Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 16/09/2019 – 03/10/2019

Medical Practitioner’s name: Dr Ashok SINGH

GMC reference number: 5193023

Primary medical qualification: MB BS 1992 Patna Medical College

Type of case
New - Misconduct

Outcome on impairment
Not Impaired

Summary of outcome
No warning

Tribunal:

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<th>Position</th>
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<tr>
<td>Legally Qualified Chair</td>
<td>Mr Lindsay Irvine</td>
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<tr>
<td>Lay Tribunal Member:</td>
<td>Mr Colin Davis</td>
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<td>Medical Tribunal Member:</td>
<td>Dr Jill Edwards</td>
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<td>Tribunal Clerk:</td>
<td>Ms Lauren Duffy</td>
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<td>Ms Chloe Ainsworth (support)</td>
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Attendance and Representation:

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<th>Role</th>
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<tr>
<td>Medical Practitioner:</td>
<td>Present and represented</td>
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<td>Medical Practitioner’s Representative:</td>
<td>Mr Sean Larkin, QC, instructed by the MDU</td>
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<tr>
<td>GMC Representative:</td>
<td>Ms Chloe Hudson, Counsel</td>
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Attendance of Press / Public
In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.
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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 - 01/10/2019

Background

1. Dr Singh qualified in 1993 from Patna Medical College in India. In October 1999, Dr Singh took up his first post in a UK hospital working as a pre-registration house officer in Orthopaedics. In August 2000, he started his Senior House Officer ('SHO') post in psychiatry at the Millbrook Mental Health Unit ('Millbrook') at Kings Mill Hospital. After working there for a year, Dr Singh worked in various posts in psychiatry until 2004 when he was employed as a Staff Grade Psychiatrist in Nottinghamshire. In 2012, Dr Singh decided to retrain as a General Practitioner ('GP'). Following 6 months as a GP registrar at a GP Practice and 18 months working in various hospital specialities in Norfolk and Norwich Hospital, Dr Singh’s final training placement was at Hellesdon GP Practice between February 2014 and January 2015.

2. The Allegation that has led to Dr Singh’s hearing can be summarised as follows. First, it is alleged that, on more than one occasion in October 2000, Dr Singh consulted with Patient A, a vulnerable patient, whilst she was at Millbrook and inappropriately touched Patient A in a way which was not clinically indicated. It is alleged that Dr Singh failed to communicate with Patient A about the examination, failed to offer Patient A a chaperone and failed to make appropriate records. It is further alleged that, in or around November and December 2000 (these dates were later amended), Dr Singh telephoned Patient A at home and told her to check her breasts and vagina for lumps.

3. It is also alleged that, during a consultation on 21 May 2014, whilst working as a GP trainee Dr Singh intentionally slid his hand across Ms C’s left breast during a consultation with her son, Child B. Further, it is alleged that on 16 January 2015, Dr Singh inappropriately touched Patient D during a consultation.

4. It is alleged that Dr Singh’s actions were sexually motivated.

5. The alleged events were the subject of a criminal trial at Norwich Crown Court in November 2016. At the criminal trial, Dr Singh pleaded not guilty and was acquitted by the jury. Dr Singh has not completed his GP training and, since his acquittal, his medical posts have been in psychiatry.
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The Outcome of Applications Made during the Facts Stage

6. On day 1 of the hearing, the Tribunal granted, Counsel for the GMC, Ms Hudson’s, application made pursuant to rule 17(6) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (‘the Rules’) to amend the allegation. On behalf of Dr Singh, Mr Larkin, Counsel, had no objections to the amendments. The Tribunal was satisfied that the proposed changes were not substantive in nature and that therefore no injustice would be caused by allowing them to be made.

7. On day 5 of the hearing, Ms Hudson, made a further application, made pursuant to the Rules, to amend the allegation. The Tribunal’s full decision on the application is included in Annex A.

8. At the end of the GMC’s case an application was made by Dr Singh’s Counsel, Mr Larkin, of no case to answer, pursuant to the Rules. As a result of this application and decisions made by the Tribunal a number of the paragraphs of the Allegation have been deleted as reflected below. The Tribunal’s full decision on the application is included at Annex B.

The Allegation and the Doctor’s Response

9. The Allegation made against Dr Singh is as follows:

Patient A

1. At all material times Patient A was vulnerable due to a mental health condition. **Admitted and found proved**

2. On 10 October 2000, you consulted Patient A whilst she was an inpatient at the Kings Mill Hospital (‘the Hospital’), and you inappropriately:

   a. touched her:

      i. down her neck and shoulder;

      ii. on her chest area;

      iii. between her breasts;

      iv. belly button;

      v. on her pubic area;

      vi. on her buttock area;

   b. leaned your right hand and/or arm on her right breast;
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e. used your right hand to grab her left breast;

d. grabbed both of her breasts over her bra;

e. inserted your finger into her:

i. trousers;

ii. underwear;

f. placed your right hand on her buttocks;

g. moved your hands around her back;

h. told Patient A you were ‘checking for weapons’, or words to that effect.

Deleted after a successful Rule 17(2)(g) application

3. You failed to:

a. offer Patient A a chaperone;

b. obtain consent to undertake your physical examination of Patient A as described at paragraphs 2a-2g above;

c. adequately communicate with Patient A with regards to the content of your examination;

d. make a record of your examination of Patient A as described at paragraphs 2a-2g above.

Deleted after a successful Rule 17(2)(g) application

4. Your actions as described at paragraph 2 were not clinically indicated.

Deleted after a successful Rule 17(2)(g) application

5. In the alternative to paragraph 4 above you failed to make an adequate record as to why these elements of your examination were clinically indicated.

Deleted after a successful Rule 17(2)(g) application

6. On 12 October 2000, you consulted Patient A whilst she remained an in-patient at the Hospital, and you inappropriately:

a. touched Patient A:
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i. down her neck and shoulder;

ii. on her chest area;

iii. between her breasts;

iv. on her buttock area;

b. _______ squeezed each of her breasts;

c. _______ moved your hands around her back;

d. _______ inserted your hand inside her;

i. trousers;

ii. underwear;

e. _______ used your little finger to touch her pubic hair;

f. _______ said to Patient A:  

i. you were ‘checking for weapons’, or words to that effect;

ii. ‘no one would believe her’ or words to that effect;

g. _______ asked Patient A if she was sexually active with her partner.

Deleted after a successful Rule 17(2)(g) application

7. _______ Your actions described at paragraph 6 above were not clinically indicated.

Deleted after a successful Rule 17(2)(g) application

8. _______ You failed to:

a. _______ offer Patient A a chaperone;

b. _______ adequately communicate with Patient A in that you failed to address her concerns about the appropriateness of the examination;

c. _______ obtain consent to undertake your physical examination of Patient A as described at paragraphs 6a-6e above;

d. _______ make a record of your examination of Patient A as described at paragraphs 6a-6e above.

Deleted after a successful Rule 17(2)(g) application
On 23 October 2000, you consulted Patient A in an outpatient clinic at the Hospital, and you inappropriately:

a. touched Patient A:
   i. down her neck and shoulder;
   ii. on her chest area;
   iii. between her breasts;
   iv. on her right breast;

b. inserted your right hand inside her top;

c. felt and/or cupped her right breast with the palm of your right hand;

d. used your thumb and finger to touch her left nipple;

e. said to Patient A ‘tell them if you want, nobody would believe you’ or words to that effect;

f. asked Patient A ‘whether she was sexually active with her partner’ and/or ‘whether her partner suffered with impotence’ or words to that effect.

Your actions described at paragraphs 9 above were not clinically indicated.

You failed to:

a. offer Patient A a chaperone;

b. adequately communicate with Patient A in that you failed to address her concerns about the appropriateness of the examination;

c. obtain consent to undertake your physical examination of Patient A as described at paragraphs 9a-9d above;

d. make an adequate note of your physical examination of Patient A as described at paragraphs 9a-9d above.
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12. In or around November, on a date between 23 October 2000 and 6 November 2000 you telephoned Patient A ("the First Telephone Call") and you failed to make an adequate record of that call, inappropriately: **Amended (by way of two separate applications) under Rule 17(6).**

Deleted after a successful Rule 17(2)(g) application

12.13. During the course of the First Telephone Call you inappropriately:

**Amended under Rule 17(6)**

a. asked whether Patient A was:
   i. "at home alone" or words to that effect;
   ii. "sitting or standing up" or words to that effect;

Deleted after a successful Rule 17(2)(g) application

b. told Patient A to:
   i. "feel both your breasts for any lumps", or words to that effect;
   ii. examine her vagina for lumps.

