PUBLIC RECORD

Dates: 01/08/2023 - 17/08/2023

Medical Practitioner's name:	Dr Surendra VERMA
GMC reference number:	2287427
Primary medical qualification:	MB BS 1973 Patna Medical College

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

Summary of outcome

No action

Tribunal:

Legally Qualified Chair	Mr Jetinder Shergill
Lay Tribunal Member:	Miss Susan Hurds
Medical Tribunal Member:	Dr John Moriarty

Tribunal Clerk:	Mx Nate Caruso-Kelly

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Anthony Haycroft, Counsel, instructed by CMS
GMC Representative:	Ms Colette Renton, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 15/08/2023

Background

1. Dr Verma qualified at Patna Medical College, India, in 1972. He practised in India until 1976, when he moved to the UK. Between 1976 and 1991, Dr Verma practised in various roles including Orthopaedic Surgery, General Surgery, and Neurosurgery. In 1992, Dr Verma completed his GP training. From 1996 until the time of these allegations he was a GP Partner at Hayes Medical Centre ('the Practice').

2. The allegations that have led to Dr Verma's hearing are split between those relating to Ms A (a receptionist at the Practice); those relating to a patient who consulted with him, Patient B; and improper accessing of medical records. The allegations can be summarised as follows.

3. It is alleged that on one or more occasion between 2018 to 2019, Dr Verma behaved inappropriately towards colleagues in that he aggressively shouted at them, and that he shouted aggressively at Ms A in front of patients and colleagues. It is also alleged on a single occasion whilst alone with Ms A, Dr Verma stood up quickly and leant over the desk towards her whilst shouting at her. It is also alleged that he inappropriately touched Ms A's shoulder and hand, and inappropriately gazed at her breasts when speaking to her.

4. In relation to Patient B, it is alleged that in a consultation at the Practice on 24 December 2019, Dr Verma touched Patient B's breasts, without explanation or a clinical indication. The GMC allege that Dr Verma's actions towards Patient B were sexually motivated.

5. The third area of the allegations is that on 9 February 2021, Dr Verma accessed the medical records of one or more members of staff at the Practice without reasonable justification for doing so.

6. The initial concerns in regard to Dr Verma's conduct were referred to the GMC on 29 January 2021 by Dr C, a partner at the Practice. The concerns in regard to Dr Verma accessing staff medical records were raised with the GMC by Dr C at a later date.

7. It is relevant to note that the allegations before the Tribunal at the start of the hearing included two paragraphs of the Allegation which the GMC decided to withdraw at the opening of the hearing. This issue is referred to later in this determination.

The Outcome of Applications Made during the Facts Stage

8. Ms Renton, counsel for the GMC, raised a preliminary matter for the Allegation to be amended by withdrawing two paragraphs under Rule 17(2)(c) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'). Mr Haycroft, counsel on behalf of Dr Verma, did not oppose the application. The Tribunal decided that paragraphs 5 and 6 of the Allegation should be withdrawn.

9. The Tribunal granted the GMC's preliminary application, made pursuant to Rule 36 (1) of the Rules, that special measures, namely the use of a screen, be put in place when Ms A gave her oral evidence. On behalf of Dr Verma, Mr Haycroft did not oppose the application. Patient B had already had such measures authorised.

10. The Tribunal was made aware of late disclosure of documents by the GMC to the doctor's representatives. That raised an issue of potential irregularity which is dealt with later in this determination. The Tribunal directed that an explanation was put forward by the GMC about how that irregularity arose. The GMC drafted a summary which was admitted into evidence under Rule 34 (1) of the Rules (both parties agreeing to that occurring).

11. The Tribunal refused the GMC's application to amend paragraph 2 of the Allegation made following the close of the GMC's case. The Tribunal's full reasoning is set out at Annex A.

The Allegation and the Doctor's Response

12. The Allegation made against Dr Verma is as follows:

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

1. On one or more occasion between 2018 to 2019 you behaved inappropriately towards colleagues in that:

    a. you aggressively shouted at one or more colleague;

To be determined.

b. you aggressively shouted at Ms A whilst in reception in front of patients and other colleagues;

To be determined.

c. on a single occasion whilst alone in your office with Ms A, you stood up quickly and leant over the desk towards her whilst shouting at her;

To be determined.

d. you inappropriately touched Ms A's shoulder and hand;

To be determined.

e. you inappropriately gazed at Ms A's breasts when speaking to her.

To be determined.

2. On 24 December 2019 you consulted with Patient B at Hayes Medical Centre ('the Practice'), during which you:

a. placed your hand beneath each of Patient B's breasts in turn;

To be determined.

b. palpated each breast with your whole hand from the bottom of the breast upwards.

To be determined.

3. Your actions as described at paragraph 2 were:

a. undertaken without you explaining to Patient B:

i. what you were going to do;

To be determined.

ii. that Patient B could refuse;

To be determined.

b. not clinically indicated;

To be determined.

c. sexually motivated.

To be determined.

4. On 9 February 2021, you accessed medical records of one or more members of staff at the Practice on the EMIS system as set out in schedule 1, without reasonable justification for doing so.

Admitted and found proved.

~~5. On 20 February 2021 you had a meeting at the Practice with Dr C and Mr D during which you:~~

~~a. refused to sign a GMS variation of contract unless the Practice retracted a complaint made against you to the GMC [relating to Patient B] ('the Complaint'), or words to that effect;~~

~~b. threatened to sue the Practice if it did not retract the Complaint or words to that effect.~~ Withdrawn.

~~6. On 22 February 2021 you called Dr C's home phone and you:~~

~~a. were verbally aggressive towards Dr C, including shouting at Dr C;~~

~~b. threatened Dr C that you "would sue the Surgery for compensation" or words to that effect.~~ Withdrawn.

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

13. At the outset of these proceedings, Mr Haycroft submitted that Dr Verma was making an admission to paragraph 4 of the Allegation. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced this paragraph as admitted and found proved.

The Facts to be Determined

14. In light of Dr Verma's response to the Allegation made against him, the Tribunal is required to determine paragraphs 1, 2, and 3 of the Allegation only.

Witness Evidence

15. The main evidence on behalf of the GMC's case came from the following factual witnesses:

- Ms A who provided a witness statement dated 27 June 2022, and also gave oral evidence in person; and
- Patient B provided a witness statement dated 25 October 2021, and also gave oral evidence in person.

16. The GMC also relied on a witness statement from Ms E, staff member at the Practice, dated 9 December 2021. She was not required to be cross-examined so her evidence is uncontested.

17. Dr Verma provided his own witness statement dated 24 May 2023 and also gave oral evidence, in person, at the hearing.

18. In addition, Dr Verma relied on three witnesses for factual and testimonial evidence:

- Dr F (XXX) who is a GP at the Shakespeare Practice, provided a witness statement dated 22 May 2023 and also gave oral evidence in person;
- Ms G, former receptionist at the Practice, provided a witness statement dated 24 May 2023 and also gave oral evidence by video link (by agreement); and
- Mr H, Dr Verma's local MP, provided a witness statement dated 22 May 2023 and also gave oral evidence by video link (by agreement).

19. Dr Verma also relied on witness statements from testimonial witnesses who were not called to give oral evidence as their evidence was not contested by the GMC:

- Ms J, patient of Dr Verma's, dated 22 May 2023; and
- Ms I, healthcare assistant and patient of Dr Verma's, dated 17 May 2023.

Expert Witness Evidence

20. The GMC relied on expert witness evidence from Dr K, in the form of two reports dated 3 August 2021 and 30 October 2021. Dr K's evidence was agreed between the parties, and he did not give oral evidence at the hearing.

21. Dr K has practiced as a principal GP since 1985, and has experience as a GP trainer, GMC assessor, clinical adviser to the Health Care Commission and has previously given expert advice to the GMC relating to the conduct and performance of GPs. Dr K was asked to provide his opinion on the standards expected of a competent GP.

Documentary Evidence

22. The Tribunal had regard to all of the relevant documentary evidence provided by the parties. The Tribunal directed that a chronology should be provided. That was necessary to navigate a complex timeline of differing events and documents. The chronology indicates whether an event/document is agreed between the parties. Where it is not agreed, it indicates which party asserts the document/event as relevant and what it purports to be. It has been invaluable in navigating the case. There are a number of irregularities in the case, on which more is set out below. One key issue is that there is very little in the way of agreement, less than a third of dates, as to a chronology of events and question marks over the provenance and reliability of certain documents. In those circumstances, it is inappropriate to summarise them here. The Tribunal has navigated the relevant documents presented by both parties and has dealt with the key documents in its determination.

The Tribunal's Approach

23. Both parties made oral and written submissions on their respective cases. Ms Renton set out the GMC's case. Mr Haycroft set out a detailed account of the law, Dr Verma's rebuttals and said there were irregularities in the case. The LQC gave detailed legal advice to the Tribunal which was followed by the Tribunal.

24. The Tribunal was mindful that the GMC has brought the case and has to prove the case against Dr Verma and that he does not have to prove or disprove anything. The Tribunal noted the LQC's advice that:

> *'The standard of proof is on the balance of probabilities. [The Tribunal needs] to be satisfied that something is more likely than not. That requires the assessment of the evidence to lead to the 'balance' tipping, however marginally, towards the GMC having proved a particular element. If that does not happen, or the balance remains genuinely tied at 50:50 then the matter is not proved.'*

25. The LQC's advice on other relevant matters is referenced later in the decision and he suggested how the Tribunal might approach the fact finding task:

> *'There is a careful path that needs to be followed before finding a charge proved by assessing: a) contemporaneous documents as the starting point; b) any other documentary evidence; c) factual witness evidence; d) good character/ usual practice matters; e) any collateral facts or surrounding circumstances; and f) expert evidence.*

The issue of irregularities [in the GMC's case as alleged by Dr Verma] would need to be weighed up in assessing a) to c).'

The Tribunal's Analysis of the Evidence and Findings

26. There were a number of matters which were raised by Mr Haycroft as irregularities in the case. The first thematic issue relates to background matters at the practice, including, what in essences amounts to, bad faith by the practice in making the GMC complaints. The second thematic issue relates to alleged 'cross-contamination' in evidence arising from the circumstances of how, why and to what extent Ms A was involved in Patient B both pursuing her complaint against Dr Verma, and setting out her evidence on different occasions. A proper understanding of the Tribunal's reasons requires an assessment of what the Tribunal made of these alleged matters and what impact they had on the assessment of the evidence and its findings.

First thematic issue: background matters at the practice

27. Mr Haycroft's submissions relied on Dr Verma's 'whistleblowing' in relation to concerns at the Practice. Those concerns were raised within the practice and externally, most notably with Mr H (the local MP). Dr Verma has set out an extensive account in his witness statement of various matters that had arisen. He refers to:

'a timeline of events which led me initially becoming aware of the allegations, and an explanation as to why I am concerned about the apparently coincidental time line of events which occurred between January 2019 and April 2022 involving the Practice Partners, the two Practice Managers at the Practice (Ms L and Mr D) and I…

I started to become concerned with certain aspects of the Practice's management. I was very proud of the Practice and its valuable place in the community and was concerned this was at risk. In particular, I had grown suspicious of Mr D's integrity…

I continued to be troubled that the Practice failed a CQC Inspection in January 2019 …and had failed to rectify the failings which were included as failures again in a further CQC Inspection in October 2019… even though Mr D had employed a second Practice Manager, Ms L to assist… Mr D dismissed my concerns and suggestions to improve the Practice during a meeting in January 2020…'

28. He goes on to refer to an issue arising because Dr M had decided to resign from the partnership, which required a variation to the contracts and lease agreement. He continues:

'In January 2020, I was concerned by an email sent to Dr N and I from NHS England regarding a complaint involving repeat prescriptions, of which both Dr N and I had no knowledge. I attempted to contact both Practice Managers, Ms L, and Mr D but they were unavailable.

At the end of January 2020, Ms L spoke to me about a complaint made by Patient B regarding a consultation with me on 24 December 2019 (GMC allegation 2-3). [Second sentence amended by being removed at the start of Dr Verma's oral evidence]. *I explained to Ms L that I had completed a chest examination only, and that I had not touched Patient B's breasts. I agreed that I had not offered Patient B a chaperone as I had considered it was unnecessary for a chest examination. I did not witness and/or receive any written information about the complaint in January 2020, and to my knowledge, there was no further action taken by the Practice or Patient B with regards to the incident, until January 2021.'*

29. He then refers to a practice meeting in February where the chaperone policy was discussed but there was no discussion about Patient B's complaint. He also refers to his suggestion in April 2020 that, due to pressures from the pandemic, XXX, Dr O, could assist. That was declined by Mr D. Dr Verma became '*increasingly concerned*' that the two practice managers were not supporting the reception and administrative staff properly. This led to a practice meeting on 12 September 2020. He states:

'At the meeting on 12 September 2020, attended by Dr C, Dr N, Mr D, Ms L, and I, I expressed my concern that the Practice did not have enough clinical cover for the large patient list. It was made clear to me that the Practice did not want XXX, Dr O, working at the Practice XXX. The Partnership Agreement did not stipulate that XXX were not allowed to work at the Practice, however at the meeting Mr D explained that he would change the Partnership Agreement in order to comply with their view that XXX should not work at the Practice.

At the meeting in September, and due to the issues highlighted above, I was beginning to feel very uneasy and intimidated about the way I was being treated by the rest of the management team. I spoke with my local MP, Mr H about my concerns on 15 October 2020, including the Practice's failed CQC inspections and failure to replace and recruit new clinical staff.

In December 2020, I was asked by the two GP Partners to sign a single page titled "Variation to Partnership deed" to reflect the end of Dr M's involvement in the

Partnership. I signed but asked to see the remainder of the Agreement. I was concerned that I only had one page of the document.

On 21 January2021, I received a call from the Senior Partner, Dr C asking me to sign a Contract GMS Variation Form (General Medical Services Contract) now that Dr M had left the Partnership. I declined on the basis that I had not yet seen the updated Partnership and Lease Agreement. On the same date, Dr C emailed me demanding the reason for not signing the GMS Contract Variation. I responded to Dr C's email saying again that I needed to see the updated Partnership and Lease Agreement (exhibit 'SV4' contains Dr C's email to me dated 21 January 2021 and my email to Dr C on 23 January 2021).

On 27 January 2021, Practice Manager, Ms L contacted me via telephone explaining that Patient B wished to escalate her complaint.

A meeting was arranged by Dr Patel to be held on 29 January 2021 -with attendees Dr N and Mr D. I XXX Dr F attend the meeting with me for support and as a witness, but this was refused. The meeting therefore did not take place, and I left the Practice with XXX, Dr F. On the same date, at 14:41, I now know that this was when Dr C wrote to the GMC regarding concerns over my conduct.

