PUBLIC RECORD

Dates: 16/11/2020 - 26/11/2020
1/03/2021 – 12/03/2021

Medical Practitioner's name:	Dr John MATTHEWS
GMC reference number:	2957575
Primary medical qualification:	BM BCh 1984 Oxford University

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

Summary of outcome

Suspension, 3 months.
Review hearing directed

Tribunal:

Legally Qualified Chair	Mrs Claire Sharp
Lay Tribunal Member:	Mr Darren Shenton
Medical Tribunal Member:	Dr Paul Diprose

Tribunal Clerks:	Mr Matthew Rowbotham and Ms Emma Saunders 23/11/2021

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Ms Vivienne Tanchel, Counsel, instructed by The Medical and Dental Defence Union of Scotland
GMC Representative:	Ms Laura Barbour, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 09/03/2021

Background

1. Dr Matthews qualified in 1984 with a BM BCh from Oxford University. Prior to the events which are the subject of the hearing, Dr Matthews became a Member of the Royal College of General Practitioners in 1990, and worked as a GP in Wallsend, Newcastle since 1991. Between 2010 and 2018, Dr Matthews was the Clinical Chair of North Tyneside Clinical Commissioning Group. At the time of the events, Dr Matthews was practising as a GP XXX where he was the Senior Partner.

2. The allegation that has led to Dr Matthews' hearing can be summarised as failing to consider the possibility that a minor, Patient A, was being sexually abused and attempting to undermine potential allegation(s) of sexual abuse regarding Patient A. It is alleged that Dr Matthews' motivation for undermining any potential allegation(s) made by Patient A was due to Dr Matthews' personal relationship with Patient A's parents, Patients B and C.

3. It is alleged that Dr Matthews was aware, as one of the GP's treating Patient A and following his consultations with Patient A and her parents, that Patient A had been bedwetting, having vivid nightmares, experiencing significant behavioural disturbances, and had a background risk of abuse. It is alleged that Dr Matthews did not consider that there was an underlying possibility of sexual abuse because Dr Matthews had a personal relationship with Patient A's parents between July 2016 and March 2017.

4. In addition, due to his relationship with Patient A's parents, it is alleged that Dr Matthews failed to make a referral to the Child and Adolescent Mental Health Service ('CAMHS') for Patient A in October 2015. In August 2016, it is alleged that Dr Matthews called Children's Social Care at Patient B's request and explained that any allegations that may have been made by, or were to come, regarding Patient A were malicious. However, it is alleged that Dr Matthews expressed Patient B's opinion as if it was his own during this call.

5. Dr Matthews is also alleged to have held a consultation with Patient C in March 2017 in which Dr Matthews knowingly made a record of an opinion that an allegation of sexual abuse made against Patient C by Patient A was malicious. It is alleged that this was Dr Matthews' personal opinion.

6. Dr Matthews' alleged personal relationship with Patient A's parents, according to the GMC, affected his therapeutic relationship with Patient A. Patient A and her parents were registered at Dr Matthews' practice.

7. The initial concerns were raised with the GMC on 15 September 2017 by Dr Matthews' Responsible Officer. This followed an investigation on behalf of North Tyneside Clinical Commissioning Group, which was undertaken after Patient A alleged Patient C had sexually abused her.

The Outcome of Applications Made during the Facts Stage

8. The Tribunal, of its own volition, under Rule 17(6) General Medical Council ('GMC') (Fitness to Practise) Rules 2004, as amended ('the Rules') determined to amend the Allegation, and include Schedules 1 – 4 in the public version of the allegation. These amendments were not opposed by the parties. Its full determination can be found in Annex A.

9. On behalf of the GMC, Ms Barbour made an application under Rule 17(6) to amend paragraph 7 of the Allegation. The application was opposed by Ms Tanchel on behalf of Dr Matthews. The Tribunal determined, after taking further submissions, to amend the allegation. Its full determination can be found in Annex B.

10. The Tribunal, of its own violation, under Rule 17(6) General Medical Council ('GMC') (Fitness to Practice) Rules 2004, as amended ('the Rules'), determined to amend Schedule 2 of the allegation. The Tribunal considered that this amendment would more accurately reflect the evidence it had received. The amendment to Schedule 2 were not opposed by the parties. Its full determination can be found in Annex C.

11. On behalf of the GMC, Ms Barbour made an application under Rule 34(1) of the Rules to admit further evidence in the form of a case note ('the Case Note') from North Tyneside Council. The application was not opposed by Ms Tanchel on behalf of Dr Matthews. The Tribunal determined that this evidence was relevant to the hearing and could be

admitted without any injustice to either party. Later, Ms Tanchel applied to have the case note excluded. This application was unsuccessful. The Tribunal's full determination can be found at Annex D.

12. Ms Barbour made an application under Rule 34(1) of the (Fitness to Practice) Rules 2004, as amended (the Rules) to admit further evidence in the form of Dr Matthews responses to a Rule 4 and Rule 7 letters from the GMC 'the material'. Ms Tanchel opposed the GMC's application. The Tribunal determined to deny Ms Barbour's application for the admission of the material. Its full determination can be found at Annex E.

13. Ms Barbour, on behalf of the GMC, made an application under Rule 34(1) of the Rules, to adduce further evidence in the form of medical records of Patient C and Ms Tanchel, under the same rule, made an application to adduce handwritten notes of a meeting between Dr Matthews and Dr E. Neither party opposed each other's application. The Tribunal determined that it was fair for this evidence to be adduced. Its full determination can be found at Annex F.

14. Ms Barbour, on behalf of the GMC, made an application under Rule 34(1) of the Rules to admit further evidence in the form of the full handwritten notes made by Dr E during the course of her meetings with Dr Matthews. This followed Ms Tanchel's application, determined in Annex F. Ms Tanchel opposed this application. The Tribunal determined to grant Ms Barbour's application. Its full determination can be found at Annex G.

15. Ms Tanchel, on behalf of Dr Matthews, made an application under rule 17(2)(g) of the Rules that there had not been sufficient evidence adduced to find some facts in the Allegation proved. The application was largely opposed by Ms Barbour on behalf of the GMC. The Tribunal determined to accept parts of Ms Tanchel's application and refused others. Its full determination can be found in Annex H.

16. On day 9 of this hearing, the Tribunal established that there would be insufficient time to conclude proceedings. It determined of its own volition to adjourn this hearing under Rule 29(2) of the Fitness to Practise Rules 2004 as amended (the Rules) part heard until a later date. Its full determination can be found at Annex I.

17. Whilst Dr Matthews was under cross-examination, Ms Barbour, on behalf of the GMC, made an application under Rule 34(1) of the Rules to admit further evidence in the form of a reflective statement submitted to the GMC at the Rule 4 stage, the GMC's Rule 4 letter to Dr Matthews, Dr Matthews' reflective statement response to the GMC's Rule 7 letter and Dr Matthews' response to Dr E's report. Ms Tanchel opposed parts of the

application but accepted that the evidence could be put to Dr Matthews's under examination. The Tribunal determined to grant Ms Barbour's application, with the exception of the GMC Rule 4 letter. Its full determination can be found at Annex J.

The Allegation and the Doctor's Response

18. The Allegation made against Dr Matthews is as follows:

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

1. At all material times, Patient A, B and C were vulnerable patients. Admitted and found proved

2. On 30 October 2015 you consulted with Patient A and her mother (Patient B) and you failed to refer Patient A to the Child and Adolescent Mental Health Service ('CAMHS'). Admitted and found proved

3. You received a telephone message the nature of which is set out at Schedule 1, regarding Patient A's bedwetting from Patient B on 15 July 2016 ('the Message'). Admitted and found proved

4. You consulted with Patient A's parents regarding Patient A's bedwetting on 18 July 2016 and you failed to:
    a. consider the possibility of underlying sexual abuse because of Patient A's:
        i. secondary enuresis; to be Determined
        ii. vivid nightmares; to be Determined
        iii. behavioural disturbance; to be Determined
        iv. background risk for abuse; to be Determined
    b. take a full history of Patient A's:
        i. night-time urinary symptoms; to be Determined
        ii. day-time urinary symptoms; to be Determined
    ~~c. seek further advice;~~ Deleted after a successful Rule 17(2)(g) application
    d. provide practical management advice to Patient A's parents; Admitted and found proved

e. adequately follow relevant guidance with respect to:

i. child protection; to be Determined

ii. safeguarding. to be Determined

~~5. Following receipt of the Message and your consultation with Patient A's parents, you failed to arrange a consultation with Patient A in order to:~~

~~a. take a full history of:~~

~~i. night-time urinary symptoms;~~ Deleted after a successful Rule 17(2)(g) application

~~ii. day-time urinary symptoms;~~ Deleted after a successful Rule 17(2)(g) application

~~b. carry out a physical examination to exclude underlying causes;~~ Deleted after a successful Rule 17(2)(g) application

~~c. provide practical management advice to:~~

~~i. Patient A;~~ Deleted after a successful Rule 17(2)(g) application

~~i.~~

~~ii. Patient A's parents;~~ Deleted after a successful Rule 17(2)(g) application

~~d. adequately follow relevant guidance with respect to:~~

~~i. child protection;~~ Deleted after a successful Rule 17(2)(g) application

~~ii.~~

~~ii. safeguarding;~~ Deleted after a successful Rule 17(2)(g) application

~~e. consider the possibility of underlying sexual abuse because of Patient A's:~~

~~i. secondary enuresis~~ Deleted after a successful Rule 17(2)(g) application

~~ii. vivid nightmares;~~ Deleted after a successful Rule 17(2)(g) application

~~iii.~~

~~iii. history of behavioural disturbance;~~ Deleted after a successful Rule 17(2)(g) application

~~iii. iv. background risk for abuse.~~ Deleted after a successful Rule 17(2)(g) application

Amended under rule 17(6)

6. You consulted with Patient A on 1 August 2016 regarding her bedwetting and you failed to:

    a. consider the possibility of underlying sexual abuse because of Patient A's:

        i. secondary enuresis; to be Determined

        ii. vivid nightmares; to be Determined

        iii. behavioural disturbance; to be Determined

        iv. background risk for abuse; to be Determined

    b. take a full history of:

        i. night-time urinary symptoms; Admitted and found proved

        ii. day-time urinary symptoms; Admitted and found proved

    c. seek further advice; Admitted and found proved

    d. provide practical management advice to:

        i. Patient A; Admitted and found proved

        ii. Patient A's parents; Admitted and found proved

    e. carry out a physical examination to exclude underlying causes; to be Determined

    f. adequately follow relevant guidance with respect to:

        i. child protection; admitted and found proved

        ii. safeguarding. Admitted and found proved

7. On 3 August 2016 you contacted Children's Social Care at the request of Patient B ~~and made the statement set out at Schedule 2 ('the Call') which was:~~ and made statements to the effect of those recorded in the case note at Schedule 2 ('the Call') which were:

    Amended under rule 17(6)

    a. the opinion of Patient A's mother; Admitted and found proved

    b. stated in a way that suggested it was your opinion. to be Determined

8. When you made the Call you:

a. provided information that was untrue in that you;

i) knew the opinion you provided was not your own but that of Patient B; to be Determined

ii) had knowledge of the risk factors as set out at paragraphs 4a and 6a; to be Determined

b. failed to record in Patient A's medical records that you had made the Call. Admitted and found proved

9. Your action as described at paragraph 7 was dishonest by reason of paragraphs 8a and 8b. to be Determined

10. Following your consultation with Patient B on 4 November 2016 in which she provided the information as set out at Schedule 3 you failed to:

a. consider sexual abuse as an underlying possibility for Patient A's bedwetting; to be Determined

b. adequately follow relevant guidance with respect to:

i. child protection; to be Determined

ii. safeguarding. to be Determined

11. Between July 2016 and December 2016 you developed a personal relationship with Patient A's parents which:

a. was inappropriate because:

i. they were your patients; to be Determined

ii. of your knowledge of the facts as set out at paragraphs 2-10; to be Determined

b. represented a conflict of interest; to be Determined

c. adversely affected your therapeutic relationship with:

i. Patient A; to be Determined

~~ii. Patient B;~~ Deleted after a successful Rule 17(2)(g) application
~~iii. Patient A's father (Patient C).~~ Deleted after a successful Rule 17(2)(g) application

12. On 3 March 2017 you consulted with Patient C, and you made a record ('the Record') as set out fully in Schedule 4 in Patient C's notes that:

a. Patient C had been accused of sexual abuse by Patient A; Admitted and found proved

b. it "seems clear this is a malicious accusation" which was;

i. Patient C's opinion and/or; Admitted and found proved

ii. your opinion. to be Determined

13. In making the Record as set out at paragraph 12 you:

~~a. recorded information that was untrue;~~ Deleted after a successful Rule 17(2)(g) application

~~b. should have known the information you recorded was untrue given your knowledge of the risk factors relating to:~~

i. ~~Patient A as set out at paragraphs 4a, 6a, and 10a;~~ Deleted after a successful Rule 17(2)(g) application

ii. ~~Patient C taking into account his medical history;~~ Deleted after a successful Rule 17(2)(g) application

c. failed to make clear whose opinion was being stated. to be Determined

14. ~~Your actions as set out at paragraph 12b were dishonest by reason of paragraphs 13a and 13b~~. Deleted after a successful Rule 17(2)(g) application

15. Following the consultation with Patient C you failed to consider that sexual abuse was a possible underlying cause for Patient A's previous presentations. To be Determined

16. Your actions as set out at paragraphs 2-15 were on one or more occasion an attempt to ~~conceal and/or~~ undermine any potential allegation(s) of sexual abuse made by Patient A against Patient C. Partially deleted after a successful Rule 17(2)(g) application

17. Your conduct as set out at paragraphs 2-15 was motivated by your personal relationship with Patient A's parents. To be Determined

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

The Admitted Facts

19. Following preliminary applications, through his counsel, Dr Matthews made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance

with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

20. In light of Dr Matthews's response to the Allegation made against him, the Tribunal is required to determine whether the remaining facts are found proven.

21. The Tribunal noted that some paragraphs of the Allegation had been withdrawn following a successful application by Ms Tanchel under Rule 17(2)(g) of the Rules. The Tribunal were mindful that it did not have to make a determination on these paragraphs of the Allegation.

Witness Evidence

22. The Tribunal received evidence on behalf of the GMC from Dr E, Secondary care consultant on the North Tyneside Clinical Commissioning Group's Governing Body and Quality & Safety Committee by video link. Dr E also provided a witness statement dated 13 December 2019, which exhibited her report regarding lessons to be learnt following Patient A's disclosure of sexual abuse and the actions of Dr Matthews.

23. Dr Matthews provided his own witness statement, dated 1 September 2020 and gave oral witness evidence at the hearing.

Expert Witness Evidence

24. The Tribunal received expert witness evidence on behalf of the GMC from Dr F. Dr F provided a report dated 17 September 2018, and a supplemental report dated 6 November 2018. Dr F also gave oral evidence at the hearing. Dr F assisted the Tribunal in understanding where Dr Matthews' care may have fell below, or seriously below, the standard expected of a doctor in Dr Matthews' position.

Documentary Evidence

25. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to, an independent report by Dr E into Dr Matthews' alleged role in a case of alleged child sexual abuse on behalf of North Tyneside Clinical Commissioning Group dated 24 July 2017; a case note from North Tyneside Council dated 3 August 2016; the medical records of Patient A and C; Dr E's handwritten notes from her meeting with Dr Matthews dated 24 May 2017 and 16 June 2017; Dr Matthews' Rule 7 response; and testimonials on behalf of Dr Matthews.

The Tribunal's Approach

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

27. The Tribunal reminded itself that it is entitled to draw inferences from what it has heard, but cannot speculate on evidence that may have been adduced or other witnesses that may have been called.

28. In terms of assessing the credibility of a witness in relation to the documentary evidence it had received, the Tribunal had regard to the case of Dutta, R (On the Application Of) v General Medical Council (GMC) [2020] EWHC 1974 (Admin), where it is made clear that it should start:

> *'[…]with the objective facts as shown by authentic contemporaneous documents, independent of the witness, and using oral evidence as a means of subjecting these to "critical scrutiny"'*

and to not fall into two common errors

> *'(1)that the stronger and more vivid the recollection* [of the witness], *the more likely it is to be accurate; (2) the more confident another person is in their recollection, the more likely it is to be accurate.'*

It was mindful that when disputes of facts arise, the Tribunal should make clear what these factual disputes are and give reasons for its findings with regard to the wording of the Allegation.

29. The Tribunal considered that the allegation of dishonesty that Dr Matthews faces is a serious one. It was therefore mindful that the evidence required to support this allegation must also be cogent, and dishonesty should not be found without consideration of all the evidence and the full circumstances of the case and without excluding as less that probable other possible explanations for Dr Matthews' conduct.

30. The Tribunal noted that evidence of Dr Matthews' good character is relevant and admissible at this stage if the alleged misconduct requires the GMC to prove Dr Matthews' guilty state of mind, to deal with Dr Matthews' credibility or if there is a dispute between Dr Matthews evidence and that of others. It considered that this evidence would be relevant to the issue of Dr Matthews' credibility and his propensity to the type of behaviour that has been alleged. The Tribunal had regard to the case of Donkin v The Law Society [2007] EWHC 414 (Admin) when considering what weight it could place on such evidence.

31. Given that Dr Matthews faces an allegation of dishonesty, the Tribunal had regard to the test for dishonesty set out in Ivey v Genting Casinos (UK) Limited (t/a Crockfords Club) [2017] UKSC 67:

> *'When dishonesty is in question the fact-finding Tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

The Tribunal considered that it must ask itself three questions. Firstly, did Dr Matthews act in the way that is alleged by the GMC on the balance of probabilities? Secondly, what was the genuine belief or knowledge Dr Matthews held regarding the facts or belief in

question? Lastly, would the actions of Dr Matthews be considered dishonest by the ordinary standards of reasonable and honest people?

32. Although the Tribunal will assess each paragraph of the Allegation separately, it was mindful that it could also assess the Allegation as a whole if the language of the Allegation required it to do so.

The Tribunal's Analysis of the Evidence and Findings

Paragraph 4(a)(i), (ii), (iii) and (iv)

33. The Tribunal found that the facts of these sub-paragraphs of the Allegation could be considered together, as they related to a cumulative set of presenting issues.

34. The Tribunal considered whether Dr Matthews had a duty to consider sexual abuse, given the presenting issues of Patient A. It had regard to the GMC's guidance on 'Protecting children and young people' (July 2012) ('the GMC Guidance'). In particular, paragraphs 2 – 5, 32 and 39, which state:

> *'2 You must consider the safety and welfare of children and young people, whether or not you routinely see them as patients. When you care for an adult patient, that patient must be your first concern, but you must also consider whether your patient poses a risk to children or young people. You must be aware of the risk factors that have been linked to abuse and neglect and look out for signs that the child or young person may be at risk. Risk factors include having parents with mental health or substance misuse issues, living in a home where domestic violence takes place, or living in poverty. But these circumstances do not necessarily lead to abuse or neglect, and child protection issues exist in all sections of society.*
>
> *3 Identifying signs of abuse or neglect early and taking action quickly are important in protecting children and young people. Working in partnership with parents and families can help children and young people to get the care and support they need to be healthy, safe and happy, and to achieve their potential. You should look out for signs that a family may need extra support, and provide such support if that is part of your role, or refer the family to other health or local authority children's services so they can get appropriate help.*

4 You must know what to do if you are concerned that a child or young person is at risk of, or is suffering, abuse or neglect or, in the case of a pregnant patient, that the child will be at risk of abuse or neglect after birth. This means you should have a working knowledge of local procedures for protecting children and young people in your area. You should know who your named or designated professional or lead clinician is, or you should have identified an experienced colleague to go to for advice, and know how to contact them.

5 You must act on any concerns you have about a child or young person who may be at risk of, or suffering, abuse or neglect.

32 You must tell an appropriate agency, such as your local authority children's services, the NSPCC or the Police, promptly if you are concerned that a child or young person is at risk of, or is suffering, abuse or neglect unless it is not in their best interests to do so. You do not need to be certain that the child or young person is at risk of significant harm to take this step. If a child or young person is at risk of, or is suffering, abuse or neglect, the possible consequences of not sharing relevant information will, in the overwhelming majority of cases, outweigh any harm that sharing your concerns with an appropriate agency might cause.

39 Any decision to delay sharing information with an appropriate agency where a child or young person is at risk of, or is suffering, abuse or neglect must be taken cautiously and only in circumstances where the increased risk to the safety or welfare of the child or young person clearly outweighs the benefits of sharing information. You must be able to justify your decision. You must record the decision not to immediately share information, along with your reasons and any advice you have received.'