13.14. Your actions described at paragraph 132 above were not clinically indicated. **Amended under Rule 17(6).**

14. You failed to make an adequate record of your telephone call to Patient A as described at paragraph 12 above. **Amended under Rule 17(6).**

15. In approximately On a further date between 23 October 2000 and 6 November–December 2000, you telephoned Patient A ("the Second Telephone Call") and you failed to make an adequate record of that call told her to examine her: **Amended (by way of two separate applications) under Rule 17(6)**

Deleted after a successful Rule 17(2)(g) application

15.16. During the course of the Second Telephone Call you told Patient A to examine her: **Amended under Rule 17(6)**

   a. breasts for lumps;

   b. vagina for lumps.

16.17. Your actions described at paragraph 165 above were not clinically indicated. **Amended under Rule 17(6)**
17. You failed to make an adequate record of your telephone call to Patient A as described at paragraph 15 above. **Amended under Rule 17(6)**

**Child B / Ms C**

18. On 21 May 2014, you consulted Child B and during the Consultation you:
   a. spoke to Ms C in an inappropriate manner;
   b. intentionally slid your hand across the left breast of Ms C.

   **Deleted after a successful Rule 17(2)(g) application**

**Patient D**

19. On 16 January 2015, you consulted Patient D and during the examination you inappropriately:
   a. inserted your fingers into Patient D’s:
      i. top;
      ii. bra;
   b. pulled Patient D’s left breast out of her bra to expose her nipple;
   c. touched Patient D’s:
      i. left breast;
      ii. left nipple;
   d. placed the stethoscope over Patient D’s left nipple.

20. In respect of your conduct described at paragraph 19 above, you failed to:
   a. obtain Patient D’s consent;
   b. offer Patient D a chaperone;
   c. adequately communicate with Patient D your intention to touch her breast and/or nipple. **Amended under Rule 17(6)**

21. You failed to adequately communicate with Patient D the way you intended to examine her. **Amended under Rule 17(6). Admitted and found proved**
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21. In the alternative to paragraph 20 above, you failed to make an adequate record of: **Amended under Rule 17(6)**
   
   a. any consent obtained;
   
   b. the offer of a chaperone.

22. Your conduct as described at paragraphs 2, 6, 9, 13, 16, 18b and 19a-19d was sexually motivated as it was in pursuit of sexual gratification. **Amended under Rule 17(6). Further amended after a successful Rule 17(2)(g) application**

The Admitted Facts

10. At the outset of these proceedings, through his counsel, Mr Larkin, Dr Singh made admissions in respect of paragraph 1 and paragraph 21 of the Allegation, as set out above, in accordance with the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced this paragraph as admitted and found proved.

Factual Witness Evidence

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

   • Dr E, GP, provided a witness statement dated 2 May 2019. He also gave oral evidence at the hearing;
   
   • Patient A provided a witness statement dated 17 November 2017. She also gave oral evidence at the hearing;
   
   • Ms C provided a witness statement dated 13 July 2017. She also gave oral evidence at the hearing;
   
   • Ms C’s husband, Mr C, provided a witness statement dated 12 November 2017. He also gave oral evidence at the hearing;
   
   • Patient D provided a witness statement dated 24 August 2017. She also gave oral evidence at the hearing;
   
   • Mr F (previous Practice Manager at Hellesdon Medical Practice) provided a witness statement dated 12 October 2017.

12. Dr Singh provided his own witness statement dated 26 July 2019. He also gave oral evidence at the hearing.

Expert Witness Evidence

13. The Tribunal also received evidence from three expert witnesses. Dr G, a Consultant Psychiatrist, was called to give evidence by the GMC to assist the Tribunal in understanding the professional standards to be expected of a doctor working in psychiatry. Dr G provided three expert reports and also gave evidence via
Skype at the hearing. Dr H, a GP, was also called to give evidence by the GMC. She provided a report dated 11 November 2018 and a supplemental report, dated 24 April 2019 and also gave oral evidence at the hearing. Dr I, a GP, provided a report, dated 16 July 2019, to assist the Tribunal in understanding the professional standards expected of a GP. Dr H and Dr I also provided a supplemental joint report ('the joint report'), dated 2 September 2019.

**Documentary Evidence**

14. The Tribunal had regard to the further documentary evidence provided by the parties. This evidence included, but was not limited to, police statements from Patient A, Dr E, Ms C, Ms C's husband, Patient D and Mr F; transcripts of interview under caution with Dr Singh, Crown Court trial transcripts; medical records of Patient A; GP records of Patient D; and GP records of Child B.

**The Tribunal's Approach**

15. 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 Singh 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.

16. In determining parts of the Allegation in which Dr Singh is alleged to have 'failed' to do something, the Tribunal must be satisfied that he had a duty or an obligation to do it in the first place.

**The Tribunal’s Analysis of the Evidence and Findings**

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

**Patient A**

**Paragraph’s 13(b) & 14**

13. During the course of the First Telephone Call you inappropriately:

   b. told Patient A to:

      i. ‘feel both your breasts for any lumps’, or words to that effect;

      ii. examine her vagina for lumps.
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14. Your actions described at paragraph 13 above were not clinically indicated.

18. The Tribunal first considered Patient A’s evidence in relation to the context of the first telephone call. In her statement to the GMC, Patient A stated that Dr Singh said, ‘I want you to examine yourself and feel both of your breasts for any lumps... Dr Singh then asked me to feel around my vagina area for lumps and abnormalities’. The Tribunal noted that Patient A’s police statement is consistent with this account.

19. The Tribunal noted that Dr Singh does not recall the telephone conversations with Patient A, however he does not dispute that one or more telephone calls were made to her following her discharge from Millbrook. The Tribunal noted that Dr Singh can recall a conversation with his Consultant, Dr J, regarding the telephone calls with Patient A. In his statement to the GMC Dr Singh confirmed:

‘I cannot now recall the detail of my conversation with Dr J in 2000 but I do remember that he told me that Patient A’s GP had told him that she had complained about the content of a call or calls I had made to her since she left the hospital which she said had been of a sexual nature. He asked me if I called her. I told him I had and why but I denied that I had said or done anything of a sexual nature during the call(s), as I had not’.

20. The Tribunal next had regard to the evidence of Patient A’s GP, Dr E. In his statement to the GMC, Dr E recalled Patient A telling him about the phone calls she had received from Dr Singh. He stated, ‘I can recall that she told me that she had received several phone calls from Dr Singh. These calls were focused on sexual aspects of her relationship’. The Tribunal next had regard to Dr E’s contemporaneous medical note from the consultation with Patient A on 30 November 2000. The Tribunal noted that the medical notes indicate that it was at this consultation that Patient A mentioned the telephone calls to Dr E that Dr Singh had made to her. The medical note states:

‘Patient complaining that she has been telephoned on several occasions by Psych SHO (Dr Singh). Some of the comments suggest the calls were of a psycho-sexual nature and seemed inappropriate and there was also a suggestion of an inappropriate examination....’

21. Although the Tribunal has already found, in the course of this hearing, that Patient A was not a credible and reliable witness, it has taken a different position in relation to Dr E’s evidence and the contemporaneous notes on which it has attached significant credibility. Thus, although Dr E’s notes reflect second hand evidence from Patient A, the fact that action was taken as a result of the complaint, including Dr Singh being spoken to by his Consultant, Dr J, which resulted in in the calls ceasing, this established for the Tribunal that such calls were made. In all the circumstances, the Tribunal is satisfied that Dr Singh made one or more telephone calls to Patient A. The Tribunal noted that Dr Singh was a junior member of the team at Millbrook at
the point he discharged Patient A, having only been at Millbrook for some 8 weeks. The Tribunal considered that Dr Singh had appreciated that Patient A’s relationship was at the root of her mental health problems and he would have been concerned about discharging her without any medication following her admission for an overdose. The Tribunal therefore accepted the appropriateness of the telephone calls that Dr Singh made to Patient A following her discharge from hospital.