At a further meeting on 30 January 2021, at the Practice, attended by XXX, Dr F and Mr D, Dr F was informed by Mr D that Patient B had sent her complaint to the GMC… I was very concerned about the complaints and equally suspicious about the coincidental timing of the complaints coming to light at the same time as my difficulties with the Partnership and Practice Managers. I was not provided with the opportunity to respond and/or seek further information about the complaints at practice level…

I was disturbed by the recent events referred to above and felt intimidated and apprehensive about the way I was being treated by the Practice Partners and Managers and felt I had no other choice other than to resign from the Partnership and Practice. Dr C agreed resignation was advised so that I did not ruin my "reputation" I resigned formally via letter on 6 February 2021 but agreed to work my notice period…

On 9 February 2021, whilst I was completing my clinical handover, I accessed the medical records of Dr C, Dr N, Ms L, and Mr D (GMC allegation 4) as I was concerned that there were members of staff at the Practice who were XXX. In particular, I was

aware that Dr N had XXX. I wrote to the GMC to inform the GMC of my concerns about Dr C...

On 20 February 2021, a meeting was held between Dr C, Mr D, Mr P (XXX). Dr F (XXX), and I. At the meeting it was indicated to me that the Practice could write to the GMC to retract the complaint…'

30. Dr Verma goes on to explain that he reported his concerns about the Practice to the CQC and NHS Counter Fraud Authority. He also explains that in April 2021 he was informed by the GMC that the complaint lodged by Dr C was being investigated.

31. Other than questions as to how the CQC inspection outcomes had affected him, Dr Verma was not cross-examined on this catalogue of serious allegations made by him in relation to others at the practice, and most notably, against Dr C who instigated the GMC referral. It was incumbent on the GMC to prove its case and at the very least, that required their case be put to Dr Verma in cross-examination. The Tribunal might also have expected to have heard from GMC witnesses to rebut these serious allegations. They form a significant part of Dr Verma's case, and the GMC was required to deal with these matters head on in order to ensure they met the burden to prove their case.

32. None of that has happened and the Tribunal has been left in the dark as to why. What is clear from the documentation before the Tribunal is that there have been a number of redactions. It is possible that these have either been made at the request of Dr Verma's legal team, or because the GMC is unable/unwilling to pursue them. It was with those concerns in mind that the Tribunal was constrained in pursuing further explanation or clarification of evidence, for fear of entering the arena or trespassing into matters that had been settled, for either legal or procedural reasons, as between the parties.

33. However, it is relevant to note that as of 10am on the first day of the hearing the Tribunal was due to be dealing with two additional paragraphs in the Allegation. Ordinarily, the Tribunal would not deal with withdrawn matters but Mr Haycroft referenced this in his closing arguments. He submitted that the GMC had already withdrawn complaints made by the Practice against Dr Verma because they were undermined. It was therefore appropriate to put that matter in its proper context.

34. The Tribunal notes that paragraph 5 would have alleged that at the practice meeting on 20 February 2021, Dr Verma had wanted Patient B's complaint retracted in exchange for signing the GMS variation of contract, and that he threatened to sue the Practice if the complaint was not retracted. The Tribunal further notes that paragraph 6 alleged Dr Verma

had telephoned Dr C at home and had been verbally aggressive and shouted at Dr C. It is also alleged Dr Verma threatened to sue the surgery for compensation.

35. It is not the Tribunal's role to decide those allegations now they are withdrawn. The Tribunal is aware that the allegations were discussed at a Pre-Hearing Meeting on 30 May 2023. It is not clear exactly what happened to undermine the GMC case on those paragraphs. However, the following was recorded in the Pre-Hearing Meeting summary:

> *'[defence solicitor] advised Dr Verma's disclosure is complete. Dr Verma will rely on 9 witness statements in total, some being factual and some testimonials, alongside audio recording of a meeting.*
>
> *[defence solicitor] advised that the recording indicates that 2 of the GMC witnesses have not given accurate accounts of the meeting, and allegations 5 and 6 are now disproven.'*

36. XXX, Dr F, provided a witness statement dated 22 May 2023. Dr F's statement says:

> *'Finally on the 20th of February 2021, I met Mr D for the last time at Hayes Medical Centre, whereby the patient's complaint was discussed again. At the meeting, Dr. SK Verma, Dr C and Mr P (XXX) were initially present. Later on, Dr C called Mr D, and Mr P called me to join the meeting. Mr D mentioned that prior to the written complaint, a verbal complaint had been made in January 2020. Mr D admitted that the delay was down to the practice not following due process.*
>
> *In exchange for Dr SK Verma to sign the GMS Contract Variation, Mr D offered for Dr C, to speak to staff to withdraw their complaints and for the patient to retract her complaint, to which Dr C agreed to. They also advised that they do a letter redacting the complaint. Mr D stated, while looking in Dr C's direction, "So, you are the only one who can speak to the staff and if you tell them, they will listen. It's not 100%, I'm sure 150%, they will listen to him." Mr D's demeanour and tone in which he said this questioned the authenticity of the complaints.'*

37. Dr F was not only a testimonial witness, but also a witness as to fact. He was not cross-examined about what he has stated in the two paragraphs set out above. The Tribunal was mindful that he may not be an impartial witness. However, he is a registered medical practitioner in good standing and has an obligation to tell the truth. The Tribunal saw no reason to consider that what he set out in his witness statement (the two paragraphs above) had not occurred as he claimed. His accounts corroborate Dr Verma's accounts. XXX.

38. The Tribunal decided that Dr Verma's concerns about what was going on in the practice, set out in the quotes above, were likely to be reliable and credible accounts of a practice failing to meet CQC standards and where there were conflicts between the partners. That sets the proper context in which the GMC complaint about Dr Verma was made by the Practice.

39. Dr Verma was only in a position to comment upon the matters he knew or had experienced. Those matters related to the deteriorating relationship with the senior management team at the Practice including the two practice managers, one of whom was a partner at the Practice. The practice managers are responsible for the management of the administrative staff. Both of them are referenced, directly or indirectly, in the background context surrounding paragraphs 1 to 3, and Dr Verma's rebuttal.

40. The conflicts were unlikely to have been confined to issues going on within senior management. The everyday experience of office tittle-tattle is something which most people have experienced, and is likely to have been occurring, in differing degrees and at different times, in this environment. It is simply implausible that the significant issues between senior management were contained in a vacuum away from administration staff, including Ms A.

41. The Tribunal has noted various references to 'staff complaints' though there is no evidence of such complaints being relied upon by the GMC, despite the expert having been provided with them. It is therefore unclear who made them, what they related to or how and when they arose. This issue further supported the evidential quagmire of this case, and the conflicts at the Practice.

42. That sets the backdrop to the Tribunal's concerns that there may have been contamination of the evidence by the conflicts at the Practice.

43. It also sets the backdrop as to the timings of various accounts put forward by the GMC witnesses, and whether those timings might affect reliability or credibility.

<u>Second thematic issue: cross-contamination</u>

44. The second thematic issue relates to alleged 'cross-contamination' in evidence arising from the circumstances of how, why and to what extent Ms A was involved in Patient B pursuing her complaint against Dr Verma; and setting out her evidence on different occasions. That included involvement with the finalisation of Patient B's GMC witness statement. The LQC indicated to Ms Renton that this was an apparent irregularity and that an explanation was required from the GMC. She had a telephone call with the paralegal who

was involved with the case. Ms Renton produced her summary of the key points set out by the paralegal. The LQC indicated that the GMC would have to deal with these matters in closing submissions.

45. The GMC case is that Patient B is a credible witness and that her accounts are consistent. The same is submitted in relation to Ms A. Submissions were made on behalf of the GMC about the apparent irregularities. It is appropriate to set out what the written submissions said, not least because we did not establish the evidential nature of the summary provided of the telephone conversation with the paralegal. The Tribunal is satisfied the written submissions adequately reflect the key issues from what that note indicated had been told to Ms Renton by the paralegal. GMC submissions stated:

> *'27. The GMC provided a document on 1st August 2023 as to the manner in which the allegations relating to Patient B were investigated. It is not sought to rehearse that document but the GMC accept that Ms A was present for most if not all of Patient B's discussions with the GMC in company with a telephone line interpreter.*
>
> *28. Ms A has seemingly appeared as a conduit for information and her IT facilities such as email and printing. Ms A has also facilitated a location for the discussions with the GMC (and possibly NHS England) in a room at the surgery.*
>
> *29. The potential relevance of this is that the Tribunal can consider whether the effect of the GMC investigation has had any impact on the weight the Tribunal ascribe to the evidence of Patient B or Ms A.*
>
> *30. Whilst the GMC may seek to improve practices in the future, it is respectfully submitted that the actual impact of Ms A's presence in the discussions with Patient B is very limited.*
>
> *31. It is clear from Patient B and Ms A they do not have a personal relationship, they are not friends. It was described how for the purpose of taking the GMC statement the process was:*
> *a. GMC ask question in English*
> *b. Question is interpreted by telephone interpreter into Romanian*
> *c. Answer given in Romanian*
> *d. Answer interpreted into English by telephone interpreter*
>
> *32. At no stage was Ms A involved in the giving of answers.*

33. In relation to the statement the process was:
a. This was written in English
b. It was sent for professional translation to Romanian
c. Both copies were sent to Patient B with Ms A copying them in
d. An amendment was made but only to the English copy, Ms A facilitated this

34. It is submitted that the difference between "encouraged" and "advised" is of such small distinction it is of no real weight.

35. It is worth noting the statement taking procedure was in October 2021. Whilst not in the height of the Covid 19 pandemic, it is submitted this was still a time where remote hearings and witness statements would have been the norm.

36. As such the GMC submit that there was no prejudice to the Doctor by the manner in which Patient B's witness statement was obtained.

37. In terms of Ms A, it was perhaps expected that following an accusation of the kind from Patient B staff would be asked if they have experienced any poor conduct from the Doctor. Ms A explained it was in those circumstances she made her complaint in early 2021 as documented in bundle C2.'

46. Mr Haycroft set out in some detail, in his Schedule A to his written submissions, the various irregularities and concerns with the evidence.

47. The LQC gave legal advice on the issue of potential cross-contamination as follows:

'Assessing cogency of the evidence will necessitate a consideration of the irregularities that have arisen in this case … There are good reasons why witnesses should not know what others are going to say. There is the obvious issue of collusion, but also the less obvious issues of undue and/or unintended influence over either or both witnesses. [The Tribunal] will have to consider what is alleged to have gone on, what the parties say about this, and what the witnesses have said occurred. [The Tribunal should consider]: a) does the issue raise an obvious question about the reliability of either/both witnesses claims; b) is there a risk that there was some obvious or less obvious form of contamination; c) is any risk of contamination potentially material to the issues we have to decide; and d) does any such risk affect the weight to be given to the evidence in part or its entirety. Once [the Tribunal has] considered all of that [it] should take any of those matters into account in taking a rounded view of the

evidence and ask…: has the GMC shown that a particular matter can be proved on the balance of probabilities with sufficiently cogent evidence?

…navigating contemporaneous documents, whilst the starting point, does not necessarily hold the entire answer... The potential for contamination in this case has been from the very beginning through to the settling of GMC statements. [The Tribunal] will have to carefully consider what [to] make of it. It is open to [it] to consider if any or all of the irregularities make little if any material difference, through to it being fundamentally erroneous and unfair. [The Tribunal] should be careful in [its] consideration of what are serious charges as part of [its] public law duty, but [it] should be mindful that [it] should not be drawn into the arena by doing the GMC's job...

There is no direct authority on point that [the Tribunal has] been taken to or that I am able to find. That perhaps gives an indication as to how unusual a set of circumstances [the irregularities arising are].'

48. A subtle aspect of cross-contamination is not only the departure from usual procedures in evidence gathering, but the extent to which Ms A, even if acting in good faith, had directly or indirectly influenced Patient B's evidence. Did she 'encourage' Patient B as Mr Haycroft has put the matter? Or did she act as neutral conduit simply 'advising' Patient B? These issues are expanded upon further in the determination.

49. On a separate matter, despite having raised the matter before the case opened, the Tribunal was not provided with declarations from the (various) translators or interpreters used by the GMC in this case. That is a standard requirement in the civil courts and tribunals, and indeed, interpreters used in hearings have to make an affirmation to interpret the evidence to the best of their ability. This is also a relevant matter to weigh up in assessing the integrity of the evidence gathering process, although in light of the other concerns, one that has perhaps diminished in significance from when it was first raised.

50. These issues set the backdrop of the concerns raised about irregularities in the case and the potential for: a) conflicts between partners influencing Ms A's evidence; and b) cross-contamination of the evidence as between Ms A and Patient B.

Application to the Allegation

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

Paragraph 1(a) and (b)

1. On one or more occasion between 2018 to 2019 you behaved inappropriately towards colleagues in that:

    a. you aggressively shouted at one or more colleague;

    b. you aggressively shouted at Ms A whilst in reception in front of patients and other colleagues;

52. The Tribunal considered paragraph 1 (a) and (b) together, as they relate to the same behaviour, in the context of the Practice.

53. The Tribunal turned to the available evidence asserting that Dr Verma shouted at one or more colleagues. The Tribunal took into account the GMC submissions that Dr Verma was likely to have been under pressure at the Practice, due to the two failed CQC inspections, increasing patients lists, the departure of a senior partner, and another salaried GP taking maternity leave. The Tribunal accepted the submission that stress levels may have been relevant in deciding if Dr Verma had acted '*aggressively*'. It was therefore not improbable this could have happened.

54. The Tribunal has seen a '*statement from staff member'*, this, Ms A confirmed in her evidence, was written by her. It includes a description of the behaviours giving rise to paragraph 1 of the Allegation and appears to be the first recorded account of these behaviours. In her witness statement dated 27 June 2022, Ms A says *'In or around May 2021 I wrote an email to Dr Q about the behaviour from Dr Verma which I had witnessed and experienced myself. I wrote to Dr Q because I thought it was important that someone higher up knew what was happenning* [sic].' However, the chronology states '*Practice refer Dr Verma to GMC - includes Ms A complaint said to be May 2021'*. This date is agreed between the parties. This referral was made three days after Dr Q has recorded in Patient B's medical record on 26 January 2021 '*Telephone consultation: asked by reception staff to talk to patient regarding a complaint, Ms A present as interpreter*'.

55. In her oral evidence, Ms A was questioned why she did not say anything until May 2021, after Patient B had given her statement to the practice. Ms A stated that '*the matter was discussed in the practice if anyone had a bad experience* [with Dr Verma]'.

56. The Tribunal considered Ms A's witness statement dated 27 June 2022 in which she stated:

'I stated that I've felt like Dr Verma has tried 'to embarrass me and belittle me openly'. I would add that Dr Verma frequently raises his voice in the Practice and has shouted at me on multiple occasions, both in his office and at the front desk in front of colleagues and patients. Whenever this happens it feels demeaning and I feel so small. … I would add that probably every receptionist at the Practice has had at least one negative interaction with Dr Verma. Not only has he shouted at me, but I have seen him shout at the other receptionists, in front of both patients and their colleagues and supervisors. If, for example, there were lots of prescriptions to be signed, Dr Verma would have a go at the receptionists. If Dr Verma wasn't happy that certain patients were booked to see him or if he thought a patient shouldn't have been booked in at all, he would shout at the receptionists and have a go at them instead of having a polite conversation.'