35. The Tribunal were satisfied that the guidance set out above demonstrated that Dr Matthews did have a duty to consider the possibility that Patient A was being sexually abused, rather than maltreatment generally, given the information he had received and the family's history. This included knowledge of Patient C's anger issues; that Patient A's older sister XXX; there had already been two previous social service investigations into the family; that the family had a 'chaotic lifestyle'; that the family were prone to attending Dr Matthews' practice without an appointment; and the presenting symptoms of Patient A, especially the secondary enuresis (as stated by Dr F on page 25 of his report).

36. When considering whether Dr Matthews did consider Patient A had been sexually abused, the Tribunal had regard to National Institute of Clinical Excellence ('NICE') clinical guideline 'Child maltreatment: when to suspect maltreatment in under 18s' published in 22 July 2009 ('NICE guidelines on maltreatment'). In particular, the definitions of 'child maltreatment' which:

> *'includes neglect, physical, sexual and emotional abuse, and fabricated or induced illness.'*

and 'to consider child maltreatment', which

> *'means that maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis.'*

and the steps a medical practitioner should take if they suspect maltreatment, which are to

1. *'Listen and observe*
2. *Seek an explanation*
3. *Record* [what is observed and why it is of concern]
4. *Consider, suspect or exclude maltreatment*
5. *Record all actions taken in 4 and the outcome'*

37. The Tribunal noted that Dr Matthews', in his witness statement, stated that he *'felt at the time that* [he] *was keeping an open mind and that we were appropriately exploring all causes of bed wetting; physical and psychogical causes were being investigated in parallel.'* This conflicts with his Rule 7 admissions that he had failed to consider the possibility of sexual abuse. The Tribunal heard that Dr Matthews was planning to investigate further in a follow up appointment where he would consult directly with Patient A alone. The Tribunal also noted that Dr Mathews had sent a fax to CAHMS for them to assist Patient A in exploring the bedwetting and vivid dreams she was having, and he was aware Patient A was being seen intermittently by CAHMS

38. The Tribunal noted Patient A's escalating disturbing behaviour that Dr Matthews was told about at this appointment included setting a BBQ on fire with bottles of lighter fuel

inside; 'hyperactivity' around eating; and cutting up Christmas lights with scissors, putting her at risk of electrocution. Dr Matthews accepted that the escalation in Patient A's behaviour were 'red flags' that should have alerted him to have considered the possibility of maltreatment.

39. The Tribunal had regard to Dr F's oral evidence that Dr Matthews had to make both a set of clinical decisions and had a safeguarding duty. Whilst Dr Matthews had begun his clinical steps, such as chasing up CAMHS and arranging for Patient A's follow up appointment, he had not addressed his safeguarding duty.

40. The Tribunal appreciated that Dr Matthews had not completed the process of enquiry set out in the NICE guidelines on maltreatment. The Tribunal accepted that Dr Matthews had 'listened and observed' and started to 'seek an explanation'. It noted that Dr F considered that arranging a follow up appointment with Patient A, despite a two week wait, was not unreasonable. However, the Tribunal found that Dr Matthews had gone no further than this. For example, the Tribunal could not see any concerns recorded in Patient A's medical records, he had failed to 'record', despite Dr Matthews' evidence that his suspicion was Patient A was suffering from emotional abuse, or there was a psychological cause.

41. In addition, the Tribunal observed in Dr Matthews' response to the GMC's letter to him at the Rule 7 of the Rules stage ('the Rule 7 response'), when writing about this consultation that he *'accepted that [he] did not consider the possibility of underlying sexual abuse on this occasion'*. It found it could not overlook this admission; it would be perverse to do so.

42. The Tribunal found these sub-paragraphs of the Allegation proved.

Paragraph 4(b)(i) and (ii)

43. The Tribunal found that the facts of these sub-paragraphs of the Allegation could also be considered together, as they related to allegations of not taking a history of similar symptoms on 18 July 2016.

44. The Tribunal noted that Patient A was not present at this consultation. It found that this meant Dr Matthews did not have a duty to take a full history of Patient A's urinary symptoms at this time. In addition, The Tribunal was mindful that Dr Matthews had asked

Patient A's parents to book an appointment for Patient A, and that this would have been a better time to have taken the history.

45. The Tribunal therefore found these sub-paragraphs of the Allegation not proved.

Paragraph 4(e)(i) and (ii)

46. The Tribunal noted that the terms 'child protection' and 'safeguarding' were used interchangeably across most of the evidence it had received. It therefore found that it could make a determination on both of these matters together. However, it accepted the definitions of each term as outlined in the North Tyneside Clinical Commissioning Group Safeguarding Children Policy (2015) ('the CCG policy') which state:

'Safeguarding and promoting the welfare of children:
This is the process of protecting children from abuse or neglect and/or preventing impairment of their health or development. This includes ensuring children are growing up in circumstances consistent with the provision of safe and effective care so as to enable them to have optimum life chances and to enter adulthood successfully.

Safeguarding and promoting the welfare of children is defined as:

- *Protecting children from maltreatment;*
- *Preventing impairment of children's health or development;*
- *Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and*
- *Taking action to enable all children to have the best outcomes, (HM Gov. 2015).*

Child Protection
This is part of safeguarding and promoting children's welfare. Child protection refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm. There are four categories of abuse (HM Gov. 2015):
[…]
Sexual abuse – this Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also

include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.
[…]'

The Tribunal noted that it was not presented with any specific guidance in relation to child protection. However, the Tribunal found that Dr Matthews had a duty to follow the guidelines and guidance, given the definition of child protection and the GMC guidance outlined above.

47. The Tribunal had regard to Dr F's report, in which he states:

'My opinion is that by failing to consider underlying abuse as a possible explanation for Patient A's presentation with secondary enuresis on […] 18.07.16, […], Dr Matthews failed to adequately follow relevant guidance with respect to child protection and safeguarding. My opinion is that this failing is seriously below the standard expected, for the reasons set out above.'

Dr F was referring to multiple appointments within this paragraph, which the Tribunal noted, but considered it relevant when dealing with this allegation in relation to 18 July 2016.

48. As noted in the Tribunal's earlier determinations, whilst Dr Matthews had taken basic clinical notes at this consultation, he did not record any further actions he intended to take or any concerns about Patient A. In this instance, the Tribunal did not observe any record of Dr Matthews considering safeguarding or child protection, and further, the Tribunal could not see any evidence he acted appropriately on the information he received by consulting the safeguarding lead at the practice.

49. Lastly, the Tribunal observed Dr Matthews' Rule 7 response letter, in which his solicitors stated on his behalf in relation to this consultation:

'It is admitted Dr Matthew did not follow guidance with respect to child protection and safeguarding. He accepts that he should have made a safeguarding referral and deeply regrets not doing so.'

50. The Tribunal concluded that given Dr Matthews' admission and the other factors it had considered in terms of duty and guidance, it determined to find this sub-paragraph of the Allegation proved.

Paragraph 6(a)(i), (ii), (iii) and (iv)

51. The Tribunal had regard to its reasoning set out in Paragraph 4 of the Allegation. It noted the guidance it had considered and sections of Dr F's report were relevant to its determinations of this sub-paragraph. It also found that the considerations within sub-paragraph 6(a) could be determined as whole.

52. As set out within its reasoning regarding Paragraph 4(a) of the Allegation, the Tribunal found that Dr Matthews did have a duty to consider the possibility of underlying sexual abuse, given the relevant guidance and the symptoms Patient A had. In particular, the Tribunal noted the guidance set out in paragraph 3 of the GMC Guidance, which informs doctors that they must take action quickly if they suspect a child is being abused. The Tribunal were concerned that, at this stage, Dr Matthews knew that Patient A would not be seen by CAHMS until 16 September 2016, more than six weeks after this consultation. It could not see that Dr Matthews had done anything to address this risk sooner, especially given his wider knowledge of the difficulties Patient A's family were experiencing and the accepted background risk of abuse. After 1 August 2016, Dr Matthews left it to the family to arrange a follow up appointment to deal with a urine sample and a physical examination if necessary – Patient A was not seen in respect of these matters until 8 November 2016.

53. The Tribunal noted that, in his Rule 7 Response letter, Dr Matthews explained that during this consultation he was '*acutely aware that Patient A was suffering from emotional abuse in a dysfunctional family*'. However, he states '*It is accepted [he] did not consider that there was an underlying possibility of sexual abuse in Patient A's case'.*

54. The Tribunal found that it could not ignore this admission, nor the evidence of Dr F and the guidance it had received. It found these sub-paragraphs of the allegation proved.

Paragraph 6(e)

55. The Tribunal first established if there was a duty for Dr Matthews to carry out a physical examination. The Tribunal had regard to Dr F's report, which states that:

'Clinical guidance (NICE, 2010) confirms that secondary bed wetting may be associated with behavioural, emotional and family problems and is more common at times of stress. Assessment should include consideration of possible underlying medical issues such as constipation, obesity and diabetes.'

Dr F stated that Dr Matthews *'did not carry out a physical examination to exclude underlying causes'* in relation to night-time wetting, which was a necessary examination.

56. The Tribunal noted that Dr Matthews did recognise that a physical examination of Patient A may be required, but he considered that it may have been more appropriate for a female doctor to do it. Dr Matthews also accepted that he could not rule out a physical cause for Patient A's bedwetting without a physical examination.

57. However, the Tribunal could not see any record of Dr Matthews conducting a physical examination of Patient A, nor arranging for one to be conducted in a timely manner. The Tribunal therefore found this sub-paragraph of the Allegation proved.

Paragraph 7(b)

58. The Tribunal had regard to his oral evidence at this hearing, where in its view Dr Matthews did admit this allegation. In oral evidence, the Tribunal observed the following discourse between Dr Matthews and Ms Barbour, Counsel for the GMC:

'Dr Matthews	*I shared the opinion, it was credible to me*
Ms Barbour	*You said it was wrong to pass on that information*
Dr Matthews	*Yes, I regret passing that information, it was not right to pass it on*
Ms Barbour	*You said you had no concerns*
Dr Matthews	*That is not correct, it was quite clear I was phoning about the bedwetting, but I did not say I had no concerns about the child overall*
Ms Barbour	*Did you share the opinion of Patient A's mother as your own?*

Dr Matthews	*It could have been taken that way*
Tribunal Chair	*Not a clear answer*
Dr Matthews	*Yes*
Tribunal Chair	*Did you share the opinion of Patient A's mother as your own*
Dr Matthews	*Yes, I explained the format*
Ms Barbour	*You said you shared the format 'that is credible to me' and that is not the same as giving the mothers opinion as if it is your own?*
Dr Matthews	*It is my view that it is the same thing*
Ms Barbour	*[Allegation 7b read out] you just said. Did you state this information in a way that suggested it was your opinion?*
Dr Matthews	*Yes*
Ms Barbour	*So you admit allegation 7b*
Dr Matthews	*Yes, in the context of sharing the mothers view which seemed credible to me. I'll have to leave it with you.'*

59. The Tribunal found that Dr Matthews ultimately conceded this point, and found this sub-paragraph of the Allegation proved.

60. In his Rule 7 response, Dr Matthews states he '*Admits that on 3 August he spoke to Children's Social Care and shared the opinion of Patient A's mother as if it was his own.'*

61. The Tribunal expressed concern that Dr Matthews, when questioned, was unable to provide simple and straightforward answers to clear questions from counsel appearing on behalf of the GMC. It found that Dr Matthews had to be directed to his previous answer in his Rule 7 letter response due to his inconsistencies during oral evidence, both in relation to this point and others.

Paragraph 8(a)(i)

62. The Tribunal noted that Dr Matthews had already stated he found Patient B's comments credible and admitted that he had stated Patient B's opinion in a way that could have been perceived as his own to Children's Social Care.

63. The Tribunal was also mindful that it had already found that Dr Matthews had not given consideration as to whether Patient A was being sexually abused. It noted that Dr

Matthews did not make a record of this call, which is consistent with his lack of recording of the concerns of maltreatment which Dr Matthews claimed to have had during his evidence.

64. 'Untrue' in the Tribunal's view is a word that means the person stating the alleged fact or belief knows that, or is reckless, it is not an accurate statement. Something can be incorrectly stated without being an untruth. It was evident to the Tribunal, as shown by his consistent accounts throughout the various investigations, that Dr Matthews truly believed that the allegation made, or to be made, to Social Services was that Patient A's parents were doing nothing about her bedwetting, something he knew to be incorrect (due to the visits made to the practice) and mirrors the allegation actually made (though not in full).

65. The Tribunal found that Dr Matthews did not volunteer during the phone call that he was concerned about the cause of Patient A's bedwetting. Dr Matthews in his oral evidence confirmed this. The wording of the allegation is that Dr Matthews knew the opinion that the allegation was malicious was untrue; the Tribunal finds that Dr Matthews truly believed in that opinion for the reasons he has given. It may have been unwise, inappropriate and unprofessional for Dr Matthews to accept Patient B's opinion, and adopt it as his own, but it was not untrue for Dr Matthews to express it as it was his genuine belief.

66. The Tribunal found this sub-paragraph of the Allegation not proved.

Paragraph 8(a)(ii)

67. The Tribunal gave careful consideration of the wording of this allegation. It found that Dr Matthews was not untruthful to give his actual opinion, despite his knowledge of the risk factors.

68. It considered that the GMC may have tried to put forward an allegation that failing to disclose Patient A's risk factors during this call was inappropriate. That is not the language of the allegation before the Tribunal. The Tribunal has already found that because Dr Matthews simply put forward his opinion, however misjudged, it does not mean that it was untrue. It has found that Dr Matthews believed that the allegation Patient B told him about was malicious.

69. Therefore, given the language of this allegation, the Tribunal did not find it proved.

Paragraph 9

70. The Tribunal noted that it had found Paragraph 8(a) of the Allegation not proven. It therefore only considered this paragraph in relation to 8(b) which Dr Matthews had admitted.

71. The Tribunal considered the three questions it must ask itself in relation to dishonesty. It first determined that Dr Matthews had made this call, and that he had not made a record of it.

72. Secondly, the Tribunal considered what was Dr Matthews' belief as regards to the facts and the wider circumstances of this case. These include:

- Dr Matthews thought the call from Patient B and the allegations made to Social Services were to do with bedwetting and the parents not taking action;
- Patient B called in distress;
- There had been two previous investigations into the family by social services;
- Dr Matthews had seen the family previously about Patient A's bedwetting;
- Dr Matthews knew Patient A was due to see CAHMS and he had recently chased the referral;
- Dr Matthews had spoken to Ms G and Dr H and told them of the new symptoms;
- Patient A had seen other health professionals;
- Patient A's sister, Patient D, XXX;
- There was an indication from the family that Patient D was the cause of Patient A's nightmares;
- Dr Matthews was aware of the risk factors in the family, including Patient C's anger issues and history of emotional abuse;
- Dr Matthews thought that the allegation made against Patient A's parents was malicious and that Patient B's opinion was credible – he agreed with Patient B's opinion and also thought the allegation was malicious;
- Dr Matthews had an ongoing relationship with the family;

- At the time he made the call, Dr Matthews was not in his GP surgery, but at the offices of his CCG.

73. Lastly, the Tribunal considered whether the actions of Dr Matthews would be considered dishonest by the ordinary standards of reasonable and honest people? The Tribunal noted that Dr Matthews' account of his understanding at the time he made this call has been consistent throughout his evidence. It noted that Dr Matthews was not in his GP surgery at the time he made the call, so he did not have an opportunity to create a contemporaneous record of the call. Dr Matthews explained that this was in part why he had forgotten to make a record at a later date.

74. The Tribunal also took into account the extensive positive testimonials it had received on behalf of Dr Matthews. Many of the testimonials commented upon his honesty and integrity. However, it found that these were of limited assistance when assessing his credibility or propensity, particularly given Dr Matthews' unimpressive performance under cross-examination.

75. The Tribunal considered that a reasonable and honest person might view the failure to record a note of the phone call as inappropriate and below the standards expected of Dr Matthews, especially given the opportunity to make the record of the call after seeing Patient C on 12 August 2016 who complained of the Social Services allegations to Dr Matthews. However, the Tribunal did not find that the ordinary person would consider Dr Matthews' failure to make a record as dishonest in these circumstances.

76. The Tribunal found this Paragraph not proved.

Paragraph 10(a)

77. The Tribunal had regard to section 1.4.10 of the NICE guidelines on maltreatment which state that a doctor should '*Consider child maltreatment if a child is reported to be deliberately wetting'.* This guidance is repeated in the 'NICE clinical guideline for Bedwetting in under 19s (2010)'. The Tribunal reminded itself that maltreatment is defined as including sexual abuse.

78. The Tribunal also had regard to the report and evidence of Dr F. Dr F explained that Dr Matthews was aware of the many risk factors in place regarding Patient A. Dr F said that

the new information from Patient B about Patient A wetting Patient C's boxer shorts (possibly deliberately), before returning them to his cupboard, could be considered a further 'red-flag' that would require urgent attention, in line with the NICE guidance. Dr F also told the Tribunal, that alongside sexual abuse, Patient A's behaviour could also be a form of 'Oppositional Defiant Disorder'. He said that this presented Dr Matthews with a serious escalation in Patient A's behaviour.

79. The Tribunal heard that Dr Matthews was thinking about a psychological cause for Patient A's behaviour, which may have occurred from maltreatment. However, Dr Matthews was not specifically considering sexual abuse. The Tribunal noted that it had already made findings relating to this matter and found that Dr Matthews did have a duty to consider the possibility Patient A was being sexually abused during this consultation too, even if the possibility was small due to the serious impact on Patient A if it was occurring.

80. In addition, Dr Matthews' Rule 7 response letter states that:

> *'It is accepted the following the consultation with Patient A's mother on 4 November 2016 Dr Matthews failed to consider sexual abuse as an underlying possibility for Patient A's possible deliberate bed wetting'*

In his witness statement at paragraph 57, Dr Matthews said '*…considering the possibility of sexual abuse of Patient A by her father was simply not within my contemplation*'.

81. The Tribunal determined that given all the circumstances it had considered, it found this sub-paragraph of the Allegation proved.

Paragraph 10(b)(i) and (ii)

82. The Tribunal had regard to its determination of paragraph 4(e) of the Allegations. It found that its reasoning remained the same, as it saw no evidence that Dr Matthews had adequately followed the relevant guidance in this instance.

83. In addition, it noted that Dr Matthews had admitted this allegation in his Rule 7 response letter, where, following his admissions to 10(a), he goes onto to state that it was also accepted that Dr Matthews *'did not follow the relevant guidance with regard to child protection and safeguarding'*.

84. The Tribunal therefore found these sub-paragraphs of the Allegation proved.

Paragraph 11

85. The Tribunal considered that before making its determination on the sub-paragraphs of paragraph 11 of the Allegation, it should form an understanding of the term 'personal'.

86. The Tribunal took account of the GMC guidance on 'Maintaining a professional boundary between you and your patient' (April 2013). It found that this guidance focused on inappropriate emotional and/or sexual relationships with patients. The Tribunal had not seen evidence that suggested Dr Matthews had a sexual or romantic relationship with his patients. The Tribunal therefore adopted the common sense everyday meaning of the word 'personal' whilst assessing paragraph 11 – 'Affecting or concerning one's private life, relationships and emotions rather than one's career or public life'.

87. The Tribunal noted that Dr Matthews gave oral evidence that his relationship with Patient A's parents was outside of a professional relationship, and that the boundaries had become blurred. In his witness statement, Dr Matthews said that he *'fully accepted that the professional boundaries of a doctor-patient relationship became blurred from July 2016.'*

88. The Tribunal considered the interactions Dr Matthews had with Patients A's parents. These included:

- XXX;
- Lending, at their request, Patients B and C his sports car in lieu of payment for XXX, before agreeing to pay for the repair in addition;
- Paying for a day's insurance for Patient C to be able to drive Dr Matthews' sports car;
- Loaning the family money on two occasions;
- Visiting the patients' home for non-clinical reasons;
- Receiving a Christmas hamper from the patients valued at around £90 despite knowledge of their financial difficulties;
- Taking calls on his personal phone from Patient B.

In addition, the Tribunal noted that Dr Matthews XXX for Patient B when she moved into rented accommodation after the events that are the subject of the Allegation. The Tribunal considered this was an indicator of a personal relationship and more likely than not to have been of a long-standing nature with Patient B, given that she felt comfortable asking Dr Matthews XXX and he agreed.