22. In relation to the context of the telephone conversations, the Tribunal noted that Dr E’s medical notes do not record the specific wording that Patient A alleged Dr Singh to have used during the telephone calls. When asked about the context of the telephone calls in his oral evidence to the Tribunal, Dr E maintained that Patient A was referring to a ‘future examination’ and that Patient A did not refer to an inappropriate physical examination that had already taken place. The Tribunal noted that Dr E’s note referencing the calls as of ‘psycho-sexual nature’ is not inconsistent with previous conversations that Dr Singh had, quite properly, recorded regarding Patient A’s relationship.

23. In relation to the specific words set out in the Allegation, the Tribunal again considered Patient A’s reliability in that Dr E’s account of the telephone calls came directly from Patient A. The Tribunal noted that Dr E’s notes do not support her recollection that the phone calls were around 20-30 minutes long. Further, the Tribunal had regard to the fact that whilst Patient A had first described feeling ‘violated’ and ‘gobsmacked’ in her earlier evidence, in her oral evidence to the Tribunal, she said she was ‘having a joke’ with Dr Singh. The Tribunal considered this made her account less credible. The Tribunal also referred to its previous findings that Patient A had been unreliable and not credible in relation to her allegations of inappropriate physical examinations of her by Dr Singh. The Tribunal determined that there was insufficient detail in Dr E’s note to support Patient A’s account of the telephone calls. Therefore, in all the circumstances, the Tribunal considered that the GMC had not adduced sufficient evidence to prove, on the balance of probabilities, that Dr Singh had asked Patient A to feel her breasts or vagina for lumps.

24. Accordingly, the Tribunal found paragraphs 13(b) and 14 not proved.

**Paragraph’s 16 and 17**

16. **During the course of the Second Telephone Call you told Patient A to examine her:**
   
a. breasts for lumps;
   
b. vagina for lumps.

17. **Your actions described at paragraph 16 above were not clinically indicated.**
25. The Tribunal noted that Patient A referred to a second telephone call from Dr Singh ‘a couple of weeks later, or possibly a month later’. In her statement to the GMC she said, ‘it was more or less the same sort of questions that he was asking and the same requests as the first telephone call’. The Tribunal had regard to the fact that Dr Singh does not recall either telephone conversation with Patient A but does not deny that he made ‘one or more’ telephone calls to her.

26. The Tribunal noted its earlier findings in relation to Patient A’s reliability and credibility in respect of this Allegation and in particular noted her evidence developing over time. The Tribunal noted that she referred to Dr Singh ‘groaning’ for the first time at the Crown Court trial which was not present in her police statement. In her oral evidence in front of this Tribunal, she made reference to ‘masturbation’. The Tribunal determined that Patient A’s recollection of events was unreliable. Having regard to its findings in respect of Allegation 13(b) and 14 above, the Tribunal considers therefore that the GMC have not adduced sufficient evidence to prove, on the balance of probabilities that Dr Singh had asked Patient A to examine her breasts or vagina for lumps.

27. Accordingly, the Tribunal found paragraphs 16 and 17, not proved.

**Patient D**

**Paragraph 19**

28. The Tribunal first had regard to Patient D’s symptoms leading up to her consultation with Dr Singh. In her witness statement to the GMC she confirms that she had ‘been ill in the days leading up to the consultation with Dr Singh…most of the time was spent ill in bed with a chesty cough, fever, shaking and cold symptoms’. The Tribunal considered the medical records of Patient D which were made by Dr Singh. They confirm that Patient D’s temperature was found to be raised and her chest and throat were clear. The Tribunal noted the GMC expert report by Dr H dated 11 November 2018 in which she stated, ‘In my opinion a chest examination was clinically indicated on 16/01/2015 because Patient D presented with a cough’. In the joint expert report prepared by Dr H and Dr I, the defence expert, both agree that the examination of the chest and heart sounds was appropriate given Patient D’s symptoms.

29. The Tribunal had regard to Patient D’s account of the chest examination. In her statement to the GMC she stated:

‘…Dr Singh then said he was going to listen to my chest. I was wearing my work top which was a polo shirt…Dr Singh told me to unbutton my top so I unbuttoned three buttons of my top. Dr Singh was stood up about half an arm’s length away from me. He was slightly to the side of me. He slipped his left hand down my shirt and under my strappy top. His hand went into the top of my bra. I felt the fingers on the nipple of my left breast. He pulled my
breast up and it went a good half way up out of my bra. I could see that my
nipple was above the bra. I could see this as I looked down my polo top. All
four of his fingers were on my breast and one finger was on my nipple. Dr
Singh used his right hand to place the stethoscope completely over my
nipple...’

30. The Tribunal found Patient D to be a straightforward and credible witness
who did not appear prone to exaggeration. The Tribunal noted that, where Patient D
could not recollect certain details she told the Tribunal this, rather than developing
her previous evidence. Patient D’s police statement, GMC statement and the
evidence that she gave at the Crown Court were generally consistent. The Tribunal
did note that in a couple of respects, Patient D had clarified her evidence. For
example, in relation to the touching of her nipple, in her evidence to the Tribunal,
she qualified her account by stating that it could have been her ‘areola’ rather than
her nipple. Further, in her police statement, she referred to Dr Singh’s ‘fingertips’
being inside her bra. When questioned by Ms Hudson, in her oral evidence at this
hearing, the Tribunal considered that her evidence had developed slightly as she
stated, ‘his fingers were in the bra up to the central knuckle’.

31. The Tribunal then noted Dr Singh’s evidence. He stated that during the
examination he placed his left hand, palm facing downwards, inside the top. He
stated that he used his fingers to raise the breast of Patient D so that he could
access the point at which he could hear the heart. Whilst occasionally unfocused in
his oral evidence, the Tribunal found Dr Singh to be a generally credible and frank
witness. Whilst it noted inconsistencies and development of his earlier evidence over
time, the Tribunal did not agree with the GMC’s submission that Dr Singh has
modified his evidence and been inconsistent throughout. For example, during his
interview under caution with the police, very shortly after the index event, Dr Singh
did not challenge Patient D’s account of the chest examination. He states:

‘It’s her body, it’s her breast and I’m sure what she’s saying is right, you
know, however I understand I was, my job was basically to listen to her heart
sound. In doing do I was not because, I was not expecting to completely
undress her, you know, but to make skin to skin contact I have to listen to
her chest and he hear sound which I’m intending to listen to is, as I said, you
know I was aiming to listen, put my stethoscope, just below her nipple so
that I can have a clear listening of that, ok and to reduce her inconvenience,
you know...’

32. The Tribunal also noted that whilst not agreeing with the timing and reason
for Patient D’s distress, Dr Singh confirmed that she did start crying during the
consultation.

33. The Tribunal also noted the GMC case that Dr Singh’s conduct in the
examination of Patient D was inappropriate, not in so much as it was clumsy but that
it was sexually motivated. The GMC submitted that their case was supported by the inconsistencies in his evidence, the lack of a credible justification for the technique he used and indication of ‘covering up’ or obscuring the reasons for Patient D’s distress during the consultation.

34. The Tribunal had regard to the expert’s opinion of the overall technique which was adopted by Dr Singh during this examination. In her report, dated 11 November 2018, Dr H stated, ‘the description given in the statement from Patient D... of the examination carried out is consistent with a chest examination from the back and an examination of the heart from the front because it is necessary sometimes to lift the left breast to hear the heart sounds and this is common practice’. In her oral evidence to this Tribunal, she noted that the technique that Dr Singh adopted by going in from the top downwards was ‘unusual’. When questioned by the Tribunal, Dr H offered a number of techniques that could be used to listen to the chest and heart sounds. She confirmed that if you approach downwards from the top, there is more breast tissue in the way. In his report, Dr I agrees with Dr H by stating ‘it is necessary sometimes and indeed common practice, to lift the breast in order to hear the heart sounds’. Dr I went on to confirm, ‘the breast can be moved in several ways. In my opinion, there is no correct way for this to be done and a practitioner will develop their own technique with the benefit of experience’.