57. The Tribunal then considered whether Ms A's account of Dr Verma's behaviour was reliable and/or credible and looked to the GMC evidence. The Tribunal considered Ms A's assertion that Dr Verma would '*have a go*' at the receptionists if there were lots of prescriptions to be signed. In her oral evidence, Ms A stated that the receptionists did not have responsibility for prescriptions, and there were two staff members whose responsibility they were. The Tribunal did not consider that there was any logical reason to shout at reception staff about prescriptions, when this was something reception staff had no responsibility for or control over. The Tribunal noted that Ms A was unable to give any concrete examples about this claimed behaviour in terms of openly embarrassing her or belittling her. She had not made any complaint to her managers about this ongoing behaviour she alleges. She said she feared losing her job but later in her evidence she indicated things were so bad she had considered leaving. The Tribunal might have expected to see some other source of evidence indicating Dr Verma behaved in the way alleged.

58. The Tribunal had not been taken to any previous reports of aggressive behaviour from Dr Verma, or reports by the Practice. The Tribunal considered that this is the sort of attitudinal issue that would be picked up and reported on by someone at some point. It is not credible that other reports had not been formalised or proceeded with. Ms A's assertion that Dr Verma shouted at her, other colleagues, or patients stands starkly alone when considering there were a number of administrative and reception staff in the Practice, and that the shouting took place in front of patients as well.

59. The Tribunal considered that the sort of public displays of aggression that Ms A described would be remembered by others. Contrary to Ms A's evidence, the Tribunal considered the evidence of Ms G, a former receptionist at the Practice. She had worked with Dr Verma for more than nine years but had now left the practice. In her witness statement and in oral evidence, Ms G maintained that Dr Verma is a professional and respectable

doctor, whom she has never personally witnessed shouting at any patients or staff. He had not shouted at her and when asked if he spoke loudly, she said he spoke in a '*normal tone*'. She was not aware of him using a '*loud voice'* in the surgery. She appeared to be reflecting on the question whether the receptionists had said Dr Verma would shout at them, and said '*no*'. She was asked if Dr Verma would shout at the receptionists if there was a backlog of prescriptions to sign and she said: '*No, never, nothing that I am aware of*'. She had not witnessed Dr Verma shout at Ms A, and that was despite her working alongside Ms A and the other reception staff every day for 5-days-a-week before November 2019, and 3-days-a-week after. The Tribunal considered that had Dr Verma had an aggressive trait it is likely to have come out under times of stress, in a busy practice, and would have come to Ms G's attention during her time working at the practice.

60. Ms G's evidence was measured and credible. She had no obvious motivation to be defending Dr Verma. It was persuasive evidence in the Tribunal's assessment. Her accounts undermined the claims made by Ms A. On that evidence alone, at best, the GMC case was tied at 50:50 and would fall at that point.

61. However, the Tribunal went on to note that Ms G's evidence was consistent with three other witnesses who were independent of Dr Verma. Ms J was not required to be cross examined. She stated her family have been Dr Verma's patients for more than 20 years, and she described him as '*thorough, patient, and professional*', and '*softly spoken'*. Ms I was also not required for cross-examination. She was a Healthcare Assistant at Shakespeare Health Centre, where Dr Verma worked with XXX Dr F. She was also one of Dr Verma's former patients. She described him as '*extremely polite and respectful'* as a colleague and as a doctor.

62. The Tribunal had a witness statement and heard live evidence from Mr H. Mr H and his family have been Dr Verma's patients for over 20 years. As his patient, Mr H described Dr Verma as '*extremely caring and responsive, always willing to listen to our concerns with attentive care and to go that extra mile'*. He indicated his wife had no concerns about being treated by Dr Verma either.

63. The Tribunal noted Mr H is Dr Verma's constituency MP, and he told the Tribunal that he regularly receives feedback from local people about their concerns about local health services, and in the case of Dr Verma stated,

> *'I can say assuredly that … I have received nothing but praise and support from constituents for the care he provides them. He is held in deep affection and respect by local residents for his dedication to our local community'.*

64. Mr H confirmed Dr Verma's accounts about concerns being raised about the practice by Dr Verma, and by others in the local area. However, Mr H stated that in meetings regarding these concerns, he *'never witnessed Dr Verma raise his voice or lose control no matter how serious the interest he obviously had in the subject of the discussion*'. In his oral evidence, Mr H stated that he often received complaints from constituents about specific doctors, and that he had never received such a complaint about Dr Verma and had in fact personally received praise for him.

65. The Tribunal noted Mr H had been the constituency MP since 1997 and had been Dr Verma's patient for 20 years. The Tribunal was satisfied, given his role as an MP serving the same area as Dr Verma's practice, that Mr H would have been alerted to any concerns relating to Dr Verma through his constituents.

66. The Tribunal was satisfied that had Dr Verma shouted at Ms A '*on multiple occasions, both in his office and at the front desk in front of colleagues and patients'* someone would have raised this somewhere. It is implausible that patients witnessing this would have simply ignored it. Had there been concerns, it was likely someone would have complained, or raised it with Mr H in some forum. It was highly improbable that a doctor shouting at staff in front of others would have not led to some form of reporting of these concerns. Mr H's evidence was weighty evidence countering the alleged attitudinal issues raised by Ms A.

67. XXX. Dr F stated:

> '[Dr Verma] *worked at Shakespeare Health Centre from April 2021 to May 2022. He displayed professionalism among our staff and patients alike during this period. Many patients had moved from Hayes Medical Centre to Shakespeare Health Centre, and his clinics would often be populated with his usual patients. The staff enjoyed his company, and we received no complaints. He was indeed an asset to our practice, where he flourished in the environment, we provided for him.'*

68. The Tribunal also took into account Dr F's oral evidence, during which he described Dr Verma as '*more the type to go silent'* when he is under stress and not quick to anger. The Tribunal accepted these accounts.

69. The totality of these sources of evidence significantly undermine Ms A's claims, and it raises the question as to why there is such a disparity between what she alleges her experience of Dr Verma was, and the experiences of others.

70. The Tribunal is satisfied that the GMC evidence was weak and was significantly undermined by other evidence. It is more likely than not that Dr Verma did not '*aggressively shout'* (or '*shout'* at all) at Ms A or others.

71. The Tribunal therefore finds paragraphs 1 (a) and (b) of the Allegation not proved.

Paragraph 1 (c)

c. on a single occasion whilst alone in your office with Ms A, you stood up quickly and leant over the desk towards her whilst shouting at her;

72. The Tribunal understands the timing of this alleged incident or the lodging of any complaint about it, is not agreed as between the parties (there is no independent evidence to verify it either). In her witness statement, Ms A refers to her May 2021 email and says:

> *'I recount a specific interaction I had with Dr Verma. While I cannot recall exactly when it happened, I believe it was 2-3 years after I started at the Practice, and I know it was before the start of the Covid-19 pandemic. In this instance Dr Verma had an issue with a booking I had made for him to see a patient who could be difficult at times. Dr Verma called me to come into his office and when I entered his office he was sat at his desk and he already appeared to be upset; his face was red and he looked angry. Dr Verma asked me why I had booked this patient with him. I don't recall what exactly he said, but I remember that he was ranting about how annoyed and upset he was that I'd booked this particular patient to see him. When I tried to explain to him what happened, he stood up quickly from behind his desk and leaned towards me over the desk. He was angry and shouting at me. I was worried that he might hit me from across the desk. I left his office crying from this interaction.'*

73. Ms A's first recorded account of this incident is allegedly in an email in May 2021 to Dr Q, a locum GP at the practice, who was carrying out an investigation into the allegations against Dr Verma:

> *'On one occasion I was called to Dr Verma's room as he wanted to complain about a patient that was booked with him. He didn't even give me the chance to explain, and just started shouting uncontrollably at me. His voice got louder and louder, and he then stood up from his chair in an angry and aggressive way. He did not physically touch me or assault me, but I was fearful that he may. I cried as soon as I left the room as I had never felt so intimidated at work before.'*

74. The Tribunal was mindful that this was not a 'timestamped' email. Furthermore, they had no further information about Dr Q's 'investigation' besides Ms A's account, so was unaware of the scope, thoroughness, or outcome of this investigation. It is convenient to note here that there was a complaints procedure at the Practice, which has not been provided to the Tribunal, and it appears this was not followed in any event.

75. Ms A's witness statement also refers to the aftermath of this incident:

> *'I spoke to my supervisor, Ms R after this interaction because I was so upset. I recall crying with her and asking if I could leave early. I recall that Ms R was trying to console me and said something along the times of 'don't worry, nothing's going to happen, [Dr Verma's] known for his behaviour'.'*

76. In her oral evidence, Ms A confirmed that she spoke to Ms R, and stated '*she didn't do much, he was well known to be angry and shout, we all needed our jobs, she did not do anything, I was told not to worry and it will be okay*'. The Tribunal was concerned that no contemporaneous note of the incident was available, especially considering the incident had been reported to a more senior member of staff. It also noted that Ms A had started working at the Practice in September 2016, so the incident is alleged to have occurred in late 2018 or 2019 ('*2-3 years after*'). If the complaint to Dr Q occurred in May 2021, then Ms A was recounting the events for the first time, in any recorded manner, around two-and-a-half years after the alleged incident.

77. The Tribunal considered that if such an incident had occurred, it may have been overheard by others in the building. It would likely have generated gossip or discussion at the Practice, particularly if Ms A was upset. However, Ms G was unable to recall any occasion on which Ms A was distressed or crying at work. The Tribunal notes the timeline fits with the time period Ms G was working at the practice 5 days a week alongside Ms A.

78. An alternative assessment of the evidence relates to a matter Dr Verma volunteered in his witness statement about an incident in August 2020:

> *'I accept that I have raised my voice to a colleague, Ms A on one occasion, over the telephone, in August 2020, which I accept is completely inappropriate and unacceptable behaviour. I spoke to Ms A shortly after the incident in order to apologise for raising my voice and ensure that Ms A was OK. I deny aggressively shouting … the conversation was about a patient being booked with me who expected a face to face consultation'.*

79. The fact that Dr Verma accepted he shouted down the phone may have been treated as undermining his usual calm approach. However, he admitted this event when it had not been relied upon by Ms A, and as such tended to support Dr Verma as a candid witness. The Tribunal further considered that Dr Verma was deeply embarrassed in describing his behaviours in August 2020 when he raised his voice at Ms A. It accepted he was likely to have acted out of character.

80. The Tribunal considered there was some similarity between this 2020 incident and the one described by Ms A. Although one was in person and one over the phone, they both related to a patient being incorrectly booked. The Tribunal concluded that it may be the case that Ms A has conflated some other issue with the incident in August 2020. It may be the case that she has been prompted by the investigation of Patient B's complaint to make her own complaint, for whatever reason. It may be the case that this entire incident is fabricated. Whatever the position, the evidence relied on by the GMC is unreliable and limited weight can be attached to it.

81. The Tribunal noted a similar theme developing from its findings at paragraphs 1 (a) and (b) that Dr Verma was not someone who would shout or be aggressive. Those allegations were based on similarly forceful evidence put forward by Ms A which did not withstand scrutiny. That scrutiny included witnesses who said the very opposite of what Ms A described. In relation to paragraphs 1 (a) and (b), the Tribunal concluded the totality of the evidence significantly undermined Ms A's claims, and raised the question as to why there is such a disparity between what she alleges her experience of Dr Verma was, and the experiences of others. Those concerns apply equally here, because again there is sufficient concern as to why the matter was not pursued in a timely manner (i.e. by formally complaining) and why there is no evidence anyone overheard Dr Verma shouting or Ms A crying. The Tribunal was concerned that Ms A came forward some time after the alleged events and after Patient B's statement was taken. Ms A was present during that statement taking process. She has had close involvement with Patient B's case from the outset. The Tribunal was concerned this has led to a blurring of lines and of her evidence. At best, she is re-framing matters which arose in a different context, misremembering or revisiting matters in the way *Dutta* describes, or at worst she is fabricating the issue for whatever reason.

82. The evidence relied on by the GMC is weak and for all of the reasons set out above the Tribunal was not satisfied on the balance of probabilities that Dr Verma acted in the way alleged.

83. The Tribunal therefore find paragraph 1 (c) not proved.

Paragraph 1 (d)

d. you inappropriately touched Ms A's shoulder and hand;

84. The Tribunal considered this allegation in two parts. First, did Dr Verma touch Ms A's shoulder and hand, and secondly, was this inappropriate touching.

85. In her witness statement, Ms A states the following:

> *'I also stated that Dr Verma has a habit of touching my shoulder and hand in a way that feels inappropriate and awkward. I would add that Dr Verma does this pretty much every time he comes over to speak with me; he often walks up behind me and puts his hand on my shoulder, waiting for me to turn around, or he'll put his hand on my hand to get my attention. He does the same thing with all of the reception staff at the Practice and has been this way since I first started working at the Practice. Dr Verma almost always is coming over to the receptionists when he is annoyed about something, so I find him touching my hands and shoulders in those instances to be especially unnerving and a bit creepy … On occasion the reception staff have discussed in passing how Dr Verma is very touchy. All of colleagues who I've spoken to about it also seem uncomfortable with Dr Verma touching us, but it seems to be common knowledge that this is just how he is.'*

86. In her oral evidence, Ms G talked about her own experiences of Dr Verma, and said that on occasion he did touch her on the shoulder. She said that it was his 'normal way' of getting the attention of the reception staff. In his oral evidence, Dr Verma accepted that he may on occasion touch staff on their shoulder to get their attention. The Tribunal therefore accepted that Dr Verma most likely did touch Ms A on the shoulder on one or more occasion.

87. The Tribunal then considered whether Dr Verma touched Ms A on the hand. The Tribunal considered Ms G's oral evidence, in which she stated that Dr Verma never touched her hand, and she never saw him touching anybody else's hand, nor did anybody complain about Dr Verma touching their hand.

88. Part of Ms A's assertions is therefore consistent with other evidence. That may mean she can draw support for the other part that is not supported by other evidence. The Tribunal decided that touching someone on the shoulder was within the range of contact that might be permissible in an office, whereas touching someone on the hand is unlikely to be so. The Tribunal was also concerned that Ms A had made a number of allegations about Dr Verma's

conduct which have not been accepted in 1a) to c) above. It has already expressed concerns as to why there is such a disparity between what she alleges her experience of Dr Verma was, and the experiences of others as regards those allegations. Here Ms A alleges conduct which is undermined by Ms G's evidence. The Tribunal is also concerned by whether this allegation has arisen because she has been influenced by the background events at the practice and the conflict between the partners. In particular, whether she was reframing events or fabricating accounts in relation to her involvement with Patient B.

89. Taking all of those matters into account, the Tribunal concluded that it was more likely than not that Dr Verma did not touch Ms A's hand.