89. The Tribunal considered it noteworthy that in Patient C's record on 17 October 2016 when Patient C consulted with another GP at the practice saying that he needed 'some help as is worried what he will do to daughter…could hit her', the doctor recorded discussing with Dr Matthews the situation, who said that he would contact Patient C as 'well known to him'. Later that day, the notes record that Dr Matthews encouraged Patient C to speak to social services. The Tribunal viewed this as an indication that Dr Matthews had a relationship with both Patients B and C, to such an extent that when Patient C disclosed threats against Patient A, the view was taken that Dr Matthews was the best placed person within the practice to address the matter.

90. The Tribunal noted that Dr Matthews accepted, in his Rule 7 response letter, that his relationship with Patient A's parents had *'developed beyond the normal doctor/ patient relationship'.* In addition, Dr Matthews stated that he *'has never lent money to patients before or found himself involved in relationships with them that would impact his practise'.* He added that he now *'fully accept that* [his] *objective thinking could have been clouded due to the more informal relationship that* [he] *had with Patient A's parents.'* In Dr Matthews' oral evidence he confirmed that he could not recall ever making a similar call to Children's Social Care.

91. In Dr Matthews' reflections following a professional boundaries course, he states: *'The person who suffered in my case was the child* (Patient A). *the underlying issue was my dual role and my close personal relationship with the parents.'*

92. The Tribunal found that Dr Matthews' actions and admissions did amount to him having a personal relationship with Patient A's parents within the common-sense definition of the word personal. The relationship was outside the parameters of a professional one, even if it was not social.

Paragraph 11(a)(i)

93. The Tribunal noted that Dr Matthews had already accepted that his relationship with Patients A's parents was inappropriate.

94. The Tribunal considered that GPs, in a broad sense, have a personal relationship with their patients. However, the nature of Dr Matthews relationship with Patient A's parents caused boundaries to be blurred as he himself accepted.

95. The Tribunal found this sub-paragraph of the Allegation proved.

Paragraph 11(a)(ii)

96. Whilst the Tribunal considered that Dr Matthews' knowledge of the facts of this case was concerning, given his failure to follow the relevant guidance, it did not find that this knowledge alone made his relationship with Patients B and C inappropriate.

97. The Tribunal found that its determination of 'personal' and paragraph 11(a)(i) of the Allegation demonstrated why Dr Matthews relationship with Patient A's parents was inappropriate.

98. The Tribunal found this sub-paragraph of the Allegation not proved

Paragraph 11(b)

99. The Tribunal was concerned that Dr Matthews was unable to outline in his oral evidence his understanding of a 'conflict of interest'. As noted, Dr Matthews had already admitted that the boundaries between himself and Patient A's parents had become blurred, and that this meant his objectivity was lost, which affected his ability to properly consider the obvious risk factors with which Patient A presented. He himself accepted that his actions made it harder for Patient A to disclose the sexual abuse she suffered at the hands of Patient C.

100. Given these issues, Dr Matthews would not have been able to discharge his primary function as a GP to the patient under his care, Patient A. The Tribunal therefore

determined this constituted a conflict of interest, and found this sub-paragraph of the allegation proven.

Paragraph 11(c)(i)

101. Dr Matthews explained in his reflective piece that his *'close personal relationship with the parents […] made if more difficult for the child to disclose what was happening at home'*. Given this statement, the Tribunal found this sub-paragraph of the allegation proved as making it more difficult for a minor patient to disclose maltreatment, including sexual abuse, inevitably adversely affects a patient's therapeutic relationship with their doctor.

Paragraph 12(b)(ii)

102. The Tribunal found that Dr Matthews' evidence was that his Record reflected Patient C's view that it was the Police who thought the allegation was malicious.

103. The Tribunal assessed Dr Matthews' previous records of his consultations with Patient C. It found that there was a pattern where Dr Matthews expressed Patient C's view by putting the word 'feels' in front of the statement. It noted that in this record, it did not have the word 'feels' in front of the statement, and so could have been interpreted as the opinion of Dr Matthews', given that this pattern was not replicated here.

104. However, the Tribunal considered that this was not enough evidence to discharge the burden of proof, and to confidently determine that Dr Matthews had written his own opinion here, despite the evidence from Dr E about Dr Matthews' beliefs about Patient C. This was not sufficient to find the allegation proved. It considered that Dr Matthews should have been more careful in writing this note, as it lacked detail and clarity about a crucial issue possibly affecting Patient A. This was even more important given the lack of any contact from the Police or Social Services.

105. The Tribunal found this sub-paragraph of the allegation not proved.

Paragraph 13(c)

106. Given the consideration the Tribunal outlined in its determination of paragraph 12(b)(ii), the Tribunal had found that it was not clear whose opinion was stated. It therefore found this sub-paragraph of the Allegation proved.

Paragraph 15

107. The Tribunal had regard to paragraph 2 of the GMC guidance. The Tribunal found that there was a duty on Dr Matthews to consider sexual abuse. It noted that this duty continued even when Patient A was not present, or if Dr Matthews saw her infrequently. Dr Matthews also had a duty to consider if Patient C posed a risk to any young person, including Patient A.

108. In determining whether Dr Matthews failed to consider if Patient A was being sexually abused, the Tribunal had regard to the evidence of Dr E. It noted that, in her report, Dr E said she was surprised that Dr Matthews had formed the view that Patient C was incapable of intimacy because of his anger issues. In her oral evidence, Dr E said she had a strong recollection of Dr Matthews' view, as she was shocked by it.

109. Dr Matthews explained that he was asked, in his meetings with Dr E, to 'float opinions' of generalities that may have been the cause of why he did not consider Patient A was being sexually abused by Patient C. Dr Matthews said that he had never actually held this view.

110. The Tribunal noted that Dr E's role was that of an investigator, who had been commissioned to undertake a review of Dr Matthews' interaction with Patient A's family for the purposes of sharing lessons with others within the clinical commissioning group. The Tribunal heard criticism of her investigative approach. However, they found Dr E to be a professional who was diligent, reflective, credible and reliable. This was enhanced by her willingness to make concessions and acknowledge deficiencies in her investigation. Because of these qualities, the Tribunal found that it preferred the evidence of Dr E to that of Dr Matthews on this point, particularly given his inability at times to answer questions straightforwardly. Dr E explained why she had remembered the conversation, which was because she had been shocked. She had recorded it within her report, and Dr

Matthews in his oral evidence had accepted that this point had not been challenged in his response to her report.

111. The Tribunal found that Dr Matthews' belief of Patient C being incapable of 'physical intimacy', and therefore unable to sexually abuse Patient A was his actual belief and a possible reason, apart from the personal relationship why he did not consider the possibility of child sexual abuse, though child sexual abuse does not constitute physical intimacy in any event.

112. In addition, the Tribunal noted that Dr Matthews had made no entry on Patient C or Patient A's records about the possibility of sexual abuse, despite Patient C telling him that the Police had interviewed him about this possibility.

113. The Tribunal found that when confronted with Patient C's disclosure, it did not appear Dr Matthews took any action. The Tribunal considered that this is where Dr Matthews' actions differed to that of other health care professionals in a similar position, because of his knowledge of, and personal relationship with, the family and his beliefs about Patient C. The Tribunal concluded that a responsible body of GP's would take some action if a father of a minor patient told them that the Police were investigating them regarding child sexual abuse, and in addition this would be in accordance with the clinical commissioning group's policy on safeguarding. The Tribunal therefore found this allegation proved.

Paragraph 16

114. The Tribunal considered which actions of the Allegation it would be able to make a determination on. It found that Dr Matthews call to social services and his recording of the opinion 'malicious accusation' in Patient C's medical notes to be the events most obviously related to this allegation. The Tribunal could not make a determination on any other paragraphs of the Allegation as it considered these to be where Dr Matthews had failed to consider something, and as such could not be a conscious attempt of his to undermine any potential allegation(s) by Patient A.

115. With regards to Dr Matthews' call to Social Services, the Tribunal were mindful that it had determined that Dr Matthews had passed on information that he believed related to Patient A's bedwetting and his opinion that the allegation was malicious. The Tribunal

accepted that Dr Matthews had not made a deliberate attempt to undermine Patient A regarding any allegations of sexual abuse in making the call, although it did have the potential to undermine and silence Patient A's voice. Dr Matthews simply had not considered the possibility of child sexual abuse. It therefore found the determination not proved in relation to this action.

116. The Tribunal accepted that, in relation to the record he made of Patient C's understanding that the Police had thought Patient A's allegation as malicious, Dr Matthews may not have been recording his own opinion.

117. In addition, Dr Matthews' counsel sought to persuade the Tribunal that there was no risk to Patient A, as she was already in care by this time. The Tribunal did not accept that there was no risk, as there would have been, for example, a potential for psychological harm to Patient A if her allegations were undermined.

118. However, the Tribunal found that Dr Matthews' actions were not a deliberate attempt to undermine a potential allegation(s) from Patient A regarding sexual abuse as he appeared again not to have considered the possibility from his lack of action. His actions may have undermined Patient A, but there was no evidence before the Tribunal of any intention to do so.

119. The Tribunal therefore found this paragraph not proved in relation to any of the actions in the Allegation.

Paragraph 17

120. The Tribunal accepted the everyday meaning of the term 'motivation' when considering this paragraph of the Allegation. It found that 'motivation' did not have to be a conscious decision to do something, rather, it is a cause for an act or omission, and may not be the main cause.

121. The Tribunal considered each paragraph of the allegation that it had found proven in turn.

122. Paragraphs 3, 11, 12a & b and 13 – The Tribunal found that these paragraphs were unrelated to its current considerations.

123. Paragraph 2 – The Tribunal found that this was human error on Dr Matthews part, and therefore did not take this allegation into account.

124. Paragraphs 4, 6 and 10 – The Tribunal found that these allegations were similar, in that they concerned Dr Matthews' failure to consider sexual abuse and to follow guidance. The Tribunal was mindful that it had determined that Dr Matthews had lost objectivity because of the blurred boundaries and personal relationship he had with the family. It considered that this was the motivation for his actions. It therefore found Paragraph 17 proven in relation to these paragraphs of the Allegation.

125. Paragraph 7 – The Tribunal found that Dr Matthews' personal relationship with Patient B was the motivation for calling social services. It therefore found Paragraph 17 proven in relation to this paragraph of the Allegation.

126. Paragraph 15 – The Tribunal considered the evidence of Dr E about Dr Matthews' beliefs regarding Patient C and the 'red-flags' that Dr Matthews was aware of as highlighted in paragraph 4, 6 and 10 of the Allegation. The Tribunal also reminded itself of its concern that Dr Matthews did not take any action after Patient C's disclosure that he had been under investigation from the Police. His explanation about his lack of action ignored the absence of contact from Social Services or the Police about this investigation to the practice or the risks to other children who may have been in contact with Patient C. The Tribunal considered that Dr Matthews' conduct was motivated by his personal relationship with Patient A's parents. It therefore found Paragraph 17 proven in relation to this paragraph of the Allegation.

The Tribunal's Overall Determination on the Facts

127. The Tribunal has determined the facts as follows:

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

1. At all material times, Patient A, B and C were vulnerable patients.

   Admitted and found proved

2. On 30 October 2015 you consulted with Patient A and her mother (Patient B) and you failed to refer Patient A to the Child and Adolescent Mental Health Service ('CAMHS').

Admitted and found proved

3. You received a telephone message the nature of which is set out at Schedule 1, regarding Patient A's bedwetting from Patient B on 15 July 2016 ('the Message').

Admitted and found proved

4. You consulted with Patient A's parents regarding Patient A's bedwetting on 18 July 2016 and you failed to:

a. consider the possibility of underlying sexual abuse because of Patient A's:

i. secondary enuresis; Determined and found proved

ii. vivid nightmares; Determined and found proved

iii. behavioural disturbance; Determined and found proved

iv. background risk for abuse; Determined and found proved

b. take a full history of Patient A's:

i. night-time urinary symptoms; Determined and found not proved

ii. day-time urinary symptoms Determined and found not proved

~~c. seek further advice;~~ Deleted after a successful Rule 17(2)(g) application

d. provide practical management advice to Patient A's parents; Admitted and found proved

e. adequately follow relevant guidance with respect to:

i. child protection; Determined and found proved

ii. safeguarding. Determined and found proved

~~5. Following receipt of the Message and your consultation with Patient A's parents, you failed to arrange a consultation with Patient A in order to:~~

~~a. take a full history of:~~

~~i. night-time urinary symptoms;~~ Deleted after a successful Rule 17(2)(g) application

~~ii. day-time urinary symptoms;~~ Deleted after a successful Rule 17(2)(g) application

~~b. carry out a physical examination to exclude underlying causes;~~ Deleted after a successful Rule 17(2)(g) application

~~c. provide practical management advice to:~~

~~i. Patient A;~~ Deleted after a successful Rule 17(2)(g) application
~~iv.~~
~~ii. Patient A's parents;~~ Deleted after a successful Rule 17(2)(g) application

~~d. adequately follow relevant guidance with respect to:~~

~~i. child protection;~~ Deleted after a successful Rule 17(2)(g) application
~~v.~~
~~ii. safeguarding;~~ Deleted after a successful Rule 17(2)(g) application

~~e. consider the possibility of underlying sexual abuse because of Patient A's:~~

~~i. secondary enuresis~~ Deleted after a successful Rule 17(2)(g) application
~~ii. vivid nightmares;~~ Deleted after a successful Rule 17(2)(g) application
~~vi.~~
~~iii. history of behavioural disturbance;~~ Deleted after a successful Rule 17(2)(g) application
~~iii. iv. background risk for abuse.~~ Deleted after a successful Rule 17(2)(g) application

Amended under rule 17(6)

6. You consulted with Patient A on 1 August 2016 regarding her bedwetting and you failed to:

a. consider the possibility of underlying sexual abuse because of Patient A's:

i. secondary enuresis; Determined and found proved

ii. vivid nightmares; Determined and found proved

iii. behavioural disturbance; Determined and found proved

iv. background risk for abuse; Determined and found proved

b. take a full history of:

i. night-time urinary symptoms; Admitted and found proved

ii. day-time urinary symptoms; Admitted and found proved

c. seek further advice; Admitted and found proved

d. provide practical management advice to:

i. Patient A; Admitted and found proved

ii. Patient A's parents; Admitted and found proved

e. carry out a physical examination to exclude underlying causes; Determined and found proved

f. adequately follow relevant guidance with respect to:

i. child protection; Admitted and found proved

ii. safeguarding. Admitted and found proved

7. On 3 August 2016 you contacted Children's Social Care at the request of Patient B ~~and made the statement set out at Schedule 2 ('the Call') which was:~~ and made statements to the effect of those recorded in the case note at Schedule 2 ('the Call') which were:

Amended under rule 17(6)

a. the opinion of Patient A's mother; Admitted and found proved

b. stated in a way that suggested it was your opinion. Determined and found proved

8. When you made the Call you:

a. provided information that was untrue in that you;

i) knew the opinion you provided was not your own but that of Patient B; Determined and found not proved

ii) had knowledge of the risk factors as set out at paragraphs 4a and 6a; Determined and found not proved

b. failed to record in Patient A's medical records that you had made the Call. Admitted and found proved

9. Your action as described at paragraph 7 was dishonest by reason of paragraphs 8a and 8b. Determined and found not proved

10. Following your consultation with Patient B on 4 November 2016 in which she provided the information as set out at Schedule 3 you failed to:

    a. consider sexual abuse as an underlying possibility for Patient A's bedwetting; **Determined and found proved**

    b. adequately follow relevant guidance with respect to:

        i. child protection; **Determined and found proved**

        ii. safeguarding. **Determined and found proved**

11. Between July 2016 and December 2016 you developed a personal relationship with Patient A's parents which:

    a. was inappropriate because:

        i. they were your patients; **Determined and found proved**

        ii. of your knowledge of the facts as set out at paragraphs 2-10; **Determined and found not proved**

    b. represented a conflict of interest; **Determined and found proved**

    c. adversely affected your therapeutic relationship with:

        i. Patient A; **Determined and found proved**

        ~~ii. Patient B;~~ **Deleted after a successful Rule 17(2)(g) application**
        ~~iii. Patient A's father (Patient C).~~ **Deleted after a successful Rule 17(2)(g) application**

12. On 3 March 2017 you consulted with Patient C, and you made a record ('the Record') as set out fully in Schedule 4 in Patient C's notes that:

    a. Patient C had been accused of sexual abuse by Patient A; **Admitted and found proved**

    b. it "seems clear this is a malicious accusation" which was;

        i. Patient C's opinion and/or; **Admitted and found proved**

        ii. your opinion. **Determined and found not proved**

13. In making the Record as set out at paragraph 12 you:

    ~~a. recorded information that was untrue;~~ **Deleted after a successful Rule 17(2)(g) application**

~~b. should have known the information you recorded was untrue given your knowledge of the risk factors relating to:~~

i. ~~Patient A as set out at paragraphs 4a, 6a, and 10a;~~ Deleted after a successful Rule 17(2)(g) application

ii. ~~Patient C taking into account his medical history;~~ Deleted after a successful Rule 17(2)(g) application

c. failed to make clear whose opinion was being stated.

Determined and found proved

14. ~~Your actions as set out at paragraph 12b were dishonest by reason of paragraphs 13a and 13b~~. Deleted after a successful Rule 17(2)(g) application

15. Following the consultation with Patient C you failed to consider that sexual abuse was a possible underlying cause for Patient A's previous presentations.

Determined and found proved

16. Your actions as set out at paragraphs 2-15 were on one or more occasion an attempt ~~to conceal and/or~~ undermine any potential allegation(s) of sexual abuse made by Patient A against Patient C.

Partially deleted after a successful Rule 17(2)(g) application
Determined and found not proved

17. Your conduct as set out at paragraphs 2-15 was motivated by your personal relationship with Patient A's parents.

Determined and found proved for paragraphs 4, 6, 7, 10 and 15

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

Determination on Impairment - 11/03/2021

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

The Outcome of Applications Made during the Impairment Stage

2. On behalf of Dr Matthews, Ms Tanchel made an application under Rule 34(1) of the Rules to admit further evidence in the form of testimonials and remedial work Dr Matthews had completed. The application was not opposed by Ms Barbour. On behalf of the GMC, Ms Barbour made an application under the same Rule to admit further evidence in the form of a witness statement and email from a responsible officer at NHS England, and a reflective piece by Dr Matthews. The application was not opposed. The Tribunal determined that all the evidence was relevant to the hearing and could be admitted without any injustice to either party.

The Evidence

3. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

4. In addition, the Tribunal received a witness statement on behalf of the GMC from Dr I, Deputy Responsible Officer and Assistant Medical Director of NHS England North, dated 21 July 2020.

5. The Tribunal also received documents including, but not limited to, documents demonstrating Dr Matthews remedial work including certificates of courses completed; testimonials regarding Dr Matthews; an email from Dr I regarding an NHS England investigation into Dr Matthews' conduct and a reflective piece composed by Dr Matthews dated 15 September 2017.

Submissions

On behalf of the GMC

6. Ms Barbour submitted that the Tribunal firstly has to determine whether the facts it had found proved amounted to misconduct, and whether that misconduct was serious. Ms Barbour drew the Tribunal's attention to the case of Nandi v General Medical Council [2004] EWHC 2317 (Admin), where serious misconduct was defined as *'conduct which would be regarded as deplorable by fellow practitioners'*.

7. Ms Barbour outlined the areas of Dr F's report where he had considered Dr Matthews' conduct had fallen below or seriously below the standards expected of a doctor. She submitted this could assist the Tribunal in its determination on misconduct. This included Dr Matthews' response to the symptoms Patient A had and how he deferred this to

CAMHS; his failure to take action given Patient A's risk factors; his failure to have a low threshold for considering whether Patient A was being sexually abused; his failure to follow safeguarding and child protection guidance; his failure to appropriately record his phone call to social services; and his inappropriate relationships with Patients B and C, who were both vulnerable. Ms Barbour highlighted that the Tribunal had found during the facts stage of this hearing that these actions had an adverse impact on the care of Patient A.

8. Ms Barbour submitted that the Tribunal would be assisted by the standards set out in Good Medical Practice (2013 edition) ('GMP'). Ms Barbour said the guidance covered the need for Dr Matthews to be 'competent, keep his knowledge and skills up to date, establish and maintain good relationships with his patients and colleagues, be honest and trustworthy, and act with integrity'. She said that Dr Matthews would also be required to 'keep his professional knowledge and skills up to date; be familiar with guidelines; adequately assess a patient's condition - taking account of their history; promptly provide or arrange suitable advice, investigations or treatment; and refer a patient to another practitioner when this serves the patient's needs.' In addition, Dr Matthews should, 'whether or not he had vulnerable adults or children and young people as patients, consider their needs and welfare and offer them help if you think their rights have been abused or denied'. Lastly, Dr Matthews should 'make sure that his conduct justified his patients' trust in him and the public's trust in the profession.'

