

PUBLIC RECORD**Dates:** 07/09/2026 - 22/09/2026**Doctor:** Dr Ravikumar RAVINDRAN**GMC reference number:** 6119217**Primary medical qualification:** Vrach 2002 St Petersburg State Medical
Academy

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

Summary of outcomeSuspension, 6 months
Review hearing directed**Tribunal:**

Legally Qualified Chair	Ms Samantha Jones
Lay Tribunal Member:	Mr George McLean
Registrant Tribunal Member:	Dr Anup Singh
Tribunal Clerk:	Alex Currie Hadi Rachrach

Attendance and Representation:

Doctor:	Present and represented
Doctor's Representative:	Patrick Cassidy, Counsel, instructed by BMA Law
GMC Representative:	Jade Bucklow, 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.

Protecting the Public

Throughout the decision-making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 17/09/2026

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

Factual Background

2. Dr Ravindran moved to the UK from India in 2013 after completing a post-graduate degree in general medicine at the Amala Institute of Medical Sciences, Kerala. Dr Ravindran is a Consultant Physician at Anuerin Bevan University Health Board in Wales. He has worked there since 2020. He obtained specialist registration in Endocrinology and Diabetes in September 2019.

3. The allegations that have led to Dr Ravindran’s hearing before the MPTS relate to his conduct in working as an independent health practitioner for Venture Startups Limited otherwise known as Updoc, a digital telehealth platform. Updoc is a technology platform that connects users seeking private health services with independent contractor health practitioners who are registered with the General Medical Council (“GMC”) and who provide such services directly to those users. Dr Ravindran was engaged to work for Updoc as an independent health practitioner from 4 September 2023 to 12 August 2024. He worked for Updoc alongside his post as a Consultant Physician.

4. In August 2023, Dr Ravindran responded to an Updoc advertisement on LinkedIn for GMC registered doctors to provide fit note certificates for patients. A fit note certificate is

obtained by patients who require sick leave from work. On 29 August 2023, Dr Ravindran met with Mr D, the XXX at Updoc, in a screening call. On 4 September 2023, Dr Ravindran was provided access to the Updoc platform. Dr Ravindran's responsibilities were, as Mr D stated, to "independently provide safe, competent patient-centred care through the platform, in compliance with relevant professional standards and to exercise his own independent clinical judgment."

5. After Dr Ravindran had taken up his position with Updoc, Updoc services broadened to include issuing a range of medical certificates, including completing medical questionnaires for applications for firearms licensing. Dr Ravindran was paid for each medical request he completed.

6. The Updoc platform was interactive. A patient submitted a request, together with relevant information and their contact details, through a questionnaire on the Updoc platform and paid for it. The request and information were collected and provided unaltered and unverified to one of the doctors who worked for Updoc. The doctor assigned to the task was chosen at random.

7. The details of the patient's submission would be included in the request to the doctor and sent to an Updoc email account which the doctor could access. The system would generate draft text, using Artificial Intelligence, which it proposed should form the contents of the letter for the patient. The doctor was given the option, by way of interactive links, to accept or reject the request or to request further information. The doctor could also edit the proposed text that would form the contents of the letter issued. The interactive links were separated one by one and encircled by different colours giving the appearance of a button to press. The link to accept the request was encircled in green and stated "Accept", the link to request further information and edit the document was encircled in purple and stated "Click here to edit the document before accepting" and the link to reject the request was encircled in red and stated "Patient's request falls outside my scope". The interactive links appeared one below the other in the order green, purple and red.

8. Once the request had been accepted by the doctor, a letter would be generated and sent to the patient. Confirmation of the acceptance would also be sent to the doctor by way of a separate email and the letter that was generated would also be sent to the doctor. If the request was rejected by the doctor, no further action would be taken but confirmation of the refusal of the request would be sent to the doctor. If the doctor requested further information, Updoc and/or the doctor could correspond with the patient by email and telephone to request further information. Doctors providing their services through the Updoc platform had the sole discretion as to whether and how to provide a medical letter (fit

note), and in respect of any recommendation or clinical outcome they considered to be clinically appropriate in accordance with their professional obligations.

9. Paragraphs one to three of the Allegation arise in respect of a request made on 30 May 2024 on the Updoc platform by Patient A for a 'Firearms Licensing Medical Information Proforma' document to be completed so that she could renew her Firearms Licence. It is mandatory for any applicant applying for a renewal of their Firearms Licence to supply a medical questionnaire /proforma completed by a GMC registered doctor. Patient A attached the cover letter to the proforma, which was addressed to the doctor completing the proforma, and the proforma document to be completed by the doctor. The cover letter stated, amongst other things:

"The police assess firearms applications and require all applicants to provide factual information from a doctor confirming whether they have ever been diagnosed with or treated for any of the following conditions, which can have a bearing on whether a person is suitable to be granted a firearm certificate".

It then listed a number of psychiatric and physical health conditions.

10. The letter further stated, on page two under the heading "How to respond": "When the medical information is being provided to the police by a doctor from a private company, the doctor must receive the applicant's medical information direct from the GP practice and not via the applicant."

11. The proforma required the doctor to indicate that they had full access to the applicant's medical records. Mr C, a Firearms Licensing Manager in the Metropolitan Police said in his statement that this was "an important point for a decision maker to take into account". The proforma also required the doctor to confirm that the medical record was continuous and to input the dates of when the records began and the date of the last consultation. The doctor was then required to tick whether the applicant was suffering from any one of a number of medical conditions, to add further detail in respect of the medical condition and the proforma had to be signed and dated by the doctor.

12. On 30 May 2024, the request was assigned to Dr Ravindran who accepted the request and asked Updoc to contact Patient A so that she could "provide details of her health summary from her GP" in order to allow him to complete the form.

13. Thereafter, email correspondence between Updoc and Patient A ensued whereby, on 31 May 2024, Patient A sent Updoc three screenshots of her NHS app which provided an

overview of her medical records. She told Updoc that the last time she had been prescribed medication was on 17 March 2014, that she had no allergies and no health conditions. She explained that:

“[t]he reason I approached you was the speed of processing the documents you advertised. This is urgent as I need to present it to the Metropolitan Police Firearm Department asap. I eagerly await your response.”

14. On 31 May 2024, the emails and screenshots were forwarded to Dr Ravindran by Updoc and he was asked to look at the message from Patient A and whether there was “anything you can do to assist this patient with this matter”.

15. On the evening of 31 May 2024, Dr Ravindran completed the proforma for Patient A. He put a cross in the box confirming that he had had full access to the applicant’s medical records. He also put a cross in the box confirming that the medical records were continuous. He input on the proforma that the records were dated from 23 March 2011, the last consultation date was 17 March 2014, and Patient A had no history of relevant medical conditions. Dr Ravindran signed the form.

16. The proforma was sent by Patient A to the Metropolitan Police who determine applications for renewals of Firearms Licences. The application was assigned to Mr E, under the command of Mr C. Mr C stated that the purpose of the questionnaire was to identify “increased risk in relation to the unsupervised possession of firearms and ammunition” in relation to a number of mental health and physical conditions.

17. When considering the proforma completed by Dr Ravindran, Mr E noticed a discrepancy on the proforma and contacted Patient A to explain the irregularity. Patient A immediately supplied another proforma that had been completed by her GP, Dr H, on 2 June 2024. The proforma completed by Dr H indicated that Patient A’s medical records dated from 1996, a more recent date of consultation was shown and there were historic relevant medical conditions from which Patient A had suffered in 1998, 1999 and 2004. When the second form was queried with Patient A, she explained that she had initially requested her GP to complete the form but due to the delay in receiving the report from her GP, she engaged the services of Updoc to supply the report. She received the proforma from her GP a few days later and thus was able to send the second proforma to the Police.

18. It is alleged by the GMC that on or around 31 May 2024 Dr Ravindran completed a ‘Firearms Licensing Medical Information Proforma’ for Patient A, whilst failing to obtain an adequate medical history or verify the medical information provided by Patient A. The GMC

allege that Dr Ravindran crossed 'yes' on the Proforma to having access to Patient A's medical record and also crossed 'yes' next to the medical record being continuous. The GMC allege Dr Ravindran did not have access to Patient A's full medical records, knew that he did not have access and allege that Dr Ravindran's actions were dishonest as a result.

19. Paragraph four of the Allegation relate to events that occurred between 8 and 10 August 2024. On 8 August 2024, Patient B filled in a medical letter consultation questionnaire on Updoc. In it she indicated that her symptoms started the day before on 7 August 2024. Under the heading 'Main reason for medical letter' she selected 'Anxiety, stress or depression'. In the box below this question, which asks the applicant to describe the timeline and details of her symptoms, Patient B submitted:

"I would really benefit from time off work due to the hot weather and I want to be spending time at the beach".

20. On the same day, at 14:22, the request from Patient B was assigned to Dr Ravindran and, in the usual way, he was sent an email populated with the information provided by Patient B. He was also provided with the proposed draft text of the letter to be issued which stated:

"To Whom It May Concern, I have reviewed [Patient B] medical history with regards to her recent health condition and determined that she is unwell and unfit for work. Consequently, she has been unable to meet her work duties and should be allowed leave from 8 to 22 August 2024 (inclusive). [Patient B] has been advised to update her regular GP for further medical support. I respectfully request that you take her health and medical symptoms into account. Sincerely,"

21. In the standard way, the email provided three links, encircled in the colours outlined above, below the text providing options for Dr Ravindran to select: 'Accept', 'Edit the document before sending' and 'Patient's request falls outside of my scope'. At 14:27, a further email was sent from Updoc to Dr Ravindran which stated, "This request has been accepted" and a letter in the same terms as proposed in the text in the email of 14:22 was created. The letter contained Dr Ravindran's signature and stamp.

22. On 8 August 2024, a newspaper reporter approached Dr Ravindran at his home and questioned him regarding his work with Updoc, including whether he had issued a medical certificate for Patient B. It turned out that Patient B had been an undercover reporter. On 10 August 2024, an article appeared in the Mail on Sunday titled "Exposed: Websites where NHS doctors will sign you off sick for a £25 fee... even if you just fancy a day at the beach." Dr Ravindran was identified specifically in the article as having issued a sick note to an

undercover reporter (Patient B), who requested a sick note on the basis the weather was nice and she wanted to spend time at the beach.

23. Thereafter, Dr Ravindran contacted Updoc by text message stating “regarding this customer [meaning Patient B], I had rejected the request. I am very sure of this. I don’t know how and by whom was this approved. can you please look into this.”

24. On 12 August 2024, Dr Ravindran resigned from Updoc. His resignation was accepted by Updoc on 13 August 2024. On 14 August 2024, Dr Ravindran again asked Updoc to look into what had happened with Patient B. He stated “I had not accepted the referral and had clicked the option ‘falls outside of my scope’ option. Updoc’s help would be hugely appreciated. It will help me immensely.”

25. On 19 August 2024, Updoc responded to Dr Ravindran stating that:
“We have reviewed our records and carried out a thorough audit. We can confirm that you accepted the issuance of a ‘work sick leave’ medical letters on two occasions for [Patient B] between 7 and 9 August (inclusive), including where she stated she wanted time off to go to the beach. Please let us know if you’d like to schedule a call with the Head of the Partner Practitioner Success Team to discuss this further.”

26. On the same day, Dr Ravindran took up Updoc’s invitation to speak with the head of the Partner Practitioner Success Team and asked for a call to be arranged. However, he told the Tribunal that no call was arranged as he had had no response from Updoc and he was provided with legal advice not to contact Updoc any further.

27. The Tribunal received evidence during the course of the hearing that Dr Ravindran had also issued a fit note to Patient B on 7 August 2024. Patient B had stated in her application on the 7 of August that her main reason for the request was “anxiety, stress or depression” and the reason being “I have been suffering with bad stress and anxiety this week and need time off work to help me cope.” She stated in this request that her symptoms had started on 5 August 2024. The request was assigned to Dr Ravindran at 15.03 and accepted by him at 15.30 with a fit note letter generated for Patient B at the same time.

28. In paragraph four of the Allegation, the GMC allege that on 8 August 2024 Dr Ravindran issued a Sickness Leave form for Patient B which stated “I have reviewed [Patient B’s] medical history with regards to her recent health condition and determined that she is unwell and unfit for work. Consequently, she has been unable to meet her work duties...”. The GMC allege that Dr Ravindran did not have sufficient information to confirm this was correct.

29. On 9 September 2024, the concerns in respect of Patient A were raised with the GMC by Mr C, a firearms licensing manager in the Metropolitan Police. On 31 January 2025, Updoc were contacted by the GMC to provide documentation related to medical certificates and documents provided by Dr Ravindran in his treatment of Patient A and Patient B.

The outcome of applications made during the facts stage

30. The Tribunal granted the GMC's application, made pursuant to Rule 34(1) of the Rules, that hearsay evidence in the form of Mr D's witness statement dated 10 April 2026 and exhibits could be admitted into the proceedings. The Tribunal's full decision on the application is included at Annex A.