90. The reference to *'inappropriately'* relates to both the '*shoulder and the hand'*. However, the Tribunal considered that it should take a purposive approach and look at touching the shoulder as a separate issue.

91. The Tribunal considered that what might be appropriate to one person may be inappropriate to another. There will be clear examples of inappropriate touching that the majority of people would consider should not occur in a workplace. Indeed, touching staff in the workplace is becoming more unacceptable and many people are now aware of the way touching in the workplace can be perceived. The Tribunal found that if Dr Verma had a habit of inappropriately touching staff on the shoulder then this would likely have been a topic of controversy and subject to complaints. The only person making such a complaint is Ms A.

92. Ms A's accounts are undermined by Ms G's oral evidence, because she said she felt Dr Verma's touching her on the shoulder was not inappropriate and was his way of getting the attention of the reception staff. The Tribunal accepted her account that this touching was not perceived negatively and was part of Dr Verma's normal behaviour. It might have been appropriate in a busy reception to do so. Equally it might be an increasingly outmoded way of interacting with staff. To that extent the fact Ms A is relatively young and the age difference between her and Dr Verma may be a factor. Cultural issues may also have been a factor. Whatever the basis for Ms A's perception of inappropriateness, it was incumbent on her to indicate, directly, or through a superior or intermediary, to Dr Verma, that she felt it was inappropriate. It is her evidence that she never did this.

93. The Tribunal decided that Ms A had not raised this matter with Dr Verma, her supervisor or the practice manager. Although Ms A states she discussed it with staff, Ms G had no recollection of Dr Verma's touching on the shoulder being discussed. The Tribunal considered that if Ms A felt she was being touched inappropriately, and that it was '*very common'* as she stated in her oral evidence, she would have raised the matter with Dr Verma

or another member of staff. This again demonstrates a mismatch between Ms A's assertions of wrongdoing, and an analysis of the surrounding facts. It calls into question the reliability and/or veracity of her accounts.

94. Finally, the Tribunal considered that Ms A made her complaint about being touched inappropriately by Dr Verma more than a year after Patient B's initial complaint. It was in the context of the issues regarding the conflict between the partners, which are set out above. The Tribunal concluded that Ms A was likely being drawn into the matters that were going on in the Practice and/or in relation to Patient B. Whether this was deliberate or unintentional, the Tribunal considered she had reframed her experiences of being touched by Dr Verma. The inconsistencies between her assertions and an analysis of the surrounding facts suggests she was being affected by the process of assisting Patient B in pursuing her complaint about being inappropriately touched.

95. Taking all this into account, the Tribunal decided the GMC evidence was weak and did not support a finding on the balance of probabilities that Dr Verma inappropriately touched Ms A's shoulder (or hand).

96. The Tribunal therefore found paragraph 1 (d) not proved.

Paragraph 1(e)

e. you inappropriately gazed at Ms A's breasts when speaking to her.

97. The Tribunal considered Ms A's witness statement, in which she states:

'I would clarify that Dr Verma often looks at my breasts when speaking with me and I have seen him stare at other colleagues' breasts as well. I cannot recall any specific instances of this happening as it seems to happen quite often. While I have not discussed with any colleagues that Dr Verma looks at my chest when speaking with me, it is a very unpleasant feeling and it feels very unprofessional.'

98. The Tribunal considered that if Dr Verma was in the habit of staring at staff member's breasts, it is highly probable that it would have been reported to a manager. It is sexualised behaviour and is not acceptable in the workplace. As such, it is more likely to be reported to managers or complained about than other, less offensive behaviours. The Tribunal further took into account that the reception area is open to the public and there are several receptionists behind reception at any given time. That makes it implausible that nobody else

would have noticed this behaviour; and independently reported it as inappropriate. Ms Kotha had no recollection of Dr Verma staring at her or anybody else's breasts.

99. When Dr Verma was asked in cross-examination if he found Ms A attractive, he appeared genuinely shocked by the question and he firstly replied '*No comment*' followed by *'I explained to you XXX was working in that practice … It never happened; I never think the way that you are suggesting to me … I can't even think of that thing*'. The Tribunal decided his response indicated that it was incomprehensible to Dr Verma that he would have been sexually attracted to a member of staff to the point that initially he could not even comment upon it. That is consistent with there being no other staff complaints before the Tribunal and that female patients had not raised any concerns in the past, something confirmed in strong testimonial evidence.

100. The Tribunal was mindful not to allow a 'domino effect' on other parts of the Allegation being not found proved. However, there was a clear pattern forming between broad, wide reaching claims by Ms A which were not supported by an analysis of the surrounding facts. The Tribunal was concerned as to how Ms A was drawn into making complaints about Dr Verma. She only made her complaints at the height of the matters set out above relating to background issues at the practice. At the same time, she was significantly involved in 'advising' or 'encouraging' Patient B to pursue her complaint against Dr Verma. The Tribunal was concerned that there may have been a negative feedback loop in terms of everything that was going on. If office tittle-tattle was happening in relation to the background issues at Practice and Patient B's complaints, it is plausible that Ms A became embroiled in that. That may have been inadvertent, but the fact that she stands apart from all the other staff as the one raising these concerns, may indicate something more nefarious. The Tribunal was concerned whether she had decided to come forward in order to bolster the case against Dr Verma.

101. The Tribunal decided the evidence was weak as regards this allegation. It was also infected with a real concern that the allegation had been exaggerated or fabricated in its entirety. The GMC had not established on the balance of probabilities that this alleged behaviour took place.

102. The Tribunal therefore found paragraph 1 (e) not proved.

Paragraph 2

2. On 24 December 2019 you consulted with Patient B at Hayes Medical Centre ('the Practice'), during which you:

a. placed your hand beneath each of Patient B's breasts in turn;

b. palpated each breast with your whole hand from the bottom of the breast upwards

103. The Tribunal considered paragraphs 2 (a) and (b) in conjunction, as they formed part of the same alleged event.

104. Paragraph 2 is underpinned by the medical records and a number of other documents. The Tribunal was mindful that there are varying degrees of disagreement about the provenance, authorship and timing of certain document and hence about their reliability. The Tribunal was mindful that handwritten notes can be amended after they have been written, and that they can be difficult to reliably date. Therefore, the Tribunal decided that the most reliable evidence was that which was entered onto Patient B's medical record. There are four relevant entries. The Tribunal was satisfied that a medical record could not be retrospectively altered without an audit trail, and was therefore likely to be a reliable, contemporaneous account on the date it was produced. That is the Tribunal's starting point in approaching the documentary evidence. There may be other documents that support or undermine what is in the record. Conversely, other documents should be navigated with reference to the medical record to establish if such other documents can be relied upon. Additional accounts and sources of evidence can be used to navigate away from the starting point if appropriate.

<u>First record entry: 24 December 2019</u>

105. The Tribunal first considered the entry made by Dr Verma into Patient B's medical record, at the conclusion of the consultation on 24 December 2019:

'24 Dec 2019 10:24, GP Surgery (Hayes Medical Centre) VERMA, SK (DR)

Problem	*Upper respiratory infection (First)*
History	*Painful Throat & Cough for 5/7*
Examination	*Nose & Throat congested & Narrpow* [sic] *Chest clear*
Medication	*Amoxicillin 500mg capsules One To Be Taken Three Times A Day 21 capsule* *Pholcodine 10mg/5ml linctus strong One 5ml Spoonful To Be Taken Three Times A Day 300ml*

Comment Emergency appointment'

106. The Tribunal considered the expert witness report by Dr K, which stated:

'Dr Verma recorded a chest examination plus an examination of Patient's nose and throat. The details of these examinations vary from GP to GP but as a minimum would be a visual examination of the nose and throat plus listening to the chest using a stethoscope. In my opinion if the medical record is accepted this was an appropriate examination. … If the medical record is accepted, in my opinion Dr Verma's record, though brief, was adequate.'

107. The Tribunal accepted Dr K's opinion and determined that the entry in Patient B's medical records shows an adequate record of a clinically indicated chest examination as part of investigation into an upper respiratory infection. Dr K states that Dr Verma did not need to offer a chaperone for a basic chest exam. He also did not criticise Dr Verma's brief entry in the record.

108. The Tribunal understands the GMC's case is that this brief entry was made in the records to cover up inappropriate touching or examination of the breast by Dr Verma which was sexually motivated misconduct. The Tribunal has borne that in mind in assessing the records and other evidence.

Evidence immediately after 24 December 2019

109. The next account of the consultation, according to Patient B in her witness statement, is that, on 27 December 2019, three days later, she attended the practice and spoke to Ms A, to ask *'if the consultation was normal and explained to her that Dr Verma touched my breasts when my symptoms were my back and throat'*. Patient B stated in oral evidence that she came to the surgery to complain, and for no other reason.

110. The Tribunal considered this account alongside a handwritten note allegedly written by Ms A, which states:

'For: Ms L
Date: 27.01.2020
Time: 10.20
Pt complained about Dr SKV says Dr touched her breast. Patient was crying/very upset. Pt complained at reception reg Dr Verma, does not wish to complain further. Information passed to Mr D.

Signed: Ms A'

111. The Tribunal also considered a further handwritten note that was dated 1 February 2020, but unsigned:

> *'1.02.20*
> *I want to discuss with someone about last consultation with Dr Verma if possible in my language as I feel I was touched in a wrong way'.*

112. The GMC assert that this was a note left by Patient B at the surgery on the 1 February 2020. However, Patient B did not recognise it and could not identify who had written it when she was giving evidence before the Tribunal.

113. The Tribunal was concerned by the discrepancy between Patient B's evidence and Ms A's evidence of when Patient B first raised concerns about her appointment with Dr Verma.

114. The Tribunal attributed little weight to the handwritten note of 1 February 2020, as not only was the note undated and unsigned, but it had also been redacted in two places, and an unredacted copy was not available.

Second record entry: 1 February 2020

115. The next relevant entry in Patient B's medical records is dated 1 Feb 2020 and reads as follows:

> *'01 Feb 2020 11:41 Administration note (Hayes Medical Centre) Ms A*
>
> *Comment* *Patient came at the surgery to book her smear test appointment. She told me that she has a concern regarding her last f2f app with Dr Verma on the 24th Dec 19 when she came in for a chest infection. Says that the Dr touched her breast while examining her and she felt that was inappropriate. I asked her if she mentioned it to anyone at the time but she said that she was too embarrassed. Pt is very upset and does not wish to see Dr Verma anymore. When asked patient said no chaperone was offered. Advise that she can see any other Dr that she feels comfortable with and if any concernes* [sic] *she can always ask for a chaperone if needed.'*

116. Ms A mentions this February 2020 interaction in her witness statement. However, the Tribunal noted that Ms A does not mention that she made an entry in Patient B's medical

records recounting the conversation which she must have had with Patient B, as the entry contains more detail than the handwritten note. Her statement says:

> *'I believe that on or around 1 February 2020 the patient returned to the Practice and left a note about the incident in writing. We made attempts to contact the patient after this but we were unable to reach her for a number of months.'*

117. Indeed, Ms A's lack of recall of her entry in the medical records on 1 February 2020 is self-evident in her accounts in 2021 to Dr Q. Ms A provided an account of her interactions with Patient B, seemingly at the request of Dr Q in early 2021:

> *'The patient was a young Romanian girl, who couldn't speak much English. She first came to the reception (on the 27th January 2020) and asked to speak in private to someone in Romanian. She was clearly really embarrassed and was also crying and visually upset. She asked me if it was normal to have a "breast exam" when she came in with a problem with her throat. She told me she couldn't understand why Dr Verma had examined both her breasts, and why this was relevant to her throat/chest infection. I specifically asked the girl to clarify what she meant by a breast exam, and using her hands she demonstrated the action of clearly palpating both breasts with her hands, with her top lifted up. I asked her if the Dr had offered her a chaperone, and she declined. The patient cried throughout, and I genuinely felt sorry for her. She kept saying that she didn't want to take it any further as she felt very embarrassed and ashamed. I tried to reassure her, and explained it would be really helpful to have something in writing. Due to her limited English, she wasn't able to write anything there and then and she needed to rush to work, but she did promise to drop a note in after a few days. On the 1st Feb 2020 she left a note stating that she had been touched inappropriately by Dr Verma. I documented the conversation I had with her in the medical notes, and I had already escalated it to the practice manager.*
>
> *The patient had booked to come in for a smear, but as she didn't attend she was receiving multiple automated text messages from the surgery, reminding her to book. On November 27th 2020 she called reception and stated that she wasn't happy to come for a smear, she didn't feel comfortable about having any further examination after the incident that occurred during her face to face consultation with Dr Verma. She stated that she was happy to proceed with an investigation, and she would come in to discuss the matter. Unfortunately, when we tried to contact her again, her phone went straight to voicemail.*

On the 26th January 2021 the patient came to the surgery again. She wanted to continue with the complaint and agreed to speak to a female GP at the surgery. I helped to translate and the patient agreed to write a statement.'

118. Ms A's recounting in early 2021 of what Patient B complained about in early 2020 was clearly different to the contemporaneous accounts from that time, including her own medical record entry of 1 February 2020. The Tribunal decided that Ms A's statement contradicts Patient B's medical records. That significantly undermines this later account.

Third record entry: 3 February 2020

119. The medical record shows that Patient B attended the practice on 3 February 2020 and saw Dr M in regard to a rash.

'03-Feb-2020 17:21 GP Surgery (Hayes Medical Centre) M (Dr)

History	*poor English* *says 4/52 ago she developed itchy rash on the legs, arms, body* *no rash today*
Comment	*she showed picture on her mobile - urticarial rash* *adv to take cetirizine 10mg od* *adv to review if necessary'*

120. The fact Patient B attended the surgery, seemingly a number of times, also contradicts Patient B's later accounts that she was afraid of coming back to the surgery, and that this was why she had not followed up her smear test reminders. These are dealt with under the 27 November 2020 entries.

Patient B's Concerns as they stood in early 2020

121. At this early stage in the evidence, the Tribunal has a medical record confirming a clinically indicated chest exam. The Tribunal decided this would have included the use of a stethoscope. The note to 'Ms L' and medical record of 1 February 2020 refer to 'breast' singular. The Tribunal considered that the entry in Patient B's medical records is consistent with her asking a question about whether the examination Dr Verma undertook was appropriate. It also limited her concerns at that time to touching of her breast in the course of an examination.

122. The Tribunal noted that this differs considerably from her later accounts, that Dr Verma touched each breast, with his hand inside her bra, and palpated them (and various other later, more descriptive accounts). Those later accounts vary significantly from the narrow focus of Patient B's concern immediately after the examination.

123. There is then a long gap in terms of Patient B's complaint. It appears she did not wish to pursue it. However, she gives an alternative narrative later in 2020.