35. The Tribunal noted the reasons why Dr Singh had chosen this technique. The Tribunal noted the stage of GP training that Dr Singh was at and his understandable anxiousness to pass the impending Annual Review of Competence Progression review. Given the ten minutes allocated for a consultation, it accepted that he would wish to practice completing his consultation within that time and would wish to adopt any practises or techniques that assisted. The Tribunal recalled Dr Singh’s evidence that his GP trainer, Dr M, had previously told him to ensure the stethoscope is placed on the skin rather than listening to the heart sounds over the patient’s clothes. The Tribunal considered any evidence to support this assertion and counter any indication of recent invention. It noted the unprompted information that Dr Singh provided at the police interview where he stated, ‘Well, so I, generally, you know, the stethoscope has to be in touch with the skin, ok’. Dr Singh had also described at the Crown Court trial that he had asked his peers about the best way carry out this type of examination. He stated that his female colleagues had described going from the top, downwards as the best technique to use. The GMC’s case is that Dr Singh had adopted this technique for sexual gratification. Taking the expert evidence into consideration, along with Dr Singh’s reasoning for this technique, the Tribunal did not accept the GMC’s submission. The Tribunal preferred Mr Larkin’s contention that Dr Singh felt under time pressure, didn’t fully explain what he was about to do in relation to a heart examination and ‘didn’t do it well’.

36. The Tribunal examined the GMC’s contention that Dr Singh had sought out Dr M after the consultation in order to ‘get in first’ his reason for Patient D’s distress. The Tribunal noted however that this was not a specially arranged meeting with Dr
M but was a routine, daily de-brief as part of Dr Singh’s GP training, together with two other such trainees.

37. Having analysed the expert opinions of the overall technique adopted by Dr Singh in respect of the chest examination the Tribunal went on to consider the appropriateness of the individual elements of the examination.

19. On 16 January 2015, you consulted Patient D and during the examination you inappropriately:

   a. inserted your fingers into Patient D’s:

       i. top;

38. Having considered the statement of Patient D and the account given by Dr Singh, the Tribunal agreed that it is not disputed that Dr Singh’s fingers were placed inside Patient D’s top for the purposes of conducting the chest examination. Both Dr H and Dr I agree that examination of the front of the chest usually involves putting fingers into a patient’s top and Patient D explained that she undid the buttons of her top to allow this to take place. It took the view that, as the examination was clinically indicated, Dr Singh’s actions in placing his fingers inside Patient D’s top were not below the standard expected of a reasonably competent practitioner.

39. In light of the above evidence, the Tribunal determined that Dr Singh’s actions in inserting his fingers into Patient D’s top was not inappropriate. Accordingly, it found allegation 19(a)(i) not proved.

19. On 16 January 2015, you consulted Patient D and during the examination you inappropriately:

   a. inserted your fingers into Patient D’s:

       ii. bra;

40. The Tribunal reminded itself of Patient D’s account of the consultation. In his report, Dr I stated that, as Dr Singh had placed his fingers over the upper left chest, this would involve coming into contact with some breast tissue. In his opinion this ‘could have led to Dr Singh’s fingers being placed inside the upper part of Patient D’s bra’. The Tribunal had regard to the joint expert report in which both doctors agree that fingers may go into the top of the patient’s bra when examining the heart and this would not be below the standard expected of a reasonably competent general practitioner unless repeated.
41. The Tribunal next considered the expert comments in relation to the degree in which the fingers are inserted into the bra. Both experts agree that it should be minimal and proportionate. They confirm that, whereas excessive intentional insertion of fingers would be below the standard, excessive accidental insertion of the fingers into a bra would not be below the standard expected of a reasonably competent practitioner. In her oral evidence to the Tribunal, Patient D referred to Dr Singh’s middle knuckle being placed inside her bra but the Tribunal considered this to be a slight development of her previous evidence. In all the circumstances, the Tribunal did not consider that, on balance, there was sufficient reliable evidence to indicate that Dr Singh placed his fingers inside Patient D’s bra to an excessive or disproportionate degree. Therefore, it did not find the GMC to have discharged its burden of proof in respect of this allegation. Accordingly, it found paragraph 19(a)(ii) of the Allegation not proved.

19. On 16 January 2015, you consulted Patient D and during the examination you inappropriately:
   b. pulled Patient D’s left breast out of her bra to expose her nipple;

42. The Tribunal had regard to both Patient D and Dr Singh’s account of the chest examination. Given the evidence provided, it considers it probable that Dr Singh pulled patient D’s left breast out of her bra and her nipple became exposed. The Tribunal had regard to the joint expert report where both experts agree that this may have happened accidentally depending on the breast anatomy and the bra worn. They agreed that that this would not fall below the standard expected of a reasonably competent general practitioner unless repeated. The Tribunal bore in mind Patient D’s description of the bra that she was wearing and her confirmation that, due to its design, her breast could have been positioned higher than usual. The Tribunal took the view that the likelihood of the nipple being exposed during examination was consequently higher. The Tribunal determined that, in the context of this method of examining the heart, Dr Singh’s actions were not inappropriate. Accordingly, the Tribunal found paragraph 19(b) not proved.

19. On 16 January 2015, you consulted Patient D and during the examination you inappropriately:
   c. touched Patient D’s:
      i. left breast;

43. The Tribunal noted that Dr Singh has not denied that his left hand was on Patient D’s breast. It had regard to the joint expert report in which both experts agreed that any examination of the left side chest may involve touching the left breast but that this should be minimal and proportionate. Patient D describes the touching of her left breast as a ‘groping’. However, the Tribunal noted that, in her oral evidence, Patient D explained that we ‘wouldn’t be here today’ if Dr Singh had
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explained what he was going to do to her. This was consistent with the evidence she gave at the Crown Court where she stated:

‘had it been explained properly that the examination entailed going inside [her] bra, maybe [she] would not have felt so shocked but nothing having been explained in terms of touching her breast, it obviously came as a shock.’

44. The Tribunal took the view that Patient D had conceded that she did not think the touching of the breast was inappropriate or disproportionate, it was the fact that Dr Singh had not communicated his actions to her as to why she was so shocked and upset. Accordingly, the Tribunal found paragraph 19(c)(i) not proved.

19. On 16 January 2015, you consulted Patient D and during the examination you inappropriately:

  c. touched Patient D’s:

    ii. left nipple;

45. Given that the stethoscope touching the nipple is the subject of allegation 19(d), the Tribunal have treated this allegation as being Dr Singh’s finger touching Patient D’s nipple. The Tribunal noted that Patient D’s police statement does not make reference to Dr Singh’s finger being on the nipple. However, in her statement to the GMC she states, ‘one finger was on my nipple’. The Tribunal bore in mind Patient D’s response when asked about this under cross-examination. Patient D qualified her answer by stating that by nipple, she could have been referring to her ‘areola’. The Tribunal considered this concession on Patient D’s part as further evidence of her credibility and straightforwardness as a witness. At the same time, in the context of the left hand going into the bra, the Tribunal took the view that the areola is distinctly separate to the nipple. Accordingly, the Tribunal found paragraph 19(c)(ii) not proved.

19. On 16 January 2015, you consulted Patient D and during the examination you inappropriately:

  d. placed the stethoscope over Patient D’s left nipple.

46. The Tribunal noted that Patient D’s GMC witness statement, police statement and evidence she gave to the Crown Court in respect of Dr Singh placing the stethoscope over Patient D’s left nipple are consistent. The Tribunal had regard to the fact that Dr Singh did not refute that this could have happened. In her report, Dr H gives the opinion that placing the stethoscope of the nipple, although unusual, was not inappropriate if this was where Dr Singh could hear the heart sounds. In his report, the defence expert, Dr I agreed with Dr H
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The Tribunal placed greater weight on the joint expert report as this report was prepared in the light of greater detail. In this report it states:

‘Both experts agree that it is not usual practice to place the stethoscope over the nipple to listen to the chest and heart but if this was where the heart sounds could be heard then it would not be below the standard expected of a reasonably competent general practitioner’.

47. The Tribunal agreed with the experts and determined that although the technique was unusual, it was not inappropriate. Accordingly, and having regard to all its earlier conclusions in relation to the general appropriateness of this examination, the Tribunal found paragraph 19(d) of the Allegation not proved.

Paragraph 20

48. The Tribunal had regard to its findings in respect of paragraph 19(a-d) and noted that save for the touching of Patient D’s left nipple, it determined that Dr Singh had examined Patient D in the manner described in the Allegation. The Tribunal also noted that it had found the examination technique used was appropriate.