9. When considering impairment, Ms Barbour reminded the Tribunal that it must assess Dr Matthews' current fitness to practise and if it is impaired, but that it could take account of the way he has acted or behaved in the past.

10. Ms Barbour submitted that Dr Matthews' level of remediation was an essential consideration. She said that the Tribunal may take the view that some of Dr Matthews' misconduct is not easily remediated, and if there had been remediation, it may take the view that there is a risk of Dr Matthews repeating this conduct. Ms Barbour submitted that for the Tribunal to be satisfied that Dr Matthews had remediated, it must first be satisfied that Dr Matthews had accepted his failings.

11. Ms Barbour submitted that the findings of this case covered a 'raft' of significant failings where Dr Matthews' objective judgement had been compromised, and he failed to have proper regard to the safeguarding functions of a doctor. She said that Patient A had deserved a high quality of care, and that the general public were relying on GP's like Dr

Matthews to provide a safety net for vulnerable members of the community. She submitted that Dr Mathews had not properly discharged his primary function as a GP and was prepared to defer away to third parties his safeguarding duties. Ms Barbour stated that these matters would be of a real and grave concern to the public at large.

12. As an example, Ms Barbour highlighted while Dr Matthews sought to 'explain away' the issues regarding his alleged position that Patient C was incapable of physical intimacy, and therefore could not sexual abuse a child; the Tribunal had found that this was Dr Matthews' genuinely held belief. She said that this demonstrated Dr Matthews' failure to recognise the length of the journey towards remediation and how far along this journey he was.

13. In terms of insight, Ms Barbour submitted that the tribunal may have concerns of Dr Matthews's shifting position between his first Rule 7 response to the GMC and his responses in oral evidence at the facts stage of this hearing. She said that this may demonstrate Dr Matthews' shortcomings in accepting his failings, a hinderance to proper reflection and a barrier to full insight. Ms Barbour said that Dr Matthews was not able to give a compelling, persuasive and cohesive version of events, and this meant he had not properly scrutinised his actions in order to gain full insight.

14. Ms Barbour submitted that it was disappointing and worrying that Dr Matthews had attended courses on professional boundaries, but had not used this to fully and properly reflect on this case. Ms Barbour submitted that Dr Matthews' evidence was that he has 'done enough' in relation to safeguarding and that the steps he had taken were 'sufficient'. She said this too demonstrated a lack of insight.

15. Ms Barbour submitted that the testimonials the Tribunal had received regarding Dr Matthews suggested he has a good reputation locally. But she submitted that these testimonials were compiled prior to the Tribunal's findings at the facts determination stage, and therefore did not take into account Dr Matthews' denial of facts that have since been found proved. She therefore asked the Tribunal to consider what weight the testimonials could be given.

16. Ms Barbour submitted that Dr Matthews' fitness to practise was currently impaired.

17. Ms Barbour submitted that a finding of impairment was required, given the serious circumstances of this case, and that Dr Matthews' insight was, at best, only developing.

This finding would not be to punish Dr Matthews, but to protect the public, declare and uphold the standards of the medical profession, and to ensure that the public's confidence in the profession was maintained.

On behalf of Dr Matthews

18. Ms Tanchel submitted that she conceded that the findings of the Tribunal at the facts stage were serious, and amounted to misconduct

19. Ms Tanchel submitted that, when determining whether Dr Matthews' fitness to practise is currently impaired, the Tribunal should approach its decision making within the parameters of *Cheatle v General Medical Council [2009] EWHC 645 (Admin)*, which states:

> *'The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct.'*

She drew the Tribunal's attention to the case of *Zygmunt, R (on the application of) v General Medical Council [2008] EWHC 2643* which states:

> *'although section 35D(2) of the 1983 Act refers to a finding that a doctor's fitness to practise is impaired, present impairment of fitness to practise can be founded on past matters. That seems sensible. The doctor's current fitness to practise must be gauged partly by his/her past conduct or performance. It must also be judged by reference to how s/he is likely to behave or perform in the future.'*

Ms Tanchel also referred the Tribunal to *R (Cohen) v GMC [2008] EWHC 581 (Admin),* which states that when assessing Dr Matthews' misconduct, the Tribunal should consider whether the *'conduct which led to the charge is easily remediable; that, second, it has been remedied; and, third, that it is highly unlikely to be repeated'*

20. Ms Tanchel reminded the Tribunal that the allegations deal with events mainly between 2016 and 2017, a short period of Dr Matthews' nearly 30 year long career. She said that the Tribunal should not find him impaired if he has been able to demonstrate, in the intervening time, that he has remedied his shortcomings. In addition, Ms Tanchel

submitted that Dr Matthews had retired in 2020, with no allegations being made against him since the events of the Allegation. She submitted that the testimonials regarding Dr Matthews show that he is a clinician who is above average, a pleasure to work with and altruistic. Ms Tanchel said that these allegations do not undermine the entirety of his practice and the testimonials show that this behaviour is out of character for Dr Matthews. Further, it is because of his deep generosity and commitment to his community that he may have acted to his own detriment in trying to assist Patients B and C.

21. Ms Tanchel highlighted to the Tribunal that Dr Matthews had voluntarily gave an undertaking for NHS England and brought this case to be discussed by the Practice. She submitted that there can be no better indication of insight than this.

22. Ms Tanchel drew the Tribunal's attention to Dr Matthews' remedial work and submitted that this demonstrated a robust commitment to remedy deficiencies in his practise and strive for high standards. This work included attending a one-day course on professional boundaries, another course regarding child protection, Dr Matthews reflecting on his performance in order to prevent such circumstances as these occurring again as shown by the audit and re-audit he had carried out on cases involving minor patients he dealt with between March and May 2018 and September and December 2018. She submitted that Dr Matthews now recognised he should have behaved differently, in particular with regards his personal relationship with the family. Ms Tanchel submitted that whilst Dr Matthews' remedial work may have occurred some time ago, remedial work and gaining insight ultimately does come to an end, as shown when Tribunals consider that there is no need to further review a doctor once their insight and remediation is complete. Ms Tanchel said that Dr Matthews' remedial work is now complete, and he remained ashamed and embarrassed because of what has occurred.

23. In reference to Dr Matthews' oral evidence, Ms Tanchel explained that Dr Matthews had not made blanket denials of allegations; he had admitted several. Ms Tanchel submitted that the Tribunal had only seen Dr Matthews give evidence over three days, but that his colleagues who provided the testimonials had known him for up to 30 years. She said their assessment would be more rounded when looking at his practice as a whole.

24. Ms Tanchel submitted that the Tribunal should be careful when assessing Dr Matthews' denial of some of the allegations, and drew the Tribunal's attention to *General Medical Council v Awan [2020] EWHC 1553 (Admin)* which states that it is:

'too much to expect of an accused member of a profession who has doughtily defended an allegation on the ground that he did not do it suddenly to undergo a Damascene conversion in the impairment phase following a factual finding that he did do it. Indeed, it seems to me that to expect this of a registrant would be seriously to compromise his right of appeal against the factual finding'

25. Ms Tanchel submitted that, when considering any further action in this case, a warning would not be a 'soft-outcome' for Dr Matthews, and that this should be used to set a marker. A finding of impairment would prevent the Tribunal from issuing a warning; Ms Tanchel warned that this may mean that the available sanctions to the Tribunal may be disproportionate if Dr Matthews was found to be currently impaired.

26. When considering the public interest in this case, Ms Tanchel submitted that a fully informed member of the public, who knew the facts of this case, would not be shocked, dismayed or surprised if Dr Matthews continued unrestricted practice, if they considered his remediation, insight and overall standard of practice, as indicated by the testimonials.

27. Ms Tanchel submitted that there is no risk to the public as Dr Matthews had fully remediated, understood what had gone wrong and that this was an isolated incident with one family. She said that Dr Matthews' fitness to practise was not currently impaired.

The Relevant Legal Principles

28. 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 judgment alone.

29. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious, and then whether the finding of such serious misconduct could lead to a finding of impairment.

30. The Tribunal must determine whether Dr Matthews's fitness to practise is impaired today, taking into account Dr Matthews'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.

31. The Tribunal had regards to the cases of *Cohen, Nandi* and *Cheatle* outlined above.

32. When considering misconduct, the Tribunal had regard to the definition given in *Roylance v General Medical Council (No.2) [2000]1 AC 311 (UKPC)*

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

33. The Tribunal had regard to the test for impairment, set out in CHRE v NMC and Paula Grant [2011] EWHC 927 Admin. In particular, the Tribunal considered whether its findings of fact showed that Dr Matthew's fitness to practise is impaired in the sense that he

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

34. When considering Dr Matthews' level of remediation and insight , the Tribunal had regard to the case of *General Medical Council v Haris [2020] EWHC 2518,* which instructs the Tribunal to consider whether Dr Matthews demonstrated that he understands now the gravity of his behaviour. The Tribunal considered that the *Awan* case, to which it had been referred by Ms Tanchel, allowed it to consider the nature of Dr Matthews' defence and any continued denial of misconduct found proved as this is relevant to his insight and remorse. However, the Tribunal remined itself that there was no evidence before it whether Dr Matthews accepted its findings as he did not give evidence after it had handed down its findings of fact, but it should not require Dr Matthews to undertake a 'Damascene conversion'.

The Tribunal's Determination on Impairment

Misconduct

35. The Tribunal first addressed each paragraph of the Allegation to determine whether it amounted to misconduct. Due to the similar nature of what was alleged, the Tribunal determined certain paragraphs together. In approaching its determinations, the Tribunal born in mind the standards expected of Dr Matthews as set out in GMP as highlighted by Ms Barbour in her submissions on behalf of the GMC.

Paragraphs 1 and 3

36. The Tribunal considered that these allegations did not amount to misconduct.

Paragraph 2

37. The Tribunal noted Dr F's opinion that this '*represent an isolated human error*', with which it agreed. It considered that this did not constitute misconduct, as it did fall below the standards expected of a doctor, but not seriously below.

Paragraphs 4, 6 and 10

38. The Tribunal noted Dr F's opinion that:

> *'…following the consultations […] Dr Matthews should have considered the possibility of underlying sexual abuse for Patient A because of secondary enuresis, vivid nightmares, behavioural disturbance and background risk for abuse. My opinion is that failure to consider abuse was seriously below the standard expected.'*

39. In relation to Dr Matthews' failure to follow relevant guidance regarding child protection and safeguarding, the Tribunal noted Dr F's opinion that such a failure was seriously below the standard expected of a reasonably competent General Practitioner:

> *'Dr Matthews failed to follow local and national guidance on child protection and safeguarding. It is my opinion that these failings placed Patient A at risk of significant harm.'*

40. Dr F in his report found that the failure to provide practical management advice about the bedwetting was:

'below the standard expected because bed wetting is distressing and embarrassing, and delay in treatment can have a negative impact on social activities and emotional wellbeing. It may also be a feature of an underlying treatable medical condition. However, my opinion is that this failing was not seriously below the standard expected because on balance the night-time wetting was most likely to be a symptom of psychological distress and this would be addressed appropriately by CAMHS.'

41. The Tribunal accepted Dr F's opinion that Dr Matthews' behaviour fell seriously below the standards expected of a doctor in his position (excluding the failure to give practical management advice). It noted Ms Tanchel on Dr Matthews behalf, accepted that the failings were serious misconduct. The Tribunal found that the significant failings amounted to misconduct, and that this misconduct was serious.

Paragraph 7

42. The Tribunal noted in Dr F's report that:

'Dr Matthews states that on 03.08.16 he phoned Children's Social Care to inform them of Patient A's recent medical history. […] In my opinion, Dr Matthews failed to ensure that the information he gave to Children's Services was accurate. This reflects poor judgment and a failure to properly consider the welfare of Patient A. In addition, if it is accepted that Dr Matthews had an inappropriate personal relationship with Patient A's parents, then it is possible that Dr Matthews allowed this relationship influence to his judgement. My opinion is that, by making this call, Dr Matthews' actions fell seriously below the standard expected because he had a professional duty to supply accurate information to allow accurate assessment of any risk to Patient A.'

43. The Tribunal accepted Dr F's opinion, though it bore in mind its previous finding that Dr Matthews had so acted under the belief that the allegations were about Patients B and C not seeking advice about Patient A's bedwetting. Again, the Tribunal noted Ms Tanchel's concessions on Dr Matthews' behalf and that Dr Matthews himself had accepted that on reflection it had been inappropriate to make this call. The Tribunal had previously found that this call had had the potential to undermine and silence the voice of the child. The Tribunal found that Dr Matthews' behaviour amounted to misconduct, and that this misconduct was serious.

Paragraph 8b

44. The Tribunal considered that, taken in isolation, forgetting to make a record of a phone call about a patient in her medical notes would not constitute misconduct. It reminded itself that Dr Matthews had not been in the Practice at the time of the call, and so would not have access to the systems needed to make the record.

45. However, when taken holistically in the context of Dr Matthews' relationship with the family, the Tribunal found that Dr Matthews should have been prompted to make a record a few days later, following his consultation with Patient C who specifically complained of the allegations made to Social Services. In addition, the Tribunal noted that the relevant guidance informs Dr Matthews that he should have made a note of this call to record why he had no concerns and to ensure colleagues reviewing Patient A's medical records had the full picture. The Tribunal considered that this does fall seriously below the standards expected of a doctor and would be considered deplorable by fellow medical practitioners. The Tribunal therefore found that Dr Matthews' behaviour did amount to misconduct, and that this misconduct was serious.

Paragraph 11

46. The Tribunal noted the opinion of Dr F that:

> *'Between July 2016 and December 2016, it is my opinion that Dr Matthews allowed a social relationship to develop with Patient A's parents. This was inappropriate because of the potential to impact adversely on patient care. It was especially inappropriate because of Dr Matthews' knowledge of the family's financial problems, the couple's marital problems, his knowledge of the father's psychological difficulties and his knowledge of Patient A's behavioural and emotional problems. My opinion is that Dr Matthews' social relationship with this family was inappropriate and extended over a significant period of time. It is my opinion that Dr Matthews' actions in this regard were seriously below the standard expected because of the risk of damaging the effectiveness of the doctor patient relationship for this family.'*

47. The Tribunal accepted this opinion and bore in mind its own finding regarding this personal relationship and its impact on the therapeutic relationship with Patient A and that it gave rise to a conflict of interest. Dr Matthews' behaviour fell seriously below the standard expected; the Tribunal found that his behaviour amounted to misconduct, and that his misconduct was serious.

Paragraphs 12 and 13

48. The Tribunal had regard to Dr F's report, which states:

> *'Dr Matthews noted that Patient B had been accused of sexual abuse by his daughter and added "seems clear this was a malicious allegation". At the time of this consultation, Dr Matthews knew of the risk factors and alerting features for abuse that applied to Patient A, and my opinion is that he should have realised that sexual abuse was a possible underlying cause for her presentations. My opinion is that Dr Matthews' care on this occasion was below the standard expected because he responded to a disclosure with significant safeguarding implications in an inadequate and uninformed way. In addition, if it is accepted that Dr Matthews had an inappropriate personal relationship with Patient B and his family, then it is possible that Dr Matthews allowed this relationship to influence his judgement. However, it is my opinion that this failing was not seriously below the standard expected because the allegation had already been acted on and there was no immediate need to consider the welfare of Patient A.'*

49. The Tribunal found that whilst it is a serious matter that Dr Matthews did not make clear in his record whose opinion was being shared, it concluded that this would not be considered deplorable by fellow medical practitioners. The Tribunal therefore did not find that this amounted to misconduct.

Allegation 15

50. The Tribunal was mindful of its determination at Paragraph 113 of its facts determination:

> *'The Tribunal found that when confronted with Patient C's disclosure, it did not appear Dr Matthews took any action. The Tribunal considered that this is where Dr Matthews' actions differed to that of other health care professionals in a similar position, because of his knowledge of, and personal relationship with, the family and his beliefs about Patient C. The Tribunal concluded that a responsible body of GP's would take some action if a father of a minor patient told them that the Police were investigating them regarding child sexual abuse, and in addition this would be in accordance with the clinical commissioning group's policy on safeguarding.'*

51. It noted Dr F's report, where he stated that Dr Matthews' failure to act following Patient C's disclosure on 3 March 2017 was not seriously below the standard expected, but the Tribunal disagreed. Dr F had assumed that the allegation had been acted upon by others, but Dr Matthews at that time would have been relying purely on the word of Patient C in the absence of any contact from the Police or Social Services.

52. The Tribunal found that given Dr Matthews had become aware of another 'red-flag', his knowledge of the family and the indication that they were under enquiry, his response was seriously below that expected. There was no indication that he had reviewed Patient A's record in light of this disclosure and considered the possibility that she had been sexually abused. The Tribunal therefore found that his behaviour did amount to misconduct and that it was serious.

Paragraph 17

53. The Tribunal had regard to Paragraph 113 of its facts determination, as set out above. It noted the cumulative failures in Dr Matthews' behaviour and considerations; his personal and inappropriate relationship with Patient A's parents and the adverse impact that this had on his therapeutic relationship with Patient A. it considered that his conduct fell seriously below the standards expected of a doctor. The Tribunal therefore found that Dr Matthews' behaviour amounted to misconduct, and that this misconduct was serious.

Impairment

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

55. The Tribunal considered that at the core of the Allegation was the proven personal relationship between Dr Matthews and Patient's B and C. The Tribunal considered that this led to Dr Matthews losing his objectivity and his consequent failings.

56. The Tribunal accepted the testimonial evidence, and found Dr Matthews to be a well respected GP, who is viewed as excellent by his patients and peers. It noted that Dr Matthews has had an unblemished career that included training other GP's and played a leading role in his local Clinical Commissioning Group. Dr Matthews had made a number of admissions at the outset of these proceedings which was to his credit and indicated insight in respect of those matters. However, the Tribunal was mindful that those giving testimonials would not be aware of his inconsistent evidence at this hearing.

57. The Tribunal found that, up until the start of this hearing, Dr Matthews' evidence of the level of his insight and remedial work was persuasive. The Tribunal noted that Dr Matthews had undertaken an audit and re-audit of his work, plus courses in child protection and professional boundaries. However, it found that the weight it could place

on this evidence was significantly undermined by his oral evidence before this Tribunal at the facts stage. The Tribunal found that Dr Matthews' oral evidence was wholly inconsistent with the journey of insight he represented himself to have taken. It considered this to be an unusual demonstration of 'reverse insight'.

58. Whilst much has been made of Dr Matthews' questioning the use of the term 'personal', the Tribunal was mindful that, at the outset of these proceedings Ms Tanchel had made it clear that the reason Dr Matthews was unable to admit paragraph 11 of the Allegation was because he was concerned 'personal' meant an improper emotional or sexual relationship due to his understanding of the relevant GMC guidance. Dr Matthews had always accepted that the relationship was inappropriate before the GMC and this Tribunal.

59. However, the Tribunal was concerned about Dr Matthews' inability to accept paragraphs 4a, 4e, 6a, 6e and 7b of the Allegation before this Tribunal. These were facts that the Tribunal found both in their own right and had been previously admitted in Dr Matthews' first Rule 7 response. His position at the outset of this medical practitioner's tribunal was wholly inconsistent with his position set out within this response. Whilst the Tribunal considered that giving oral evidence may have been a stressful and unfamiliar experience for Dr Matthews, it did not appear to the Tribunal that Dr Matthews was overawed by the process. He simply had failed to answer several key questions in a straightforward way and his oral evidence was at odds with the other evidence of insight and remediation. It noted that Dr Matthews had not taken the opportunity at this stage to provide any further oral evidence into his insight or remediation.

60. The Tribunal considered that given these issues, Dr Matthews had not satisfactorily demonstrated that he has sufficient insight or fully remediated his conduct. It appeared to the Tribunal that he had only remediated his conduct in relation to the parts of the Allegation he accepted at the outset and not the facts that the Tribunal had found proved. As a result, the Tribunal were not satisfied that Dr Matthews fully understood the gravity of his behaviour in full. The Tribunal was not looking for a 'Damascene conversion', but the weight it could place on Dr Matthews' evidence of insight and remediation had been seriously undermined by his own oral evidence and inconsistent statements.

61. In light of these findings, the Tribunal found that Dr Matthews is currently impaired on all three limbs of the overarching objective. The Tribunal found there was a risk of repetition

if Dr Matthews returned to practise, the Tribunal needed to uphold the proper standards of the profession, and that confidence in the medical profession would be seriously undermined if the Tribunal were not to make a finding of impairment.