Events around 27 November 2020

124. The Tribunal then considered which document was the next most contemporaneous account. The Tribunal determined that this was a further handwritten note dated 27 November 2020:

> *'Date: 27.11.20*
> *Time: 16.30 PM*
> *Pt not happy to come in for any examination. Still worried about her f2f app with Dr Verma. She would like the matter to be investigated.'*

125. Ms A recounted this conversation in her statement made to Dr Q in early 2021:

> *'On November 27th 2020 she [Patient B] called reception and stated that she wasn't happy to come in for a smear, she didn't feel comfortable about having any further examination after the incident that occurred during her face to face consultation with Dr Verma. She stated that she was happy to proceed with an investigation, and she would come in to discuss the matter.'*

126. Ms A refers to this date in her witness statement, and says the following:

> *'On 27 November 2020 the patient called into the Practice to schedule a smear test and explained that she wasn't comfortable coming in after being seen by Dr Verma as she was concerned she may run into him. I spoke with the patient on this occasion and I may have made a note of this call, but I cannot remember if I did. I believe I also informed Ms L of the patient's call.'*

127. The Tribunal has not been provided with any evidence that any action was taken in regards to this complaint being raised, if indeed it was raised on 27 November 2020 as claimed.

128. Patient B sets out her reasons why she had not attended the surgery in her account of the 27 January 2021:

> *'I was being invited to a smear test and other appointments during 2020 but I didn't respond as I was too scared to see Dr Verma again. It was around this time I was advised by Ms A about the option I had of making a complaint to the practice. I decided to write a statement to the Practice which I did on 27 January 2021'.*

129. The Tribunal found that while Patient B had apparently stated that she was not comfortable to come in for her smear exam, she had attended the surgery since her consultation with Dr Verma on 24 December 2019 on 3 February 2020. She also attended to make her complaint though there remains a question in the evidence over whether this happened on 27 January 2020 or 1 February 2020, or that there were two separate visits. The Tribunal found that this undermines Patient B's claim that she was unable to come into the Practice for fear of seeing Dr Verma. That is particularly given that the complaint was not being proceeded with early in 2020, there was a long gap between then and the note of 27 November 2020 being produced. There is no action taken as a result of it. Those matters cast doubt as to its provenance. All of those factors point to a potentially contaminated narrative between Ms A and Patient B as to the reliability of Patient B's account.

<u>Fourth record entry: 26 January 2021</u>

130. The Tribunal further took into account an entry in the medical records dated 26 Jan 2021. It dealt with a complaint by Patient B but she also sought medical advice in relation to a rash. The relevant part states as follows:

> *'26 Jan 2021 16:30 Telephone consultation (Hayes Medical Centre) Q (Dr)*
>
> *History Asked by reception staff to talk to patient regarding a complaint, Ms A present as interpreter.*
> *Refer to complaint file for details of complaint...'*

131. The Tribunal noted that Ms A's written account for Dr Q likely followed the telephone consultation between Dr Q, Patient B, and Ms A on 26 January 2021. The Tribunal was concerned that this appointment was not conducted with a professional interpreter, nor was Dr Q investigating the complaint at that point. Further, the Tribunal has not been provided with the '*complaint file'* that Dr Q refers to in her entry. That undermined the weight to be attached to it as a reliable account of events.

132. The Tribunal decided that Ms A has been involved with the majority of the interactions Patient B has had with surgery staff up until this point.

Escalation of Patient B's complaint in early 2021

133. The next account given by Patient B is the statement provided to the Practice. The Tribunal was mindful that while the Romanian version is signed and dated 27 January 2021, the English translation, provided by Ms A, is not signed or dated.

134. Ms A recounts in her witness statement how this statement was produced:

> *'On 26 January the patient returned to the Practice in person and told us that she was ready for us to look into her allegations and she wanted to help. On this same date Dr Q asked that the patient write a statement of what happened. The patient returned on the following day to provide us with her typed statement in Romanian. As I speak Romanian, I offered to translate the patient's statement with her and I translated it with the patient next to me in the room upstairs at the Practice.'*

135. The statement is as follows:

> *'Approximately one year ago, more precisely in Dec 2019 I rang the surgery because I was coughing and my upper back was hurting. I was booked with Dr Verma and explained what the problem was. I do not remember if he looked down my throat at the beginning. I was not asked if I want a witness (chaperone) during the consultation. After explaining my reason for being there Dr Verma asked me to lift my blouse which I did, keeping only my bra on. He then slowly started touching my back and asked me if I felt any pain in certain places on my back. Sitting on the chair in front of me he started touching me starting with my back and slowly coming towards the front, underneath my breast and slowly started palpating my left breast holding it with his whole hand and looking into my eyes all this time he asked me if I am ok and then he grabbed my right breast and asked me the same thing. When he touched me like that I was very surprised as I wasn't warned and I did not understand what the was connection could be between my throat pain the examination of my breasts.'*

136. The Tribunal considered that while this is the first detailed account that Patient B provided, and the GMC contend that it is the most contemporaneous document, it was produced more than a year after events took place, was translated by Ms A who is not a professional translator and was herself involved in other allegations against Dr Verma, and it differs greatly from the previous accounts given. The Tribunal therefore found that this was not a reliable, nor contemporaneous account of events.

137. The Tribunal then considered the statement provided to NHS England in May 2021. The Tribunal was not aware of when, why and by whom the matter was referred to NHS England. The Tribunal was mindful that, as with the above statement from January 2021, Ms A acted as an interpreter for Patient B, and no official translation of the account was provided.

138. In the NHS England statement, Patient B describes the incident as follows:

> *'Pt B said that she had experienced a sore throat and bad cough with some backpain on coughing. She was concerned that it might be something serious. Her husband had called the surgery and made the appointment for her about two hours prior to the consultation . Her appointment was also during the morning.*
>
> *Pt B said that she had never seen Dr V before her consultation with him. She said that she arrived at the surgery expecting to see a female doctor…*
>
> *She knocked on the consulting room door and entered. Dr V had said something to the effect of 'Hello, come and sit down.'*
>
> *She had sat in the chair at the side of the consulting desk and Dr V had been in front of the long edge of the desk. She said that at one point he had pulled his chair towards her. …*
>
> *Pt B said that Dr V had turned his chair so that he was face to face with her and wheeled his chair towards her with his legs opened. He had pulled his chair up very close to her.*
>
> *Pt B said overall reliving the event made her feel very embarrassed as she felt almost as though she was cheating on her husband. She said that Dr Verma had asked her what was bothering her and why she had come to the surgery. He asked her where it hurt She said that his words at the beginning seemed normal for a doctor. She told him that she had throat pain, a cough and her back was hurting when she coughed.*
>
> *She said that the whole consultation was not much longer than five minutes.*
>
> *She said that Dr V had not told her he needed to examine her but instead had just asked her to lift up her top. The top she had been wearing was the type which came up at the back and front when lifted and it wasn't possible to only lift one side. She said*

she had been wearing a bra but commented again that she had believed she would be seeing a female doctor.

She said that Dr V began his examination of her, still sitting in his chair but leaning inwards towards her and putting his stethoscope on her back. He had then used his hand pressing her back and asking if it hurt As his hands moved down her back, she could feel the tips of his fingers creep around the sides onto her breasts. He had used his whole hand on her back, but it was just the tips of the fingers that were touching her breasts. He had then used his stethoscope on the front of her chest.

He had put the head of the stethoscope over different parts of her chest and had moved it downwards at her bra line. She said that she had now known how to react and was confused. He had then begun touching her with his hand and pressing using his whole hand, starting from the bottom of the breast and moving up the breast, bit by bit, until he had felt the whole breast. Every time he pressed, he asked her if it hurt. He didn't touch her chest area. He repeated the same on the right breast. She commented that her own hands were holding up her blouse throughout the examination.

Pt B said that Dr V's hands went inside her bra but that this was only on her left side as she believed that her eyes must have signalled her shock and discomfort, so he did not do this on her right side. He did not touch her nipple on either breast.

The examination had been with the flat of Dr V's hands and he had not cupped her breasts at any point.'

139. The Tribunal noted several inconsistencies between this account and Patient B's other accounts. Firstly, that Patient B described a stethoscope being used, however she does not mention a stethoscope in her GMC statement, and in her oral evidence she denied that a stethoscope was used. Secondly, she states that Dr Verma only put his hand inside her bra on the left side, but in oral evidence was clear that he put his hand inside her bra on both sides, and this again differs to her account on 27 January 2021 where she does not mention that Dr Verma put his hand inside her bra at all.

140. The Tribunal considered that this second and more detailed account shows an embellishment of the details, going further than previous accounts to include touching inside the bra, touching of both breasts, touching the whole of the breasts, and reframing the event as highly sexualised.

141. The Tribunal finally considered Patient B's account prepared for these proceedings, in which she states:

> *'When I entered the room for the consultation, we both were sitting on chairs and Dr Verma asked me to tell him about my symptoms. I explained that my upper back was hurting and I was coughing. I cannot recall if Dr Verma looked at my throat. Dr Verma did not mention anything about needing a chaperon, he just asked me to lift my blouse and did not explain a reason for this. When I lifted my blouse, I still had my bra on. Dr Verma then pressed my back with one hand and asked if this was painful, I said yes. Whilst he was still sat in the chair, he moved his hand from my back to my left breast in my bra and was palpating is, holding it in his hand. At this point Dr Verma looked directly into my eyes and asked if I was ok, I didn't say anything. He then moved his hand to my right breast, felt it up and down, and again asked me if I was ok.'*

142. The Tribunal considered that this account again differed from the NHS England account, and the 27 January 2021 account. Firstly, there is no mention of a stethoscope being used at all. Secondly, the description of how Dr Verma touched her breast has changed from '*starting from the bottom and moving up bit by bit'* to '*in my bra and was palpating it'*, which are significantly different actions. Finally, the Tribunal noted the use of medical language in this statement which differs from those before, for example '*symptoms', and 'palpate'*.

143. The Tribunal took into account that while Patient B was provided with an interpreter while this account was taken by the GMC, Ms A was present in the room. This occurring, at the settling of the GMC statement was a serious irregularity. Ms A then altered Patient B's witness statement after it has been signed. An email was provided to the Tribunal which indicated Ms A had responded to the GMC paralegal as follows:

> *'Before I send the statement, I would like to mention that in paragraph 7 it has been mentioned [that Patient B] has been encouraged by me to write a statement when in fact she has been advised about the options that she have (sic).'*

144. The material change was to alter the word 'encourage' which appears in the Romanian version, with the word 'advise' in the English version. Patient B told the Tribunal that she was happy with the Romanian version of her statement in which the Romanian word 'encourage' had not been amended. Tribunal had been provided with both versions, purportedly signed on the 25 October 2021 even though Ms A had emailed the GMC on the 27 October 2021 with the proposed amendment. The Tribunal considered that it is possible that Ms A's involvement in the original 27 January 2021 statement, NHS England statement,

and GMC statement, has resulted in contamination between their accounts, and may have contributed to the escalation and embellishment of Patient B's account given the similarity with the terminology being used. Mr Haycroft made extensive submissions as to the catalogue of irregular occurrences in this case. The Tribunal accepted those submissions and that Ms A's involvement was improper.

145. The Tribunal also took into account the context of events at the Practice at the time this complaint was made, January 2021. Dr Verma states that on 21 January 2021, he declined to sign updated contracts regarding his partnership at the Practice and this dispute escalated in the following weeks. In a meeting attended by Dr F and Dr Verma on 20 February 2021, it was indicated to Dr Verma that the '*Practice could write to the GMC to retract the complaint*' if Dr Verma was to agree to the new contract, which Dr F confirms. The Tribunal was concerned that the Practice's ongoing dispute with Dr Verma may have influenced their decision to refer Patient B's complaint to the GMC, and further that the Practice may have influenced Patient B in some way.

146. Finally, the Tribunal took into account the evidence of Mr H, that Dr Verma had been concerned for some time about the mismanagement at the Practice, and considered that this may have contributed to tensions between Dr Verma and the other partners and managers:

> *'In October 2020, Dr Verma became so concerned about activities within the practice that he came to meet me and set out his worries about the management and staffing of the surgery and the way he was being treated.*
>
> *At that meeting he explained that as a result of his engagement in highlighting the need for reforms at the practice, he was being intimidated as a result of collusion between the other partners and staff. Because he had exposed serious weaknesses in the operation of the surgery and the ongoing failure to address these issues, he was being treated as a troublemaker.*
>
> *He was extremely concerned for the safety of patients. His concerns included the appointment of the practice manager and the veracity of his qualifications for the post, the failure of the practice manager to address the issues of clinical safety that he, Dr Verma, had raised, and the capacity of the management team to tackle the weaknesses identified by two CQC appraisals.'*

147. In conclusion, the Tribunal, taking the most contemporaneous accounts from December 2020 and January 2021, concluded that it was more likely than not that Dr Verma had conducted a clinically indicated chest exam using a stethoscope, and Patient B may have

been confused as to why he had done this. That is particularly so given: a) this was a short, emergency consultation; b) she had been expecting to see a female doctor; c) she spoke 'poor English'; and d) Dr Verma spoke English with a strong accent which she may not have fully understood. Further, it is possible that he had touched her breasts accidentally, either with some part of his hand or with his stethoscope. The Tribunal determined that Patient B's later accounts, in January 2021, May 2021, October 2022, and in her oral evidence, have become exaggerated and embellished, most likely through a combination of her own misremembering of the event, the unprofessional translation of her accounts, and Ms A's involvement as a member of staff from the Practice, which was involved in an ongoing dispute with Dr Verma.

148. The Tribunal therefore found paragraphs 2 (a) and (b) not proved.

Paragraph 3

149. Having found that Dr Verma did not undertake the actions as described at paragraph 2, paragraph 3 of the Allegation must be found not proved.

The Tribunal's Overall Determination on the Facts

150.The Tribunal has determined the facts as follows:

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

1. On one or more occasion between 2018 to 2019 you behaved inappropriately towards colleagues in that:

    a. you aggressively shouted at one or more colleague;

    Determined and found not proved.

    b. you aggressively shouted at Ms A whilst in reception in front of patients and other colleagues;

    Determined and found not proved.

    c. on a single occasion whilst alone in your office with Ms A, you stood up quickly and leant over the desk towards her whilst shouting at her;

    Determined and found not proved.

    d. you inappropriately touched Ms A's shoulder and hand;

Determined and found not proved.

e. you inappropriately gazed at Ms A's breasts when speaking to her.

Determined and found not proved.

2. On 24 December 2019 you consulted with Patient B at Hayes Medical Centre ('the Practice'), during which you:

a. placed your hand beneath each of Patient B's breasts in turn;

Determined and found not proved.

b. palpated each breast with your whole hand from the bottom of the breast upwards.

Determined and found not proved.

3. Your actions as described at paragraph 2 were:

a. undertaken without you explaining to Patient B:

i. what you were going to do;

Determined and found not proved.

ii. that Patient B could refuse;

Determined and found not proved.

b. not clinically indicated;

Determined and found not proved.

c. sexually motivated.

Determined and found not proved.