The Allegation and the doctor's response

31. The Allegation made against Dr Ravindran is as follows:

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

1. On or around 31 May 2024, you completed a 'Firearms Licencing Medical Information Proforma' ('the proforma') for Patient A, and you:
 - a. failed to:
 - i. obtain an adequate medical history in that you did not have access to Patient A's full medical records; **To be determined**
 - ii. verify the medical information provided to you by Patient A. **To be determined**
 - b. crossed 'yes' to the question 'Have you had access to the patient's full medical record to complete this report?' which was untrue; **To be determined**
 - c. crossed 'yes' to the question 'Is the medical record continuous?' which was untrue. **To be determined**
2. When completing the proforma you:
 - a. did not have access to Patient A's full medical records; **To be determined**
 - b. knew you did not have access to Patient A's full medical records. **To be determined**
3. Your actions at paragraphs 1b and 1c were dishonest by reason of paragraph 2. **To be determined**

4. On 8 August 2024, you issued a ‘Medical Letter- Sickness Leave’ form to Patient B which stated “I have reviewed [Patient B’s] medical history with regards to her recent health condition and determined that she is unwell and unfit for work. Consequently she has been unable to meet her work duties...”, when you did not have sufficient information to confirm this was correct. **To be determined**

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

The admitted facts

32. At the outset of these proceedings, through his Counsel, Mr Patrick Cassidy, Dr Ravindran made admissions to paragraphs 1a to 1c, paragraphs 2a to 2b and paragraph 3 of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The facts to be determined

33. In light of Dr Ravindran’s response to the Allegation made against him the Tribunal is required to determine whether Dr Ravindran’s issuing of a ‘Medical Letter – Sickness Leave’ form to Patient B was made when Dr Ravindran did not have sufficient information to confirm the contents were correct. This is paragraph four of the Allegation.

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

- Mr C, firearms licensing manager at the Metropolitan Police dated, 19 February 2026.
- Patient A, dated 10 March 2026.
- Mr D, XXX at Venture Startups Limited (Updoc), dated 10 April 2026

35. Dr Ravindran provided his own witness statement and gave oral evidence at the hearing.

Expert witness statement

36. The Tribunal had regard to an expert report by Dr F, a General Practitioner (“GP”), dated 7 July 2025 submitted and relied on by the GMC. Dr F gave a written expert report

only. Dr F qualified as a GP in 2000 and has held various roles including partnership, a salaried doctor, a retainer and a locum. Dr F has relevant experience in issuing sick certificates known as a “MED3”, firearms applications and various other types of private notes or letters covering insurance claims, legal issues, employment or need for education. Dr F’s expert report provided comment to assist the Tribunal in understanding the accuracy of the procedure taken to issue the medical pro-forma for Patient A and the sickness note for Patient B by Dr Ravindran.

Documentary evidence

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

- GMC complaint form from Mr C
- Pages from Patient A’s medical records relating to correspondence with Police, 4 September 2024
- ‘Firearms Licensing Medical Information Proforma’ completed by Dr Ravindran, 31 May 2024
- A further ‘Firearms Licensing Medical Information Proforma’ completed by Dr H, Patient A’s GP, dated 2 June 2024
- Correspondence between Patient A and Updoc and Dr Ravindran dated between 30 May 2024 and 3 June 2024
- Screenshot of health summary from Patient A sent to Updoc, 30 May 2024
- Correspondence and report received by Patient A from Updoc, 3 June 2024
- Medical letter issued by Dr Ravindran to Patient B, 8 August 2024

The Tribunal’s approach

38. The Tribunal received written and oral submissions from both parties at the conclusion of the facts stage.

The Tribunal accepted the Legally Qualified Chair’s advice.

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

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

41. The Tribunal was mindful of paragraphs one to four of Good Medical Practice Guidance that was referred to by Ms Jade Bucklow, Counsel for the GMC and considered it to serve as a reminder that Dr Ravindran was under the duty of being competent when he was undertaking his role as a doctor registered with the General Medical Council.

42. The Tribunal was mindful of the principle set out in the case of *Byrne v General Medical Council* [2021] EWHC 2237 (Admin), specifically in regards of the careful analysis of evidence that is required in a serious Allegation whilst taking into account the inherent probability or improbability of an event happening.

43. The Tribunal was also mindful of the principle established in *O v Secretary of State for Education* [2014] EWHC 22 (Admin), that the seriousness of an Allegation does not, of itself, require more cogent evidence before it can be established and that the seriousness of the Allegation does not alter the applicable standard of proof.

44. The Tribunal considered that a feature of this case was to assess the credibility of Dr Ravindran, given that he has provided evidence, in order to determine which version of events is to be preferred over the other. However, the Tribunal was mindful that there was no burden on the doctor to prove or disprove anything.

45. The Tribunal also took account of the Guidance for MPTS Tribunals published on 30 September 2025 and effective from the 24 November 2025, particularly Part A of Section 3.

46. Furthermore, the Tribunal reminded itself of the principles laid down in the leading case of *R (Dutta) v General Medical Council* [2020] EWHC 1974, in that it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth. The best approach was nonetheless to base factual findings on inferences drawn from documentary evidence and known or probable facts.

47. The Tribunal was mindful that its task at this stage is to consider the evidence and submissions and make findings in relation to the factual Allegation in dispute.

48. Moreover, The Tribunal reminded itself of paragraphs 18 to 24 of the MPTS Guidance regarding hearsay evidence and re-stated that in considering the admitted hearsay evidence of Mr D, the Tribunal would need to adopt a careful balancing exercise when considering the impact and weight attached to his evidence, especially when it is considered to be a key evidence for a particular Allegation.

Bad Character Application

49. The parties made submissions as to whether the Tribunal should consider paragraphs one to three of the Allegation, that had already been admitted and found proved, to demonstrate a propensity to commit the conduct alleged at paragraph four of the Allegation.

50. Ms Bucklow submitted that the parties should take account of paragraphs one to three of the Allegation when considering the propensity of Dr Ravindran to commit the conduct alleged in paragraph four. She submitted that the evidence showed an irresponsible pattern of behaviour on behalf of Dr Ravindran in issuing medical letters or proformas while paying insufficient attention to the documents he was authorising or signing as correct. Mr Cassidy submitted that paragraphs one to three were different in nature, extent and in terms of the legal test for the GMC to prove. He stated that there was a significant difference between paragraphs one to three compared to paragraph four of the Allegation particularly as the Tribunal were not required to consider dishonesty in relation to paragraph four. He urged the Tribunal not to take account of the admitted behaviour in paragraphs one to three as part of its decision-making in relation to paragraph four.

51. The Tribunal accepted the Legally Qualified Chair's advice. The Tribunal was advised of the case of *Craig v Farriers' Registration Council* [2017] EWHC 707 (Admin) which affirmed that regulatory tribunals could consider relevant previous conduct of a similar nature when considering whether the registrant was of good character in relation to issues of credibility and propensity.

52. The Tribunal considered whether the conduct admitted and found proved in paragraphs one to three of the Allegation was similar in nature and extent to the conduct alleged in paragraph four of the Allegation and if so, whether in its turn it shows propensity.

53. In determining the issues of bad character and propensity, the Tribunal considered whether the conduct established in paragraphs one to three was sufficiently similar to the

allegation in paragraph four to demonstrate a relevant propensity. The Tribunal considered that the conduct alleged was of a similar nature. Dr Ravindran worked for same organisation namely Updoc, which used the same system, when he considered the requests from Patient A and Patient B. The conduct happened close in time to each other (one at the end of May 2024, the other at the start of August 2024). In both instances, Dr Ravindran was carrying out the same role, namely completing a request for a medical certificate, though the Tribunal acknowledged that the content of the request was different. The Tribunal did not consider this to be a sufficient distinguishing factor that prevented the Tribunal from properly coming to a conclusion that the conduct was relevant to propensity. In both instances, Dr Ravindran failed to consider carefully whether he had sufficient information before providing a response to the request.

54. The Tribunal acknowledged Mr Cassidy’s argument that distinguished the different paragraphs of the Allegation from a legal perspective in that the Tribunal did not need to find dishonesty proved in relation to paragraph four. However, the Tribunal still found the conduct of Dr Ravindran to be of a similar nature despite the differences in the legal issues. The Tribunal considered that it was the factual nature of the conduct which was the important issue to determine propensity not whether the legal definition of dishonesty had been met.

55. The Tribunal for that reason determined that the fact that Dr Ravindran had admitted to the conduct in paragraphs one to three of the Allegation could be considered when considering whether Dr Ravindran had the propensity to commit the conduct alleged in paragraph four.

The Tribunal’s analysis of the evidence and findings

Paragraph 4 of the Allegation

56. The Tribunal considered the evidence in respect of paragraph four of the Allegation.

57. The Tribunal considered paragraph four of the Allegation to have two limbs to be assessed in turn. The first limb is whether Dr Ravindran had issued a ‘Medical Letter – Sickness Leave’ form to Patient B on 8 August 2024. The second limb is whether Dr Ravindran had sufficient information to issue the fit note.

58. It was accepted by Dr Ravindran that on 8 August 2024, he did not have sufficient information to issue a letter as he did not have sufficient information that indicated a medical illness or health-related condition. As such, Dr Ravindran stated that “the request was

unreasonable and not consistent with the usual purpose or criteria for sick leave.” The Tribunal agreed with Dr Ravindran’s characterisation of the request and found that he did not have sufficient information to issue the fit note. The Tribunal also accepted and found that the fit note had been issued in Dr Ravindran’s name given that they had received a copy of the letter signed and stamped with Dr Ravindran’s signature and details. The second limb of paragraph four was found proved.

59. Therefore the crux of the dispute lay in respect of the first limb, whether Dr Ravindran had clicked the link to accept the request.

60. The Tribunal received and heard evidence from Dr Ravindran that he believed he did not accept the request because he realised that it was inappropriate, and he recalled on 8 August that he had already accepted a request for Patient B on the day before. In his statement, Dr Ravindran stated “I am still not sure how the request was accepted. The above three options lie close together and probably I might have clicked the accept option by mistake. My real intention was not to accept the request.” The Tribunal further heard evidence from Dr Ravindran that he had not intended to accept the request because he recalled at the time that he had issued a fit note for the same patient the day before.

61. The Tribunal considered the documentation before it that demonstrated that the request had been accepted, as indicated by an email from Updoc to Dr Ravindran at 14:27. The Tribunal also considered that Updoc had been asked to look into the matter and had confirmed after a review of their records and a thorough audit, that the request had been accepted.

62. On a plain reading of paragraph four of the Allegation, the Tribunal found that the allegation was proved because it was only asked to find whether Dr Ravindran had issued a letter. There was no evidence to indicate that it was anyone other than Dr Ravindran who had accepted the request and issued the letter through Updoc.

63. However, the further question for the Tribunal to determine, because of the matters raised by Dr Ravindran in his defence, was whether he intended to or whether he accidentally clicked to accept the request.

64. In considering whether it was accidental, the Tribunal rejected Mr Cassidy’s argument that the interface of Patient B’s request as it appeared in the Tribunal’s bundle was significantly different to how it would have appeared on Dr Ravindran’s phone such that the request could have been accepted accidentally. The Tribunal considered that although the interface could have appeared smaller on a phone screen, the links that permit the doctor to

accept or reject requests were widely separated and colour coded. The Tribunal considered that it was less likely that Dr Ravindran's finger slipped between the buttons.

65. Furthermore, the Tribunal heard and accepted evidence that Dr Ravindran was experienced in using the Updoc system on both his phone and computer. By the time Dr Ravindran came to consider the request for Patient B, he had been using the Updoc systems for 11 months. His evidence was that he had issued two to three medical letters per day though not all of the same nature. His evidence was that he issued medical letters for stress, anxiety or depression about two to three times per week. The Tribunal were satisfied that Dr Ravindran was experienced in using Updoc's systems by 8 August 2024. Furthermore, the Tribunal considered that there was a duty on Dr Ravindran to ensure that he used the system competently.

66. The Tribunal considered and took account of the fact that there appeared to be a lack of training when enrolling doctors to work for Updoc. The Tribunal also noted and was disappointed by the lack of assistance from Updoc in assisting Dr Ravindran after the issue with Patient B was reported in the Mail on Sunday, and in not sufficiently engaging with the Tribunal in these proceedings (as explained in Annex A). It was considered by the Tribunal that Updoc did not engage in the proceedings and instead chose to protect its own commercial interests.

67. However, despite the lack of assistance from Updoc, and the limited training that appeared to have been provided to Dr Ravindran, the Tribunal found that he was competent and experienced in using the Updoc system. There was no evidence that he had complained about a lack of training or that he had accidentally committed such an error before. Further the Tribunal noted that any training he would have been given would have been limited to the use of the Updoc platform and not on how to exercise his professional clinical decision making. The Tribunal considered that Dr Ravindran had been using the system on a daily basis for over 11 months by the time he came to accept Patient B's request. The Tribunal rejected the explanation that he clicked the link accidentally or that there "was a glitch in the system", as Dr Ravindran had described.