62. The Tribunal has therefore determined that Dr Matthews's fitness to practice is impaired by reason of misconduct.

Determination on Sanction - 12/03/2021

1. Having determined that Dr Matthews' 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.

Submissions

On behalf of the GMC

2. Ms Barbour drew the Tribunal's attention to the Sanctions Guidance (November 2020) ('SG'). Amongst other paragraphs, she highlighted Paragraph 21 which states:

> *'…once the tribunal has determined that a certain sanction is necessary to protect the public (and is therefore the minimum action required to do so), that sanction must be imposed, even where this may lead to difficulties for a doctor. This is necessary to fulfil the statutory overarching objective to protect the public.'*

3. Ms Barbour submitted that the Tribunal may consider that Dr Matthews has demonstrated limited insight in that he had only made partial admissions, 'rowed-back' from admissions he made at the Rule 7 stage and was unable to give a cohesive account of events when giving his oral evidence. This was despite attending courses relevant to the events that had occurred and the passage of time allowing him to reflect. Ms Barbour submitted that some of Dr Matthews' actions may be irremediable, including that he knew, or should have known, that Patient A was subject to harm. She said that Dr Matthews' failings were serious and persistent, and that these included both his clinical actions and the inappropriate relationship with Patient A's parents.

4. Ms Barbour highlighted to the Tribunal that Dr Matthews had provided little reflection on the impact these events would have had on Patient A. She added that despite many 'red-

flags' presented by Patient A, Dr Matthews had repeatedly failed in his duties as a GP regarding Patient A.

5. Ms Barbour submitted that a sanction of erasure would be the most appropriate in this case. Alongside Dr Matthews' lack of insight and remediation, she said that he repeatedly failed a vulnerable patient, despite being an experienced GP who should have had the tools to ensure proper boundaries were in place. Ms Barbour submitted that a sanction less punitive than erasure would not be appropriate, as Dr Matthews had demonstrated a failure to properly remediate and gain insight, his actions were a serious departure from GMP and that his conduct was seriously below the standard expected of a doctor in his position. Ms Barbour submitted that public confidence in the medical profession would be seriously undermined if a robust sanction was not given. She said that a member of the public, aware of all the facts of this case, would be shocked if the Tribunal did not impose a sanction of erasure.

On behalf of Dr Matthews

6. Ms Tanchel submitted that the appropriate sanction in this case is to place conditions on Dr Matthews' registration. She submitted that in mitigation Dr Matthews has received many positive testimonials, made admissions regarding some paragraphs of the Allegation, and accepted that he failed to follow relevant guidance at points. She said Dr Matthews understood the issues that occurred, and he accepted that his relationship with Patient A's parents was inappropriate. Ms Tanchel submitted that Dr Matthews has gained insight and remediated these points.

7. Ms Tanchel submitted that in relation to paragraphs 4, 6 and 10 of the Allegation, these were clinical failings in relation to a discrete matter involving one family. Such failings could be remediated, and that Dr Matthews had already undertaken remediation. She submitted that Dr Matthews' testimonials point towards someone who is willing to learn and be mentored, and that there was no suggestion he would not engage with remediation and training.

8. Ms Tanchel submitted that it would be wrong of the Tribunal to only consider sanction through the prism of just the Allegation and the events within this hearing. She submitted that the Tribunal should look at the entirety of Dr Matthews' practice as set out in the testimonials. She highlighted that Dr Matthews had not been subject to any fitness to practise concerns before or after these events.

9. Ms Tanchel submitted that any sanction imposed should not be increased due to the evidence he gave during the course of this hearing. She said this stage was about looking at Dr Matthews' wider practice, and should include consideration of the public interest in allowing a well respected doctor to remain within the medical profession.

10. Ms Tanchel said if the Tribunal was not persuaded that conditions were the appropriate and proportionate sanction, an order of suspension would demonstrate how seriously the Tribunal has viewed the issues that have arisen in this case and send a strong message of deterrence to the profession, as well as maintain public confidence. She said that Dr Matthews' conduct was not fundamentally incompatible with continued registration and that the public would be best served if Dr Matthews was on the front line, treating patients. She submitted that Dr Matthews had, for example, been part of the coronavirus vaccination program.

The Relevant Legal Principles

11. In reaching its decision, the Tribunal has taken account of the SG and of the overarching objective. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Matthews' interests with the public interest. It has borne in mind that the purpose of sanctions is not to be punitive, but to protect patients and the wider public interest, though any sanction imposed may have a punitive effect.

12. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own judgment.

13. The Tribunal reminded itself of the case directions given by the Legally Qualified Chair at the impairment stage regarding the cases of *Haris* and *Awan.*

The Tribunal's Determination on Sanction

14. The Tribunal considered the aggravating and mitigating factors in this case. It had regard to the case of *Arunachalam v General Medical Council [2018] EWHC 758 (Admin)* which reminded the Tribunal it must evaluate these factors and the weight to place on them, and not simply list them.

<u>Aggravating</u>

15. The Tribunal considered that there were no additional aggravating factors in this case, other than the serious misconduct which it had previously found and should not be 'double-counted' against Dr Matthews.

16. The Tribunal did not consider that Dr Matthews had failed to tell the truth during the course of these proceedings. In its view, there was a difference between not answering a question straightforwardly or not admitting an allegation later found proved, and failing to tell the truth. The Tribunal considered that Dr Matthews' inability to accept that his duty to Patient A had been breached as early as 18 July 2016 was relevant to insight, but was not a failure to tell the truth.

Mitigating

17. The Tribunal found the following mitigating factors:

- Dr Matthews accepted, in part, his mistakes and made early admissions to some paragraphs of the Allegation;
- Dr Matthews has taken substantial remedial steps of his own accord, and reflected on the events that occurred. The evidence from the responsible officer, including the exhibits to the witness statement, and the testimonials provided, indicated that Dr Matthews is able and prepared to do more reflection;
- Dr Matthews has discussed the issues in this case with colleagues;
- Dr Matthews has had a long and unblemished career, with no evidence of the behaviour considered in this case being repeated;
- The Tribunal received many positive and powerful testimonials regarding Dr Matthews;
- Dr Matthews has continued to work and serve his community with the agreement and oversight of his responsible officer.

18. Having considered the aggravating and mitigating factors in this case, the Tribunal also recognised the seriousness of the misconduct found and the harm that had been caused to Patient A by others, which may have been prevented or reduced if Dr Matthews had not failed in his duty, motivated by his personal relationship with Patients B and C.

19. The Tribunal noted that Dr Matthews had provided little reflection or insight about the impact these events would have had on Patient A. It considered that whilst Dr Matthews had reflected on the clinical aspects of the case, he had not reflected on this aspect or been able to explain to the Tribunal when asked his understanding of the meaning of the

phrase 'conflict of interest'. The Tribunal found this added significant counterbalance to the mitigating factors and meant Dr Matthews lacked full insight. Whilst the mitigating factors of this case are multiple, their weight is reduced when considered alongside the seriousness of this case and Dr Matthews' lack of insight into the impact the events had on Patient A and the matters found proved by the Tribunal.

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

No action

21. The Tribunal determined that in view of the serious nature of the Tribunal's findings on impairment, it would be neither sufficient, proportionate nor in the public interest, to conclude this case by taking no action.

Conditions

22. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Matthews's registration. It has borne in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

23. The Tribunal found that it could potentially formulate conditions that would address Dr Matthews' clinical failings. It accepted that these dealt with a discrete area of Dr Matthews' practice into which he has demonstrated some insight and remediation.

24. However, the Tribunal could not formulate conditions that would address Dr Matthews' failings with regards the inappropriate personal relationship he had formed with the family, his actions arising from that relationship, and the matters it had found proved. It considered that whilst Dr Matthews had attended a short professional boundaries course, it did not appear to have given him the insight required into the core issue of proper professional boundaries, the impact of his failings on Patient A, and the full extent of his serious misconduct.

25. In addition, the Tribunal found that imposing conditions on Dr Matthews' registration would not adequately address the need to protect the public interest in the medical profession and uphold the three limbs of the overarching objective, given the seriousness of its findings.

Suspension

26. The Tribunal then went on to consider whether suspending Dr Matthews' registration would be appropriate and proportionate.

27. The Tribunal found the following paragraphs of SG helpful in reaching its determination on this sanction:

> *'97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> *a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*
>
> *b In cases […] where the doctor demonstrates potential for remediation or retraining.*
>
> *e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
>
> *f No evidence of repetition of similar behaviour since incident.*
>
> *g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

28. The Tribunal considered that Dr Matthews' behaviour was not fundamentally incompatible with being a doctor, and that his risk of repeating this behaviour was low. While it could not find at the impairment stage that Dr Matthews was highly unlikely to repeat his misconduct due to the lack of sufficient insight and remediation, it did not consider that there was evidence to support a finding of a significant risk of repetition.

29. The Tribunal was satisfied that Dr Matthews does not have a deep-seated attitudinal problem when considering child sexual abuse or a flagrant/reckless disregard of the relevant guidance. The Tribunal found that Dr Matthews has demonstrated that he is capable of gaining insight and completing work towards remediating and reflecting on his actions. It considered, for example, that Dr Matthews would be able to successfully

complete an intensive professional boundaries course. It was noteworthy that Dr Matthews undertook substantial remediation shortly after it was clear Patient A had been subjected to child sexual abuse, and had fully cooperated with a number of investigations by a number of agencies. There was no evidence before this tribunal of a failure to engage by Dr Matthews.

30. The Tribunal also had regard to the public interest in ensuring that good doctors are able to practise. It had regard to the testimonials, character evidence and the fact that Dr Matthews is participating in the coronavirus vaccination program. It considered that whilst, as a result of Dr Matthews' actions Patient A may have suffered harm, it would not be proportionate or in the public interest to erase Dr Matthews' name from the medical register, given all the circumstances of this case. The Tribunal therefore determined to impose an order of suspension on Dr Matthews' registration, on the basis that it was the least restrictive sanction possible to protect the public.

31. When determining the length of Dr Matthews' suspension, the Tribunal had regard to the seriousness of its findings and the time it considered Dr Matthews needed to further remediate and reflect on the matters it had found proved and the impact the events would have had on Patient A. It found that a period of three months would mark the seriousness of its findings, send a signal to the medical profession and the public, and allow Dr Matthews the time to reflect and attend any courses or complete other professional development work that may assist him in his remediation and insight.

32. The Tribunal determined to direct a review of Dr Matthews' case. A review hearing will convene shortly before the end of the period of suspension, unless an early review is sought. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Matthews to demonstrate how he has developed insight into the areas of concern the Tribunal have highlighted throughout its determinations. It therefore may assist the reviewing Tribunal if Dr Matthews provided:

    - reflections on the issues raised in this hearing;
    - evidence of his medical skills and knowledge being kept up-to-date;
    - evidence of any developmental work in relation to professional boundaries, child sexual abuse, child protection, safeguarding and other relevant matters.

    Dr Matthews will also be able to provide any other information that his considers will assist.

Determination on Immediate Order - 12/03/2021

1. Having determined to suspend Dr Matthews' registration, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Matthews' registration should be subject to an immediate order.

Submissions

On behalf of the GMC

2. Ms Barbour submitted that the GMC did not seek an immediate order.

On behalf of Dr Matthews

3. Ms Tanchel submitted that an immediate order is not necessary and would be disproportionate as Dr Matthews would be suspended for a four month period if it did impose an immediate order.

4. Ms Tanchel also highlighted the lapse of time since the incident and that the risk of repetition had been found to be low. She confirmed that Dr Matthews was not subject to an interim order and had been practising unrestricted. Ms Tanchel said that there was no real immediate risk to patient safety.

The Tribunal's Determination

5. The Tribunal acknowledged that the sanction it had imposed was in respect of all three limbs of the overarching objective. This included maintaining and promoting proper professional standards and upholding public confidence in the medical profession.

6. However, given the submissions the Tribunal received from Counsel representing both parties and the fact that Dr Matthews had been practising unrestricted, the Tribunal determined that it was not necessary to impose an immediate order in this case.

7. This means that Dr Matthews' registration will be suspended 28 days from when notice of this decision is deemed to have been served upon him, unless he lodges an appeal. If Dr Matthews does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

Confirmed
Date 15 March 2021

Mrs Claire Sharp, Chair

ANNEX A – 24/11/2020

Application to Amend the Allegation

1. The Tribunal, of its own volition, noted two areas of concern with the hearing information sheet, and requested submissions from parties. The first concern related to Paragraph 5(e)(iii) of the allegation, where the numbering had been duplicated. The Tribunal perceived that the following amendment may rectify this concern.

5. Following receipt of the Message and your consultation with Patient A's parents, you failed to arrange a consultation with Patient A in order to:

[…]

e. consider the possibility of underlying sexual abuse because of Patient A's:

i. secondary enuresis

ii. vivid nightmares;

iii. history of behavioural disturbance;

iii. background risk for abuse.

To

5. Following receipt of the Message and your consultation with Patient A's parents, you failed to arrange a consultation with Patient A in order to:

[…]

e. consider the possibility of underlying sexual abuse because of Patient A's:

i. secondary enuresis

ii. vivid nightmares;

iii. history of behavioural disturbance;

~~*iii.*~~ *iv. background risk for abuse.*

2. The second concern related to the inclusion of the following schedules in the public hearing information sheet, which had been redacted. The Tribunal considered that the schedules did not contain anything that could not be read in public.

Schedule 1

'left message to say that has started wetting the bed, is changing school and going to start at [another school] in September. Has phoned CAMHS and been told that 27th on list for ADHD assessment'

Schedule 2

"Dr Matthews XXX wanting to share that the allegations that may have or are to come in respect of this child he feels are malicious allegations. Dr Matthews advised parents have sought all appropriate services in respect of the child. He wanted it noted that he has no concerns"

Schedule 3

"last night [Patient A] slept in father's boxer shorts and then put them back wet into his cupboard"

Schedule 4

"Stress related problem (Review). Has been accused of sexual abuse by daughter, very stressed, interviewed by Police but seems clear this is a malicious accusation. XXX

Submissions

On behalf of the GMC

3. Ms Barbour submitted that she had no objections to these amendments being made.

On behalf of Dr Matthews

4. Ms Tanchel submitted that she also had no objections to the amendments.

Tribunal's Decision

5. The Tribunal was mindful of paragraph 17(6) of the General Medical Council's (Fitness to Practise) Rules 2004, as amended, (the Rules) which 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.

6. The Tribunal determined that the first amendment corrected a typographical error and could be made without injustice to either party.

7. The Tribunal determined that the second amendment did not include any confidential information and could also be made without injustice to either party.

ANNEX B – 24/11/2020

Application to Amend the Allegation

1. On behalf of the GMC, Ms Barbour made an application under Rule 17(6) of the Rules, to amend paragraph 7 of the Allegation as follows:

7. On 3 August 2016 you contacted Children's Social Care at the request of Patient B and made the statement set out at Schedule 2 ('the Call') which was:

a. the opinion of Patient A's mother;

b. stated in a way that suggested it was your opinion.

To

*7. On 3 August 2016 you contacted Children's Social Care at the request of Patient B and made the statement**s as** set out at Schedule 2 ('the Call') which was:*

a. the opinion of Patient A's mother;

b. stated in a way that suggested it was your opinion.

Submissions

On behalf of the GMC

2. Ms Barbour submitted that the way paragraph 7 of the Allegation is currently written could lead to a 'semantic argument' between the parties, as the content of Schedule 2 clearly is not a verbatim account. She submitted that the Allegation is still capable of being proven as it is currently drafted, as the Tribunal should take a common sense approach, but the amendment streamlined matters and avoids distracting the Tribunal with semantics, losing focus on the core issues.

3. Ms Barbour submitted that in regards to the case note from which the wording of Schedule 2 has been taken, there may be a legal argument as to whether the note is admissible, even after the amendment had been made. Ms Barbour noted that the allegation is based on hearsay evidence, and updated the Tribunal on the efforts made by the GMC to contact the person who had made the note. She said that the person had left Children's Social Care, and had not responded to any emails from the GMC, despite consenting to the agency involved supplying her contact details.

4. Ms Barbour concluded by submitting that this amendment could be made without injustice or disadvantage to Dr Matthews, and would assist the Tribunal in approaching the real issue of misconduct in this case.

On behalf of Dr Matthews

5. Ms Tanchel opposed the amendment. She submitted that the case note has been with the GMC since at least February 2019, and that this application is past 'the eleventh hour'. She said that the skeleton argument she had received from the GMC in the weeks leading to this hearing made no mention of amending the Allegation.

6. Ms Tanchel submitted that she had given no objection to admitting the case note into evidence given the way the Allegation is currently written. However, if the allegation was amended as sought, then Ms Tanchel would have opposed the admission of the case note as it is hearsay evidence.

7. In addition, Ms Tanchel submitted that, if the Allegation was originally drafted as the GMC now seeks, then Dr Matthews' representatives could have made efforts to contact the person who wrote the case note. Ms Tanchel submitted that Dr Matthews could not have a fair hearing if this amendment were to be made without the attendance of the person who took the note at this hearing.

8. Ms Tanchel submitted that amending the Allegation would not streamline it, and highlighted to the Tribunal that Ms Barbour had submitted that the Allegation could be proven as it is currently written. She asked the Tribunal to consider the purpose of changing the Allegation now.

9. Ms Tanchel submitted that the overarching objective does not override the need to ensure this hearing is held in a fair manner. She said that it was part of the mandatory process that the GMC composes its Allegation and that Dr Matthews has a fair chance to respond to it.

Tribunal's Decision

10. The Tribunal was mindful of paragraph 17(6) of the General Medical Council's (Fitness to Practise) Rules 2004, as amended, (the Rules) which 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.*

11. The Tribunal considered Ms Tanchel's submission that she would have objected to the admission of the case note as hearsay evidence had the Allegation been written as the GMC are now applying to change it. It determined that, if it were to allow the application from the GMC, Ms Tanchel would still be in a position to challenge the admission of the case note as evidence and that application would be considered. In addition, the Tribunal noted that it could determine how much weight to place on the note when considering this case.

12. The Tribunal next considered Ms Tanchel's submission that Dr Matthews' representatives could have attempted to make contact with the person who made the note. The Tribunal accepted Ms Barbour's submissions that the GMC had sent emails to an address it had been told belonged to the person who wrote the note, but had not received any reply. It did not consider that Dr Matthews' representatives were likely to have more success and it noted that the case note had been recorded by a social worker in the course of her employment.

13. The Tribunal determined that the amendment was not a significant change to the Allegation and could be made without any injustice to Dr Matthews.

14. However, the Tribunal found that the Allegation still did not reflect clearly the factual basis of the case faced by Dr Matthews. It was clear to the Tribunal that Schedule 2 is not a statement made by Dr Matthews, but notes of an interaction between him and a social worker. The Tribunal considered that it was in the interests of Dr Matthews and the need to uphold the overarching objective to protect the public to ensure that the allegation was properly framed. The Tribunal asked the representatives to consider a further amendment and suggested the following:

*7. On 3 August 2016 you contacted Children's Social Care at the request of Patient B and made ~~the statement set out at Schedule 2 ('the Call') which was~~: **statements that gave rise to the creation of the call note set out in Schedule 2 which were:***

a. the opinion of Patient A's mother;

b. stated in a way that suggested it was your opinion.

Submissions on Tribunal's Proposal

<u>On behalf of the GMC</u>

15. Ms Barbour submitted that the Tribunal's amendment might incorrectly refocus the attention of the allegation on the person who wrote the note, and away from the actions of Dr Matthews. Ms Barbour submitted a further amendment was considered instead:

*7. On 3 August 2016 you contacted Children's Social Care at the request of Patient B ~~and made the statement set out at Schedule 2 ('the Call') which was:~~ **and made statements to the effect of those recorded in the case note at Schedule 2 ('the Call') which were:***

a. the opinion of Patient A's mother;

b. stated in a way that suggested it was your opinion.

She submitted that this amendment ensured that the Allegation is phrased in a way that focused on the live issues, not semantics.

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

16. Ms Tanchel submitted that the Tribunal's suggestion created a risk of an inference that Dr Matthews' had the power to create the case note. She submitted that this was not the intention nor rationale behind the Tribunal's suggestion.

17. Ms Tanchel submitted that the GMC's proposed wording, outlined in Ms Barbour's submissions, was a better reflection of what the GMC has alleged and better reflected the position. However, she still opposed the amendment as she considered it to be a material change. She submitted that her submissions in relation to the GMC's original application to amend the allegation remained relevant in regards to the GMC's current amendment.

Tribunal's Decision

18. The Tribunal considered the GMC's new wording proposed by Ms Barbour. It found that this wording more accurately reflected what is being alleged.

19. When considering whether to allow GMC's application to amend the Allegation, the Tribunal had regard to the investigative report of Dr E which recorded her understanding of Dr Matthews' alleged responses on the issue of what was said to the social worker. It also noted Dr Matthews' statement in the bundle submitted to the Tribunal for pre-reading and his account therein. It found that the amendment better represented Dr Matthews' understanding of the Allegation he faces.