20. In respect of your conduct described at paragraph 19 above, you failed to:

a. obtain Patient D’s consent;

49. The Tribunal noted that Patient D and Dr Singh’s accounts are consistent in that they state that Dr Singh touched Patient D’s left breast. Although Dr Singh has asserted that he did not intend to intend to ‘manhandle’ the breast, the Tribunal is of the view that touching the breast is the inevitable result of this method of examination. Dr Singh has stated that his intention was to locate the apex beat and listen to the heart sounds. The Tribunal had regard to Dr Singh’s comment under police caution where he states:

‘The only thing perhaps, which will be my kind of, you know something learning from here is that, you know perhaps tell people that while I’m listening to your chest might end up touching your nipple. So, they may be forewarned, you know’.

50. The Tribunal had regard to the expert evidence in relation to consent. In her report, Dr H referred to the unbuttoning of Patient D’s polo top buttons as ‘implied consent’ and this would be adequate for a ‘usual’ chest examination. However, she goes on to state that:

‘if Patient D’s description of the examination is accepted, then in her opinion ‘Dr Singh did not obtain consent for the examination because he did not mention his intention to handle the breast and a reasonably competent practitioner
would know that a female patient would expect to be asked for consent before her breast was handled.’

51. The Tribunal considered Dr I’s report. Whilst he repeats and agrees with Dr H’s opinion that unbuttoning the top could be sufficient implied (or informal) consent for a ‘usual’ chest examination from the front, he does not discuss the appropriateness of consent in relation to the touching of the breast but only mentions the touching of the nipple. The Tribunal noted that in the joint report there is again no reference to the appropriateness or otherwise of the touching of the breast in the context of consent.

52. The Tribunal next had regard to the GMC guidance ‘Intimate examination and chaperones’. Paragraph 3 of the guidance states:

‘Intimate examinations can be embarrassing or distressing for patients and whenever you examine a patient you should be sensitive to what they may think of as intimate. This is likely to include examinations of breasts, genitalia and rectum, but could also include any examination where it is necessary to touch or even be close to the patient’

53. In all the circumstances, the Tribunal preferred the more cautious approach to obtaining consent advanced by Dr H. The Tribunal determined that, given that the technique used by Dr Singh meant that he would inevitably touch an intimate area, he had a duty to obtain informed consent from Patient D and her implied consent in unbuttoning the shirt was not sufficient. Accordingly, the Tribunal found paragraph 20(a) of the Allegation proved.

20. In respect of your conduct described at paragraph 19 above, you failed to:

b. offer Patient D a chaperone;

54. It is alleged that Dr Singh had a duty to offer Patient D a chaperone and he failed to do so.

55. The Tribunal had regard to the expert opinion on this matter. Both experts agree that it is not usual to offer a chaperone for a chest examination. However, both experts agree that, if Dr Singh’s intention was to feel the breast, to a ‘degree beyond the usual peripheral touch’ and this was not incidental, then a chaperone should have been offered and his actions would fall seriously below the standard expected.

56. The Tribunal considered the GMC guidance, ‘Intimate examination and chaperones’. In relation to chaperones paragraph 8 states:
‘When you carry out an intimate examination you should offer the patient the option of having an impartial observer (a chaperone) present wherever possible’.

57. The Tribunal also had regard to Dr Singh’s GMC witness statement in which he states that it was not his usual practice to offer a chaperone to female patients for a chest or heart examination that did not involve the removal of clothing. Dr Singh went on to state, ‘with hindsight, however, in my view of the way I did this examination on that day, I should have considered that the patient herself might perceive the examination to be an intimate one, even if I did not.’ Although the Tribunal accept that Dr Singh might not have considered it necessary at the time, the Tribunal considered that, based on the GMC guidelines, it was something that he could reasonably have been expected to consider given the examination technique he used.

58. In all the circumstances, the Tribunal determined that, as Dr Singh’s technique for the examination inevitably involved handling the breast, he had a duty to offer a chaperone to Patient D. Accordingly, the Tribunal found paragraph 20(b) of the Allegation proved.

**Paragraph 22**

59. The Tribunal determined that Dr Singh failed to obtain appropriate consent from Patient D. It also found that Dr Singh had a duty to offer Patient D a chaperone and failed to do so. As paragraph 22 refers to ‘in the alternative of paragraph 20’, paragraph 22 of the Allegation is found not proved.

**Paragraph 23**

60. The Tribunal found paragraphs 13, 16 and 19 not proved. Accordingly, paragraph 23 of the Allegation is not proved.

**The Tribunal’s Overall Determination on the Facts**

61. The Tribunal has determined the facts as follows:

**Patient A**

1. At all material times Patient A was vulnerable due to a mental health condition. **Admitted and found proved**

2. On 10 October 2000, you consulted Patient A whilst she was an in-patient at the Kings Mill Hospital (‘the Hospital’), and you inappropriately:
   a. touched her:
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i. _______ down her neck and shoulder;
ii. _______ on her chest area;
iii. _______ between her breasts;
iv. _______ belly button;
v. _______ on her pubic area;
vi. _______ on her buttock area;
b. ______ leaned your right hand and/or arm on her right breast;
e. ______ used your right hand to grab her left breast;
d. ______ grabbed both of her breasts over her bra;
e. ______ inserted your finger into her:
   i. trousers;
   ii. underwear;
f. ______ placed your right hand on her buttocks;
g. ______ moved your hands around her back;
h. ______ told Patient A you were ‘checking for weapons’, or words to that effect.

Deleted after a successful Rule 17(2)(g) application

3. ______ You failed to:
   a. ______ offer Patient A a chaperone;
   b. ______ obtain consent to undertake your physical examination of
      Patient A as described at paragraphs 2a-2g above;
   c. ______ adequately communicate with Patient A with regards to the
      content of your examination;
   d. ______ make a record of your examination of Patient A as described at
      paragraphs 2a-2g above.

Deleted after a successful Rule 17(2)(g) application

4. ______ Your actions as described at paragraph 2 were not clinically indicated.
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Deleted after a successful Rule 17(2)(g) application

5. In the alternative to paragraph 4 above you failed to make an adequate record as to why these elements of your examination were clinically indicated.

Deleted after a successful Rule 17(2)(g) application

6. On 12 October 2000, you consulted Patient A whilst she remained an in-patient at the Hospital, and you inappropriately:

   a. touched Patient A:
      i. down her neck and shoulder;
      ii. on her chest area;
      iii. between her breasts;
      iv. on her buttock area;

   b. squeezed each of her breasts;

   c. moved your hands around her back;

   d. inserted your hand inside her:
      i. trousers;
      ii. underwear;

   e. used your little finger to touch her pubic hair;

   f. said to Patient A:
      i. you were ‘checking for weapons’, or words to that effect;
      ii. ‘no one would believe her’ or words to that effect;

   g. asked Patient A if she was sexually active with her partner.

Deleted after a successful Rule 17(2)(g) application

7. Your actions described at paragraph 6 above were not clinically indicated.

Deleted after a successful Rule 17(2)(g) application

8. You failed to:
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a. offer Patient A a chaperone;

b. adequately communicate with Patient A in that you failed to address her concerns about the appropriateness of the examination;

c. obtain consent to undertake your physical examination of Patient A as described at paragraphs 6a-6e above;

d. make a record of your examination of Patient A as described at paragraphs 6a-6e above.

Deleted after a successful Rule 17(2)(g) application

9. On 23 October 2000, you consulted Patient A in an outpatient clinic at the Hospital, and you inappropriately:

a. touched Patient A:
   i. down her neck and shoulder;
   ii. on her chest area;
   iii. between her breasts;
   iv. on her right breast;

b. inserted your right hand inside her top;

c. felt and/or cupped her right breast with the palm of your right hand;

d. used your thumb and finger to touch her left nipple;

e. said to Patient A ‘tell them if you want, nobody would believe you’ or words to that effect;

f. asked Patient A ‘whether she was sexually active with her partner’ and/or ‘whether her partner suffered with impotence’ or words to that effect.