68. The Tribunal considered whether Dr Ravindran had not intended to accept the request because he recalled, on 8 August 2024, having issued a fit note to Patient B the day before. The Tribunal did not accept Dr Ravindran's explanation. The Tribunal noted that there was a lack of any contemporaneous evidence that provided this explanation as to why he did not intend to accept the request on 8 August.

69. The Tribunal had seen text messages and emails exchanged between Dr Ravindran and Updoc immediately after the Mail on Sunday article was published and nowhere in those messages did Dr Ravindran explain this was the reason he did not intend to accept the request. The Tribunal also saw an appraisal form completed on 11 December 2024 and approved by Dr Ravindran on 15 December 2024, in which he met with a consultant from his Trust and in which he explained the circumstances of what had happened with Patient B. He did not explain in that meeting, as detailed in the document, that he had already issued a fit note on 7 August 2024 for the same patient. Further, the Tribunal saw Dr Ravindran's response to the GMC dated 27 January 2025 when they first notified him of the Allegation. In that response, there was no mention of the 7 August 2024 request. The first time Dr Ravindran had raised this as part of his defence was in his written statement to the MPTS for the hearing, submitted on 1 September 2026.

70. The Tribunal also considered that Dr Ravindran failed to explore the mistake that he suspected happened and failed to check his emails to make sure that the alleged "glitch in the system" did not affect other patients. The Tribunal had regard to the fact that Dr Ravindran had dealt with requests that were similar in nature to that in paragraph four of the Allegation but he did not need to be an expert in stress, anxiety and depression to request further information and complete these forms.

71. The Tribunal heard oral evidence from Dr Ravindran and acknowledged that he had tried to offer his assistance to the Tribunal in providing a detailed account despite him having no burden to prove or disprove anything. The Tribunal further acknowledged that Dr Ravindran had no previous complaints against him. The Tribunal considered that, on the balance of probabilities, Dr Ravindran's explanation that he did not intend to accept the request of Patient B on 8 August 2024 because he had already accepted a request and issued a fit note for her the day before was rejected by the Tribunal. It was not supported by any contemporaneous evidence.

72. Further, the Tribunal considered that, given his admitted conduct at paragraphs one to three of the Allegation that Dr Ravindran had a propensity to accept requests and complete forms without checking that he had the sufficient information to complete them, and that he had acted carelessly in the past. The Tribunal considered that the conduct proved at paragraph four demonstrated that Dr Ravindran had been careless and irresponsible in his duties as a doctor, as expressed at paragraphs one to four of Good Medical Practice 2024.

73. The Tribunal determined that Dr Ravindran had some financial motivation in completing fit notes. It also determined that he was under some pressure from patients and

Updoc to give quick turnarounds for requests. Dr Ravindran also told the Tribunal that he felt constrained in requesting further information from Updoc patients, because their requests often had some urgency. The Tribunal did not accept this, given that obtaining sufficient information was part of his duties as a doctor.

74. The Tribunal also acknowledged that Dr Ravindran wished to help and care for patients. But, in this instance, the Tribunal considered that he had become complacent in his checking and completion of medical letters for Updoc.

75. The Tribunal determined that Dr Ravindran accepted patient B's request carelessly and in doing so he failed to meet the standard of care required from him as doctor. However, it acknowledged that he did not intend to cause anyone harm in doing so.

76. The Tribunal has therefore determined and found paragraph four of the Allegation proved.

The Tribunal's overall determination on the facts

77. The Tribunal has determined the facts as follows:

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

1. On or around 31 May 2024, you completed a 'Firearms Licencing Medical Information Proforma' ('the proforma') for Patient A, and you:
 - a. failed to:
 - i. obtain an adequate medical history in that you did not have access to Patient A's full medical records; **Admitted and found proved**
 - ii. verify the medical information provided to you by Patient A. **Admitted and found proved**
 - b. crossed 'yes' to the question 'Have you had access to the patient's full medical record to complete this report?' which was untrue; **Admitted and found proved**
 - c. crossed 'yes' to the question 'Is the medical record continuous?' which was untrue. **Admitted and found proved**
2. When completing the proforma you:
 - a. did not have access to Patient A's full medical records; **Admitted and found proved**

- b. knew you did not have access to Patient A's full medical records. **Admitted and found proved**
3. Your actions at paragraphs 1b and 1c were dishonest by reason of paragraph 2. **Admitted and found proved**
4. On 8 August 2024, you issued a 'Medical Letter- Sickness Leave' form to Patient B which stated "I have reviewed [Patient B's] medical history with regards to her recent health condition and determined that she is unwell and unfit for work. Consequently she has been unable to meet her work duties...", when you did not have sufficient information to confirm this was correct. **Determined and found proved.**

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

Determination on Impairment – 21/09/2026

78. This determination was handed down in public.

The evidence

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

80. In addition to the witness statement that Dr Ravindran had provided at stage one, he also provided a Reflection and Insight statement dated 17 September 2026.

81. The Tribunal considered the testimonials it had received in support of Dr Ravindran from colleagues and employers, which it had received at stage one. The Tribunal acknowledged that testimonials relating to character or good standing in the community have limited relevance at this stage of the proceedings.

82. The Tribunal also had regard to the expert report of Dr F that was dated 7 July 2025.

83. The Tribunal received additional evidence on behalf of Dr Ravindran, namely:

- A Certificate of Continuing Professional Development (CPD) titled 'Professionalism & Boundaries in Use of Social Media' dated 14 September 2025.

- A Certificate of CPD titled 'Module on Insight' dated 10 September 2025.
- A Certificate of CPD titled 'Probity for Healthcare Professionals' dated 7 September 2025.
- A Certificate of CPD titled 'Module on Remediation' dated 12 September 2025.
- A Certificate of CPD titled 'How to Ensure a similar Mistake or Misconduct will not be repeated in Future' dated 27 September 2025.
- A Certificate of CPD titled 'Ethics and Ethical Standards for Doctors' dated 13 September 2025.
- Patient Feedback Survey dated 18 November 2024.
- Colleague Feedback Survey dated 18 November 2024.

Submissions

GMC submissions

84. On behalf of the GMC Ms Bucklow submitted that the Allegations found proved by Dr Ravindran's admission and through the Tribunal's findings amount to serious misconduct and engage all three limbs of the overarching objective as set out in section 1(a) of the Medical Act 1983.

85. Ms Bucklow referred to the MPTS Guidance (MPT Hearings > Part B: Stage two - Impairment > Steps 2(a) to (e)) throughout her submissions.

86. Ms Bucklow first referred to section 2a of the MPTS Guidance, which requires the Tribunal to consider whether the facts that have been found proven engage one or more of the grounds of impairment. Ms Bucklow submitted that the Tribunal must be satisfied that there is a legal basis for considering whether a doctor's fitness to practise is impaired. Ms Bucklow submitted that Dr Ravindran is impaired by reason of his misconduct.

87. Ms Bucklow submitted that misconduct is a matter of judgement for the Tribunal rather than a matter of proof. She referred to *Roylance v General Medical Council (GMC) (No.2) [2000] 1 AC 311* to assist the Tribunal in identifying the essential elements of misconduct.

88. Ms Bucklow referred to paragraphs 81, 89(a) and 89(b) of *Good Medical Practice* within her submissions as relevant in Dr Ravindran's case:

'81 You must make sure that your conduct justifies patients' trust in you and the public's trust in your profession.'

‘89 You must make sure any information you communicate as a medical professional is accurate, not false or misleading. This means:

a you must take reasonable steps to check the information is accurate.

b you must not deliberately leave out relevant information.’

89. Ms Bucklow submitted that the seriousness of the facts found proven in this case is a relevant consideration for both the Tribunal’s assessment of misconduct and impairment. Ms Bucklow submitted the facts found proven by the Tribunal do represent a pattern of behaviour by Dr Ravindran in his capacity as a doctor, which falls so far short of the standards of conduct reasonably expected as to amount to serious misconduct.

90. Turning to section 2b of the MPTS Guidance for the issue of where on the spectrum of seriousness the Allegation lies, Ms Bucklow submitted that Dr Ravindran’s conduct falls at the higher end of the spectrum of seriousness. Ms Bucklow submitted that the Allegation includes admitted and proven dishonesty, which has occurred within Dr Ravindran’s professional role as a doctor rather than outside of his professional practice.

91. Ms Bucklow sought to remind the Tribunal that relevant case law relating to dishonesty has consistently found that it lies at the top end of the spectrum of misconduct for a medical professional, because of the impact it has on public confidence. Ms Bucklow referred to the case of *Khan v GMC [2015]* where a finding of dishonesty was recognised as lying at the top end of the spectrum of misconduct.

92. Ms Bucklow submitted that paragraphs one to three of the Allegation concern dishonesty. Ms Bucklow suggested the nature of the dishonesty is particularly serious because the risks posed to both the patients and the wider public were significant. Ms Bucklow submitted the risk was that a firearms licence may have been issued erroneously to somebody unfit to hold unsupervised access and the risk also extended to the individual patient in terms of self-harm with a firearm, or the wider public in terms of acts of violence. Ms Bucklow referred to the statement of Mr C and Dr F’s expert report to assist the Tribunal in contextualising the seriousness of the misconduct.

93. Ms Bucklow submitted the admitted conduct in paragraphs one to three significantly undermines public confidence in the profession due to the inherent risk that both the patient and members of the public were placed at as a result of Dr Ravindran’s dishonesty, complacency, and recklessness.

94. Ms Bucklow submitted it was ‘simply fortuitous’ that the Police became aware the firearms certificate was misleading, which only occurred because Patient A had also sought the same information from her GP around the same time. Ms Bucklow submitted there was a very real risk that this matter would never have come to the Police’s attention, or come at a significantly delayed point, and a firearms certificate would have been issued where otherwise it would have been declined. Ms Bucklow submitted this reflects the general risk of signing off a firearms certificate with false and inadequate information.

95. Turning to paragraph four, Ms Bucklow submitted that, whilst the risks to the patient were less significant than in paragraphs one to three, they are still present. Ms Bucklow submitted a proper assessment for Patient B was not carried out and suggested that in some cases removing workplace structure and social interaction from those with anxiety and depression can exacerbate their symptoms, meaning signing a patient off for work may not be in their best interests.

96. Ms Bucklow submitted that public confidence in the profession would be undermined by the circumstances in which Dr Ravindran’s issued Patient B a fit note.

97. Ms Bucklow referred to paragraph 36 of the MPTS Guidance for features that may increase seriousness. She submitted there is a degree of repetition in Dr Ravindran’s case. Ms Bucklow also submitted in respect of Patient A there was a reckless disregard for patient safety and professional standards.

98. Ms Bucklow submitted that Dr Ravindran must have or ought to have known that it was dishonest to sign medical paperwork related to Patient A’s firearms application. He did not check there were any relevant medical conditions and signed to the effect he had checked Patient A’s medical record. This posed a material and serious risk for both the patient and wider public.

99. Turning to step 2c of the MPTS Guidance relating to any relevant context and its potential impact, Ms Bucklow submitted that Dr Ravindran had placed emphasis on the fact the allegations occurred whilst working for Updoc, where he had not been provided appropriate training and there was a pressure to turn requests around quickly. Ms Bucklow submitted that this does not provide the mitigation Dr Ravindran has at times inferred that it does.

100. Ms Bucklow submitted that the lack of training and experience of issuing sick notes, particularly for anxiety and depression, is a ‘red herring’ as none of the allegations or conduct

found proved arose from lack of training or familiarity with the types of medical documents Dr Ravindran was signing.

101. Ms Bucklow suggested to the Tribunal that the questions posed in the firearms certificate for Patient A does not require training for Dr Ravindran to have understood the questions or answer them truthfully. Ms Bucklow reminded the Tribunal of their findings at the facts stage that Dr Ravindran's claim that he lacked experience in the Updoc software had been rejected and that Dr Ravindran was experienced in the Updoc software at the time of issuing the fit note for Patient B.

102. Ms Bucklow submitted Dr Ravindran had taken on work with Updoc voluntarily for additional private income and was not being pressured by anyone to undertake the work. Ms Bucklow submitted that Dr Ravindran has highlighted a degree of time pressure from Updoc which the Tribunal had accepted at the facts stage. However Ms Bucklow submitted Dr Ravindran had a choice whether to accept a request at all and that the only consequence if Dr Ravindran missed a request or had it reallocated was that he would not be paid for dealing with that request.

103. Turning to step 2d of the MPTS Guidance relating to Dr Ravindran's response to the Allegation, Ms Bucklow submitted that Dr Ravindran admitted paragraphs one to three at a later stage of the investigation and proceedings. Ms Bucklow acknowledged in her submissions that Dr Ravindran had stated he had come to recognise the grave consequences of his decision and that if the individual had a relevant mental or physical condition which was not identified, this could have potentially endangered Patient A and members of the public. Dr Ravindran did also acknowledge at stage one that his conduct would undermine public confidence in the profession.