4. On 9 February 2021, you accessed medical records of one or more members of staff at the Practice on the EMIS system as set out in schedule 1, without reasonable justification for doing so.

Admitted and found proved.

~~5. On 20 February 2021 you had a meeting at the Practice with Dr C and Mr D during which you:~~

~~a. refused to sign a GMS variation of contract unless the Practice retracted a complaint made against you to the GMC [relating to Patient B] ('the Complaint'), or words to that effect;~~

~~b. threatened to sue the Practice if it did not retract the Complaint or words to that effect.~~ Withdrawn.

~~6. On 22 February 2021 you called Dr C's home phone and you:~~

~~c. were verbally aggressive towards Dr C, including shouting at Dr C;~~

~~d. threatened Dr C that you "would sue the Surgery for compensation" or words to that effect.~~ Withdrawn.

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

Determination on Impairment - 16/08/2023

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

The Evidence

152. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence as follows.

153. Dr Verma provided his own witness statement dated 16 August 2023, in which he stated that as part of his remediation he has reflected on his actions of 9 February 2021 when he accessed his colleagues' medical records. Dr Verma stated that at the time, he was extremely concerned about the standards of care at the Practice and felt that he was being pushed out of the Partnership by the practice manager. Dr Verma apologised for his actions and stated that he has undertaken CPD to refresh his memory about confidentiality.

154. The Tribunal also received in support of Dr Verma three testimonials, one from Dr S, a former colleague of Dr Verma's at the Practice, and two from former patients.

155. The Tribunal also received certificates for CPD courses which Dr Verma has undertaken between May 2021 and August 2023.

Submissions

156. On behalf of the GMC, Ms Renton submitted that the admission to paragraph 4 of the Allegation amounts to serious misconduct. Ms Renton reminded the Tribunal of the expert report of Dr K, in which he states that:

> *'if there was no medical reason to access the records Dr Verma was in breach of data protection. In my opinion this would be in breach of the standard of behaviour expected of a reasonably competent General Practitioner and if shown that there was no medical reason for this breach would be seriously below the standard, in my opinion.'*

157. Ms Renton further submitted that data protection is an important consideration for any doctor, and Dr Verma has conceded this in his witness statement. Ms Renton submitted that regardless of any ongoing dispute between the doctors at the Practice and the staff, they were entitled to privacy of their medical information. Ms Renton submitted that regardless of Dr Verma's intentions, he did not respect formal procedures for dealing with complaints of the nature he was making, and it is not for Dr Verma to supplant the place of any investigatory body. Ms Renton submitted that according to the witness statement of Ms Sharon Windsor, Dr Verma had attempted to access the medical records on a second occasion.

158. Ms Renton submitted that Dr Verma has breached paragraphs 35 and 36 of Good Medical Practice (2013, as amended) ('GMP'). Ms Renton submitted that Dr Verma's misconduct was behaviour which falls seriously below the standard to be expected, and that Dr Verma has failed to uphold the reputation and standards of the medical profession, meaning the profession has been called into disrepute.

159. In regard to insight, Ms Renton submitted that Dr Verma has shown some insight in his witness statement and accepts that accessing the records was inappropriate regardless of his intention. Ms Renton further accepted that Dr Verma appears to show remorse and has made attempts at remediation as far as is possible, however submitted that while there is no

obvious reason to believe that Dr Verma would act in this manner again, it is impossible to know what is in someone's mind before they make such a poor decision, even taking into account remediation undertaken.

160. In regard to the overarching objective, Ms Renton submitted that there are no patient safety issues in this case, however a finding of impairment is necessary to uphold public confidence in the profession, as the public may be concerned that a doctor would access medical records without good reason, and further that a finding of impairment is necessary to uphold proper standards in the profession. Ms Renton submitted that a finding that Dr Verma's fitness to practise is not impaired would seriously undermine limbs (b) and (c) of the overarching objective, as his actions represent a serious departure from what would be expected of a doctor in his position.

161. On behalf of Dr Verma, Mr Haycroft submitted that Dr Verma accepts, with the benefit of hindsight, that he breached paragraphs 50 and 65 of GMP, as well as paragraph 120 of the Confidentiality Guidance:

> *'120 You must not access a patient's personal information unless you have a legitimate reason to view it.'*

162. As such, Mr Haycroft submitted that Dr Verma accepts that paragraph 4 of the Allegation amounts to serious misconduct. Mr Haycroft submitted that while Dr Verma had a justification for doing so, namely his concern for patient safety, this justification was not a 'reasonable' or 'legitimate' one (in law). Mr Haycroft submitted that there was a reasonable and legitimate reason for the records to be accessed but not by Dr Verma, and he went about it in the wrong way. Mr Haycroft submitted that while this was not a case of the records being accessed for gratuitous or personal reasons, Dr Verma should have made the appropriate referrals and allowed investigation to take place.

163. Mr Haycroft submitted that a finding of impairment should only be made on public interest grounds, and not on the basis of public protection. Mr Haycroft submitted that Dr Verma has shown significant insight in that he has: apologised, acted wholly out of character in an otherwise unblemished 50-year career, undertaken appropriate CPD, shown genuine remorse, and engaged throughout the process, XXX.

164. Mr Haycroft submitted that Dr Verma has done all he can to remediate his past actions and that the risk of repetition is low. Finally, Mr Haycroft submitted that if the Tribunal consider that there is current impairment in this case it should not be on a personal

level as there is clearly no current risk to patient safety, however it may be found on the basis of public interest.

The Relevant Legal Principles

165. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

166. 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 serious misconduct and then whether the finding of that misconduct which was serious could lead to a finding of impairment.

167. The Tribunal must determine whether Dr Verma's fitness to practise is impaired today, taking into account Dr Verma's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

168. The Tribunal was referred to the test for impairment as set out in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) (*'Grant'*):

> *'a) Whether the registrant has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;*
>
> *b) Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;*
>
> *c) Whether the registrant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession. … '*

169. The Tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 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.

The Tribunal's Determination on Impairment

Misconduct

170. The Tribunal considered that Dr Verma, in accessing his colleagues medical records, had failed to adhere to the following paragraphs of GMP:

'50 You must treat information about patients as confidential. …

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

171. The Tribunal further considered that Dr Verma had failed to adhere to paragraph 120 of the Confidentiality Guidance:

'120 You must not access a patient's personal information unless you have a legitimate reason to view it.'

172. The Tribunal took into account Dr K's report; however, it was mindful that Dr K caveated his opinion by clearly stating that he wished to avoid commenting beyond his expertise on matters of data protection and could only comment on the standards to be expected of a competent GP. The Tribunal further considered that Dr K had not been made aware of the full circumstances surrounding Dr Verma's actions, in particular the ongoing conflict at the Practice which at the time Dr Verma believed justified his actions.

173. The Tribunal, in its determination on the facts, has set out in some detail the background matters at the Practice. This background is relevant to the Tribunal's assessment at this stage as well. The Tribunal accepted the account given by Dr Verma, that, at the time, he believed he was acting in the best interests of his patients and had real concerns about the conduct of his colleagues, in particular his GP Partners and the practice manager. The tribunal noted he had already raised these concerns with his local MP. In his witness statement, Dr Verma stated:

'I consider I tried my best in the circumstances to voice my concerns to the other Partners, however my concerns were ignored, and it very much felt like I was being pushed out of the Partnership. I consider that when I voiced my concerns this gave Mr D a catalyst to remove me from the picture. I was not a GP Partner who would stand and watch quietly whilst the Practice began to fail. It was extraordinarily disappointing when I found evidence that some of the staff members at the Practice had been XXX. At this point I had already resigned from my role as a GP Partner at the Practice, a role I had been holding for over 24 years, three days prior, however I still felt let down by my colleagues. I understand now that I should not have attempted to do my own investigations.'

174. In his submissions on behalf of Dr Verma, Mr Haycroft accepted that the allegation amounts to serious misconduct.

175. The Tribunal determined that whatever Dr Verma's well-meaning justification at the time, his actions in accessing the medical records of colleagues amounted to a serious departure from GMP and a breach of professional standards. The Tribunal notes Dr Verma now accepts this with the benefit of hindsight. The Tribunal bore in mind the importance of every patient's medical record remaining confidential and was mindful that even though Dr Verma was looking into specific matters, he may have unintentionally come across deeply personal and private matters. The Tribunal therefore determined that Dr Verma's actions constituted a breach of professional standards, namely confidentiality.

176. The Tribunal bore in mind that Dr Verma was a partner at the Practice for some 24 years and has maintained his good character throughout his 50 years of medical practice. The Tribunal took into account that Dr Verma only accessed his colleagues' medical records on one occasion. It appeared that this all happened around the same time of day. Therefore, it considered that this was more likely to be a lapse in judgment under what were likely to have been stressful and exceptional circumstances. This led to poor decision making, rather than being a character flaw of any kind.

177. The Tribunal has given careful thought to whether Dr Verma's actions, when viewed in light of the exceptional circumstances in the case did indeed amount to serious misconduct. The Tribunal considered that other members of the profession, and members of the public, fully apprised of the facts of this case, may have had a different view about why Dr Verma acted in the manner he did, and as such, the decision to find serious misconduct was a finely balanced one.

178. On this finely balanced decision, the Tribunal has concluded that Dr Verma's conduct amounted to misconduct which was serious.

Impairment

179. The Tribunal, having found that the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct, Dr Verma's fitness to practise is currently impaired.

180. The Tribunal first considered whether Dr Verma has shown insight into his actions. The Tribunal was satisfied the totality of the evidence shows full insight and full remediation.

In his statement, for example, Dr Verma says, '*I have refreshed my memory about confidentiality and can only apologise for improperly accessing the medical records and assure the MPT it will not happen again*'. The Tribunal further took into account that Dr Verma has undertaken extensive CPD over the last two years (including courses directly relevant to this misconduct), has shown genuine remorse, and has engaged fully with the regulatory process.

181. The Tribunal then considered whether there is a risk of repetition in this case. The Tribunal concluded that the risk of repetition is so low as to be remote. The Tribunal took into account that Dr Verma has shown complete insight into his actions and has remediated his misconduct. The Tribunal further considered that it is highly unlikely that Dr Verma will find himself in the exceptional circumstances in which he found himself at the Practice ever again. There is nothing to support the contention that Dr Verma has an ongoing issue regarding 'poor decision making'.

182. The Tribunal considered that Dr Verma has failed to adhere to GMP and the Confidentiality Guidance. The Tribunal accepted that accessing medical records in this manner was a breach of professional standards. It was mindful that the overarching objective might not be upheld if a finding of impairment was not made. The Tribunal made this finding of impairment solely on the basis of Dr Verma's past conduct which occurred in exceptional circumstances and is extremely unlikely to be repeated. There is no future risk.

183. Again, this was a finely balanced decision but overall, the public interest required the past misconduct to be properly marked.

184. The Tribunal therefore found that a finding of impairment is necessary 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.

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

Determination on Sanction - 17/08/2023

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

The Evidence

187. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

Submissions

188. On behalf of the GMC, Ms Renton submitted that the appropriate sanction in this case is suspension. Ms Renton submitted that the mitigating features are the doctor's good character, the lapse of time since the incident occurred, the insight, remorse and remediation which Dr Verma has shown, and the low risk of repetition. Ms Renton submitted that the aggravating factors in this case are abuse of professional position, in that it was a poor decision to look at records which was only possible due to Dr Verma's status as a doctor, breach of professional standards, and the finding of serious misconduct.

189. Ms Renton submitted that to take no action in this case would not be appropriate. Ms Renton referred the Tribunal to paragraphs 19 and 68 of The Sanctions Guidance (2020) ('SG') and submitted that this is not one of those cases where a decision to take no action would be appropriate, because although the decision was finely balanced, the Tribunal has found that Dr Verma's misconduct was serious.

190. Ms Renton submitted that conditions would not be appropriate in this case. Ms Renton further submitted that conditions would not be workable and directed the Tribunal to the factors set out in paragraph 81 of the SG.

191. Ms Renton directed the Tribunal to consider paragraphs 91 and 92 of the SG in relation to suspension. Ms Renton submitted that the public interest limbs of the overarching objective are engaged in this case and a sanction of suspension would be appropriate. Ms Renton further submitted that whilst the misconduct of Dr Verma has been found to be serious, the GMC accepts that it is not fundamentally incompatible with continued registration. Ms Renton submitted that, nevertheless, it is important that a signal is sent out regarding behaviour befitting a doctor, and however well-meaning they may be, a doctor should not try to supplant the role of a regulator or prosecuting authority.

192. Ms Renton directed the Tribunal to paragraph 93 of the SG and submitted that this is fully applicable to this case, given that the doctor has accepted this allegation at the outset and the Tribunal has previously found that there is a low risk of repetition. Ms Renton further submitted that the factors at paragraph 97 a, e, f, and g are applicable in this case, and that suspension would therefore be an appropriate and proportionate sanction in this case,

addressing the two limbs of the overarching objective which are engaged. Ms Renton submitted that the suspension need not be lengthy and that no review is sought.

193. Finally, Ms Renton directed the Tribunal to paragraphs 107 and 108 of the SG and submitted that erasure is not necessary to maintain the high standards of the profession, in circumstances where the doctor has engaged and presented information which might mitigate or assuage the Tribunal's concerns over his misconduct and the likelihood of repetition of the same.

194. On behalf of Dr Verma, Mr Haycroft submitted that the appropriate sanction in this case is to take no action. Mr Haycroft submitted that the mitigating factors are as follows: Dr Verma has shown insight and made an apology, Dr Verma has no prior fitness to practise history, Dr Verma was suffering from work related stress at the time, there has been a significant lapse of time without repetition, Dr Verma has remediated his misconduct, and Dr Verma has expressed regret. Mr Haycroft submitted that the only aggravating factor in this case is that Dr Verma has abused his professional position, albeit with the best of intentions.

195. Mr Haycroft submitted that while the public interest is important, it is also in the public interest to retain and get back to work in an unrestricted manner, an otherwise good clinician. Mr Haycroft further submitted that the Tribunal's concern with public confidence in the profession would not be carried to the extent of feeling it necessary to sacrifice the career of an otherwise competent doctor.

196. Mr Haycroft directed the Tribunal to paragraphs 68 – 70 of the SG and submitted that the exceptional circumstances which exist in this case are that: this is an unusual and exceptional case, as set out in the impairment decision, the admitted failure was the first failure in Dr Verma's 50 years of practice, this was a lapse of judgment under stressful circumstances, Dr Verma has shown insight, there is a low risk of repetition, Dr Verma has accepted his failure amounted to serious misconduct, it would be unjust to place Dr Verma in a worse position than if he had not remediated and conditions might have been felt appropriate, there is no public protection element in this case, and a finding of impairment alone suffices to meet the public interest whereby it is properly marked.

197. Mr Haycroft submitted that if the Tribunal did choose to impose a period of suspension on Dr Verma's registration, it should be for the shortest possible period and with no review. Mr Haycroft finally submitted that erasure would be disproportionate since the misconduct was not fundamentally incompatible with continued registration.

