Determination on the Facts

159. The Tribunal has determined the facts as follows:

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

1. On or around 27 March 2021, whilst treating Patient A in the Accident and Emergency department at Royal Hampshire County Hospital, you:

a. dug your fingers into Patient A's shoulder;
Not proved

b. squeezed Patient A's fingers;
Not proved

c. touched Patient A's breasts on one or more occasion;
Not proved

d. squeezed Patient A's nipple on one or more occasion;
Not proved

e. chanted to Patient A in a hypnotic way;
Not proved

f. said to Patient A:

i. 'you will lust for me' or words to that effect;
Not proved

ii. 'you'll want to kiss me' or words to that effect;
Not proved

2. Your actions as described at paragraph 1a-d above amount to inappropriate physical contact with Patient A.
Not proved

3. On or around 27 December 2021, whilst treating Patient B at Lewisham Hospital, you:

a. asked Patient B to remove her:

i. vest on one or more occasion;
Not proved

ii. bra on one or more occasion;
Not proved

iii. trousers;
Not proved

iv. underwear;
Not proved

when it was not clinically indicated;

b. told Patient B:

i. to go to a nearby garage to buy some water for herself and some coffee for you;
Not proved

ii. that Patient B's boyfriend was causing her sleepwalking and anxiety and that Patient B was not to trust him or her parents;
Not proved

iii. that no one understood Patient B and her symptoms apart from you;
Not proved

iv. to wait at the bus stop and that you would pick Patient B up after your shift and take her home;
Not proved

c. spoke to Patient B on one or more occasion in a hypnotic way.
Not proved

4. Your actions set out at:

a. paragraphs 1a-e and 2 were carried out without Patient A's consent;
Not proved

b. paragraph 3c were carried out without Patient B's consent;
Not proved

c. paragraphs 1, 2, 3a, 3b ii-iv and 3c were sexually motivated.
Not proved

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.
Not impaired

160. XXX

ANNEX A - 14/11/2023

Application for the admission of further evidence

161. On 13 November 2023, Mr Rawlinson, Counsel on behalf of Dr Garrard, made an application for the admission of the supplemental report of Professor D dated 8 November 2023. This application was made under Rule 34(1) of the General Medical Council (GMC) (Fitness to Practise Rules) 2004 as amended ('the Rules'), which states:

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

162. Professor D's initial report was dated 4 June 2022 and the supplemental report was prepared after receipt of redacted General Practitioner (GP) notes and witness statements in November 2023. He provided expert evidence on behalf of Dr Garrard.

Submissions

Submissions on behalf of Dr Garrard

163. Mr Rawlinson submitted that it would be fair and relevant to admit this report. He stated that Professor D could be cross examined on both versions of his report if the GMC wished to do so. Mr Rawlinson explained that Professor D had completed his first report and, after receipt of the GP notes and witness statements, the supplemental report was produced. He stated that it was Professor D's opinion that Patient B was suffering from serotonin syndrome at the time in question.

164. Mr Rawlinson, in response to Mr Hamlet's submissions, submitted that fairness goes both ways. He stated that Dr Garrard was facing very serious allegations and his registration was at risk. Mr Rawlinson stated that Professor D would be required to answer questions of his evidence fairly and impartially, given his duty to the Tribunal as an expert witness. Mr Rawlinson submitted that there would be no mischief in terms of allowing the admission of the report and that the evidence could have a direct bearing on the outcome of the case.

Submissions on behalf of the GMC

165. Mr Hamlet, Counsel on behalf of the GMC, submitted that the GMC was neutral in terms of this application. He stated that Professor D's first report had been served on the GMC three weeks ago, and the supplementary report had been served on Friday 10 November 2023. Mr Hamlet raised the issue of fairness given that timing.

166. Mr Hamlet stated that he recognised that the Tribunal has a wide discretion to receive evidence under Rule 34(1) of the Rules, and that the report was plainly relevant as it goes to the question of Patient B's memory and perception at the time. In terms of timings, Mr Hamlet stated that the GMC had taken a pragmatic decision when receiving the first report not to seek further expert evidence but made it clear that the GMC was reserving the right to obtain a report in the course of this hearing if it was able to do so.

Tribunal's Decision

167. The Tribunal had regard to Rule 34(1) of the Rules, as quoted above, and the submissions made by both parties.

168. The Tribunal noted that Professor D had set out his initial view that Patient B may have been suffering from serotonin syndrome at the time in question and sought additional GP records and information. The supplemental report has now been produced after receipt of that further information. The GMC has had sight of the first report for three weeks, in which the issue of serotonin syndrome was clearly raised. The Tribunal acknowledged that the GMC would be able to challenge Professor D's evidence and had reserved the right to obtain its own report if needed. Further, it would assist the Tribunal in considering Professor D's oral evidence to have sight of the written report which would set out his up-to-date view in the light of the further information provided.

169. In considering all of the circumstances, the Tribunal determined that the supplemental report was relevant and that it would be fair to admit it. As such, the Tribunal determined to grant Dr Garrard's application for the admission of the supplemental expert report of Professor D.

ANNEX B - 20/11/2023

Application for the admission of further evidence

170. On 20 November 2023, Mr Hamlet, Counsel on behalf of the GMC, made an application for the admission of the evidence of Dr C, Consultant in Emergency Medicine and Intensive Care and Clinical Toxicologist. This application was made under Rule 34(1) of the Rules, which is quoted in full in Annex A.

171. Dr C's report was dated 16 November 2023 and had been provided to Dr Garrard's legal representatives on 17 November 2023. Mr Hamlet confirmed that Dr C was available to give oral evidence at the hearing on 20 November 2023.

Submissions

Submissions on behalf of the GMC

172. Mr Hamlet stated that Dr C's report addressed the case of Patient B and the issue of serotonin syndrome. Mr Hamlet referred to the comments that he had made earlier in the hearing that the GMC may wish to obtain an expert report following receipt, close to the hearing start date, of the second report of Professor D on behalf of Dr Garrard.

173. Mr Hamlet submitted that the evidence of Dr C was plainly relevant and that his report was in direct response to Professor D's report. He referred to the timing of the receipt of that evidence and submitted that, given the timing, it was also fair to admit this evidence. Mr Hamlet submitted that the evidence went to an existing issue and that it was open to Dr Garrard and his legal representatives to challenge the evidence. He submitted that the Tribunal should exercise its discretion and admit the evidence.

Submissions on behalf of Dr Garrard

174. Mr Rawlinson stated that there was no objection to the admission of the further evidence. He confirmed that the report had been received by Dr Garrard's legal representatives on 17 November 2023 and that instructions had been taken from Dr Garrard over the weekend. Mr Rawlinson stated that they had also provided Dr C's report to Professor D so the evidence would not cause a hiatus in proceedings. He stated that he could ask questions of the expert on behalf of Dr Garrard.

Tribunal's Decision

175. The Tribunal had regard to Rule 34(1) of the Rules, as quoted in Annex A, and the submissions made by both parties.

176. The Tribunal determined that the evidence of Dr C was clearly relevant in respect of the issue of Patient B and serotonin syndrome. The Tribunal noted that Dr Garrard and his legal representatives had been able to review the evidence and provide it to their expert.

177. In considering all of the circumstances, the Tribunal determined that Dr C's report was relevant and that it would also be fair to admit it. As such, the Tribunal determined to grant the GMC's application for the admission of the evidence of Dr C.