104. Ms Bucklow submitted however that when considering insight and remediation, the timing of Dr Ravindran's statements and any stage at which an apology was offered should be considered by the Tribunal. Ms Bucklow submitted that the emphasis on lack of experience and training in Dr Ravindran's statements represents a lack of insight. Ms Bucklow suggested that the issuing of a sick note could not be reasonably attributed to either a lack of training or experience. Ms Bucklow submitted that as Dr Ravindran's own evidence states he recognised issuing a fit note to Patient B was inappropriate and had been declined, it is not the case that lacking sufficient knowledge or experience played a role in this incident.

105. Ms Bucklow submitted Dr Ravindran did have a clear understanding of how to use the technology and that Dr Ravindran was seeking to deflect responsibility due to his complacency and not exercising due diligence or complying with the requirements of GMP.

Ms Bucklow submitted that Dr Ravindran resigned from Updoc at the time of these incidents and seemingly sought to separate from Updoc as soon as possible. Ms Bucklow submitted Dr Ravindran's subsequent admissions and any associated insight have come very late in the investigation or after the Tribunal's findings.

106. Ms Bucklow submitted paragraph 92 of the MPTS Guidance is relevant in this case:

'92. In many cases, evidence of complete or well-developed insight will have the impact of decreasing the level of current and ongoing risk to one or more of the three parts of public protection posed by the doctor. However, where the allegation falls at the higher end of the spectrum of seriousness and therefore the starting point for assessing current and ongoing risk to public protection is high, the impact of insight and remediation and the weight it carries may be less because the risk to public protection arising from these concerns is generally more difficult to address.'

107. Turning to remediation, Ms Bucklow submitted Dr Ravindran has completed relevant online courses but the Tribunal should consider whether there is evidence that learning has been embedded and put into practice since those courses were undertaken. On Dr Ravindran's reflective statement, Ms Bucklow submitted that whilst it is clear he accepts his actions were wrong and why they were wrong, he does not appear to have reflected to a great extent about why he acted the way that he did and why he chose to sign a form dishonestly.

108. Ms Bucklow submitted there is a lack of depth to Dr Ravindran's introspection as to why he behaved in the way he did for financial gain. Ms Bucklow submitted there is no evidence of underlying financial strain for Dr Ravindran. Ms Bucklow submitted Dr Ravindran's statement does not explore why financial gain would cause him to take such a risk despite the low financial remuneration, which is outweighed by the significant risk to the public.

109. Ms Bucklow referred to paragraphs 107 – 109 of the MPTS Guidance as relevant to the Tribunal in this case:

'107. The following should be considered when assessing the impact of remediation:

- is the allegation easily remediable?*
- has the allegation been remedied or is it being remedied?*
- is the allegation highly unlikely to be repeated?*

108. *Allegations about poor performance, the impact of a health condition or insufficient knowledge of the English language are generally more easily remediable than others.*

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

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

110. Ms Bucklow submitted that in this case Dr Ravindran was reckless and the nature or the circumstances suggest there is an underlying issue with Dr Ravindran's attitude. Ms Bucklow submitted that dishonesty is ultimately a behavioural and attitudinal concern. Where the Allegation falls at the higher end of the spectrum of seriousness it is known that in these types of cases that the behaviour is more difficult to remediate.

111. Turning to step 2e of the MPTS Guidance relating to an assessment of current and ongoing risk to public protection to decide if a doctor's fitness to practise is impaired, Ms Bucklow referred to relevant case law on impairment *Cohen v General Medical Council [2008] EWHC 581 (Admin)* ("*Cohen*") and the principles derived from Dame Janet Smith's fifth Shipman report, subsequently endorsed in *CHRE v NMC and Grant [2011] EWHC 927 (Admin)* ("*Grant*"). Ms Bucklow noted these principles are distilled into the MPTS Guidance and suggested paragraph 134 is of assistance to the Tribunal:

'134. In cases where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current and ongoing risk to public protection will be high. Evidence of relevant context that decreases risk and evidence of insight and remediation that decreases risk may have less impact and carry less weight because these types of allegations can be more difficult to remediate. Evidence of the doctor having kept their knowledge and skills up to date may also be less relevant. This should be considered by the MPT when they are reaching a view on risk and a conclusion that the doctor poses a current and ongoing risk to one or more of the three parts of public protection requiring restrictive action in response may be needed, particularly as the allegation is likely to engage public confidence.'

112. Ms Bucklow submitted that probity concerns are difficult to remediate, though not impossible. Ms Bucklow submitted that case law has established that evidence of good

clinical practice or expertise does not necessarily assist when dealing with breaches of fundamental tenets of the profession such as probity.

113. Ms Bucklow concluded by submitting that this case falls at the higher end of the spectrum of seriousness and the starting point for assessing current and ongoing risk is high due to dishonesty and its type. Ms Bucklow submitted Dr Ravindran's conduct put patient safety directly at risk for both Patient A and Patient B.

114. Ms Bucklow submitted public confidence would be significantly undermined if no finding of impairment were made. Ms Bucklow submitted Dr Ravindran had acted dishonestly and carried out reckless conduct which has brought the profession into disrepute.

115. Ms Bucklow submitted a finding of impairment is also necessary to maintain proper professional standards and send a signal to the wider profession that conduct of this nature will result in a finding of impairment and robust regulatory action.

116. Ms Bucklow submitted that concerns in this case are not easily remediable because of their nature and seriousness, but even if the Tribunal find Dr Ravindran has remediated sufficiently to no longer pose a risk of harm to a patient or public safety, it is still the type of case where remediation is not going to meaningfully address the public confidence issues that are engaged. Ms Bucklow submitted for these reasons Dr Ravindran's fitness to practise is impaired.

Dr Ravindran's submissions

117. On behalf of Dr Ravindran Mr Cassidy submitted Dr Ravindran does not dispute that his fitness to practise is impaired. He submitted that the Tribunal should contextualise the wrongdoing. He submitted that the sanctions issues can be dealt with in a way which allows for Dr Ravindran's continued registration albeit with a temporary penalty.

118. Mr Cassidy submitted that there is no disagreement with the purposes set out by the GMC for which the Tribunal have to make a decision in relation to impairment and that the Tribunal's task is to assess the situation. Mr Cassidy submitted that the Tribunal will have regard to all of the materials submitted which reflect upon questions that the Tribunal have to answer at this stage. Mr Cassidy submitted that the Tribunal should have regard to the patient feedback and reflective document that has gone before it and other materials that impact upon Dr Ravindran's perception of his wrongdoing. Mr Cassidy submitted that at the sanction stage, he hopes to revisit the wrongdoing and call Dr Ravindran in relation to sanction to deal with additional matters that are relevant to sanction alone.

The relevant legal principles

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

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

121. To assess whether Dr Ravindran poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal will consider:

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

122. The Tribunal will consider the MPTS Guidance and particularly the guidance in respect of Case Type Two: Dishonesty from the Introduction to the MPTS Guidance which applies in Dr Ravindran's case given the findings in relation to paragraph three of the Allegation. The Tribunal will also have regard to paragraph 11 of the MPTS Guidance that sets out the definition for misconduct that reflects the current case law. The Tribunal will also consider the applicable version of *Good Medical Practice* which came into effect 30 January 2024.

123. The Tribunal will consider the test as set out in *Roylance* relating to misconduct. The Tribunal will also consider the case of *Nandi v General Medical Council [2004] EWHC 2317 (Admin)* where it was stated that the adjective 'serious' must be given its proper weight and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.

124. Once the Tribunal has determined that there has been a finding of misconduct, the Tribunal must consider whether Dr Ravindran’s fitness to practise is currently impaired by reason of that misconduct. The Tribunal will refer to the five-step process for determining impairment set out in the MPTS Guidance to assist in this determination.

125. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report as adapted in the cases of *Cohen* and *Grant*. The Tribunal noted that Mrs Justice Cox in *Grant* at [71] stated that it was essential not to lose sight of the following fundamental considerations set out by Mr Justice Silber in *Cohen* at [62]:

“Any approach to the issue of whether a doctor’s fitness to practice should be regarded as “impaired” must take account of “the need to protect the individual patient, and the collective need to maintain confidence profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the [profession]”.

126. In so doing, the Tribunal will take account of the following guidance set out by Dame Janet Smith in the Fifth Shipman report as adopted by Mrs Justice Cox in *Grant*:

*‘...the tribunal should consider whether the findings of fact in respect of the doctor.
... show that his fitness to practise is impaired in the sense that he:*

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

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

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

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

127. The Tribunal note that their findings in relation to dishonesty only relate to the misconduct that has been found proved in relation to paragraphs one to three of the Allegation. The Tribunal had regard to the case of *Ahmedsowida v GMC [2021] EWHC 3466 (Admin)* at [114-125] when considering its findings in relation to dishonesty at the impairment stage.

The Tribunal's determination on impairment

Step 2A: legal basis for considering impairment - Misconduct

128. Fitness to practise must relate to one of the grounds of impairment set out in s35C(2) Medical Act 1983. The Tribunal was satisfied based on its determination of the facts that in this matter the relevant ground is misconduct.

129. At all times, the Tribunal had regard to the Introduction section and Part B of Section Three of the MPTS Guidance.

130. The Tribunal had regard to the following paragraphs of GMP 2024:

4 You must follow the law, our guidance on professional standards, and other regulations relevant to your work.

6 You must provide a good standard of practice and care. If you assess, diagnose, or treat patients, you must work in partnership with them to assess their needs and priorities. The investigation or treatment you propose, provide, or arrange must be based on this assessment, and on your clinical judgement about the likely effectiveness of the treatment options.

7 In providing clinical care you must:

a adequately assess a patient's condition(s), taking account of their history, including:

- i. symptoms*
- ii. relevant psychological, spiritual, social, economic, and cultural factors*
- iii. the patient's views, needs, and values.*

....

c promptly provide (or arrange) suitable advice, investigation or treatment where necessary

....

e propose, provide or prescribe effective treatment based on the best available evidence

....

14 You must make good use of the resources available to you, and provide the best service possible, taking account of your responsibilities to patients and the wider population.

69 You must make sure that formal records of your work (including patients' records) are clear, accurate, contemporaneous and legible.

81 You must make sure that your conduct justifies patients' trust in you and the public's trust in your profession.

89 You must make sure any information you communicate as a medical professional is accurate, not false or misleading. This means:

a you must take reasonable steps to check the information is accurate.

b you must not deliberately leave out relevant information

c you must not minimise or trivialise risks of harm

d you must not present opinion as established fact.

Paragraphs 1a, 1b, 1c, 2a, 2b, and 3 - Patient A

131. The Tribunal acknowledged that Dr Ravindran had admitted, and it had found proved, paragraphs one to three of the Allegation in respect of Patient A.

132. The Tribunal considered that paragraphs 4, 81 and 89 of GMP were relevant to paragraphs one to three of the Allegation.

133. The Tribunal acknowledged that the ultimate decision to produce a firearm licence to Patient A was for the Police but the Tribunal considered that the proforma was an important document. It was mandatory that it be completed by a doctor in support of an applicant's application for a licence. It was requested and relied upon by the Police to assist them in determining whether a firearms licence should be renewed. The Tribunal reminded itself of the explanation provided in Mr C's statement of the importance of accurate reporting by medical doctors in proformas that supported applications for renewals of firearms licences. His statement said that:

"An accurate oversight of an applicant's medical history is essential in an assessment as to whether a person can be permitted to possess a lethal barrelled weapon

unsupervised without giving rise to a danger to public safety or the peace. This is recognised in firearms licencing guidance and law as a key area of suitability and is why the provision of medical questionnaires is now mandatory, whether there is suspicion of a relevant condition or not. Inaccurate, false or rushed provision of these assessments can lead to significant medical history being missed, which has in other cases contributed to fatalities involving lawfully held firearms.”

134. Regarding the proforma completed by Dr Ravindran, the Tribunal recognised that Dr Ravindran had not received any training or been aware of the statutory guidance in completing a firearms renewal application before he was asked to undertake the request on 30 May 2024 for Patient A. However, the Tribunal considered that Dr Ravindran had sufficient information on the form itself, as well as access to the statutory guidance, which would have aided him in completing the form. On his own admission, Dr Ravindran failed to carefully read the form and failed to have regard to the statutory guidance despite the onus being on him to do so. The Tribunal considered that given Dr Ravindran had not completed a firearms licensing proforma before, it was even more important that he carefully read and checked all of the information available to him, and he failed to do so.

135. The Tribunal accepted the evidence it had seen that Dr Ravindran had attempted on a number of occasions to request medical information from Patient A by email but that his request that she provided a “health summary” from her GP was insufficient to meet the requirements set out on the form. As per the guidance, it was also incorrect for Dr Ravindran to obtain the records from the patient, and they should have been obtained from her GP. The Tribunal accepted that Dr Ravindran had come under some pressure from the patient who stated she wanted the request urgently. The Tribunal accepted Dr Ravindran’s evidence that he had succumbed to the pressure from the patient in an effort to assist her.