20. The Tribunal also considered that the amendment was not a substantial change, and simply made the allegation easier to understand in light of the factual matrix. It reminded itself that Ms Tanchel would have the opportunity to challenge the admissibility of the case note and the Allegation itself, irrespective of this amendment.

21. The Tribunal therefore determined that this amendment would assist parties in engaging with and understanding the allegation, which would help serve the overarching objective and not cause any injustice. It determined to allow the amendment as submitted by the GMC.

ANNEX C – 24/11/2020

Application to Amend the Allegation

1. The Tribunal, of its own volition, under Rule 17(6) of the Rules, determined to amend Schedule 2 of the Allegation as follows:

"Dr Matthews XXX wanting to share that the allegations that may have or are to come in respect of this child he feels are malicious allegations. Dr Matthews advised parents have sought all appropriate services in respect of the child. He wanted it noted that he has no concerns"

To

"Dr Matthews XXX wanting to share that the allegations that may have or are to come in respect of this child he feels are malicious allegation~~s~~. Dr Matthews advised parents have sought all appropriate services in respect of the child. He wanted it noted that he has no concerns"

Tribunal's Decision

2. The Tribunal was mindful of paragraph 17(6) of the General Medical Council's (Fitness to Practise) Rules 2004, as amended, (the Rules) which 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.

3. The Tribunal had regard to the case note from which the wording of Schedule 2 was taken. It noted that in the case note, the second reference to 'allegations' was not pluralised, and read 'allegation'. The Tribunal considered that this amendment would more accurately reflect the evidence it had received.

4. Both parties did not oppose the amendment, and the Tribunal considered that the amendment could be made without injustice.

ANNEX D – 24/11/2020

Admission of Evidence

1. On Day 1 of the hearing, Ms Barbour on behalf of the GMC made an application under Rule 34(1) of the Rules to admit further evidence in the form of a case note ('the Case

Note') from North Tyneside Council, dated 3 August 2016. The case note was allegedly created by a member of the council's Children Social Service's team following a call from Dr Matthews.

2. Following no opposition from Ms Tanchel on behalf of Dr Matthews, the Tribunal determined to admit the evidence.

3. However, a further application to amend paragraph 7 of the Allegation, detailed in Annex B, prompted Ms Tanchel to apply to exclude the case note.

Submissions

On behalf of Dr Matthews

4. Ms Tanchel submitted that the case note is the sole and decisive evidence in relation to paragraph 7 – 9 of the Allegation, though it was relevant in that it demonstrated that the call between Dr Matthews and the note taker took place. However, she submitted that the case note could not assist the Tribunal in determining what Dr Matthews' state of mind was. She said this was important given that Dr Matthews faces a dishonesty allegation. She noted that dishonesty is one of the most serious allegations a doctor can face, and that Dr Matthews' career is at risk.

5. Ms Tanchel submitted that the case note is hearsay evidence, and drew the Tribunal's attention to the case of *Nursing & Midwifery Council v Ogbonna [2010] EWCA civ 1216*. The case outlines a test for admitting hearsay evidence which can only be relied upon if it is relevant, fair and in the interests of justice. The weight which may be put on the evidence is irrelevant when assessing fairness. Ms Tanchel also drew the Tribunal's attention to the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)* where the following factors were set out as relevant to the admissibility of evidence:

(a) Whether the statements were the sole and decisive evidence in support of the charges;
(b) The nature and extent of the challenge to the contents of the statements;
(c) Whether there was any suggestion that the witnesses had reasons to fabricate their allegations;
(d) The seriousness of the charge, taking into account the impact which adverse findings might have on the appellants' career;
(e) Whether there was a good reason for the non-attendance of the witness;

6. Ms Tanchel submitted that the only way to test whether Dr Matthews was dishonest was to draw an inference from the case note. She said that the case note was not a verbatim record of what Dr Matthews said, and the Tribunal should not draw an inference from it.

7. Ms Tanchel submitted that she would be unable to explore the evidence and put it in context, as the note taker is not available as a witness. She submitted that, for example, the note taker left the service quickly and it is not clear why she left the service. This could have been because she was dishonest or incompetent, but Ms Tanchel accepted that she had no basis to make such submissions in the absence of the witness.

8. Ms Tanchel submitted that the GMC had only sent on email in order to trace the note taker, despite the power and resource to make much more extensive efforts.

9. Ms Tanchel submitted that when taking into account the reports from the expert witness and the investigator, whilst both were aware of a conversation taking place between Dr Matthews and the note taker, they could not comment on the case note's veracity.

10. Ms Tanchel concluded that the GMC's suggested approach of admitting the case note, then asking the Tribunal to determine what weight to attach to it was flawed. She said this negated the first step of the process, which is to assess whether it is fair to admit the case note, before determining what weight it should be given.

On behalf of the GMC

11. Ms Barbour submitted that the case note is not the sole and decisive evidence in relation to paragraph 7-9 of the Allegation. She submitted that there is relevant evidence in Dr Matthews' response to the GMC's Rule 7 responses, which set out the Allegation Dr Matthews faces. She said that, within the Rule 7 letter, there are words that correlate with the words used in the case note.

12. Ms Barbour submitted that the words in the case note are also quoted in the expert's and investigator's reports. However, she conceded that in the investigator's report, Dr Matthews said that the case note was a misrepresentation of his views. Nevertheless, Ms Barbour submitted that having essentially accepted the words set out in the case note, Dr Matthews could not now 'row back' and assert that the case note is inaccurate.

13. In relation to not being able to question the note taker, and in response to Ms Tanchel's interpretation of the case of *Ogbonna*, Ms Barbour submitted that *Ogbonna* involved a witness whose attendance at the hearing had never been sought. She highlighted that the GMC had made several attempts to contact the note taker in this case. This included obtaining the note taker's email from the agency where she was registered and sending emails. She said that, even if the note taker was available to be questioned, the note taker could not realistically be expected to remember the conversation, as it was now many years ago. When considering whether Ms Tanchel, on behalf of Dr Matthews, was entitled to examine the note taker in relation to the case note, Ms Barbour drew the Tribunals attention to the case of *R (Bonhoeffer) v GMC [2011] EWHC 1585 (Admin)* where it was held that:

> *There is, in my judgment, no absolute rule whether under Article 6 or Judgment in common law entitling a person facing disciplinary proceedings to cross-examine witnesses on whose evidence the allegations against him are based. Nor does such an entitlement arise automatically by reason of the fact that the evidence of the witness in question is the sole or decisive basis of the evidence against him. Nor, so far as Rule 34 is concerned, does it follow automatically from a conclusion that hearsay evidence would be inadmissible under the gateways of section 114 and/or 116 of the 2003 Act that it would be unfair for the FTPP to admit it under the Rule.*

14. Ms Barbour submitted that the case note would be admissible in a criminal proceeding, where the admission threshold is significantly higher than that in these proceedings. Ms Barbour drew the Tribunal's attention to section 117 of the Criminal Justice Act 2003, which sets out a test for admitting a document made during the course of business. Ms Barbour submitted that, when considering this test and in the particular circumstances of this case, there were no proper grounds for excluding the case note.

Tribunal's Decision

15. In reaching its decision, the Tribunal noted that Dr Matthews' responses to the Rule 7 material which Ms Barbour had referenced in her submissions were not before it. The Tribunal considered that if evidence was to be considered by it, that evidence should be adduced in the proper way. The Tribunal's full determination on this application can be found at Annex E.

16. After refusing Ms Barbour's application for the material to be admitted into evidence, the Tribunal considered the remaining points of the submissions from both parties.

17. The Tribunal had regard to the questions of fairness and relevance, in order with Rule 34(1) of the Rules:

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

18. The Tribunal was also mindful of the guidance set out in *Ogbonna* and the factors to consider when admitting hearsay evidence set out in *Thorneycroft.*

19. The Tribunal determined that the case note was relevant, as it was directly referred to in the Allegation Dr Matthews faced.

20. The Tribunal next considered whether it would be fair to admit the case note. It considered that the case note was not the sole and decisive evidence in relation to Allegation 7, as the Tribunal found that it would be able to examine the evidence of Dr E's report on behalf of North Tyneside CCG in which the case note is discussed. The Tribunal also noted that it had been transcribed in full into the expert report from Dr F, which the Tribunal had already viewed. Dr Matthews himself was likely to give evidence about the conversation.

21. The Tribunal understood that the content of the case note was challenged by Dr Matthews. He challenged whether the document reflected the entirety of the conversation and whether it showed dishonesty. The Tribunal noted that it would be likely to need to follow the test set out in *Ivey v Genting Casinos (UK) Limited (t/a Crockfords Club) [2017] UKSC 67* when considering dishonesty. It states:

> *When dishonesty is in question the fact-finding Tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.*

22. The Tribunal could find no grounds to suggest the case note was fabricated. It bore in mind that the note taker was a professional social worker making the note in the course of her role. The Tribunal could draw no adverse inferences from Ms Tanchel's submission that the social worker 'suddenly left' the council. In addition, the Tribunal were satisfied that sufficient efforts had been made to contact the note taker, as outlined in Ms Barbour's submissions. The Tribunal noted that, given the lapse of time, it was likely that the witness may not recall the conversation, even if they were able to be called.

23. The Tribunal were mindful that the allegation of dishonesty that Dr Matthews faces is serious. It noted that if found proved, it could have a seriously detrimental effect on Dr Matthews' career.

24. The Tribunal had been informed by Ms Barbour that the case note had been omitted from the hearing bundle due to human error, and it was accepted by Dr Matthews' representative that the document had been disclosed in the Rule 7 bundle.

25. Having taken all of these factors into account the Tribunal determined to grant the GMC's application for the admission of the case note, as it was fair and relevant to do so.

ANNEX E – 24/11/2020

Admission of Further Evidence

1. On day 2 of the hearing, on behalf of the GMC, Ms Barbour made an application under Rule 34(1) of the (Fitness to Practise) Rules 2004, as amended (the Rules) to admit further evidence - Dr Matthews' response to a Rule 4 letter from the GMC, his two Rule 7 responses, a second set of Rule 7 allegations and the Rule 15 allegation. This is referred to as 'the material' throughout this determination.

2. This application followed the GMC's application to admit a case note ('the case note'), which is detailed in Annex D which was paused as Ms Barbour wanted to rely on the material to assist this application.

3. In addition to supporting her application to admit the case note, Ms Barbour applied for the material to be admitted as evidence during the fact-finding stage of this hearing in addition.

Submissions

<u>On behalf of the GMC</u>

4. Ms Barbour submitted that the material was relevant because Dr Matthews had made admissions to the matters alleged in paragraph 7 of the Allegations in his first Rule 7 response. Following service of amended Allegations, Ms Barbour submitted that Dr Matthews then gave a differing version of events in his second Rule 7 response. She submitted that it would be contrary to the overarching objective for Dr Matthews to make admissions as to the facts in early accounts and in his Rule 7 responses, only then to seek to prevent the Tribunal from taking those admissions into account.

5. Ms Barbour gave an example whereby if Dr Matthews did not give evidence at this hearing, in such circumstances, his responses to the Rule 7 letters would be important.

6. Ms Barbour submitted that it would be 'within the law' for the material to be admitted, and would be admitted in criminal proceedings where the threshold is higher than for these proceedings.

7. Ms Barbour submitted that it would also be fair to admit the material. She submitted that Dr Matthews had set out a factual description of what he said occurred in the responses. Ms Barbour said that if Dr Matthews' responses were an accurate account of what had occurred, there should be no impact upon the fairness of referring to this account when considering the Allegation.

8. Ms Barbour concluded by submitting that the material ought to be admitted to allow the Tribunal to carry out its proper function of scrutinising the facts of this case.

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

9. Ms Tanchel submitted that it would be unlawful to admit the material, and drew the Tribunal's attention to sections 4 and 5 of 'Denman's Act' - the Criminal Procedure Act 1865, which states:

> *4. As to proof of contradictory statements of adverse witness.*
> *If a witness, upon cross-examination as to a former statement made by him relative to the subject matter of the indictment or proceeding, and inconsistent with his present testimony, does not distinctly admit that he has made such statement, proof may be given that he did in fact make it; but before such proof can be given the circumstances of the supposed statement, sufficient to designate the particular occasion, must be mentioned to the witness, and he must be asked whether or not he has made such statement.*

> *5. Cross-examinations as to previous statements in writing.*
> *A witness may be cross-examined as to previous statements made by him in writing, or reduced into writing, relative to the subject matter of the indictment or proceeding, without such writing being shown to him; but if it is intended to contradict such witness by the writing, his attention must, before such contradictory proof can be given, be called to those parts of the writing which are to be used for the purpose of so contradicting him: Provided always, that it shall be competent for the judge, at any time during the trial, to require the production of the writing for his inspection, and he may thereupon make such use of it for the purposes of the trial as he may think fit.*

10. Ms Tanchel highlighted the change in the Allegation that had been put to Dr Matthews between his first and second Rule 7 letters from the GMC. She said that the way in which the Allegation's wording has shifted over time was unfair, and was based on Dr Matthews' responses, not on any new evidence that had been disclosed.

11. Ms Tanchel submitted that Dr Matthews is yet to admit or deny any of the allegations and has not had an opportunity to address the Tribunal about any inconsistencies there may be in his responses. She said it would be unfair and unlawful for them to go before the Tribunal.

Tribunal's Decision

12. The Tribunal had regard to the questions of fairness and relevance, in order with Rule 34(1) of the Rules:

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

13. In reaching its decision, the Tribunal was mindful that it must both protect the public and hold a fair hearing. It found that it did not have to decide between either option. It was also mindful that if it found that it was lawful for the letters to be admitted, it must also determine whether they are relevant, and then if it is fair to admit them.

14. It noted Ms Tanchel's submissions on 'Denman's Act', but reminded itself that it is bound by the most recent relevant acts, including the Medical Act 1983 (as amended) and the GMC Fitness to Practise Rules 2004 (as amended). It was not persuaded that Denman's

Act forbade the admission of the material generally; it only dealt with how to adduce inconsistent statements in cross-examination.

15. The Tribunal were satisfied that given rule 34(1) of the Rules, it was lawful to admit the evidence.

16. The Tribunal next considered whether the material was relevant. The Tribunal reminded itself that it must not only find if the material is relevant to the application to exclude the case note, but also at the fact-finding stage.

17. In terms of the material's relevance to the application to exclude the case note, the Tribunal was not persuaded that the material was of relevance in relation to the application to exclude the case note. The questions it would need to consider for that application would not be assisted by the material.

18. However, the Tribunal found that the material was of relevance to the fact-finding stage of the hearing, as it has a relevance to the Allegation, especially as the Allegation had evolved.

19. The Tribunal next considered whether it was fair to admit the material at the fact-finding stage. The Tribunal was mindful that it would not usually view the material during a hearing, unless Dr Matthews was neither present nor represented. It noted that Dr Matthews had not wanted to rely on the Rule 7 responses in order to put his case.

20. The Tribunal noted that the Allegation the GMC had sent to Dr Matthews had significantly altered between the two Rule 7 responses and the changes appeared to be based on Dr Matthews' responses and not new evidence. It considered that the Allegations became more serious over time, including the addition of an allegation of dishonesty, a potentially career ending allegation, which did not appear in the GMC's first Rule 7 letter to Dr Matthews. This was correspondence between legal teams discussing the Allegation, and not intended to be part of the evidence at the fact-finding stage. For this stage, the GMC bears the burden of proof and is required to prove its case to the civil standard based on the evidence, not solicitors' correspondence. It therefore determined that it would be unfair to admit the material at the fact-finding stage, and dismissed the GMC's application for the admission of the material.

ANNEX F – 26/11/2020

Admission of Further Evidence

1. Ms Barbour on behalf of the GMC made an application under Rule 34(1) of the Rules to admit further evidence in the form of the medical records of Patient C.

2. Under the same Rule, Ms Tanchel made an application for three pages of handwritten notes made by Dr E during the course of her meeting with Dr Matthews to be admitted ('the handwritten notes').

Submissions

On behalf of the GMC

3. Ms Barbour submitted that there had already been a discussion between Ms Tanchel and herself regarding Patient C's medical records. Ms Barbour submitted that the GMC did not oppose the records being in the bundle, and suggested that they may be of relevance in relation to paragraph 1 of the Allegation, in assessing the vulnerability of Patient C.

4. Ms Barbour did not oppose Ms Tanchel's application for the handwritten notes to be admitted. However, Ms Barbour made a further application that all of Dr E's handwritten notes of her meetings with Dr Matthews should be admitted. Ms Barbour's application was granted by the Tribunal, and its determination on this matter can be found at Annex G.

On behalf of Dr Matthews

5. Ms Tanchel submitted that the handwritten notes should be admitted as she wished to examine Dr E on potential differences between these notes and the information Dr E included in her final investigation report to North Tyneside Clinical Commissioning Group.

6. Ms Tanchel did not oppose Ms Barbour's application to admit the medical records of Patient C.

Tribunal's Decision

7. The Tribunal had regard to the questions of fairness and relevance, in order with Rule 34(1) of the Rules:

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

8. In reaching its decision, the Tribunal accepted the submissions of Ms Barbour and Ms Tanchel, and noted that neither party had opposed either application.

9. The Tribunal determined to grant both applications, as it considered the evidence to be relevant to this hearing, and would not cause injustice to either party.

ANNEX G – 26/11/2020

Admission of Further Evidence

1. Ms Barbour, on behalf of the GMC, made an application under Rule 34(1) of the Rules to admit further evidence in the form of the full handwritten notes made by Dr E during the course of her meetings with Dr Matthews.

2. This application followed Ms Tanchel's application to admit three pages of Dr E's handwritten notes from her meetings with Dr Matthews.

3. Ms Barbour made the application during her examination of Dr E, following the close of Ms Tanchel's cross-examination.

Submissions

On behalf of the GMC

4. Ms Barbour submitted that Dr E has been cross-examined on the full handwritten notes in regards to her recollection of her meetings with Dr Matthews. Ms Barbour said that the full handwritten notes would assist the Tribunal by having access to a contemporaneous account of the conversations that occurred between Dr E and Dr Matthews.

5. Ms Barbour highlighted, for example, that Ms Tanchel, on behalf of Dr Matthews, had challenged Dr E on the number of times Dr Matthews had visited the home of Patient A's parents. Ms Barbour said the full handwritten notes would give the Tribunal an opportunity to deal with any inconsistencies such as this.

On behalf of Dr Matthews

6. Ms Tanchel opposed the GMC's application, as she explained there would be no opportunity for her to re-examine Dr E on this new evidence. She submitted that the burden of proof in this hearing lay with the GMC, and that admitting new evidence at this stage was unfair, and meant that she now faced a 'shifting target'.

Tribunal's Decision

7. The Tribunal had regard to the questions of fairness and relevance, in order with Rule 34(1) of the Rules:

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

8. In reaching its decision, the Tribunal first considered whether the notes were relevant to this hearing. Given the Tribunal's previous determination outlined in Annex F regarding the three pages of notes Dr E took during her conversation with Dr Matthews, it found that these notes would also be relevant for the same reasons. The Tribunal determined that the full handwritten notes would assist them in understanding the conversations that occurred between Dr E and Dr Matthews, and any inconsistencies that may have occurred.

9. The Tribunal also considered that because the full handwritten notes had been challenged in examination of Dr E, it would be fair to admit them in order for Dr E to be able to respond properly to any further questions.

10. However, the Tribunal was becoming increasingly concerned that both parties were producing evidence in a way that was not in keeping with the general process of a hearing. It considered that to admit the evidence at this stage could be unfair as Ms Tanchel, on behalf of Dr Matthews, had concluded her examination of Dr E, and would not be able to ask questions about the full handwritten notes. The Tribunal therefore determined that in order to remedy this unfairness, it would allow Ms Tanchel an opportunity to further cross-examine Dr E about this new evidence.

11. The Tribunal determined to grant Ms Barbour's application for the admission of further evidence in the form the full handwritten notes Dr E made during her meetings with Dr Matthews.

ANNEX H – 26/11/2020

Application under Rule 17(2)(g)

1. At the end of the GMC's case at the fact-finding stage, Ms Tanchel, on behalf of Dr Matthews, made an application under Rule 17(2)(g) of the Rules, which states:

The practitioner may make submissions regarding whether sufficient evidence has been adduced to find some or all of the facts proved, and the MPT shall consider and announce its decision as to whether any such submission should be upheld.