Deleted after a successful Rule 17(2)(g) application

10. Your actions described at paragraphs 9 above were not clinically indicated.

Deleted after a successful Rule 17(2)(g) application

11. You failed to:
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a. offer Patient A a chaperone;

b. adequately communicate with Patient A in that you failed to address her concerns about the appropriateness of the examination;

c. obtain consent to undertake your physical examination of Patient A as described at paragraphs 9a-9d above;

d. make an adequate note of your physical examination of Patient A as described at paragraphs 9a-9d above.

Deleted after a successful Rule 17(2)(g) application

12. In or around November, On a date between 23 October 2000 and 6 November 2000 you telephoned Patient A ('the First Telephone Call') and you failed to make an adequate record of that call, inappropriately: Amended (by way of two separate applications) under Rule 17(6).

Deleted after a successful Rule 17(2)(g) application

12.13. During the course of the First Telephone Call you inappropriately:

Amended under Rule 17(6)

a. asked whether Patient A was:

   i. ‘at home-alone’ or words to that effect;

   ii. ‘sitting or standing up’ or words to that effect;

Deleted after a successful Rule 17(2)(g) application

b. told Patient A to:

   i. ‘feel both your breasts for any lumps’, or words to that effect; Found not proved

   ii. examine her vagina for lumps. Found not proved

13.14. Your actions described at paragraph 132 above were not clinically indicated. Amended under Rule 17(6). Found not proved

14. You failed to make an adequate record of your telephone call to Patient A as described at paragraph 12 above. Amended under Rule 17(6).
15. In approximately On a further date between 23 October 2000 and 6 November December 2000, you telephoned Patient A ('the Second Telephone Call') and you failed to make an adequate record of that call told her to examine her: Amended (by way of two separate applications) under Rule 17(6)

Deleted after a successful Rule 17(2)(g) application

15.16. During the course of the Second Telephone Call you told Patient A to examine her: Amended under Rule 17(6)

a. breasts for lumps; Found not proved

b. vagina for lumps. Found not proved

16.17. Your actions described at paragraph 165 above were not clinically indicated. Amended under Rule 17(6). Found not proved

17. —— You failed to make an adequate record of your telephone call to Patient A as described at paragraph 15 above. Amended under Rule 17(6)

Child B / Ms C

18. On 21 May 2014, you consulted Child B and during the Consultation you:

a. —— spoke to Ms C in an inappropriate manner;

b. —— intentionally slid your hand across the left breast of Ms C.

Deleted after a successful Rule 17(2)(g) application

Patient D

19. On 16 January 2015, you consulted Patient D and during the examination you inappropriately:

a. inserted your fingers into Patient D’s:

i. top; Found not proved

ii. bra; Found not proved

b. pulled Patient D’s left breast out of her bra to expose her nipple;

Found not proved

c. touched Patient D’s:
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i. left breast; **Found not proved**

ii. left nipple; **Found not proved**

d. placed the stethoscope over Patient D’s left nipple. **Found not proved**

20. In respect of your conduct described at paragraph 19 above, you failed to:

a. obtain Patient D’s consent; **Found Proved**

b. offer Patient D a chaperone; **Found Proved**

c. adequately communicate with Patient D your intention to touch her breast and/or nipple. **Amended under Rule 17(6)**

21. You failed to adequately communicate with Patient D the way you intended to examine her. **Amended under Rule 17(6). Admitted and found proved**

21.22. In the alternative to paragraph 20 above, you failed to make an adequate record of: **Amended under Rule 17(6)**

a. any consent obtained; **Found not proved**

b. the offer of a chaperone. **Found not proved**

22.23. Your conduct as described at paragraphs 2, 6, 9, 132, 165, 18b and 19a-19d was sexually motivated as it was in pursuit of sexual gratification. **Amended under Rule 17(6). Further amended after a successful Rule 17(2)(g) application. Found not proved**

**Determination on Impairment - 03/10/2019**

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 Singh’s fitness to practise is impaired by reason of misconduct.

**The Evidence**

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

3. In addition, the Tribunal received testimonials from the following witnesses on Dr Singh’s behalf:
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- Dr K, a Psychiatry Speciality Doctor;
- Dr L, a Consultant Forensic Psychiatrist.

Submissions

On behalf of the GMC

4. Ms Hudson submitted that Dr Singh’s actions amounted to serious misconduct and his fitness to practise is currently impaired. She referred to ‘Good Medical Practice’ (2013) (‘GMP’) and the GMC’s ‘consent and chaperone guidance’ and stated that it is Dr Singh’s responsibility to be familiar with the guidance and ensure that it is followed. She submitted that Dr Singh failed to establish a good relationship with Patient D, failed to adequately communicate with her and lacked empathy when she became distressed.

5. Ms Hudson reminded the Tribunal of Dr H’s expert evidence in which she stated that if Patient D’s account was accepted and there was not adequate communication from Dr Singh in respect of how he was going to examine her heart, this fell seriously below the standards expected of a reasonably competent doctor. In relation to obtaining consent, she submitted that Dr Singh should have been aware his technique would inevitably cause him to touch Patient D in an area that she might consider intimate. Further, in relation to Dr Singh’s failure to offer a chaperone, Ms Hudson submitted that this showed a complete lack of regard for Patient D and this fell seriously below the standard expected of a reasonably competent practitioner.

6. Ms Hudson acknowledged that Dr Singh has accepted, in his witness statement, that with hindsight he should have offered a chaperone and has apologised for his poor communication with Patient D. She reminded the Tribunal that they will need to assess Dr Singh’s level of insight and any action that he has taken to remediate his mistakes. She stated that there were a series of errors in the consultation with Patient D and reminded the Tribunal to take account of the need to promote and maintain public confidence in the profession and the need to reaffirm to doctors and to the public the standard of conduct that is expected.

On behalf of Dr Singh

7. Mr Larkin submitted that Dr Singh’s conduct did not amount to serious misconduct. He stated that, although the examination had been carried out in a ‘clumsy’ manner, Dr Singh’s intention was to avoid the breast in its entirety. He submitted that this one-off incident does not amount to serious misconduct.

8. Mr Larkin referred the Tribunal to Dr Singh’s GMC witness statement, where Dr Singh has clarified his understanding of the GMC guidance in relation to consent
and chaperones during intimate examinations. Mr Larkin submitted that Dr Singh regrets failing to communicate with Patient D and referred to Dr Singh’s interview with the police in which Dr Singh describes the incident as a ‘learning point’. He stated that Dr Singh apologised to Patient D at the earliest opportunity and submitted that that this is evidence that he has learnt from this experience.

9. Mr Larkin stated that the Crown Court trial, together with these proceedings, have had a devastating effect on Dr Singh’s personal and professional life and because of XXX, there has been less of an opportunity for him to demonstrate remediation. He referred to the positive testimonials on behalf of Dr Singh and told the Tribunal that Dr Singh has been offered a substantive post in psychiatry, dealing with primarily male patients.

10. Mr Larkin concluded by submitting that, when the case examiners considered this case, the issue of impairment was aligned to the sexual allegations. They considered that Dr Singh’s inept technique and inadequate communication on one occasion would not provide a realistic prospect of a finding of impairment.

The Relevant Legal Principles

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

12. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted:

   a. First, whether the facts as found proved amounted to misconduct and that the misconduct was serious;
   b. Second, whether the finding of that misconduct could lead to a finding of impairment. (GMC v Cheatle [2009] EWHC 645 [Admin])

13. The Tribunal had particular regard to the cases of Calhaem v GMC [2007] EWHC 2606 in which the court held that mere negligence does not constitute misconduct albeit ‘depending upon the circumstances, negligent acts or omissions that are particularly serious may amount to misconduct’. The Tribunal also took account of Roylance v GMC [2000] 1 AC 311 in which Lord Clyde stated that misconduct is conduct that brings the profession into disrepute and it must be serious. It was also mindful of Meadow v GMC [2007] 1 AER 1 in which it is stated that misconduct could not be viewed as anything less than serious professional misconduct.

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

The Tribunal’s Determination on Impairment

Misconduct

15. The Tribunal reminded itself that it had not found any sexual motivation
proven in relation to the Allegation against Dr Singh. The Tribunal also bore in mind
Dr Singh’s admissions in respect of his failure to adequately communicate with
Patient D.