136. The Tribunal also took account of the fact that Dr Ravindran had been placed in a difficult position by Updoc to approve a firearms licensing application on a quick turn-around basis when he was not given sufficient information to do so.

137. Nonetheless, the Tribunal considered that once Dr Ravindran had accepted the request, he was required to act according to his duties as set out in Good Medical Practice and in accordance with the requirements of the form. If he was not able to do so, then he should have rejected the request rather than dishonestly complete a form without sufficient information.

138. The Tribunal acknowledged that it may be difficult for any doctor completing the proforma to have access to a complete version of the GP medical records of a patient (for

example due to patients moving GP practices, the historical age of GP records, the documentation of records sometimes being historically poor and the fact that some patients access private treatment which may not be communicated to a GP). However, it considered that the three screenshots from Patient A's NHS app on which Dr Ravindran relied fell well below the standard expected in respect of completing the proforma. Further, the Tribunal determined that sufficient information was available to complete the proforma as was demonstrated by the fact that Dr H had been able to accurately record the historic relevant medical condition. The Tribunal accepted Dr F's opinion that the information would have been available to Dr Ravindran had he requested it.

139. In respect of paragraphs one and two of the Allegation the Tribunal considered that Dr Ravindran performed work within his competence. However, in completing the form without obtaining sufficient information, he had acted carelessly and recklessly. Dr Ravindran had accepted that he had not read the information on the form properly or referred to the statutory guidance. The Tribunal considered that his actions in this request fell far below the standards expected of a doctor and what was proper in the circumstances.

140. In respect of paragraph three of the Allegation in which it had been found proven that Dr Ravindran had acted dishonestly, the Tribunal considered that he had acted contrary to the standards expected in GMP. To act in such a way meant that he did not alert the Police to relevant mental health conditions previously suffered by Patient A. The Tribunal had regard to the fact that once the Police were aware of Patient A's previous medical conditions (by means of the proforma completed by Dr H), her Firearms Licence had in fact been refused by the Police. The Tribunal considered that Dr Ravindran's actions in being dishonest to the Police put Patient A and public safety at risk. The Tribunal determined that Dr Ravindran's dishonesty could have hindered the Police's ability to assess the risk to Patient A and the public of her possessing a firearm. The Tribunal were also concerned by the fact that his dishonesty was motivated by financial gain. The Tribunal considered that this conduct fell far short of the standards expected of a doctor and what was considered proper in the circumstances.

141. The Tribunal considered Dr Ravindran's actions to have diminished public confidence in the profession and the importance of maintaining professional standards.

142. The Tribunal, therefore, considered Dr Ravindran's actions to have a legal basis for findings of impairment namely misconduct.

Paragraph 4 – Patient B

143. The Tribunal considered that paragraphs 4, 6, 7, 14, 69, 81 and 89 of GMP were relevant to paragraph four of the Allegation.

144. The Tribunal acknowledged that doctors do produce fit notes on the basis of written information alone as outlined by Dr F in her report. The Tribunal considered the request in question that Dr Ravindran had received from Patient B. It considered that the information provided on the request was insufficient. Patient B's explanation in that she wanted to "*go to the beach*" was clearly not enough reason for Dr Ravindran to have accepted to give her a fit note.

145. The Tribunal took account of Dr F's evidence that issuing a fit note based on the information that had been provided by Patient B was not the standard expected of a doctor. The Tribunal accepted this evidence and determined for itself based on its findings at stage one that the information fell far short of what was expected in issuing fit notes.

146. The Tribunal considered Dr Ravindran's actions to be careless and reckless because he did not have the sufficient information to assess the patient's condition. His actions in issuing a fit note undermined the importance of patient assessments prior to producing fit notes and undermined the system of issuing fit notes. The Tribunal considered that his actions fell well below the standards expected of a doctor as set out in GMP.

147. The Tribunal considered Dr Ravindran's actions to have diminished the public confidence in doctors.

148. The Tribunal, therefore, considered Dr Ravindran's actions to have a legal basis for findings of impairment namely misconduct.

Step 2b: where on the spectrum of seriousness the allegation lies?

Paragraph 1a, 1b, 1c, 2a, 2b, and 3 - Patient A

149. The Tribunal then went on to consider where on the spectrum of seriousness paragraphs one to three of the Allegation lie. The Tribunal considered the appropriate starting point for assessing seriousness was medium.

150. The Tribunal considered the whole purpose of the proforma is to serve as an extra layer of protection to the public to assist the Police in determining whether to issue a firearm certificate to a person who may otherwise be unfit to hold a licence. The Tribunal considered that Dr Ravindran's actions undermined the purpose of this system. The Tribunal assessed

the seriousness of Dr Ravindran's actions in completing the proforma without having the sufficient information and, considered it especially serious due to the inherent danger associated with facilitating an unsuitable person to possess a firearm. The Tribunal considered that the safeguards put in place to protect the individual and the wider public were not followed and could have potentially resulted in significant harm.

151. The Tribunal had regard to the MPTS case specific guidance and observed that *“allegation relating to dishonesty falls at the high end of the spectrum of seriousness. Even a single incident of dishonesty can have a significant harmful impact and pose a risk to public protection.”*

152. The Tribunal acknowledged Ms Bucklow's submission that cases of dishonesty are not easily remediable because of their nature. The Tribunal also considered that acts of dishonesty where they concern the professional role of a doctor are significant especially when the doctor is experienced. Moreover, the Tribunal considered the impact of an incorrectly issued firearm certificate to be significant given the risk for harm was potentially high.

153. The Tribunal considered whether any features increased the seriousness of the allegation. The Tribunal acknowledged that this was one instance of dishonesty and Dr Ravindran's actions were not persistent and that he had no previous history of being dishonest. The Tribunal additionally considered that Dr Ravindran was financially motivated however, the Tribunal had no information on the level of benefit derived from his actions. However, the Tribunal did not consider that his misconduct presented features at the highest end of the spectrum of seriousness. Therefore, taking account of all of these factors, the Tribunal considered that Dr Ravindran's actions fall on the mid-range spectrum of seriousness.

Paragraph 4 – Patient B

154. The Tribunal considered that the starting point on the spectrum of seriousness was on the lower end of medium. The Tribunal considered one purpose of the fit note system is to help employers appropriately adjust working arrangements to encourage employees to return to work, as well as confirming that the employee is ill. The Tribunal considered that Dr Ravindran's actions undermined the purpose and effect of this system.

155. The Tribunal considered that the behaviour by Dr Ravindran found proved in paragraph four of the Allegation demonstrated a repeated pattern of recklessly and carelessly signing forms and producing letters through Updoc.

156. The Tribunal considered that Dr Ravindran's action in signing the fit note was misleading.

157. In considering whether any features increased the seriousness of the Allegation, the Tribunal considered that Dr Ravindran had undermined the system designed to uphold the wellbeing and protection of the public. In doing so he had a reckless disregard for patient safety because it meant he was signing off a patient from work which may not have been in her best interests. The Tribunal considered this fell below the professional standards required of him.

158. The Tribunal therefore determined that Dr Ravindran's actions fell in the mid-range on the spectrum of seriousness which meant that the starting point for assessing risk was at the medium level.

Step 2c: what is the impact of any relevant context known about Dr Ravindran and/or his working environment?

In relation to the whole of the Allegation – Patient A and B

159. The Tribunal considered it relevant that it had found that there appeared to have been a lack of training from Updoc and considered that Dr Ravindran was engaged in a type of work that encouraged quick turnarounds instead of seeking detailed information to make an informed decision. However, the Tribunal equally had regard to the fact that it appeared that Dr Ravindran was not comfortable in the way Updoc conducted its work, but nevertheless he remained working for them. The Tribunal also had regards to its findings that any lack of training should have not impacted the basic skills and knowledge required from Dr Ravindran in completing the proforma and fit note and that Dr Ravindran was experienced in using the Updoc platform by the time he came to complete the requests for Patient A and Patient B.

160. The Tribunal acknowledged Ms Bucklow's submissions in that Dr Ravindran joined Updoc on his own volition when he put himself forward and applied for the job. It further considered that Dr Ravindran was not pressured to do this job and that the ultimate decision of accepting and rejecting requests through Updoc was up to him. Further, any requests that he would have rejected would have been reallocated to someone else and therefore there was no danger to the public in rejecting requests that were outside the capabilities of Dr Ravindran.

161. The Tribunal considered that the impact of any relevant context known about Dr Ravindran and his working environment does not alter the level risk identified above and the risk remained in the mid-range level of seriousness.

Step 2d: how has Dr Ravindran responded to the Allegation?

In relation to whole of the Allegation – Patient A and B

162. The Tribunal has acknowledged that Dr Ravindran has responded to the Allegation and has been involved fully in the proceedings. It also had regard to the two statements that he made which included reflections and insight.

163. The Tribunal acknowledged that Dr Ravindran apologised for his actions for the first time before the proceedings started and took this into consideration when assessing his insight.

164. The Tribunal acknowledged that Dr Ravindran has developed some insight. The Tribunal considered that Dr Ravindran could have developed clearer insight particularly as to the reasons he acted in the way the Allegation proposes. The Tribunal agreed with Ms Bucklow that it still did not have any real understanding as to the reasons why Dr Ravindran acted dishonestly and completed the requests in the way he did, although the Tribunal recognised that Dr Ravindran had admitted that he had been motivated by financial gain.

165. In respect of remediation, the Tribunal acknowledged the further evidence received on behalf of Dr Ravindran, namely the six certificates of Continuing Professional Development. However, in considering whether the courses were enough evidence to demonstrate remediation, the Tribunal considered that Dr Ravindran had not explained what each course set out in his CPD certificates entailed and whether the content of the courses addressed or remediated his misconduct. The Tribunal considered that the Tribunal had not received sufficient evidence as to how Dr Ravindran had embedded his learning such that there would not be a repetition of his misconduct in the future. The Tribunal also considered that dishonesty can be difficult to remediate.

166. The Tribunal considered the detailed and thoughtful reflective statement made by Dr Ravindran. The Tribunal noted the reflective statement had some suggestion to an action plan that Dr Ravindran was hoping to complete, but that it had not received any detailed evidence in respect of this action plan. Overall, it appeared to the Tribunal that Dr Ravindran is still working on his remediation.

167. The Tribunal took account of the fact that Dr Ravindran had resigned from Updoc in 2024.

168. The Tribunal acknowledged the positive patient and colleague feedback and testimonials concerning Dr Ravindran and took into account that he appears to have been open and frank with his colleagues about the Allegation and considered this to be in Dr Ravindran's favour. Further, the Tribunal considered that Dr Ravindran had provided information in his statements that suggested that he had read the statutory guidance and informed himself of the relevant practice of completing fit notes and firearms licensing applications. Therefore, it appears that he has kept his knowledge and skills up to date.

169. Overall, the Tribunal found that Dr Ravindran has a low risk of repetition but it was not non-existent. The Tribunal could not be satisfied that Dr Ravindran would never repeat the misconduct.

170. The Tribunal considered that Dr Ravindran's response to the Allegation reduced the level of seriousness, but it was not sufficient to take it out of the mid-range.

Step 2e: Tribunal's decision as to whether Dr Ravindran poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment.

171. The Tribunal was mindful of the nature of the Allegation and the seriousness of risk especially regarding paragraphs one to three of the Allegation.

172. The Tribunal considered that all three limbs of public protection were engaged. Paragraphs one to three of the Allegation particularly engaged the need to protect, promote and maintain the health, safety and well-being of the public. Dr Ravindran's actions were a reckless disregard for patient and public safety. In respect of paragraph three of the Allegation the Tribunal considered he had also acted dishonestly. The Tribunal considered that all paragraphs of the Allegation engaged the remaining two limbs, namely to promote and maintain public confidence in the profession and to promote and maintain professional standards and conduct.

173. The Tribunal assessed the reflective statement and saw the need for further reflection that identifies detailed reasons for his actions and the action plan which Dr Ravindran is working on. The Tribunal also saw the need for further steps to be taken to sufficiently lower the risk to the public.

174. Having considered all of the reasons it had outlined above, the Tribunal was satisfied that there was a current and ongoing risk to public protection on all three limbs and that the level of risk was at the medium level.

175. It considered that his misconduct posed a risk to patient and public safety, undermined public confidence and standards in the profession. Given the lack of evidence regarding steps taken to sufficiently lower the risk, his risk on public protection was at the medium level.

176. The Tribunal has therefore determined that Dr Ravindran's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 22/09/2026

177. This determination was handed down in public.

The evidence

178. The Tribunal has reviewed its findings at the facts and impairment stages and taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

179. Dr Ravindran gave oral evidence in person at the sanction stage.

Submissions

On behalf of the GMC

180. On behalf of the GMC, Ms Bucklow submitted that the decision as to the appropriate sanction was a matter for the Tribunal, exercising its own independent judgment. The GMC's submissions were advanced to assist the Tribunal in reaching that decision.