2. Ms Tanchel submitted that the application was in relation to the following paragraphs of the Allegation:

4. You consulted with Patient A's parents regarding Patient A's bedwetting on 18 July 2016 and you failed to:
…
c. seek further advice;
…

5. Following receipt of the Message and your consultation with Patient A's parents, you failed to arrange a consultation with Patient A in order to:

a. take a full history of:
i. night-time urinary symptoms;
ii. day-time urinary symptoms;

b. carry out a physical examination to exclude underlying causes;

c. provide practical management advice to:

i. Patient A;

ii. Patient A's parents;

d. adequately follow relevant guidance with respect to:

i. child protection;

ii. safeguarding;

e. consider the possibility of underlying sexual abuse because of Patient A's:

i. secondary enuresis

ii. vivid nightmares;

iii. history of behavioural disturbance;

~~*iii.*~~ *iv. background risk for abuse.*

Amended under rule 17(6)

7. On 3 August 2016 you contacted Children's Social Care at the request of Patient B ~~*and made the statement set out at Schedule 2 ('the Call') which was:*~~ ***and made***

statements to the effect of those recorded in the case note at Schedule 2 ('the Call') which were:
Amended under rule 17(6)

b. stated in a way that suggested it was your opinion.

8. When you made the Call you:

a. provided information that was untrue in that you;

vii. knew the opinion you provided was not your own but that of Patient B;
viii. had knowledge of the risk factors as set out at paragraphs 4a and 6a;

…

9. Your action as described at paragraph 7 was dishonest by reason of paragraphs 8a and 8b.

11. Between July 2016 and December 2016 you developed a personal relationship with Patient A's parents which:

…

a. adversely affected your therapeutic relationship with:

i. Patient A;

ii. Patient B;

iii. Patient A's father (Patient C).

12. On 3 March 2017 you consulted with Patient C, and you made a record ('the Record') as set out fully in Schedule 4 in Patient C's notes that:

…

b. ii. your opinion.

13. In making the Record as set out at paragraph 12 you:

a. recorded information that was untrue;
b. should have known the information you recorded was untrue given your knowledge of the risk factors relating to:

i. Patient A as set out at paragraphs 4a, 6a, and 10a;
ii. Patient C taking into account his medical history;

c. failed to make clear whose opinion was being stated.

14. *Your actions as set out at paragraph 12b were dishonest by reason of paragraphs 13a and 13b.*

15. *Following the consultation with Patient C you failed to consider that sexual abuse was a possible underlying cause for Patient A's previous presentations.*

16. *Your actions as set out at paragraphs 2-15 were on one or more occasion an attempt to conceal and/or undermine any potential allegation(s) of sexual abuse made by Patient A against Patient C.*

17. *Your conduct as set out at paragraphs 2-15 was motivated by your personal relationship with Patient A's parents.*

Relevant Legal Principles

3. The Tribunal had regard to the case of *R v Galbraith [1981] 2 All ER 1060* which sets out a two part test to follow in order to ascertain the strength of the GMC's evidence. It states: *How then should the judge approach a submission of 'no case'?*

(1) If there is no evidence that the crime alleged has been committed by the defendant, then there is no difficulty. The judge will of course stop the case.

(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.

(a) Where the judge comes to the conclusion that the Crown's evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, upon a submission being made, to stop the case.

(b) Where however the Crown's evidence is such that its strength or weakness depends on the view to be taken of a witness' reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.

The Tribunal also asked itself the following questions in order to reach its determinations:

1. Was there any evidence before the Tribunal upon which it could find each allegation proved?
2. Was there some evidence, but of such an unsatisfactory character, that the Tribunal, properly directed as to the burden and standard of proof, could not find each allegation proved?

3. Was there some evidence, the relevant strength or weakness of which was dependent upon the Tribunal's view of the reliability of a witness?

4. It was mindful that if one possible view of the facts or evidence meant that a paragraph of the Allegation could be found proved, it should proceed to determine the facts regarding that allegation at the appropriate juncture. Ms Tanchel made it clear in her submissions that if the Tribunal was unpersuaded by her argument about a particular limb of the Galbraith test, the Tribunal should consider if the other limb applied.

5. Both representatives referred the Tribunal to the authorities of:
   - *Lawrance v General Medical Council [2015] EWHC 586 (Admin);*
   - *Soni v General Medical Council [2015] EWHC 364 (Admin);*
   - *Re H (Minors)(Sexual Abuse: Standard of Proof) [1996] AC 563;*
   - *Sharma v General Medical Council [2014] EWHC 1471 (Admin);*
   - *Fish v General Medical Council [2012] EWHC 1269 (Admin).*

   The LQC also confirmed in summary the nature of the directions she intended to deliver for the fact-finding stage, including the need for very cogent evidence to find dishonesty and the "Soni principle" regarding the proper drawing of inferences.

6. The case of *Razak v General Medical Council [2004] EWHC 205 (Admin)* reminded the Tribunal to look at all the evidence it has before it, while both representatives agreed that when taking the GMC's case at its highest, the Tribunal should not select only the best parts.

7. The Tribunal was mindful that it must determine each paragraph of the Allegation on an individual basis, unless it is linked to another paragraph. However, it also noted that it did not have to consider them in the order that they are drafted. When making its determination, the Tribunal found it helpful to consider Ms Tanchel's and Ms Barbour's submissions on each individual paragraph, rather than as a whole. As such, the Tribunal have presented its determination below in this manner.

The Tribunal's Determinations

Paragraph 4c

8. Ms Tanchel drew the Tribunal's attention to the medical records of Patient A, and highlighted the occasions where Dr Matthews had made a record of contacting a nurse consultant at the Child and Adolescent Mental Health Service ('CAMHS') and spoke to a

child psychologist about Patient A's risk factors. She submitted that there is no evidence that Dr Matthews did not seek any further advice, and said that these two records showed the contrary, demonstrating limb 1 of *Galbraith.*

9. Ms Tanchel also submitted that the allegation has been drafted in a way that sets no time frame for Dr Matthews to have sought advice.

10. Ms Barbour submitted that the records highlighted by Ms Tanchel do not show that Dr Matthews sought advice from other professionals, but merely that he was sharing information. She submitted that if Dr Matthews was seeking advice, he may have asked *'what should I do about Patient A's case?'.*

11. The Tribunal adopted the meaning of 'advice' as it is used in normal language. It considered that Patient A's records show Dr Matthews had an ongoing discussion with colleagues about Patient A's new symptom of bedwetting, and how this could be managed. It noted, for example, that the child psychologist at CAMHS had written to Dr Matthews following their discussion, saying that she would *"begin a more detailed assessment of the current situation and ongoing needs".* The Tribunal considered that in this instance, 'advice' had been sought by Dr Matthews through his ongoing discussions with other professionals. If the GMC meant to refer to specific advice or actions, it should have so drafted the allegation.

12. The Tribunal also considered Dr F's expert report, in which he did not consider Dr Matthews' actions as a serious failing and did not refer to any failure to seek advice at this point; he commented *"the night-time wetting was most likely to be a symptom of psychological distress and this could be addressed appropriately by CAMHS"*

13. The Tribunal noted that the allegation did not contain a time frame.

14. For these reasons, the Tribunal determined that there is no case to answer in relation to Paragraph 4c of the Allegation as there was no evidence to allow this allegation to be found proved.

Paragraph 5

15. Ms Tanchel made submissions as to why this paragraph should not proceed on the basis on no case to answer.

16. Ms Barbour submitted that the GMC conceded that given Dr F's evidence, there was no case to answer.

17. The Tribunal noted the medical records of Patient A included a record of a consultation with her on 1 August 2016. This followed a consultation on 18 July 2016 with Patient A's parents. The Tribunal had regard to Dr F's evidence that this was not an unacceptable period of time to wait for a consultation, and that no time frame had been specified in the allegation.

18. The Tribunal determined that there is no case to answer in relation to Paragraph 5 of the Allegation on the basis that there was no evidence to allow this allegation to be found proved.

Paragraph 7b

19. Ms Tanchel submitted that a properly directed Tribunal would be mindful of the limitations of the case note, and the weight which it should be given. She said that there is no information before the Tribunal on how the case note came into evidence, and it was hearsay evidence. She said the case note was brief, unclear, non-verbatim and it was not open to her on behalf of Dr Matthews to ask questions of the writer.

20. Ms Tanchel reminded the Tribunal that the burden of proof is on the GMC to prove the facts that have been alleged, and that the GMC should not rely on waiting for Dr Matthews' explanation of the case note.

21. Ms Tanchel also submitted that whilst Dr Matthews' call to social services is dealt with in Dr E's evidence, there are significant inconsistencies between Dr E's report, her witness statement and her handwritten notes. As an example, Ms Tanchel said that it was unclear who was saying what in Dr E's handwritten notes, and that Dr E said that her notes were 'aide memoires' and not verbatim.

22. Ms Tanchel submitted that, within the test set out in *Galbraith*, the Tribunal could not be satisfied that Dr Matthews made statements to social services in a way that indicated it was his opinion and limb 2 was engaged.

23. Ms Barbour submitted that both parties agree that a call was made to social services by Dr Matthews that was not of his own volition, but prompted by Patient B.

24. Ms Barbour submitted that the person who took the case note of the call was careful to note down Dr Matthews' name and practice. She submitted that the call taker showed a degree of care when making the note in the course of her employ. Ms Barbour said that there was no reason for the social worker to lie or misrepresent what Dr Matthews said.

25. Ms Barbour said that Dr E's evidence will also assist the Tribunal, as she gave Dr Matthews an opportunity to explain what occurred during the phone call. Ms Barbour submitted that Dr E had no reason to misconstrue or make up what Dr Matthews said. Ms Barbour submitted that it is important to keep in mind that Dr Matthews admitted to Dr E that he did not know what the allegations he was calling about were, and said that these were allegations that had, or were to be, made. She said that Dr E had been conscientious when giving evidence and the Tribunal should look at her evidence in the round.

26. Ms Barbour submitted that this paragraph of the Allegation should be considered at the end of the facts stage, not now as it was a matter for the Tribunal then to assess the reliability of her evidence.

27. The Tribunal noted that it had found that the case note was admissible and determined that it is itself evidence which on the basis of one possible view of the facts it could make a finding of proven in relation to the allegation, despite its shortcomings.

28. In relation to Dr E's evidence, it reminded itself of the case of *Dutta, R (On the Application Of) v General Medical Council (GMC) [2020] EWHC 1974 (Admin)* which guides the Tribunal in assessing Dr E's evidence. It reminded itself that it was open to the Tribunal to accept parts of Dr E's evidence but not all, and to bear in mind the fluidity of memory. It also considered that there was no basis to suggest Dr E has acted in anything but good faith, despite the criticism she has faced. Her notes, while not verbatim, appeared to contain quotations, but the inconsistencies in her evidence also had to be taken into account. The Tribunal determined that there is sufficient evidence before it to allow this allegation to proceed, though it would need to carefully weigh the reliability of Dr E's evidence.

Paragraph 8ai

29. The Tribunal noted that both parties agreed that this allegation would fall if there was no case to answer for 7b. As the Tribunal have determined that there is a case to answer for 7b, then there is a case to answer for this allegation for the same reasons.

Paragraph 8aii

30. Ms Tanchel submitted that there is no evidence before the Tribunal that Dr Matthews knew about the allegation that Patient A was being sexually abused before he made the call; Dr Matthews only knew about the allegation in 2017. Dr Matthews had focused on the new symptom of bedwetting when making the call. Ms Tanchel submitted that when she canvassed Patient A's symptoms with Dr F, he said that they were not specific to sexual abuse and could be symptoms of other types of maltreatment.

31. Ms Barbour highlighted to the Tribunal that Dr Matthews had said to the social worker that his call was about allegations that had been made by, or were to come, about Patient A. She said that the Tribunal should not assume that Dr Matthews was just referring to bedwetting when considering his comment about allegations that 'were to come', and he should have had in mind all the risk factors.

32. The Tribunal considered that as it had found that there is a potential for paragraph 7b to be proven, there is potential for 8aii to be proven. The Tribunal were mindful that it has evidence before it including the case note, Dr E's account of her meetings with Dr Matthews and Dr F's evidence. The Tribunal determined that it would need to assess the reliability of the evidence before it and this was not a case where there was no evidence to support the allegation.

Paragraph 9

33. Both parties and the Tribunal agreed that the correct test for dishonesty is set out in the case of Ivey *v Genting Casinos (UK) Limited (t/a Crockfords Club) [2017] UKSC 67*, where finding dishonesty is considered a fact-finding exercise.

34. Ms Tanchel submitted that the burden of proof lies with the GMC, and drew the Tribunal's attention to the case of *Re H (Minors)(Sexual Abuse: Standard of Proof) [1996] AC 563* where it was found that the more serious an allegation is, the stronger the evidence needs to be to support such a finding. She said that this paragraph of the Allegation is predicated on the hearsay evidence of the case note, and the confusing and

tenuous evidence of Dr E. Ms Tanchel submitted that due to the weakness of this evidence, there should be no case to answer as it falls under the second limb of *Galbraith.*

35. Ms Tanchel submitted that the judgment in the case of *Fish v General Medical Council [2012] EWHC 1269 (Admin)* was relevant, where it notes that an allegation of dishonesty should not be found against anyone unless there is solid grounds to do so. She highlighted to the Tribunal that there is no previous finding of dishonesty against Dr Matthews, and that he is of good character.

36. Ms Barbour submitted that this Allegation should be considered at the end of the fact-finding stage, not now, as the Tribunal would need to consider the full factual matrix and circumstances of the case. She submitted that due to Dr Matthews' actions, there is a 'quagmire' which led to its dishonest action and she asked the Tribunal to consider if Dr Matthews would have taken the actions that he did for any other family - the nature of the relationship was key.

37. The Tribunal reminded itself that the standard of proof in this hearing is based on the civil standard, though it accepted the position as set out *Re H*. It bore in mind the criticism of the evidence that preceded this allegation when considering paragraphs 7b and 8a, and the need for cogent evidence when making a finding of dishonesty and the Soni principle. It was also mindful that Dr Matthews' statement has yet to be challenged, and that he is of previous good character, which is relevant to credibility and propensity at the fact finding stage.

38. However, the Tribunal was mindful that it had determined that there was one possible view of the evidence put forward before it that could lead it to find dishonesty, such as the case note, Dr E's evidence and the Doctor's statement. It also had regard to the overarching objective, including the need to protect patients and uphold standards in the profession.

39. The Tribunal therefore determined that there is a case to answer in relation to Paragraph 9 of the Allegation.

<u>Paragraph 11c</u>

40. Ms Tanchel submitted that the evidence the GMC relied on to prove these paragraphs of the Allegation are Patient A and C's records. Ms Tanchel highlighted to the Tribunal that Patient B's medical records had not been adduced into evidence and said that nowhere in the records of Patient A or Patient C is there evidence of the therapeutic relationships with those patients being adversely affected. Ms Tanchel submitted that Dr Matthews did no more than what other clinicians had done and had not attempted to conceal anything from other clinicians.

41. Ms Tanchel submitted that the expert witness, Dr F, could not say what was in Dr Matthews' mind at the time of the events, and therefore his evidence could not be used when determining this allegation.

42. Ms Tanchel also submitted that it was difficult to understand what was meant by 'personal', and that this remained an undefined concept.

43. Ms Barbour invited the Tribunal to apply the normal, everyday, common sense meaning of the word 'personal'.

44. Ms Barbour submitted that the Tribunal could not decide whether there had been an adverse effect at this stage. She said the Tribunal would need to decide first if Dr Matthews had been blind to the possibility that Patient A was being sexually abused because of the view he had of Patient A's parents. Ms Barbour submitted that the Tribunal would also need to decide if Dr Matthews' phone call to social services was made as it was alleged, as if this was the case, it would have 'silenced the voice' of Patient A. Ms Barbour accepted that there were no records before the Tribunal regarding Patient B – she said that the therapeutic relationship arose there because Patient B was Patient A's mother.

45. The Tribunal determined that because it did not have the medical records of patient B, there was no evidence to prove paragraph 11cii, and there was therefore no case to answer. It defined a therapeutic relationship as one 'to care, to treat, to heal' and this did not apply purely to a parent of a patient. In any event, the alleged adverse effect for Patient B was unknown.

46. In relation to paragraphs 11ci and 11ciii, the Tribunal was mindful that the term 'personal' was undefined. However, it accepted that it could use the everyday definition, and could consider this further at the end of the fact-finding stage.

47. The Tribunal considered that paragraph 11ci was based on making a finding about the potential comments Dr Matthews made to social services. It considered the call could potentially have had an adverse affect, as it may have stopped any further actions being taken to safeguard Patient A, even if made to spare the family stress. Similarly, the entry in Patient C's records of 3 March 2017 may have adversely affected Dr Matthews' therapeutic relationship with Patient A if his opinion was the allegation of child sexual abuse was malicious. The Tribunal determined that on one possible view of the evidence it could make the finding of proved on paragraph 11ci, and therefore determined that there remains a case to answer.

48. The Tribunal considered that paragraph 11ciii centred on the entry of 3 March 2017. It noted that the allegation of child sexual abuse as set out in that entry could not have an adverse effect on the therapeutic relationship with Patient C as it described the allegation against Patient C as malicious. There was no evidence before the Tribunal to allow this paragraph to be found proved.

Paragraph 12bii

49. Ms Tanchel highlighted to the Tribunal the inconsistencies in Dr E's notes that had been submitted previously, and submitted that there are further inconsistencies with the notes she made about Dr Matthews' recording of the consultation with Patient C on 3 March 2017. She said this included the notes made being different to that presented in the chronology of her report, and that Dr E had fallen into a trap of giving her opinion that the Record reflected Dr Matthews' opinion. Ms Tanchel highlighted that in other medical records Dr Matthews made, it was clear which parts of the medical records were the history (what Patient C told Dr Matthews) and comment (Dr Mathews' opinion of Patient C and their consultation). She said that it would be unfair for the Tribunal to draw the inference that the opinion was Dr Matthews', based on Dr E's misunderstanding.

50. Ms Barbour submitted that Dr Matthews' Record for Patient C is clear in that it details what Patient C has told him, and what is Dr Matthews' opinion. Ms Barbour submitted that this can be shown by the way the note is written, whereby it states '*seems clear that is a malicious allegation* '. She submitted that, in other notes, Dr Matthews writes that Patient C '*feels*' when stating Patient C's opinion. She asked the Tribunal to consider why the Record did not read that Patient C '*"felt" that is a malicious allegation*'.

51. In addition, Ms Barbour said that Dr E recalled clearly a discussion with Dr Matthews where he said that he did not believe that due to Patient C's anger issues, this meant in Dr Matthews' view Patient C was incapable of intimacy, and therefore could not have sexually abused Patient A. Ms Barbour submitted that Dr E had said that this stuck in her mind, and recalled asking Dr Matthews '*do you really believe that?*'. Given Dr E's recording of Dr Matthews' view of Patient C, there is a plain and common sense reading of the Record that it was Dr Matthews' opinion and not Patient C's.

52. The Tribunal considered that the Record could be read as either Patient C or Dr Matthews' view. Because it had reached this determination, it considered that there remains a case to answer in relation to this paragraph. It considered that it would need to draw an inference from the wider evidence it had before it before it could reach a determination.

Paragraph 13

53. Ms Tanchel submitted that the Record is Dr Matthews' record of what has happened, and that no one has been called to challenge it. She said there is no evidence that they are not the words of Patient C and no evidence that Dr Matthews knew that they were untrue, even given his knowledge of the risk factors. Ms Tanchel said Dr Matthews simply recorded what Patient C told him. In addition, she pointed out third parties can carry out child sexual abuse.

54. Ms Barbour submitted that paragraphs 12b and 13a of the Allegation go hand in hand, in that if the Tribunal considered 12b to be proven, then the whole of what Dr Matthews had written was untrue. She said that a reasonably competent GP should only provide a professional view of what Patient C said.

55. In relation to paragraph 13b of the Allegation, Ms Barbour submitted that Dr Matthews should have known that it was not clear that the allegation was malicious, given the risk factors set out in paragraph 4a and 6a of the Allegation. Ms Barbour said that these factors alone should have been enough to stop Dr Matthews concluding that this was a malicious allegation.

56. The Tribunal first considered paragraph 13a. The Tribunal considered that if Dr Matthews had recorded faithfully what Patient C had said, then it could not be untrue if Patient C had told Dr Matthews it was a 'malicious allegation'. It considered that it did not have

enough evidence to be in a position to objectively test whether what is recorded was untrue; it simply was not in a position to decide if the allegation was or was not malicious. There was no evidence before it on this point. It therefore concluded that there is no case to answer in relation to this allegation.