16. The Tribunal had regard to the following paragraphs of the GMC guidance,
‘Intimate examinations and chaperones (2013)’:

3 Intimate examinations can be embarrassing or distressing for patients
and whenever you examine a patient you should be sensitive to what
they might think of as intimate. This is likely to include examinations of
breasts, genitalia and rectum, but could also include any examination
where it is necessary to touch or even be close to the patient.

5 Before conducting an intimate examination, you should:

a. explain to the patient why an examination is necessary
   and give the patient an opportunity to ask questions

b. explain what the examination will involve, in a way the
   patient can understand, so that the patient has a clear idea of
   what to expect, including any pain or discomfort

c. get the patient’s permission before the examination and
   record that the patient has given it

d. offer the patient a chaperone.’

17. The Tribunal next had regard to the expert evidence in relation to how those
guidelines should be applied in practice. In her report, dated 11 November 2018, Dr
H stated the following:

‘If Patient D’s description of the examination is accepted then in my opinion
Dr Singh did not obtain consent for the examination because he did not
mention his intention to handle the breast and a reasonably competent
general practitioner would know that a female patient would expect to be
asked for consent before handling Patient D’s breast. In my opinion, Dr
Singh’s actions in not obtaining consent before handling Patient D’s breast
inside her bra were seriously below the standard expected of a reasonably competent general practitioner.

In my opinion, if Patient D’s account is accepted adequate communication at the consultation on 16/01/2015 would have included an explanation of why and how Dr Singh was going to examine Patient D’s heart. In my opinion if this was not done and Patient D’s statement that she had no warning that Dr Singh was going to put his left hand on her breast is accepted then Dr Singh’s actions fell seriously below the standard expected of a reasonably competent general practitioner as this could cause distress, embarrassment and upset to a patient.

In my opinion, if the examination was carried out as described by Patient D...then Dr Singh should have offered a chaperone because he handled her breast and nipple and this in my opinion would be considered an intimate examination. If Dr Singh did not offer a chaperone to Patient D then in my opinion his actions fell seriously below the standard expected of a reasonably competent general practitioner.

18. The Tribunal noted the view of the defence expert, Dr I, that Dr Singh’s, ‘failure to explain to Patient D how he was going to conduct the examination fell below the standard of a responsible practitioner’. He did not agree with Dr H that it fell seriously below. The Tribunal also noted in the joint expert report, the view that whilst touching the breast and failing to communicate an intention to examine in that area might amount to seriously falling below the appropriate standard, the level of fault turned on the degree and extent of the intended touching.

19. The Tribunal was particularly struck by Dr H’s opinion in relation to chaperoning which the Tribunal considered apposite in relation to consent also. She stated:

‘The difference between an examination which did or did not require a chaperone can be subtle and vary between patients and their perceptions. This is usually dealt with by communication skills of a general practitioner explaining what they were doing and why, combined with their knowledge and observations of their patient’.

20. The Tribunal noted the fact that Dr Singh has admitted, from the outset and consistently thereafter, his failure to adequately communicate with Patient D. The Tribunal reminded itself of Patient D’s oral evidence in which she commented that if Dr Singh had adequately explained what he was going to do before the examination and offered ‘another person’(a chaperone) then, ‘we wouldn’t be here today’. The Tribunal considered this to emphasise the importance of good, effective communication between the doctor and patient and that had he fully explained his intended examination, her consent was likely to have been forthcoming.
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21. The Tribunal noted its earlier findings, namely that Dr Singh had conducted an appropriate and clinically indicated examination. However, notwithstanding Dr Singh’s evidence that he had not intended the examination to be intimate, the Tribunal determined that the technique used by Dr Singh, and described as ‘unusual’ by Dr H, meant that he would inevitably touch an area that Patient D might consider intimate. On the basis of GMP and the expert reports, the Tribunal was satisfied that Dr Singh’s failure to adequately communicate with Patient D, obtain consent and offer a chaperone fell seriously below the standard of a competent GP.

22. Whilst the Tribunal has found Dr Singh’s conduct to be seriously below the expected standard, each of the elements of the Allegation found proved are interrelated and concern a single examination of a single patient on a single occasion. It determined that he had conducted it in an inept manner but with good intent and attempted consideration for the patient’s dignity in that he was trying to avoid her having to undress. It considered therefore, his failings in relation to the issue of communication, obtaining consent and offering a chaperone in the context of a well-intentioned but clumsy and rushed examination. In all the circumstances and taking into account the legal principles set out earlier, the Tribunal concluded that this places Dr Singh’s conduct at the lower end of the spectrum so as not to amount to misconduct.

23. Having determined that the facts in this case do not amount to misconduct, the Tribunal has accordingly determined that Dr Singh’s fitness to practise is not impaired.

Determination on Warning – 03/10/2019

1. The Tribunal determined that the facts found proved did not amount to misconduct and, as such, Dr Singh’s fitness to practise was not impaired. The Tribunal invited submissions from the parties as to whether a warning was required, in accordance with s35D (3) of the Medical Act 1983.

GMC Submissions

2. Ms Hudson referred the Tribunal to the ‘Guidance on Warnings’ document (February 2018) (‘the warnings guidance’), and submitted that a warning is necessary in this case as there had been significant departures from GMP and the ‘consent and chaperone’ guidance. She submitted that a warning will operate as a necessary deterrent to ensure that this kind of behaviour is not repeated.
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Submissions on Dr Singh’s behalf

3. Mr Larkin submitted that Dr Singh’s conduct was not conduct that falls just short of the threshold for a finding of impaired fitness to practise. He submitted that as there was no misconduct in this case it does not meet the threshold for a warning. He stated that the Tribunal should also consider the mitigating factors in this case as set out in the guidance. Mr Larkin submitted that Dr Singh met all of these.

The Tribunal’s Determination on Warning

4. In making its decision the Tribunal exercised its own judgement. It took account of the specific circumstances of this case and had regard to the submissions provided by both parties.

5. The Tribunal had regard to the warnings guidance including the test at paragraph 16:

'A warning will be appropriate if there is evidence to suggest that the practitioner’s behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstances:

- there has been a significant departure from Good medical practice...

6. The Tribunal took account of the fact that warnings are a serious response for concerns that fall below the threshold for a finding of impaired fitness to practise. Warnings may have the effect of highlighting to the wider profession that such conduct or behaviour is unacceptable. The Tribunal found that there had been a significant departure from the principles set out in the GMC guidance.

7. The Tribunal then had regard to paragraph 33 of the warnings guidance which states:

'33 However, if the decision makers are satisfied that the doctor’s fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of aggravating or mitigating factors to determine whether a warning is appropriate. These might include:

The level of insight into the failings:

a. A genuine expression of regret/ apology.
b. Previous good history.
c. Whether the incident was isolated or whether there has been any repetition.
d. Any indicators as to the likelihood of the concerns being repeated.
8. The Tribunal noted that this was an isolated incident and had regard to Dr Singh’s genuine apology to Patient D at the Crown Court and at these proceedings. They also had regard to the testimonial provided by Dr L in which he stated ‘the colleagues feedback provided for his annual appraisals in 2017 and 2018 are extremely positive and commented favourably on his ability to work collaboratively with the team and attested to his empathy and warmth towards his patients’. In relation to paragraph 33(e), the Tribunal also noted the communication skills training that Dr Singh had successfully completed. The Tribunal determined that there was no likelihood of repetition in this case and could identify no aggravating factors.

9. The Tribunal has therefore determined not to impose a warning on Dr Singh’s registration.

10. XXX

11. That concludes this case.

Confirmed
Date 03 October 2019 Mr Lindsay Irvine, Chair
Application to amend the Allegation

1. On behalf of the GMC, Ms Hudson made an application under Rule 17(6) of the Rules, to amend paragraphs 12 and 15 of the Allegation as follows:

12. In or around November On a date between 23 October 2000 and 6 November 2000, you telephoned Patient A (‘the First Telephone Call’) and you failed to make an adequate record of that call.

15. In approximately On a further date between 23 October 2000 and 6 November December 2000, you telephoned Patient A (‘the Second Telephone Call’) and you failed to make an adequate record of that call.

2. Ms Hudson submitted that, in light of the evidence from Patient A and Dr E, the dates at paragraphs 12 and 15 should be amended to make the allegation more precise. She submitted that it would be fair and reasonable to amend the dates to ensure the charge is accurate and submitted that the amendments could be made without any injustice to Dr Singh.