181. Ms Bucklow submitted that the most appropriate sanction is one of erasure which is the minimum sanction required to address all three limbs of the overarching objective as set out in the Medical Act 1983.

182. Ms Bucklow submitted that Dr Ravindran's dishonesty arose within his role as a doctor and the nature of his dishonesty put patients and the wider public at risk. Ms Bucklow

noted that regarding Patient A and the firearms certificate, a medical assessment is fundamental and can only come from a doctor. Regarding Patient B Ms Bucklow reminded the Tribunal of their findings at the impairment stage that Dr Ravindran had undermined the fit note system and shown a repeated pattern of recklessness and carelessness when signing forms. Ms Bucklow submitted that whilst the Tribunal had assessed Dr Ravindran's conduct had fallen into the mid-range of seriousness the findings in respect of Dr Ravindran's conduct were significant.

183. Ms Bucklow submitted anything lower than erasure would be insufficient as allegations of dishonesty are serious and significantly undermine public confidence in the profession. Ms Bucklow highlighted some features as relevant when considering the impact on public confidence:

- i. The dishonesty occurred as part of Dr Ravindran's professional life;
- ii. The potential consequences of the dishonesty could have resulted in serious injury or death to a patient or the public;
- iii. The conduct was financially motivated;
- iv. The conduct was only brought to an end by third parties, namely a journalist and the police, uncovering what Dr Ravindran had done and referring the matter to the GMC;
- v. After two years Dr Ravindran's remediation is far from complete notwithstanding the difficulty in remediating dishonesty and a member of the public would be concerned as to why his remediation was limited despite the significant passage of time;
- vi. There is insufficient evidence of how Dr Ravindran's learning has been embedded and this had not improved by Dr Ravindran giving evidence at the sanction stage.

184. Ms Bucklow submitted that the Tribunal did not have an understanding as to why Dr Ravindran had acted dishonestly. Ms Bucklow suggested that it took the involvement of third parties for Dr Ravindran to realise his conduct was wrong and that it would or should have been clear to Dr Ravindran that his conduct was dishonest at the time. Ms Bucklow submitted Dr Ravindran's insight is not established or robust. Ms Bucklow submitted that from a public confidence perspective there is a lack of reasoning or mitigation for why Dr Ravindran acted in the way he did.

185. Ms Bucklow submitted that relevant case law has consistently found dishonesty lies at the top end of the spectrum of misconduct, even where there has been a one-off instance of misconduct, due to its impact on public confidence. Ms Bucklow cited the case of *Bolton v Law Society [1994] 1 WLR 512* which set down the principle that the collective reputation of

the profession and confidence of the public are factors that are more important than the individual fortunes of a professional member.

186. Ms Bucklow referenced the case of *Khan v General Medical Council [2015] EWHC 301 (Admin)* in relation to dishonesty lying at the top end of the spectrum of gravity of misconduct and that cases of proven dishonesty can be expected to fall on the side of maintaining public confidence in the profession by a severe sanction against the doctor. Ms Bucklow also referred the Tribunal to the case of *Nicholas-Pillai v General Medical Council [2009] EWHC 1048 (Admin)* which states the principle that erasure is the appropriate sanction even in a case of a one-off instance of dishonesty.

187. Ms Bucklow submitted there is repetition in this case regarding the incidents with both Patient A and Patient B and a suggestion of a broad pattern of behaviour or attitudinal approach by Dr Ravindran in his work for Updoc.

188. Ms Bucklow submitted that it would not be proportionate for the Tribunal to take no action or to apply a conditions of practice order. She submitted there are no exceptional circumstances to justify taking no action and that conditions would not be appropriate due to the nature of the concerns. Ms Bucklow submitted there are no meaningful, measurable conditions in cases of dishonesty and would not maintain public confidence in the profession given the Tribunal's findings at the impairment stage.

189. Ms Bucklow submitted that a sanction of suspension would not be sufficient to address the patient safety or public confidence concerns due to the seriousness of the allegations and high level of risk attached to such findings. Ms Bucklow submitted Dr Ravindran's insight and remediation is lacking which also would make suspension inappropriate. Whilst acknowledging that the Tribunal found the risk of repetition to be low, Ms Bucklow submitted that a risk of repetition of dishonesty is difficult to address and expressed concern about the lack of insight Dr Ravindran has shown in terms of the causes of his conduct. She submitted that therefore there remains a risk of repetition. Ms Bucklow submitted Dr Ravindran's remediation was only prompted by the fact he was under investigation by the GMC. Ms Bucklow submitted that it is unclear that anything could be achieved by a 12-month suspension. In the alternative, Ms Bucklow submitted that if the Tribunal do decide to impose a sanction of suspension then a review should be directed by the Tribunal.

190. Ms Bucklow submitted that the Guidance indicates erasure may be appropriate even when a doctor does not pose a risk to patient safety, as it is the most appropriate and proportionate sanction to maintain public confidence in this case. Ms Bucklow submitted Dr

Ravindran's conduct was a serious departure from GMP and arose from an attitudinal and behavioural concern that is difficult to remediate. Ms Bucklow submitted that for the reasons stated above Dr Ravindran's misconduct falls in the category of erasure which is the only sanction that will adequately maintain all three limbs of the overarching objective.

On behalf of Dr Ravindran

191. On behalf of Dr Ravindran, Mr Cassidy submitted that Dr Ravindran accepts his conduct was a serious departure from GMP and that dishonesty always amounts to serious misconduct. Mr Cassidy submitted that the dishonesty was isolated and that in order to be proportionate the Tribunal need to answer the Allegation with a sanction appropriate for the findings in the case.

192. Mr Cassidy submitted that it is a singular incident of dishonesty without any persistence of a predatory nature. He submitted that Dr Ravindran has had no previous matters before May 2024 and that his references and testimonials reflect to Dr Ravindran's credit. Mr Cassidy submitted no harm was caused to any patients in this case despite the risk, especially in relation to the firearms certificate for Patient A. In respect of Patient B Mr Cassidy reminded the Tribunal that the application was a construct by a journalist.

193. Mr Cassidy submitted that the Tribunal has already made findings which contextualise Dr Ravindran's behaviour. Mr Cassidy submitted that Dr Ravindran did make attempts to gain further material from Patient A and that there was some pressure from Patient A to complete the firearms certificate quickly.

194. Mr Cassidy submitted that erasure is a sanction for conduct that is fundamentally incompatible with continued registration and that the Tribunal is looking to impose the least punitive sanction to allow the public interest to be expressed. Mr Cassidy submitted that suspension would be appropriate to reflect the serious misconduct and suspension is proportionate to the levels of remediation and risk which Dr Ravindran now presents.

195. Mr Cassidy submitted that Dr Ravindran has a degree of insight that allowed him to say it took him until September 2025 to understand the issues of public confidence, trust in the profession and dishonesty which all became more apparent. Mr Cassidy submitted there is significant remediation demonstrated by Dr Ravindran despite his understanding not being complete and his language being imperfect.

196. Mr Cassidy submitted Dr Ravindran now understands the dishonesty and wrongness of his conduct and that he has significant remorse for undermining the professional guidance,

confidence and trust of doctors. Mr Cassidy submitted that in terms of the likelihood of Dr Ravindran carrying out similar allegations or departures of GMP, he has attended this hearing for 12 days, prepared statements and given evidence. Dr Ravindran has not been involved in any other matters in the last two and a half years and was working for the Updoc platform without colleague support. Mr Cassidy submitted that Dr Ravindran has shown reflections that he does not want to return to that work environment where he was making poor decisions.

197. Mr Cassidy submitted that the Tribunal's finding of a medium risk to public protection at the impairment stage was correct and that proportionality is relevant. Mr Cassidy submitted that the singularity of the activity and exposure is a matter of relevance in placing the appropriate sanction with the available options.

198. Mr Cassidy submitted that suspension prevents Dr Ravindran from working and sends a signal to the public that serious misconduct cannot be condoned by a sanction any less than suspension. Mr Cassidy submitted that this would not undermine public confidence and would be the proportionate response. Mr Cassidy concluded by submitting that it would be appropriate for the Tribunal to direct a review if the Tribunal determined a sanction of suspension.

The Tribunal's determination on sanction

199. The Tribunal was reminded that the decision as to the appropriate sanction to impose is a matter for its independent judgement. There is no burden or standard of proof. When determining the appropriate sanction, if any, it should have regard to the principle of proportionality and should start by considering the least restrictive option. The Tribunal acknowledged that any sanction decision needs to be proportionate, transparent and fair and meet the level of current and ongoing risk posed to public protection that it had found in the impairment decision.

200. The Tribunal reminded itself that the main reason for imposing a sanction is to protect the public and that sanctions are not imposed to punish or discipline doctors, even though they may have a punitive effect. The Tribunal must balance Dr Ravindran's interests against the public interest. The Tribunal reminded itself that the reputation of the medical profession as a whole is more important than the interests of an individual doctor.

201. The Tribunal reminded itself of its finding at the impairment stage that the ongoing risk to public protection was medium. The Tribunal had determined that all three limbs of public protection were engaged, namely, to protect, promote and maintain the health, safety

and well-being of the public; to promote and maintain public confidence in the profession and to promote and maintain proper professional standards and conduct for members of the profession.

202. In making its decision on sanction, the Tribunal has reviewed its decision on facts and impairment. It has referred to the sanctions bandings for misconduct cases as set out in Part C of the Guidance for MPT hearings. It noted that the indicative sanctions banding for a case of dishonesty where there was a medium level of risk to public protection was “Suspension 3 to 9 months”. It has also considered the impact of any specific sanction type, where applicable, and has taken account of the references or testimonials provided.

203. Although the Guidance includes indicative sanctions bandings, as set out above, the Tribunal acknowledged that these are indicative rather than binding and any decision on sanction is one ultimately for the Tribunal. Accordingly, the Tribunal started its consideration at the lowest possible sanction.

No action

204. In reaching its decision as to the appropriate sanction to impose in this case, the Tribunal first considered whether to take no action. In doing so it noted that neither counsel submitted that taking no action would be an appropriate or sufficiently proportionate sanction in this case.

205. The Tribunal considered that taking no action would not be an appropriate or a proportionate response. The Sanctions Guidance indicated that such a finding was appropriate in “exceptional circumstances” but that “exceptional circumstances are unusual, special, or uncommon, so such cases are likely to be very rare.” Given the findings against Dr Ravindran include a finding of dishonesty, the Tribunal considered that there was no exceptional reason as to why no action should be ordered. The Tribunal has found that there is a medium risk to public protection and as such the Tribunal considered that taking no action would fail to maintain public safety, public confidence or uphold professional standards.

Conditions

206. The Tribunal next considered whether to impose a period of conditions on Dr Ravindran’s registration. In doing so it noted that neither counsel submitted that a period of conditional registration would be the appropriate or sufficiently proportionate sanction in this case.

207. In reaching its decision the Tribunal noted that conditions should be appropriate, workable and measurable and the Tribunal had regard to the relevant paragraphs of the Guidance.

208. The Tribunal acknowledged that Dr Ravindran had taken relevant CPD courses in 2025, that he now had a workplace mentor who he met with on a regular basis and that he was looking to attend a Schwartz round as soon as possible, where he would explain his experiences in this Tribunal to the whole health board. Further, Dr Ravindran was undertaking reflective practice. Dr Ravindran had referred to this as an “action plan” (though the Tribunal had not seen a documented version).

209. The Tribunal considered that conditions would not be appropriate. Though it may address the risk to public protection the Tribunal found that conditions would not address the root cause of the misconduct. The Tribunal also considered that conditions would not provide an opportunity for Dr Ravindran to remediate. The Tribunal considered that conditions are not appropriate where there has been a finding of dishonesty when referring to the relevant case law and Guidance that dishonesty sits at the higher end of the spectrum of seriousness. The Tribunal considered that conditions would not mark the seriousness of the Tribunal’s findings on the impact of Dr Ravindran’s misconduct on public protection.

210. The Tribunal considered that conditions would not be workable as no conditions have been proposed that would address the root cause of the findings. The Tribunal found that Dr Ravindran has shown some insight but that it is not fully developed. The Tribunal acknowledged that Dr Ravindran is clearly willing to remediate but again his remediation is not fully developed. The Tribunal found that conditions are difficult to measure where there was a finding of dishonesty.

Suspension

211. The Tribunal went on to consider suspension. It referred to paragraph 45 of the Sanctions Guidance:

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

- a. conditions are not appropriate, measurable and/or workable*
- b. the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions, and suspension is necessary to stop the*

- doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or*
- c. *the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.'*

212. The Tribunal acknowledged that it had found that there was a risk to patient and public safety and the Tribunal considered that public confidence must be maintained. The Tribunal acknowledged that it had found at the impairment stage that there was a medium level of risk to public protection and a low (but not non-existent) risk of repetition. Therefore, a finding of suspension was appropriate where a low risk of repetition existed and it was necessary for Dr Ravindran to stop practising while he continued to develop his insight and work on his remediation.