57. The Tribunal next considered paragraph 13bi and 13bii. The Tribunal had regard to its reasoning set out in its consideration of 13a. It considered that if it had found that there was not enough evidence to conclude that there was a case to answer in relation to 13a due to lack of evidence about the allegation itself, then it would be contradictory to conclude that there is a case to answer in regards to 13bi and 13bii. It therefore determined that there was no case to answer for paragraphs 13bi and 13bii.

58. In regard to 13c, the Tribunal considered that it did have evidence in the form of the Record. It had regard to its reasoning set out in its consideration of paragraph 12. Given that the record could be read as either being the opinion of Dr Matthews or Patient C, it found that it would only be able to make a determination on this allegation when considering the wider factors of the case. It therefore determined that there is a case to answer in regards to paragraph 13c of the Allegation.

Paragraph 14

59. The Tribunal heard submissions from both parties on this paragraph. However, it noted that given it had found that there is no case to answer in relation to paragraphs 13a and 13b of the Allegation, then it determined that there is also no case to answer with regards this paragraph.

Paragraph 15

60. Ms Tanchel submitted that the latest medical records the Tribunal have for Patients A and C are dated 6 March 2017. She said that there is nothing that records what Dr Matthews did after the allegation of sexual abuse was mentioned by Patient C. Ms Tanchel submitted that the Allegation also does not contain a time frame in which Dr Matthews should have acted. She said there was no evidence to prove this allegation.

61. Ms Barbour submitted that the allegation of sexual abuse was disclosed on 3 March 2017, during Dr Matthews' consultation with Patient C. She submitted that Dr F said that if Dr Matthews had taken the appropriate steps, and suspected that there was sexual abuse of

Patient A due to this consultation, then the 'red flags' should have been reviewed and action taken. Ms Barbour submitted that Dr Matthews took no action, and that this allegation could therefore only be considered once all of the evidence is heard. Ms Barbour pointed out that other children could have been at risk.

62. The Tribunal noted that it had Patient A and Patient C's medical records between 3 and 6 March 2017. It also noted that it had evidence of what a reasonable competent doctor should have done in the form of a safeguarding flow chart presented by Dr F, which demonstrated the path to take when it is suspected that there is a safeguarding issue with a child. The Tribunal considered that it is the absence of evidence in regards to Dr Matthews' actions between 3 and 6 March 2017 means there is a case to answer. It did not know why Dr Matthews did not take action during these three days, but had received evidence from an expert about the positive obligation to act. It determined that it would need to hear what Dr Matthews did or did not consider in order to properly make a determination on this paragraph.

Paragraph 16

63. Ms Tanchel submitted that there is no evidence that Dr Matthews concealed or undermined any potential allegation(s). She submitted that other clinicians had access to Patient A's records, and that there is no evidence Dr Matthews attempted to stop Patient A from speaking to other clinicians or set out on a path to hide things. Ms Tanchel said that at the time, the only allegation that had been made to social services was regarding bedwetting, and that there was no evidence that Dr Matthews knew about allegations of sexual abuse before 2017, and so he could not have undermined any potential allegation in any event.

64. Further, Ms Tanchel highlighted to the Tribunal that Patient A had seen other clinicians alone and that they were also informed of her symptoms. She said it put them in a difficult position as it appears that they also had failed to deal with the issues.

65. Ms Barbour submitted that if it is accepted that in the call to social services, Dr Matthews stated that there may be allegations to come, and that any allegation made was malicious, then this undermined Patient A and silenced the voice of the child. She said therefore that before the Tribunal could make a determination on this Allegation, there needed to be a thorough understanding of all of the evidence to determine this allegation.

66. The Tribunal noted that this allegation, if found proved, would have serious consequences for Dr Matthews' career. It reminded itself that it needed cogent evidence in order to find this allegation proved as it was significant.

67. The Tribunal considered that it could not find any evidence that Dr Matthews had attempted to conceal any sexual abuse of Patient A. However, it noted that it could take a view of Dr Matthews' record of his consultation with Patient C on 3 March 2017 where he made a note that it seemed clear the allegation of sexual abuse was a 'malicious allegation', and the case note of Dr Matthews' call to social services as attempts to undermine such allegations. In addition, the Tribunal considered it would need to take into account Dr E's evidence about Dr Matthews considering Patient C as being incapable of physical intimacy due to his anger issues, and subsequently unable to sexual abuse Patient A, as possible evidence of Dr Matthews attempting to undermine such allegations.

68. The Tribunal therefore determined that there was no case to answer with regards to any attempt to conceal sexual abuse of Patient A; however, there was a case to answer with regards to the allegation that Dr Matthews attempted to undermine any such allegation.

Paragraph 17

69. Ms Tanchel submitted that, as outlined in her submissions on paragraph 16, other clinicians were involved in the care of Patient A. She submitted that Dr F had conceded that the other clinicians, who were not alleged to have been motivated by a personal relationship with Patient's B and C, should have also alerted that there was a safeguarding or child protection issue with Patient A. She said that Dr Matthews does not seek to hide behind the argument that other clinicians should also have done something, but demonstrated his relationship was not the motivation for any possible clinical failings.

70. Ms Barbour submitted that the Tribunal should look at the obligations that fall to a GP as outlined by Dr F, and the cumulative effect of each of the appointment's Dr Matthews had with the patients. She said the Tribunal needed to focus on Dr Matthews' actions and not the actions of other clinicians. She pointed out, that other clinicians had not rung social services at the request of Patient B, nor written that Patient A's allegation(s) 'seemed malicious'.

71. Ms Barbour submitted that the Tribunal would need to bear in mind all the Allegation in order to reach a conclusion about Dr Matthews motivation.

72. The Tribunal considered that there is evidence that whilst other clinicians did act in a similar way to Dr Matthews, they did not have all the personal contacts that Dr Matthews had with the Patients. It noted, for example, that it is accepted Dr Matthews had received a hamper of food from Patients B and C, lent his sports car to Patient C, acted a guarantor for Patient B for a lease, lent money to Patient B, received calls from Patient B on his personal mobile, asked Patient C to carry out XXX, called social services at the request of Patient B, and recorded the allegation of child sexual abuse against Patient C seemed malicious.

73. The Tribunal considered that there was still a case to answer in relation to these issues. The Tribunal therefore determined that it would need to consider this paragraph of the allegation in light of its other findings.

ANNEX I – 26/11/2020

Determination on adjournment under Rule 29(2)

1. On the final day of this hearing, Day 9, the Tribunal established that there would be insufficient time to conclude proceedings. It determined of its own volition to adjourn this hearing under Rule 29(2) of the Fitness to Practise Rules 2004 as amended (the Rules) part heard until a later date.

2. The Tribunal noted that it had concluded making its determination on Ms Tanchel's application under Rule 17(2)(g) on behalf of Dr Matthews, and considered that it would be likely that the next stage would be to receive oral evidence from Dr Matthews under oath. It determined that it would be undesirable for Dr Matthews to remain under oath, as it considered it would not have sufficient time to conclude his evidence today.

3. The Tribunal asked for submissions on possible dates to reconvene. After deliberation, it considered that it would need 10 days to conclude this hearing, and suggested that these could be accommodated in either March 2021 or April 2021.

Submissions

On behalf of the GMC

4. Ms Barbour submitted that she would not be available for some of the dates the Tribunal suggested. When considering if someone could replace her as a representative for the GMC, Ms Barbour said that that the GMC would be concerned if she was not able to continue in this case. She said that it would be difficult for another representative to understand the personality of witnesses who had given evidence, which would be crucial in reaching a decision at the facts stage.

5. Ms Barbour said that this hearing had been in a state of flux, and it would be difficult for another representative to understand what may occur as the hearing has not been 'straightforward' so far.

On behalf of Dr Matthews

6. Ms Tanchel submitted that most of the dates would be suitable. She said that it would ensure Dr Matthews had as fair a hearing as possible. Ms Tanchel submitted that it would be unfair to continue the hearing virtually, particularly at the fact finding stage; it would not be fair to Dr Matthews as the Tribunal would not be able to judge his evidence in the same way as other witnesses. However, she was less concerned about a virtual hearing from the impairment stage onwards.

The Tribunal's Decision

7. The Tribunal was mindful that it needed to have the complete Tribunal available to complete the hearing. Given the availability of parties and the Tribunal, the Tribunal agreed that 1 – 12 March 2021 would be the most optimal dates to reconvene

8. It noted that Ms Barbour would not be available to represent the GMC after Day 5, 5 March 2021. The Tribunal considered that it would be able to conclude the fact finding stage of this hearing during this time. It found that, although undesirable, the fairest solution would be to continue with the hearing after this date at the impairment stage with a new representative from the GMC.

Case Management Direction

9. The Tribunal made a case management direction that any testimonial evidence upon which the doctor wishes to rely on at the fact finding stage be provided to the MPTS by 15 February 2021.

ANNEX J – 09/03/2021

Admission of Further Evidence to put to the Witness

1. On behalf of the GMC, Ms Barbour made an application to admit further evidence in the form of a reflective statement that Dr Matthews submitted to the GMC as part of his response to the GMC's Rule 4 of the General Medical Council ('GMC') (Fitness to Practise) Rules 2004, as amended (the Rules) letter ('the Rule 4 reflective statement') dated 3 May 2018 if Dr Matthews did not accept the propositions to be put to him on behalf of the GMC during his future cross-examination. Ms Barbour also wished to adduce the Rule 4 letter sent by the GMC to Dr Matthews as contextual information to assist the Tribunal's deliberations regarding this application to demonstrate that Dr Matthews chose to send this statement to the GMC.

2. In addition, Ms Barbour made an application to admit evidence in the form of the first response to a Rule 7 letter under the Rules ('the Rule 7 response') from Dr Matthews' solicitors on his behalf dated 5 February 2019 if Dr Matthews did not accept the propositions to be put to him on behalf of the GMC during his future cross examination.

3. During a further period of Dr Matthews' oral witness evidence, Ms Barbour submitted an application for Dr Matthews' response to Dr E's report to be adduced if Dr Matthews did not accept the propositions to be put to him during his future cross-examination. The response is undated, but is accepted to have been created between May and August 2019, following Dr Matthews' meeting with Dr E and receipt of her report.

4. Ms Barbour explained that the Rule 4 reflective statement, the Rule 7 response letter and Dr Matthew's response to the report may not need to go before the Tribunal, and were to be used to raise concerns about inconsistencies between these documents and Dr Matthews' evidence during his oral witness evidence at this hearing.

5. The Tribunal was concerned that Dr Matthews was going to be asked questions about documents that it may be unable to view, though accepted the procedure would normally be that if the proposition arising from the document was accepted by the

witness, it would not be supplied with the document. It also considered whether the documents could be redacted before they were put before the Tribunal to allay any concerns the parties may have that the documents could be considered as part of their decision making outside of any inconsistencies the documents may demonstrate. It invited submissions on these points.

Submissions

On behalf of the GMC

6. Ms Barbour submitted that she wished to put the Rule 4 reflective statement, Rule 7 letter and Dr Matthews' response to Dr E's report to Dr Matthews during his oral witness evidence and explore whether he agreed or disagreed with parts of them. She submitted that if Dr Matthews disagreed with any part or parts of the statements made in any of these documents, it may be that the documents should be shown to the Tribunal.

7. Ms Barbour submitted that the Rule 4 reflective statement was sent to the GMC along with a certificate obtained by Dr Matthews following a boundaries course. She said that there are parts of the Rule 4 reflective statement that are directly inconsistent with the oral witness evidence Dr Matthews had given under oath. She submitted that the Rule 4 reflective statement also contained admissions to disputed facts in the Allegation.

8. Ms Barbour submitted that the Rule 4 letter from the GMC to Dr Matthews should be considered, as it would assist the Tribunal in determining what obligations Dr Matthews had at this stage in terms of how he should respond.

9. Ms Barbour submitted that the Rule 7 response was not written by Dr Matthews but was composed by his solicitors. However, Ms Barbour submitted that this letter would not have been sent without Dr Matthews' knowledge and consent, and that it was incumbent on him to ensure all facts within it were accurate.

10. In relation to the Tribunal's determination in Annex E, where it did not grant Ms Barbour's previous application to admit the Rule 7 response, Ms Barbour said that this application was on different grounds. She said that her application now was to test inconsistencies in Dr Matthews' evidence whilst under oath. Further, she submitted that the Tribunal would also be able to ask questions to Dr Matthews about any inconsistencies.

11. In similar reasoning to that given in her submissions about the Rule 4 reflective statement, Ms Barbour said Dr Matthews' response to Dr E's report contained parts that

are inconsistent with Dr Matthews' oral witness evidence, and she wished to test these inconsistencies.

12. Ms Barbour submitted that in all cases it would be beneficial to admit the evidence to the Tribunal, should there be any inconsistencies during Dr Matthews' oral witness evidence, as it would assist the Tribunal in assessing the facts and potential wider issues with Dr Matthews' culpability.

13. Ms Barbour did not ultimately make any submissions regarding the adducing of Dr Matthews' response to Dr E's report as following an adjournment overnight, Ms Tanchel on behalf of Dr Matthews confirmed there would be no objection, should it be necessary, to show the Tribunal this document if Dr Matthews did not accept the propositions to be put to him.

On behalf of Dr Matthews

14. Ms Tanchel submitted that the process of putting the Rule 4 reflective statement to Dr Matthews whilst he is under oath to consider any inconsistencies was permissible as a matter of law. However, she considered that this may be unfair and felt that the number of applications by the GMC to adduce evidence was now becoming oppressive.

15. Ms Tanchel submitted that there was some tension between the standard wording of the Rule 4 letter from the GMC and the need for Dr Matthews' to respond to it. She highlighted paragraph 73 of Good Medical Practice (2013 edition) ('GMP') which states:

> *You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality.*

Ms Tanchel submitted that there was a burden on Dr Matthews to reply, but at the time, he was not aware that his response would be considered at a Tribunal. She submitted that it would be unfair for the Tribunal to view a document that was created for a different purpose and context than to go before the Tribunal, and therefore Dr Matthews' Rule 4 reflective statement should not go before the Tribunal.

16. Ms Tanchel submitted that this hearing was not about punishing Dr Matthews' but protecting the public.

17. In relation to the application to admit the Rule 7 response, Ms Tanchel highlighted that Ms Barbour had already made an application, outlined in Annex E, for this evidence to be admitted *'for the whole hearing'*. She said that the Tribunal determined to deny this application, and that it should not go behind its determination. Ms Tanchel said that it would be an abuse of process if the Tribunal did and a breach of legitimate expectations. Ms Tanchel submitted that this is the fourth time the GMC had attempted to put the Rule 7 letter before the Tribunal and said neither Dr Matthews nor herself had expected to be confronted with it again.

18. Ms Tanchel did not have any objections to Dr Matthew's response to Dr E's report going before the Tribunal should any inconsistencies arise. However, Ms Tanchel expressed frustration that this document could have been included in the main bundle of evidence at a much earlier stage, before the start of this hearing.

Tribunal's Decision

19. The Tribunal did not consider the applications made by the GMC to be oppressive. A party faced with a witness who then allegedly is giving evidence inconsistent with previous statements made by or on behalf of that witness was entitled to seek to put these statements to that witness. This was generally something that could not be predicted in advance as the witness had to make the statement which was argued to be inconsistent with previous statements to trigger such an application.

20. The Tribunal had regard to the questions of fairness and relevance, in order with Rule 34(1) of the Rules:

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

21. The Tribunal also had regard to the Denman Act, the Criminal Procedure Act 1865, outlined in Annex E, specifically:

> *4. As to proof of contradictory statements of adverse witness.*
> *If a witness, upon cross-examination as to a former statement made by him relative to the subject matter of the indictment or proceeding, and inconsistent with his present testimony, does not distinctly admit that he has made such statement, proof may be*

given that he did in fact make it; but before such proof can be given the circumstances of the supposed statement, sufficient to designate the particular occasion, must be mentioned to the witness, and he must be asked whether or not he has made such statement.

5. Cross-examinations as to previous statements in writing.
A witness may be cross-examined as to previous statements made by him in writing, or reduced into writing, relative to the subject matter of the indictment or proceeding, without such writing being shown to him; but if it is intended to contradict such witness by the writing, his attention must, before such contradictory proof can be given, be called to those parts of the writing which are to be used for the purpose of so contradicting him: Provided always, that it shall be competent for the judge, at any time during the trial, to require the production of the writing for his inspection, and he may thereupon make such use of it for the purposes of the trial as he may think fit.

Rule 4 letter from the GMC to Dr Matthews

22. The Tribunal was mindful that this is a standard letter sent to all doctors at the Rule 4 stage of the GMC's investigation. The Tribunal noted that Ms Barbour had read out the relevant paragraph of the letter relating to a doctor responding to the GMC at the Rule 4 stage to the Tribunal, and it had made a record when this occurred. The Tribunal therefore determined that this letter did not need to be admitted into evidence as context as the key section inviting the doctor to respond was well known to all.

Rule 4 reflective statement

23. In reaching its decision, the Tribunal considered that it had not previously heard an application regarding the Rule 4 reflective statement.

24. The Tribunal accepted that it was relevant for this piece of evidence to be put to Dr Matthews, as it would allow an examination into any alleged inconsistencies in Dr Matthew's evidence.

25. Following its deliberation on the Rule 4 letter from the GMC to Dr Matthews', the Tribunal considered that Dr Matthews was under no obligation to provide this reflective document (even considering paragraph 73 of GMP), and that it was his choice to do so to demonstrate to the GMC his reflections. Its introduction would allow the GMC to challenge Dr Matthews about the alleged inconsistent statements. It therefore

considered that it was also fair for the Rule 4 reflective statement to be adduced into evidence.

26. It determined to first allow the Rule 4 reflective statement to be put to Dr Matthews during his oral witness evidence. If Dr Matthews' disagreed with any part of the statements it would follow the process of Rule 34(1) and the Denman Act, and allow it to be adduced to the Tribunal.

27. At the close of Dr Matthews' oral evidence, the Tribunal had seen the Rule 4 reflective statement

Rule 7 response letter

28. The Tribunal had regard to Rule 34(1) of the Rules, and considered that the Rule 7 response letter was relevant, as it would be able to assist the Tribunal in considering any inconsistencies within Dr Matthews' evidence.

29. In regard to fairness, the Tribunal was mindful of its decision in Annex E. It considered that if it were to allow the GMC's application, it would not go behind its previous determination or be an abuse of process. The Tribunal considered that it needed to assess if Dr Matthews was being honest during his oral evidence. This was a different basis to which Ms Barbour made the unsuccessful application outlined in Annex E. The Tribunal noted that the Rule 7 response letter would be used to test inconsistencies in Dr Matthews evidence and in a wider consideration regarding propensity and credibility.

30. The Tribunal considered that whilst the Rule 7 response letter was not written by Dr Matthews, it was based on a factual matrix of instructions communicated by Dr Matthews to his solicitors. It noted that the letter would have been seen by Dr Matthews before it was submitted to the GMC. The Tribunal therefore determined that it would be fair for Ms Barbour to examine Dr Matthews on the response letter in order to explore any potential inconsistencies in relation to his oral witness evidence.

31. In addition, the Tribunal subsequently found that, should any inconsistencies arise, it would also be fair for it to view the response letter as part of the process outlined above. The Tribunal noted that the evidence would only be used to assist it in considering inaccuracies or concerns regarding Dr Matthews' credibility or his oral evidence.

32. The Tribunal was given this document during Dr Matthews' oral witness evidence.

Dr Matthews' response to Dr E's Report

33. The Tribunal considered that this document was relevant to this hearing, as it was written by Dr Matthews in response to a piece of evidence it had already viewed and allegedly inconsistent with his statements. In similar reasoning to that set out in its determination on the Rule 4 reflective statement, it also found it was fair for the evidence to be put to Dr Matthews to assess if there were any inconsistencies between the response to Dr E and his oral witness evidence. In addition, if there were any inconsistencies, the Tribunal found that it would be fair for it to view this document.

34. The Tribunal did not view a redacted version of this evidence during Dr Matthews' oral witness evidence.

Schedule 1
'left message to say that has started wetting the bed, is changing school and going to start at [another school] in September. Has phoned CAMHS and been told that 27th on list for ADHD assessment'

Schedule 2
"Dr Matthews XXX wanting to share that the allegations that may have or are to come in respect of this child he feels are malicious allegations. Dr Matthews advised parents have sought all appropriate services in respect of the child. He wanted it noted that he has no concerns"
Amended under rule 17(6)

Schedule 3
"last night [Patient A] slept in father's boxer shorts and then put them back wet into his cupboard"

Schedule 4
"Stress related problem (Review). Has been accused of sexual abuse by daughter, very stressed, interviewed by Police but seems clear this is a malicious accusation. XXX"

Schedules included under rule 17(6)