The Tribunal's Determination on Sanction

198. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken the SG into account and borne in mind the overarching objective.

199. The Tribunal reminded itself that the main reason for imposing any 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. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Verma's interests with the public interest.

200. The Tribunal has already set out its decision on facts and impairment which it took into account during its deliberations on sanction. Before considering what action, if any, to take in respect of Dr Verma's registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case.

201. When considering the SG, the Tribunal considered paragraphs 17 – 20 of the SG particularly relevant:

> *'17 Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession (see paragraph 65 of Good medical practice). Although the tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.*
>
> *18 Failure to follow Good medical practice does not automatically mean action will be taken. The guidance sets out the principles of good practice, not thresholds at which it is considered a doctor is unsafe to work.*
>
> *19 Good medical practice is the benchmark that doctors are expected to meet subject to any mitigating or aggravating factors. Action is taken where a serious or persistent breach of the guidance has put patient safety at risk or undermined public confidence in doctors.*
>
> *20 In deciding what sanction, if any, to impose the tribunal should consider the sanctions available, starting with the least restrictive. It should also have regard to the principle of proportionality, weighing the interests of the public against those of the doctor (this will usually be an impact on the doctor's career, eg a short suspension for a doctor in training may significantly disrupt the progression of their career due to the nature of training contracts).'*

202. The Tribunal was satisfied that the proper reading of those paragraphs is that action should be taken where there is a serious breach of professional standards which undermined public confidence in the profession. However, in acknowledging the mitigating and aggravating factors, the Tribunal considered that there is scope to consider a gradation of seriousness, and furthermore that the overall sanction needs to be proportionate and give effect to the overarching objective.

Aggravating Factors

203. The Tribunal considered the submission that paragraph 55 (d) is a relevant aggravating factor in this case. This states:

> *'55 Aggravating factors that are likely to lead the tribunal to consider taking more serious action include:*
>
> *…*
>
> *d abuse of professional position (see paragraphs 142–150), particularly where this involves:*
>
> *i vulnerable patients*
> *(see paragraphs 145–146)*
>
> *ii predatory behaviour*
> *(see paragraphs 147–148)'*

204. The Tribunal accepts that while it is correct that Dr Verma could not have accessed his colleagues' medical records save for his position as a doctor, the predominant intention of paragraph 55 (d) is to deal with doctors who exploit patients from the position of power which a doctor occupies. The Tribunal considered paragraphs 142 – 150 which refer to improper sexual and emotional relationships with patients, treating vulnerable patients, predatory behaviour, and sexual misconduct. The Tribunal considered that it would be excessive to say that Dr Verma using his computer login to access medical records is an abuse of power. The Tribunal therefore concluded that the 'abuse of professional position' does not encapsulate the misconduct in this case. There is also a risk of double counting. The issue in this case is about breach of confidentiality and the SG does not list this as an aggravating feature.

205. The Tribunal further considered that in its determination on impairment it stated the following:

> *'The Tribunal accepted the account given by Dr Verma, that, at the time, he believed he was acting in the best interests of his patients and had real concerns about the conduct of his colleagues, in particular his GP Partners and the practice manager. '*

206. The Tribunal considered that it would be perverse to make the finding that Dr Verma's misconduct was an abuse of his professional position. The Tribunal accepted that Dr Verma was attempting to uphold proper standards at the Practice by looking for evidence of

wrongdoing. The Tribunal has set out what it makes of Dr Verma's intention in the previous determinations and particularly when it made the finely balanced decision that his actions amounted to misconduct and on impairment.

207. The Tribunal rejected the submission that Dr Verma was attempting to 'supplant' the role of the regulator, which constituted an abuse of his professional position. The Tribunal considered that Dr Verma was looking at the records in order to determine if his suspicions were correct, before he raised the issues with the GMC and other relevant bodies. Although looking at the records was wrong, he was not intending to take on the role of investigator, but to confirm his suspicions to support any serious allegation he may make.

208. The Tribunal further rejected the submission that the reference to 'serious' misconduct in the Tribunal's impairment decision meant 'serious' formed an aggravating feature. All cases reaching sanction stage have established 'serious' as an inherent part of establishing impairment, as required under case law. The GMC's argument that 'serious' was an aggravating feature in and of itself was wrong. However, the Tribunal accepted that there are gradations of seriousness, and in some cases, this may require closer scrutiny to determine whether this forms an aggravating feature. The converse is also true in terms of whether a matter was less serious.

209. In conclusion, the Tribunal considered the remaining aggravating circumstances listed in the SG and was unable to identify any others. It determined that no aggravating features apply in this case.

Mitigating Features

210. The Tribunal took into account the factors listed at paragraphs 24 and 25 of the SG:

> *'24 The tribunal needs to consider and balance any mitigating factors presented by the doctor against the central aim of sanctions (see paragraphs 14–16). The tribunal is less able to take mitigating factors into account when the concern is about patient safety, or is of a more serious nature, than if the concern is about public confidence in the profession.*
>
> *25 The following are examples of mitigating factors.*
>
> > *a Evidence that the doctor understands the problem and has insight, and of their attempts to address or remediate it. This could include the doctor admitting facts relating to the case, apologising to the patient (see paragraphs 42–44), making efforts to prevent behaviour recurring, or correcting deficiencies in performance or knowledge of English.*
> >
> > *b Evidence that the doctor is adhering to important principles of good practice (ie keeping up to date, working within their area of competence), and of the doctor's character and previous history. This could include evidence that the doctor has not previously been found to have impaired fitness to*

practise by a tribunal, a previous MPTS panel or by the GMC's previous panels or committees.

c *Circumstances leading up to any incidents that raise concern – eg inexperience (see paragraphs 27–30) or a lack of training and supervision at work.*

d *Personal and professional matters, such as work-related stress.*

e *Lapse of time since an incident occurred.'*

211. The Tribunal was satisfied that the majority of the mitigating factors at paragraph 25 apply in this case.

212. In regard to 25 (a), the Tribunal has found the following in its decision on impairment:

'The Tribunal was satisfied the totality of the evidence shows full insight and full remediation.'

213. In regard to 25 (b), the Tribunal has found the following in its decision on impairment:

'The Tribunal further took into account that Dr Verma has undertaken extensive CPD over the last two years (including courses directly relevant to this misconduct), … The Tribunal bore in mind that Dr Verma was a partner at the Practice for some 24 years and has maintained his good character throughout his 50 years of medical practice.'

214. In regard to 25 (c), the Tribunal has, in its decision on the facts, set out the extensive background to this case, and has rehearsed these matters in the finely balanced decision on impairment and misconduct. These issues are dealt with further below.

215. In regard to 25 (d), the Tribunal has found the following in its decision on impairment:

'Therefore, it considered that this was more likely to be a lapse in judgment under what were likely to have been stressful and exceptional circumstances. This led to poor decision making, rather than being a character flaw of any kind.'

216. Finally, in regard to 25 (e), the Tribunal bore in mind that this incident occurred more than 2 years ago, and there is no evidence that the misconduct has been repeated since.

No action

217. The Tribunal first considered whether to conclude the case by taking no action.

218. The Tribunal took into account, in particular, paragraphs 68 - 70 of the SG:

'68 Where a doctor's fitness to practise is impaired, it will usually be necessary to take action to protect the public (see paragraphs 14–16). But there may be exceptional circumstances to justify a tribunal taking no action.

69 To find that a doctor's fitness to practise is impaired, the tribunal will have taken account of the doctor's level of insight and any remediation, and therefore these mitigating factors are unlikely on their own to justify a tribunal taking no action.

70 Exceptional circumstances are unusual, special or uncommon, so such cases are likely to be very rare. The tribunal's determination must fully and clearly explain:

a what the exceptional circumstances are

b why the circumstances are exceptional

c how the exceptional circumstances justify taking no further action.'

219. The Tribunal further took into account paragraphs 14- 16 of the SG, as referred to at paragraph 68:

'14 The main reason for imposing sanctions is to protect the public. This is the statutory overarching objective, which includes to:

a protect and promote the health, safety and wellbeing of the public

b promote and maintain public confidence in the medical profession

c promote and maintain proper professional standards and conduct for the members of the profession.

15 Each reference to protecting the public in this guidance should be read as including the three limbs of the overarching objective set out in paragraph 14.

16 Sanctions are not imposed to punish or discipline doctors, but they may have a punitive effect.'

220. The Tribunal noted that, as stated in paragraph 68 of the SG, it would usually be necessary to take action to protect the public, and has acknowledged this in relation to upholding the overarching objective in its decision on impairment:

'The Tribunal therefore found that a finding of impairment is necessary 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.'

221. The Tribunal is satisfied that the use of the word 'usually' in paragraph 68 of the SG allows for a situation where the Tribunal may consider that taking no action is permissible, but only if exceptional circumstances apply. For the reasons set out earlier, the Tribunal was not persuaded by the GMC submission that the Tribunal's references to 'serious' in the decision on impairment create a bar to taking no action being considered at this stage. Mr Haycroft submitted that the GMC's submission on this matter was a 'non sequitur' and the Tribunal agrees with that submission.

222. The Tribunal is satisfied that it is able to put the factual matrix of the allegation into its proper context. The Tribunal accepts that in some circumstances the seriousness of the misconduct is such it would require a specific course of action, which may include a sanction further up the 'scale', however the converse is also true. A proper fact-sensitive consideration of a case may disclose exceptional circumstances which can permit no action being taken.

223. The Tribunal first considered whether exceptional circumstances arise in this case. The Tribunal concluded that the exceptional circumstances in this case are that Dr Verma had, at the relevant time, come to the end of a long association with a practice where he was a partner, and was facing what he perceived as a deliberate attempt to exclude him from the Practice. Dr Verma had been trying for some time to escalate or raise concerns about standards at the Practice. When he accessed the medical records, he was seeking to find evidence in order to communicate his concerns to the relevant regulatory bodies. The Tribunal noted that Dr Verma asserts that he raised these concerns to the GMC on the same day that he accessed the records, and no evidence has been produced to undermine that assertion. He had already raised concerns with his MP and went on to raise matters with the CQC and NHS England. He was not, in the Tribunal's view, 'supplanting' the regulator. Furthermore, Dr Verma himself faced allegations which he strongly denied, and which he believed were being used to prevent him from addressing deficiencies in the Practice.

224. The Tribunal has set out the full extent of the circumstances in its facts determination, which it relies on here, and notes that it largely rehearses an account which has not been challenged by the GMC in cross-examination. The Tribunal concluded that the background of this case renders the case to be one that is 'unusual, special or uncommon' and as such is one that is 'very rare'.

225. The Tribunal then considered how these exceptional circumstances justify taking no action in this case. The Tribunal considered that Dr Verma had engaged in misconduct for reasons which were apparently in keeping with upholding the overarching objective. That was to raise patient safety concerns and concerns about NHS fraud. His misconduct arises because he went about it the wrong way. The Tribunal went on to consider conditions and agreed with Ms Renton's submissions that they would not be appropriate or workable in this case. That then leaves suspension as the next available sanction.

226. The Tribunal decided that it would be perverse to punish Dr Verma in those circumstances by imposing an order of suspension, which was the only other viable option

open to the Tribunal. The Tribunal concluded that a period of suspension would be an escalation which was not justified in this case. The Tribunal found that a period of suspension would be disproportionate. The fact that a period of suspension may be short, does not properly reflect the escalation from 'no action' where there was a practical inability to impose conditions. It also fails to properly reflect the gravity of the allegations that have formed part of this hearing, and which have fallen away predominantly due to concerns about the background at the Practice and the cross contamination of evidence relied on by the GMC. Imposing an order of suspension would also fail to properly reflect the significant mitigation in the case.

227. In addition, the Tribunal considered that it has already made two finely balanced decisions which conclude that Dr Verma had committed misconduct and that his fitness to practise is impaired. The Tribunal is satisfied these two findings send a sufficiently strong signal to both Dr Verma and the profession about expected standards. The Tribunal considered that a finding of impairment satisfies the public interest in marking the misconduct as unacceptable.

228. In conclusion, the Tribunal determined that the overarching objective is upheld by the finding of impairment which marks Dr Verma's past misconduct. It is therefore appropriate and proportionate to conclude the case with no action.

229. The Tribunal has therefore determined to take no action.

230. XXX.

231. That concludes the case.

ANNEX A – 04/08/2023
Application to Amend the Allegation

232. On behalf of the GMC, Ms Renton made an application under Rule 17(6) of Fitness to Practise Rules (2004, as amended) ('the Rules'), to amend paragraph 2 of the Allegation ('paragraph 2') to read as follows:

2. On 24 December 2019 you consulted with Patient B at Hayes Medical Centre ('the Practice'), during which you:

    a. placed your hand ~~beneath~~ on each of Patient B's breasts in turn;

    b. palpated each breast with your ~~whole~~ hand ~~from the bottom of the breast upwards~~.

Submissions

On behalf of the GMC

233. On behalf of the GMC, Ms Renton submitted that the Allegation is 'black and white' either the touching happened, or it did not. She submitted that the proposed amendment would, in effect, simplify and clarify the Allegation. Ms Renton submitted that as this is a case where Dr Verma denies paragraph 2 of the Allegation in its entirety, and this is not a case where there has been a suggestion of accidental touching or a misconstrued brush of the hand, there would be no injustice to Dr Verma. Ms Renton submitted that the allegation remains the same – that Dr Verma has touched Patient B's breasts and in doing so has palpated them – and the amendments would simply remove unnecessary elements of the Allegation.

234. Ms Renton further submitted that Dr Verma's case is that no touching occurred, and Patient B had been cross-examined on that basis and not on the basis that she was touched in the manner described in the Allegation. If those who represent Dr Verma feel that Patient B has given an inconsistent account, Ms Renton submitted that is a factor to consider when making submissions on the weight to be attached to Patient B's evidence.

235. Ms Renton submitted that there is a risk that if the amendment is not made, while the GMC can still prove its case, there is an additional and unnecessary element to the Allegation which the Tribunal will have to consider. Ms Renton submitted that the issue in this case is whether the touching happened or whether it did not, and that this amendment does not

constitute a material change to the Allegation. Ms Renton therefore submitted that the amendment can be made without injustice.

236. Ms Renton submitted that in regard to the timing of the application, lateness is not in itself injustice. Ms Renton submitted that it is in the public interest to amend the Allegation because if it were to be found not proved on the basis that the touching did not happen exactly in the manner described, then it would be found not proved on a technicality. Further, Ms Renton accepted that because Patient B has given a number of accounts, the Tribunal may well consider any inconsistencies, however she submitted that this does not go to whether the allegation of touching is in itself a fabrication.