213. The Tribunal recognise the risk of repetition is low. However the Tribunal note that Dr Ravindran is still working in a professional setting where he can complete medical letters including fit notes. The Tribunal found that a period of suspension would be required due to the level of risk found and because Dr Ravindran's insight and remediation are still developing. The Tribunal considered that Dr Ravindran would need some time to develop his insight and remediation to demonstrate he is ready to return to unrestricted registration.

214. However, the more important reason for a finding of suspension to be imposed is in order to maintain public confidence in the profession and maintain professional standards. The Tribunal reminded itself that dishonesty is a serious finding of misconduct. The Tribunal in particular considered that the following features meant that it was proportionate and fair to impose a period of suspension:

- i. Consequences of Dr Ravindran's dishonesty are significant in terms of undermining public confidence;
- ii. Dr Ravindran's misconduct was only ended by third parties, namely the Police and journalists;
- iii. After two years, Dr Ravindran had only developing not fully established insight;
- iv. Dr Ravindran had not demonstrated a good understanding of why Dr Ravindran acted dishonestly;
- v. Dr Ravindran had undermined the purpose of the fit note system;
- vi. Dr Ravindran had undermine the purpose of the Firearms Licensing system;
- vii. Dr Ravindran had been careless and reckless in not obtaining sufficient information. This behaviour had also been repeated between Patient A and Patient B.

- viii. Dr Ravindran had demonstrated a reckless disregard for patient safety as his actions could have given rise to serious harm. The Tribunal considered it would therefore undermine public confidence if a suspension was not imposed.

215. In terms of deciding the length of the suspension, the Tribunal referred to paragraph 46 of the Guidance:

46. 'The MPT will need to decide the appropriate length of time that suspension should be put in place for, up to the maximum of 12 months. The following factors will be relevant:

- a. the assessment of the level of current and ongoing risk to public protection posed by the doctor*
- b. the reasons for assessing suspension as being the proportionate response*
- c. the amount of time the doctor is likely to need to remediate, complete treatment for and/or recover from a health condition that is having, or is likely to have, an impact on their ability to practise safely and effectively, and/or*
- d. the amount of time the parties will reasonably need to prepare for any review of whether the doctor continues to pose a current and ongoing risk to public protection requiring restrictive action in response or is safe to return to unrestricted practice.'*

216. The Tribunal considered that a six-month suspension would be appropriate in Dr Ravindran's case. The Tribunal reminded itself that there was some evidence of insight and remediation but that Dr Ravindran's insight was still developing and, on his own admission, there was further remediation work to be done. The Tribunal noted that there was low risk of repetition but the risk is not completely removed.

217. Whilst acknowledging that there was a low risk of repetition, the Tribunal considered the allegations were serious and Dr Ravindran had undermined two sets of systems designed to protect patients and the public, which means a signal is required to be sent out to avoid undermining public confidence and ensure professional standards are maintained. The Tribunal were mindful of the caselaw that dishonesty is extremely serious and that often a sanction of erasure is appropriate. For the reasons set out in this decision, the Tribunal considered that a sanction of erasure was not appropriate but that a six-month period of suspension, being in the middle to high end of the range in the indicative sanction bandings was appropriate.

218. The Tribunal considered that anything less than 6 months would not allow enough time for Dr Ravindran to undertake the required development of insight and remediation or properly embed his learning.

Erasure

219. Finally, the Tribunal went on to consider whether to impose a sanction of erasure on Dr Ravindran's registration.

220. The Tribunal considered paragraphs 55 and 57 of the guidance, which state:

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

...

57 'Erasure may be the proportionate response where:

- a) Conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public*
- b) The doctor's behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place*
- c) The doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and/or*
- d) The seriousness of the facts found proven and/or impact of any relevant context that increased the current and ongoing risk to public protection mean the effect of the doctor continuing to hold registration is such that it will undermine public confidence in the profession.'*

221. The Tribunal considered that suspension would be a proportionate sanction in Dr Ravindran's case and that erasure was not proportionate. In considering the MPTS guidance, the Tribunal considered that Dr Ravindran's misconduct had not actually caused serious harm to anyone, only a risk of harm. Further, that Dr Ravindran had not shown a persistent lack of insight into the seriousness of the Allegation and about his misconduct and consequences. To the contrary, Dr Ravindran has engaged with his regulator and the fitness to practise process, made admissions at the outset of the hearing, submitted two statements which contained his reflections and demonstrated his insight and given oral evidence twice in this hearing.

Though the Tribunal had found and maintained its findings after hearing Dr Ravindran's evidence at the sanction stage that his insight and remediation are developing rather than being established, the Tribunal considered that this was not a case where his insight could be said to be persistently lacking.

222. Whilst the findings of fact are serious, the Tribunal reminded itself that it had found a medium level of risk to public protection at the impairment stage with a low risk of repetition. The Tribunal considered that it was important that there was only one instance of dishonesty in relation to Patient A. The Tribunal acknowledged the case law that stated that dishonesty was serious, often requiring a sanction of erasure. The Tribunal also recognised that it had found that the dishonesty had posed a risk to patient and public safety. But, in its view, when considering where on the spectrum of dishonesty Dr Ravindran's actions lay, the Tribunal considered it was not at the higher end of the spectrum of dishonesty. Therefore, the nature of the dishonesty coupled with the Tribunal's findings on Dr Ravindran's personal context, his developing insight, remediation and engagement in these proceedings did not justify erasure.

223. The Tribunal reminded itself that the least restrictive sanction to maintain public protection was required and considered that suspension would sufficiently mark the record, maintain public safety, public confidence in the profession and maintain professional standards.

224. The Tribunal therefore found that a sanction of erasure would not be proportionate in the circumstances and that a suspension of six months would be the most appropriate sanction.

Review Hearing

225. The Tribunal determined to direct a review of Dr Ravindran's case. The Tribunal considered that a review would be useful to assess Dr Ravindran's progress and directed that one should take place before the expiry of the suspension order pursuant to section 35D(4A) of the Medical Act 1983.

226. The Tribunal wishes to clarify that at the review hearing the onus will be on Dr Ravindran to demonstrate how he has remediated and developed his insight. The Tribunal considered that it may assist the reviewing Tribunal if Dr Ravindran could:

- demonstrate any further reflections on the misconduct and the Tribunal's findings

- provide any further remediation including but not limited to how he has completed his action plan
- provide his reflections on the causes of his misconduct.

227. Dr Ravindran will also be able to provide any other information that he considers will assist.

Determination on Immediate Order - 22/09/2026

228. This determination was handed down in public.

229. Having determined that Dr Ravindran's registration is to be suspended for six months with a review directed, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Ravindran's registration should be subject to an immediate order.

Submissions

Submissions on behalf of the GMC

230. On behalf of the GMC, Ms Bucklow submitted that the GMC would seek an immediate order for the reasons found in the Tribunal's findings that all three limbs of public protection are engaged in Dr Ravindran's case. Ms Bucklow submitted that there is a patient and public safety concern as well as a public confidence concern. Ms Bucklow submitted that in light of the Tribunal's determination to suspend Dr Ravindran for six months it would maintain public confidence if that suspension were immediate and reflected the findings the Tribunal had made.

Submissions on behalf of Dr Ravindran

231. On behalf of Dr Ravindran Mr Cassidy submitted that given Dr Ravindran was not currently working because of this hearing, he does not have a patient list in the foreseeable future and so there is no submission against an immediate order being put in place.

The Tribunal's determination

232. The Tribunal referred to the relevant section of the Guidance, including:

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

80. In the context of an immediate order, the best interests of the doctor includes avoiding putting them in a position where they may come under pressure from patients and/or may repeat the behaviour or poor performance giving rise to the allegation, particularly where this may also put the doctor at risk of committing a criminal offence. It may also include where the doctor's ability to practise safely and effectively may be impacted by an ongoing health condition.

81. When deciding if an immediate order is needed, the MPT should balance these considerations against the other interests of the doctor, which may be to return to work pending the outcome of any appeal, and against the wider public interest which may require an immediate order is put in place.

...

83. The decision whether to impose an immediate order is at the discretion of the MPT based on the facts of the case. When deciding if an immediate order is needed the MPT should consider the seriousness of the proved allegation and the level of current and ongoing risk to public protection posed by the doctor.

84. It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:

- a. the doctor poses a risk to patient safety*
- b. the risk to one or more parts of public protection is high, and/or*
- c. immediate action is needed to maintain public confidence in the medical profession.*

233. The Tribunal had regard to the paragraphs set out above. The Tribunal had found that all three limbs of public protection were engaged with a medium level of risk.

234. The Tribunal decided to impose an immediate order of suspension on the grounds that it was necessary to protect members of the public, that it was otherwise in the public interest, and that it was in the best interests of Dr Ravindran. The Tribunal considered that this would be consistent with its findings that there was a medium risk to public protection,

that all three limbs were engaged and there was a risk of repetition, albeit low. The Tribunal noted that Dr Ravindran was in favour of an immediate order.

235. This means that Dr Ravindran's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

ANNEX A – Application to admit hearsay evidence - 10/09/2026

236. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004,

as amended (the Rules), to sit in private when the matters under consideration were confidential.

237. Ms Jade Bucklow, Counsel on behalf of the GMC, made an application under Rule 34(1) of the Rules to admit hearsay evidence from Mr D, the XXX at Venture Startups Limited (Updoc), a witness who was to be called by the GMC.

Factual Background

238. Updoc is a technology platform that connects users seeking private health services with independent contractor health practitioners who are registered with the GMC and who provide such services directly to those users. Dr Ravindran was engaged to work for Updoc as an independent health practitioner from 4 September 2023 to 12 August 2024. It was through this platform that Dr Ravindran issued a firearms medical certificate to Patient A, which is the subject of paragraphs one to three of the Allegation, and a fit note to Patient B, which is the subject of paragraph four of the Allegation.

239. On 17 August 2026, Dr Ravindran's defence representatives informed the GMC that Mr D would be required to give evidence. This notification came late in the day after the defence had failed to comply with case management directions in respect of identifying witnesses that were required. The GMC then sought the availability of Mr D to attend. It was this contact that prompted Mr G, General Counsel and Company Secretary to Updoc, to contact the GMC on behalf of Mr D to explain his concerns XXX, should he be required to give evidence.

240. The Tribunal saw a telephone note dated 26 August 2026 between Mr G and the GMC's legal representative which explained that XXX. The GMC canvassed Mr D's position with the defence and invited them to consider whether questions could be put in writing to Mr D. This option was declined by the defence.

241. On 27 August 2026, after a further email from Mr G, the GMC's legal advisor requested that XXX. The GMC legal advisor also enquired as to whether there was anyone else in the company in the same or similar role to Mr D who could give evidence relating to their systems.

242. On 31 August 2026, Mr G responded to the GMC legal advisor explaining that "given the sensitive nature of the matter, it is a difficult request" and suggesting that Updoc were not able to require sensitive XXX information from employees. Further that "there was no

one else who could talk to Updoc systems at the time”, which the Tribunal took to mean at the time when Dr Ravindran worked for Updoc.

243. Despite Mr G’s response, a doctor’s letter was produced by Mr D from XXX.

244. The letter did not state whether Mr D XXX.

245. The Tribunal and the defence were only given this letter on the first day of the hearing.

246. The Tribunal were told that the GMC had had no further contact with either Mr G or Mr D since they had communicated with Mr G on 31 August 2026. The GMC had decided that it was disproportionate and XXX to compel him to attend.

247. On the first day of the hearing, the Tribunal had made a direction for further information to be provided about XXX. The Tribunal had asked for details of whether Mr D XXX. The response the Tribunal received to its direction on the morning of 9 September was that XXX, did not understand the legal basis for the Tribunal’s request and that it would ordinarily require 10 days’ notice to prepare an appropriate response.

248. On 10 September the Tribunal received a further response XXX explaining that it could respond to the Tribunal’s direction within 24-48 hours of receiving confirmation of approval of the fee and a copy of the formal Tribunal direction. The XXX also stated that Mr D wanted to discuss the request with his legal representatives. XXX.

Submissions

On behalf of the GMC

249. Ms Bucklow submitted that when the principles established in the case law of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)* (“*Thorneycroft*”) are properly applied to the facts of this case, they favour the admission of Mr D’s evidence as hearsay. Ms Bucklow addressed her submissions according to the principles set out in *Thorneycroft*.

250. Ms Bucklow submitted that Mr D’s evidence was highly relevant to the case and provided important explanatory context. Ms Bucklow submitted that Mr D’s evidence and the documents exhibited to it did not appear to be in dispute.

251. Ms Bucklow submitted that paragraphs one to three of the Allegation are admitted by Dr Ravindran and in any event the evidence of Mr D was not the sole and decisive evidence in relation to these paragraphs. However, there was some evidence exhibited to Mr D's statement only which was fundamental to the Tribunal's understanding of the chronology of events that underpin paragraphs one to three of the Allegation.