237. Having been asked to clarify practicalities in recalling Patient B; on day 3 Ms Renton stated that Patient B had not been contacted as she was a vulnerable witness. She stated the GMC would only do so once the outcome of the amendment application was made, and the purpose of recalling her was clarified by the defence. Ms Renton submitted that if Mr Haycroft were to reopen his cross-examination of Patient B, it is unclear how he would put Dr Verma's case differently. Ms Renton submitted that if Mr Haycroft had wished to cross-examine Patient B on the inconsistencies in her accounts, he had an opportunity to do so when she gave her oral evidence, and he will have the opportunity to make submissions on the evidence in due course. Finally, Ms Renton submitted that if Patient B were to be recalled, the GMC would seek to ask the defence to properly indicate what they require of her, in order for the Tribunal to properly assess whether it would be proportionate to recall her. Ms Renton submitted that the availability of Patient B should not be determinative in the Tribunal's decision whether to amend the Allegation.

<u>On behalf of Dr Verma</u>

238. On behalf of Dr Verma, Mr Haycroft resisted the GMC's application to amend the Allegation, and submitted that the test to be applied is whether the amendments can be made without injustice to Dr Verma. Mr Haycroft submitted that the timing of this application is an injustice as the doctor had come to answer the case that had been notified under Rule 15. Mr Haycroft accepted that while Dr Verma denies there was any inappropriate touching, Mr Haycroft had prepared the case and undertaken his cross-examination of Patient B in relation to the Allegation in its current form.

239. In regard to his cross-examination of Patient B, Mr Haycroft submitted that this was undertaken on the basis of the Allegation as it stands, based upon that 'charge' and no other 'charge', and he therefore deliberately did not ask questions which may now be relevant if

the amendments were to be made. Mr Haycroft therefore submitted that he would ask to recall Patient B and ask her further questions if the Allegation were to be amended. Mr Haycroft submitted that he would be unable to provide an outline of questions to be asked of Patient B at this stage, as he would have to revisit her evidence in detail and analyse his position. He said he would likely have a number of questions for Patient B and would have to revisit the issue of the inconsistencies in Patient B's various accounts.

240. Mr Haycroft further submitted that the timing of the application was, following the end of Patient B's evidence, in which she gave inconsistent evidence to her previous accounts, and following the close of the GMC case. He said the application arises from 'settling in' questions which had elicited a brand-new account, and that there were now four accounts, which the GMC simply did not like. Mr Haycroft submitted that a witness having given inconsistent accounts is not a good enough reason for the Allegation to be amended.

241. In regard to any difficulty in recalling Patient B, Mr Haycroft said that we do not know whether Patient B was willing to attend, when she might attend, how she might attend (in person or by video), and whether an interpreter would be available. He submitted that this raised the risk of this case not concluding in the allotted time.

LQC advice to the Tribunal

242. The LQC advised the Tribunal that the power under Rule 17 (6) of the Rules is discretionary and an amendment can be made if it can be done without injustice. The LQC notes that neither party had relied on any specific authorities (of which there are few on point). The LQC indicated that the Tribunal should take a purposive approach to charges rather than dismiss them on a technicality. That gives effect to the Tribunal's public law duties and the public interest. However, that approach could not enlarge the scope of the charges so as to change the nature of the case the doctor has to meet, or otherwise cause injustice. On the issue of the defence being required to set out why Patient B was required, the LQC advised the Tribunal that where, as in this case, the doctor was represented by a competent, regulated legal professional, it would be inappropriate to require them to set out proposed defence questions. The issue of Patient B's availability and Ms Renton's submissions on day 3 were considered afresh by the Tribunal.

243. The Tribunal was advised that the power is discretionary. A natural reading of the rule is that there are two broad considerations: a) 'should be amended'; and b) injustice.

The Tribunal's Approach

244. Paragraph 17(6) of the Rules states:

'17(6) Where, at any time, it appears to the Medical Practitioners Tribunal that—

(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and

(b) the amendment can be made without injustice,

it may, after hearing the parties, amend the allegation in appropriate terms.'

245. The application to amend arose on day 2, at the close of the GMC case. Attempts were made by the LQC to allay the GMC's apparent concerns about the case being thrown out on a technicality by indicating that the Tribunal could take a purposive approach. Furthermore, the Tribunal wanted to establish if Patient B was readily available to give evidence. It was appropriate to clarify that as she had flown in especially from Romania and her evidence was taken out of turn to accommodate her necessity to return home on a pre-booked flight. At the start of day 3, the Tribunal was informed no enquiries had been made with Patient B. The Tribunal indicated it was aware that amendment and undercharging applications may lead to delays and adjournments, and a wider time frame than the hearing slot may be required.

246. The LQC clarified that the Tribunal was under a public law duty to revisit any decisions it has made, even up to the end of a hearing. However, it was appropriate in the circumstances to indicate that that the Tribunal's deliberations about the application on day 2 had been much shorter than anticipated because of the concordant and emphatic views expressed. It was appropriate to indicate that so that proper consideration could be given by the GMC to the proportionality of contacting Patient B and/or pursing the application to amend. It was particularly appropriate given the 'catch 22' position that had arisen whereby the GMC's position, as the Tribunal understood it was that: a) Patient B was vulnerable and contacting her unnecessarily was not appropriate; b) the defence should clarify why she should be recalled in person; and c) Patient B should not be contacted unless the Tribunal had decided the amendments should be made. The hearing had become frozen in this impasse between competing positions as to the appropriateness of the application between the parties, and the Tribunal's attempts to be fair to both sides and to ensure due care towards a vulnerable witness.

247. Both parties initially agreed that an oral decision on this application would be acceptable but later agreed with the Tribunal's view that given the significance to the 'losing party' of whatever was decided, a written decision should be handed down before the case proceeded any further. That was appropriate in order to crystalise the reasons for the Tribunal's decision without the risk of it being affected by any additional evidence later in the process. However, having heard broadly the same submissions from both parties again on day 3, the Tribunal reconvened to announce that the GMC's application to amend paragraph 2 was refused. The parties then set out timetabling and Ms Renton indicated for timetabling purposes that the GMC would require time to consider whether to apply for judicial review.

Tribunal's Decision

Background matters

248. On day 1 of the hearing the GMC applied to amend the Allegation by withdrawing paragraphs 5 and 6. There was no application to 'simplify' paragraph 2 at that stage. The application arose at the end of the GMC case. No 'half time' submission was made under rule 17(2)(g); and the Tribunal is awaiting to hear from Dr Verma.

249. The timing of the application to amend has put the Tribunal in an invidious position in deciding this application. That is because it likely to be impermissible to weigh up the relative strengths and weaknesses in the evidence at this stage. The Tribunal is not conducting a quasi-rule 17(2)(g) exercise. If the application had been made at the end of the doctor's case and prior to going into camera, then the Tribunal may have been in different position in assessing all of the evidence. However, there are concerns that the amendment has only arisen due to matters arising from Patient B's oral evidence.

250. The 'simplification exercise' that the GMC was now proposing had not been made before the Rule 15 letter was issued, before the hearing date or prior to hearing from Patient B. Patient B's evidence was seemingly different, in some details at least, from her earlier accounts. Mr Haycroft's submissions were in effect that the application was made because Patient B's evidence had changed. The Tribunal was concerned that this was indeed the case.

251. The Tribunal considered each of the GMC's submissions regarding the need to make this amendment to the Allegation, as it understood them. First, that the amendment could be made without injustice and while the GMC could still prove its case, there was an additional and unnecessary element to the Allegation which the Tribunal will have to find proved (i.e., the simplification submission). Secondly, that the amendment does not constitute a material change to the Allegation, bearing in mind that the defence position would remain the same (i.e., the no material change submission). Thirdly, that if paragraph 2 were to be found not proved on the basis that the touching did not happen exactly in the manner described, then it would be found not proved on a technicality (i.e., losing on a technicality argument).

Legal concepts

252. The Tribunal was mindful of its duty in upholding the overarching objective under section 1(1B) of the Medical Act 1983, namely:

- 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.

253. The Tribunal was also aware of its public law role as encapsulated in *PSA v. NMC and Silva* [2016] EWHC 754 (wrongly referred to as *Da Costa* in the hearing) which states:

'28. In this regard, it is important to note that the role of a disciplinary body, such as this Panel, considering issues such as fitness to practise is very different from that of a criminal court considering allegations brought by a prosecuting authority. One very significant difference is the importance of the disciplinary body having regard to the imperative need for protection of the public rather than punishment of the "offender". Another difference, important for present purposes, was expressed in the following terms at paragraph 80 of the judgment of the court delivered by Lord Phillips in Ruscillo v Council for the Regulation of Health Care Professionals and General Medical Council [2004] EWCA Civ 1356:

i. "The disciplinary Tribunal should play a more proactive role than a judge presiding over a criminal trial in making sure that the case is properly presented and that the relevant evidence is placed before it."'

254. The Tribunal was aware of the dereliction of duty that would ensue from a case which is undercharged as encapsulated in *PSA v NMC and Macleod* [2014] EWHC 4354, which recites:

'26. "Serious procedural irregularity" includes what might be shortly described as "undercharging", that is, omitting from the heads of charge allegations reflecting the true seriousness of the conduct complained of…'

255. The Tribunal was satisfied the three concepts above are an ongoing duty on a Tribunal, and would include matters that arose in camera at the end of the facts stage in any given case. The Tribunal was well aware of its role to avoid a technical loss of a charge where the underlying evidence disclosed concerns which would be an affront to the overarching objective. The Tribunal accepted that the timing of the application was not a good basis on which to refuse the application. The courts have accepted that amendments may arise late in the process and cause delays, see for example *PSA v HCPC and Doree* [2017] EWCA Civ 319:

'56. … There will no doubt be cases where a late amendment of the allegations faced by a registrant will be justified, even after the evidence has been heard and findings of fact have been made….'

Paragraph 2 consideration

256. The Tribunal has not been told how this paragraph arose. From the Tribunal's experience, the GMC would rely on expert evidence. The expert report, dated 03/08/21, from Dr K lists a number of documents he was provided with, only some of which are before the Tribunal. His report states:

'5. Whether the examination (as described by Patient B) was appropriate. If Patient B's version of events is accepted [Dr Verma] placed his hand beneath her left breast. He then palpated the breast, with his whole hand from the bottom of the breast upwards… The process was repeated on the right. Patient states that no consent was obtained, and no chaperone was offered.'

257. The Tribunal notes the operative words in Paragraph 2 mirror those in the expert report:

> *'a) placed your hand beneath each of Patient B's breasts in turn; [and] b) palpated each breast with your whole hand from the bottom of the breast upwards*.'

258. The Tribunal is satisfied that the expert had been apprised of Patient B's complaints including her statement of 27 January 2021. That document is the Romanian language statement translated by Ms A for Patient B to pursue her complaint. The Tribunal was mindful that contemporaneous documents are the starting point for any fact-finding exercise at the end of stage one, although other evidence may persuade a Tribunal to depart from that if it is sufficiently probative/ persuasive.

259. The Tribunal is satisfied that the GMC has had ample opportunity to redraft paragraph 2 given the expert report was provided two years ago.

260. The Tribunal had concerns about the timing of the amendment application, after Patient B had given evidence. All the Tribunal can say at this stage of the hearing is that her account did not squarely accord with the 27 January 2021 statement.

261. The Tribunal considered whether injustice would arise from the amendment. The Tribunal was satisfied the starting point at the end of stage one will be the statement of 27 January 2021, on which the expert report was produced. That expert report was relied on to formulate the charges. The GMC's application to amend after Patient B's evidence was an attempt to reframe the charges to suit her changed account. The Tribunal agrees with Mr Haycroft's submission that this this was an attempt to reframe the charge to fit potentially inconsistent accounts from Patient B. The proposed amendments would fundamentally change the scope of the case in the Tribunal's assessment. The proposals may also fall foul of the principles that the most contemporaneous documents are the starting point for an assessment of evidence.

262. Furthermore, the 'no material change submission' is not persuasive. The Tribunal is satisfied that a doctor facing disciplinary proceedings is entitled to know the case that has to be met. Dr Verma has attended to defend the Allegation as charged. It also accepts Mr Haycroft's submission that he will need to revisit his cross-examination and decide if there are questions to be put, which he indicated was likely. The proposed amendment would materially change the scope of Paragraph 2: a) in terms of what Patient B first complained about; and b) in terms of how the defence had put its cross-examination questions.

263. The 'losing on a technicality argument' is not persuasive. As matters stand, the Tribunal has not yet turned its mind to assessing the evidence. It has not been provided with any submissions as to how the apparent irregularity of Ms A being involved with Patient B's case may or may not affect the evidence. It has not been provided with a detailed chronology or detailed submissions to unpick the consistency or inconsistency as between what was said by whom. It has not heard from Dr Verma. It has not heard closing submissions on facts. It has not received legal advice about the consideration of evidence other than the starting

position mentioned above. It has not considered the evidence in the round or had deliberations on what to make of the complaints. To state that Paragraph 2 might be lost on a technicality is premature. No detailed and informed consideration as to the relative strengths or weaknesses of the case has been undertaken by the Tribunal. The Tribunal is well aware that it has an ongoing public law duty as referenced above, and that may in appropriate circumstances lead to amendments to charges at a later point, including having to come out of facts stage deliberations, if appropriate.

264. All of those factors lead the Tribunal to conclude that the amendments should not be made; and that injustice would be inevitable if they were made as a result of this application.

265. The Tribunal's primary decision is as set out above, however for the sake of completeness, the Tribunal went on to consider the implications of having to recall Patient B to give evidence. Mr Haycroft would have to review the evidence and consider further cross-examination. The Tribunal accepted his submission that this is an exercise he would have to carry out. The Tribunal notes, there may be a legal technicality of obtaining consent from the Foreign Office that the GMC would have to comply with in terms of evidence from abroad. That is if Romania is a country amenable to such requests. The Tribunal does not know whether Patient B would be willing to give further evidence, and if so, when, and how that would be arranged, and may not be in her best interests as she is vulnerable. These matters are obvious impediments to timely progress of the hearing concluding. Whilst lateness of amendments is not prohibited, the reasons set out in the above paragraphs set out the weaknesses in the GMC's application. Further delays in those circumstances are likely to be unknown. Delays in progressing the case without good reason is a further relevant consideration as to where injustice may lay.

266. Taking into account all of the above, the Tribunal determined to refuse the GMC's application to amend paragraph 2 of the Allegation.

SCHEDULE 1

Records viewed on EMIS system on 09/02/2021:

Data viewed	Permission to view	Patient name
Care record viewed	Higher level	Ms L
Care record viewed	Higher level	Ms L
Api Patient Data Extraction	Higher level	Ms L
Care record viewed	Higher level	Ms L
Api Patient Data Extraction	Higher level	Mr D
Care record viewed	Higher level	Mr D
Care record viewed	Higher level	Mr D
Care record viewed	Higher level	Dr N
Api Patient Data Extraction	Higher level	Dr N
Care record viewed	Higher level	Dr N
Care record viewed	Higher level	Dr N
Care record viewed	Higher level	Dr C
Care record viewed	Higher level	Dr C
Care record viewed	Higher level	Dr C
Api Patient Data Extraction	Higher level	Dr C