252. Ms Bucklow submitted that it was important for the Tribunal to have Mr D's evidence and these documents so they can appreciate what steps were or were not taken by Dr Ravindran before issuing the firearms certificate to Patient A.

253. Ms Bucklow submitted that in respect of paragraph four, the statement and exhibits of Mr D are sole and decisive. However, an important caveat to this was that Dr Ravindran does not appear to dispute the factual evidence Mr D can provide, namely the timings of the request, how it was made and sent to Dr Ravindran, and that the letter that was issued.

254. Ms Bucklow submitted that Dr Ravindran's response to paragraph four of the Allegation within his defence statement was that he believed he had rejected Patient B's request for a sickness note and he is therefore unclear why it was accepted and the sickness note issued.

255. Ms Bucklow submitted that the Tribunal do need to consider the issues in the case and the factual matters that they need to determine. Part of the Tribunal's consideration as to whether it is fair to admit the evidence requires examination of the issues and how far the doctor would be prejudiced if they were not able to explore matters that are in dispute with the witness.

256. Ms Bucklow submitted it is unclear what part of Mr D's statement is in dispute factually. Ms Bucklow submitted that Dr Ravindran's response to paragraph four of the Allegation is that he did not select the option of accepting Patient B's request, and if he did so it was a mistake caused by the options being close together. Ms Bucklow submitted that Mr D cannot assist with this issue.

257. Ms Bucklow submitted that Dr Ravindran's counsel wished to explore issues such as Updoc as an operating platform, ability of the platform to communicate with a patient, the induction and training process, and any learning that Updoc has undertaken because of this case. Ms Bucklow submitted that Mr D does not indicate that he had any role in the induction or training process. Ms Bucklow submitted that Dr Ravindran is not prejudiced by his absence in this regard, as Dr Ravindran is able to speak to the training and induction he received, or any concerns he raised about his training and preparedness to undertake the role.

258. Ms Bucklow submitted there was no suggestion or credible evidence that Mr D has fabricated his evidence, nor would he be motivated to do so. Ms Bucklow submitted that Mr D's statement is largely a production statement.

259. Ms Bucklow submitted that the most serious allegation in this case, is dishonesty in relation to providing a medical certificate in respect of possession of a firearm, as alleged at paragraphs one to three of the Allegation. Ms Bucklow noted that allegation is admitted.

260. In respect of the reasons for Mr D's non-attendance and the steps taken by the GMC to secure his attendance, Ms Bucklow submitted that the steps taken by the GMC to secure Mr D's attendance have been guided by XXX. Ms Bucklow submitted that as the concern elicited by Mr G during a call between him and the GMC on 26 August 2026, was considered to be genuine, Mr D had not been contacted directly about his attendance since. Ms Bucklow submitted that all communication including the request for further XXX evidence had been through Mr G.

261. Ms Bucklow submitted that the GMC had decided not to compel Mr D to attend the hearing and consider this a disproportionate step XXX. Ms Bucklow submitted that the GMC was satisfied that the combined evidence of the call with Mr G, and the XXX, should he be compelled to attend.

262. Ms Bucklow submitted that Dr Ravindran's defence have been offered the opportunity to put questions to Mr D in writing, which was declined. Ms Bucklow submitted that it is not clear why Dr Ravindran's representatives' questions could not be sufficiently addressed in writing.

263. Ms Bucklow concluded her submissions by inviting the Tribunal to admit the statement and exhibits of Mr D as hearsay evidence.

264. In respect of the further information received from XXX on 10 September Ms Bucklow submitted that it was a matter for the Tribunal but it appeared likely that XXX would not be able to provide the information requested by the Tribunal. It was Ms Bucklow's position that the Tribunal could proceed to determine the hearsay application.

On behalf of Dr Ravindran

265. Mr Cassidy submitted that the defence indicated they would need Mr D to attend around 3 weeks ago which is more than adequate time to make inquiries and to underline to

the witness their need to attend. Mr Cassidy submitted that none of the XXX details were available to the defence until the first day of the hearing.

266. Mr Cassidy submitted that the advice given by the GMC was that XXX. Mr Cassidy submitted that it was put to the GMC that if Mr D could not attend XXX, someone of equivalent status within the company who could describe the evidence could be produced. Mr Cassidy submitted that nothing came from this and the next stage was an invitation for the defence to put the written questions in without at that point there being any XXX that was being told to the defence at that stage. Mr Cassidy submitted this was the reason that no questions were put in the absence of a witness who was required.

267. Mr Cassidy submitted that under Rule 34(1) a Tribunal may admit evidence they consider ‘fair and relevant to the case before them’. Mr Cassidy submitted that with regard to paragraph four of the Allegation Mr D produces significant evidence which the Tribunal will have to assess the importance of, but with the understanding that there is no ability to cross-examine.

268. Mr Cassidy submitted that there was a significant disadvantage for Dr Ravindran not to question Mr D. Mr Cassidy noted lines of questioning and information that the Tribunal would be without such as the issuing of certificates, the constraints that the organisation place on a doctor, the structure of access to the patient and the onboarding of the doctor and any training that was given.

269. Mr Cassidy submitted that there was no evidence that the GMC had indicated to Mr D that he could attend remotely or that XXX. Mr Cassidy submitted that the conversation between the GMC and Mr G within the telephone note was effectively a ‘listening ear’ to the descriptors of Mr G without providing any pushback or indicating that there were other ways for this witness to give evidence.

270. Mr Cassidy submitted that further exposure may be shone upon the activities of Updoc that they are unwilling or not desiring of. Mr Cassidy submitted that criticism could be made of Updoc’s operating platform and their model of issuing online certificates. Mr Cassidy submitted this is something that would be in the minds of Mr D and Mr G given the nature and extent of the coverage at the time of these incidents.

271. Mr Cassidy submitted that for these reasons it would not be fair to admit Mr D’s evidence in the absence of cross-examination and in the absence of a good reason for Mr D’s non-attendance. Mr Cassidy acknowledged that there was no direct conflict or matters in dispute in Mr D’s evidence or the documents that he had produced by way of exhibits but

submitted that there was material around the business model, onboarding, training and the whole setup of issuing of fit notes which will be denied examination of by Mr D's absence.

272. In respect of the further information received from XXX on 10 September, Mr Cassidy reiterated a summary of his submissions on the hearsay application and submitted that the Tribunal would not have confidence that a further adjournment would produce any further material. It was his position that a pragmatic and realistic approach was not to delay proceedings any further by waiting for the material requested.

Legal advice

273. The Tribunal had regard to Rule 34(1) of 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."

274. The Tribunal should first consider whether the evidence in question was relevant to any question to be determined by the Tribunal. If deemed relevant, the Tribunal should then consider whether it would be fair to Dr Ravindran to allow the GMC to rely on the additional evidence. The additional documents should only be admitted if that could be done without injustice to either party.

275. The Tribunal was mindful of the principles set out in the case of *Thorneycroft*. This set out a number of factors that the Tribunal is entitled to take into account when considering whether or not to admit evidence as hearsay.

276. The Tribunal referred to paragraphs 18 – 24 of Section 3 of the *MPTS Guidance* on MPT hearings relating to Hearsay evidence. The Tribunal reminded itself in particular of paragraph 23 of the Guidance:

23. *'To decide whether to admit evidence from an absent witness the MPT should consider:*

- is there a good reason for the witness's non-attendance and, consequently, for the admission of the absent witness's untested statements as evidence?*
- does the evidence of the absent witness constitute the sole or decisive basis for a conviction or the factual findings?*
- are there sufficient counter-balancing factors to ensure a fair hearing?'*

277. The Tribunal noted that if the witness statement is admitted, the Tribunal will need to adopt a careful balancing exercise when considering the impact and weight to attach to the evidence, especially where it is key evidence for a particular allegation.

The Tribunal's Decision

278. The Tribunal bore in mind the test set out in *Thorneycroft* by Judge Thomas when deliberating the outcome of the Hearsay application:

*“(i) whether the statements were the sole or decisive evidence in support of the charges;
(ii) the nature and extent of the challenge to the contents of the statements;
(iii) whether there was any suggestion that the witness had reasons to fabricate their allegations;
(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant’s career;
(v) whether there was a good reason for the non-attendance of the witnesses;
(vi) whether the Respondent had taken reasonable steps to secure their attendance...”*

279. The Tribunal considered the reasons put forward by the GMC for Mr D’s non-attendance and the evidence provided, namely XXX and the telephone call note and email exchanges between Mr G and the GMC between 26 August to 31 August 2026. The Tribunal reminded itself that on the first day of the hearing it had asked the GMC for further enquiries about securing another employee in Mr D’s place. The Tribunal were told this would not be possible and that Mr D had not been contacted since the end of August.

280. In regards to the response from XXX that the Tribunal received on the morning of the 9 September, the Tribunal considered it would not be feasible to obtain this information from XXX within the timetabled hearing. It was disappointed by the steps taken by the GMC, particularly that they had not informed Mr G or Mr D as to the concerns raised by the Tribunal and the GMC had not contacted XXX. On that basis, the Tribunal decided to hear the hearsay application. In regards to the further information received from XXX on the 10 September, the Tribunal considered the parties’ submissions and decided that it was unlikely XXX would be able to give the information as requested and that the information would be provided within a timescale that meant the timetabled hearing would not be jeopardised. The Tribunal proceeded to determine the hearsay application.

281. The Tribunal considered that there was no good and cogent reason put forward for Mr D’s non-attendance. The Tribunal found that the XXX was lacking in information. The

letter stated only that Mr D was anxious in attending, however the Tribunal identified that as common to all witnesses due to attend regulatory hearings to give evidence. The Tribunal noted that there was no detail of XXX that prevented his attendance at the hearing. The Tribunal found that it appeared that no steps had been taken either by the GMC or Dr I to assess if XXX could be made to facilitate Mr D to give his evidence. The Tribunal was disappointed that the GMC had not taken an active role to try to facilitate the attendance of Mr D and it was particularly surprised that no discussion had taken place to discuss XXX. The Tribunal considered the information provided was not sufficient to provide a good reason for Mr D's non-attendance.

282. The Tribunal was mindful of the direction in *Thorneycroft* that the absence of a good reason for the witness' nonattendance did not automatically result in the exclusion of the evidence.

283. The Tribunal made a careful assessment weighing up competing factors. The Tribunal agreed with the GMC's submission that Mr D's evidence was not the sole and decisive evidence in relation to paragraphs one to three of the Allegation and that it was the sole and decisive evidence in relation to paragraph four of the Allegation. However, as admissions to paragraphs one to three of the Allegation appeared to be forthcoming, the Tribunal focused on the merits of excluding Mr D's evidence in respect of the dispute regarding paragraph four of the Allegation.

284. The Tribunal considered it important that the defence had submitted that there were no paragraphs of Mr D's statement that were in dispute. Further that none of the documents exhibited by Mr D were in dispute as to their contents. However, the Tribunal noted that the defence wished to cross-examine Mr D on a number of contextual and circumstantial matters in relation to Updoc as an operating platform, the ability of the platform to communicate with the patient, the induction and training process and any learning that Updoc has undertaken as a result of this case.

285. The Tribunal considered that Mr D's statement was akin to a production statement wherein its main purpose was to exhibit documents to prove the Allegation. The Tribunal also noted that the main issue in dispute between the parties in respect of paragraph four of the Allegation appeared to be whether Dr Ravindran clicked, or meant to click, the button to accept Patient B's request which generated the sick note, and that was not a matter with which Mr D could assist. It was a factual matter that lay within Dr Ravindran's knowledge.

286. The Tribunal considered that they could see no reason Mr D had to fabricate what was contained within his statement.

287. Looking at the seriousness of paragraph four of the Allegation, the Tribunal noted that if paragraph four was found proved it could be serious. If proved this paragraph could indicate repeated conduct by Dr Ravindran's signing off medical notes without sufficient information. The Tribunal noted that dishonesty was not alleged in relation to paragraph four. The Tribunal also considered that completing a sickness letter without sufficient information on which to base it could have serious implications on Dr Ravindran's career.

288. In all the circumstances the Tribunal considered that despite there being no good reason for Mr D's non-attendance, Dr Ravindran was not disadvantaged by the admission of Mr D's statement. The Tribunal considered it dispositive that the contents of the statement and the documents exhibited were not in dispute and the evidence provided by Mr D did not go to the central issue in the case. Further, it would be open to Dr Ravindran to explain how the processes of Updoc worked when he was employed there, if Dr Ravindran chose to give evidence, and he could call any evidence he wished. While noting that the burden of proof is on the GMC and not Dr Ravindran, the Tribunal noted that given the GMC's lack of evidence regarding Updoc's processes, any evidence proffered by Dr Ravindran would effectively be unchallenged.

289. The Tribunal noted that in admitting Mr D's statement, the Tribunal would attach such weight to the statement as it saw fit to at each stage of these proceedings.

290. The Tribunal therefore determined to admit Mr D's witness statement as hearsay evidence.