3. On behalf of Dr Singh, Mr Larkin submitted that the defence team had already raised this issue with the GMC and that the GMC have had plenty of time to amend the allegation prior to the evidence being heard. However, he conceded that the amendments could be made without any injustice to Dr Singh.

The Tribunal’s decision

4. 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.’

5. The Tribunal had regard to Patient A and Dr E’s evidence and the medical notes from his consultations with Patient A in relation to the timing of the phone
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calls set out in the allegation. It has also taken into account Mr Larkin’s concession that the amendments to the allegation could be made without injustice.

6. The Tribunal determined that the amendments were appropriate in the light of the written and oral evidence adduced by the GMC and determined that paragraphs 12 and 15 of the allegation could be amended in the manner applied for without injustice to Dr Singh. Accordingly, the Tribunal accedes to the application.
Application for no case to answer from Dr Singh

1. At the close of the case on behalf of the General Medical Council (GMC), Mr Larkin, Counsel on behalf of Dr Singh, made submissions under Rule 17(2)(g) of the GMC (Fitness to Practise) Rules 2004 (the Rules) in respect of those paragraphs of the Allegation not already admitted and found proved. Rule 17(2)(g) states:

   ‘the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld’.

Submissions on behalf of Dr Singh

2. Mr Larkin submitted that the test to be applied by a Medical Practitioners Tribunal in determining whether to accede to a submission of no case to answer is that set out, suitably modified, for regulatory proceedings, by Lord Lane LCJ in R v Galbraith [1981] 1 WLR 1039 at 1042:

   ‘(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty – the judge will 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 concludes that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case.

   (b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witnesses 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 on which the 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.’

3. Mr Larkin submitted that the evidence of the GMC is tenuous and suffers from inherent weakness and inconsistency. He referred the Tribunal to the case of R v
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Shippey [1988] Crim LR 767 which is best known for the comment that ‘taking a prosecution case at its highest did not mean picking out the plums and leaving the duff behind’. He submitted that Patient A is a stark example of that principle in operation. He drew the Tribunal’s attention to the inconsistent statements Patient A has made in her GMC witness statement, police witness statement and evidence she provided at the Crown Court.

4. Mr Larkin submitted that Patient A’s accounts are not capable of reliance. He stated that it is clear that Patient A suffers from self-professed memory problems, has a long history of mental health issues and has previously suffered from auditory hallucinations. When Patient A’s credibility and reliability is tested by considering versions of events from the same witness, accounts of other witnesses and compared to independent evidence such as medical records, Mr Larkin submitted that Patient A fails on each of these tests. Mr Larkin submitted that an example of this is her comment that she ‘would tell anyone who would listen’. He reminded the Tribunal of the range of people she interacted with such as psychiatrists, staff at A&E and police officers and submitted that it defies belief that she was repeatedly ignored and no record ever kept. She repeatedly gave evidence that she told Dr E everything that Dr Singh had done to her, however her account is directly contradicted by Dr E. He made a contemporaneous note of that conversation in which there was no mention of the sexual assault. Mr Larkin submitted this is just one example which damages Patient A’s credibility beyond repair.

5. Mr Larkin stated that the expert evidence adduced by the GMC demonstrates that the examinations of Child B and Patient D were clinically indicated. In relation to Child B, the experts agree that a doctor could touch the child for the purpose of the examination and might come into contact with the mother’s breast in doing so. In relation to Patient D, the experts agree that the doctor is likely to come into contact with the breast tissue when conducting a chest examination of a female patient and that putting the stethoscope over Patient D’s breast and/or nipple if the heart sounds can be heard there is not below the standard of care expected. Mr Larkin submitted that it is not sufficient for a mother/patient to believe that the contact was sexually motivated and that the GMC have not adduced any evidence to prove this.

6. Mr Larkin provided a summary of the evidence in relation to the paragraphs of the Allegation that form this application.

7. In relation to paragraphs 2-5 – Mr Larkin submitted that Patient A’s account of her second appointment with Dr Singh has changed significantly over time. It is alleged that Dr Singh touched inside her pants and said he was ‘searching for weapons’. Mr Larkin stated that there is no reference to this in Patient A’s witness statement to the police. Further, her response whilst giving oral evidence to this Tribunal was that she had told the police officer everything and he must have ‘forgot to write it down’. He stated that there is no support for the assertion that Patient A immediately reported the incident to the receptionist. Mr Larkin drew the Tribunal’s
attention to the nursing records and submitted that Patient A made no complaint to them about Dr Singh’s behaviour and did not express any concern about seeing him again during her stay at Millbrook Mental Health Unit.

8. **In relation to paragraphs 6-8** – Mr Larkin submitted that it is Patient A’s evidence that she told Adult B about the initial sexual assault by Dr Singh. Patient A stated that she had asked Adult B to attend the second appointment with her and that Dr Singh had asked Adult B to leave the room. Mr Larkin submitted that it is unrealistic that Adult B would leave the room if he had been told that Patient A had been sexually abused. He referred the Tribunal to Patient A’s account of her appointments with Dr E. Following the appointment with Dr Singh on 12 October 2000, Patient A saw Dr E the following day. In her oral evidence to this Tribunal, she claims she mentioned the sexual assault to Dr E at this appointment. In his oral evidence to the Tribunal, Dr E denied this. The medical notes from that appointment make no mention of this. Mr Larkin submitted that the GMC must accept that there is no evidence in relation to this discussion.

9. **In relation to paragraphs 9-11** – Mr Larkin referred the Tribunal to the medical notes made by Dr Singh for the consultation on 23 October 2000. The notes state that Adult B attended the consultation. Mr Larkin submitted that if Adult B was asked to leave, there would be no sensible reason for him to do so. Mr Larkin referred to paragraph 9(f) of the allegation. Following this appointment, Dr Singh wrote to Dr E setting out his findings. Mr Larkin submitted that that the contents of the letter are entirely consistent with Patient A’s medical records. He further submitted that Dr N, a specialist Registrar in psychiatry at Millbrook had similarly documented ‘impotency secondary to sciatica’ in his note of his consultation with Patient A on 13 November 2000 so he also clearly thought this was relevant to Patient A’s history.

10. **In relation to paragraphs 12-17** – Mr Larkin submitted that Dr Singh does not dispute that he made one or more telephone calls to Patient A. He submitted that any telephone call made to Patient A was made against the background of a junior psychiatrist discharging a patient without medication or treatment. He further submitted that, as the nature of her relationship was a key trigger factor, it would not be unreasonable for that to arise as an issue in any conversation. Mr Larkin referred the Tribunal to Patient A’s witness statement to the police where she said she could not be sure if the calls were for sexual gratification, her evidence at the crown court which referred to Dr Singh ‘groaning’ and her oral evidence to this Tribunal where she said she believed that Dr Singh was masturbating. Mr Larkin submitted that the GMC case depends on a witness who can have no credibility, has contradicted herself and is contradicted by other evidence.

11. **In relation to paragraphs 18-12** – Mr Larkin reminded the Tribunal that Ms C has consistently denied that there was any examination of child B, save the use of a stethoscope. He submitted that this is inconsistent with the medical notes. Mr Larkin
submitted that, where there is a clinically indicated examination conducted appropriately with an accepted risk of accidental contact, it is incumbent upon the GMC to adduce evidence of sexual motivation. He submitted that there is none in this case. He referred to the fact that Ms C raised her concerns with the practice manager, Mr F. In his GMC witness statement, Mr F stated that Ms C had told him that she ‘did not know’ if the touching was deliberate. Mr Larkin stated that his statement is evidence of the earliest recorded complaint and submitted that the GMC cannot ask the Tribunal to prefer one witness over the other because it suits their case. Mr Larkin referred the Tribunal to the expert evidence where it was opined that the communication described by Ms C did fall below but not seriously below the standard expected therefore it is submitted that even if it is found that Dr Singh spoke to Ms C in an inappropriate manner, it is not capable of amounting to misconduct.

12. In relation to paragraphs 21-22 – Mr Larkin submitted that the actions described in paragraphs 19 and 23 were appropriate and that the GMC has not adduced any evidence to show that these were sexually motivated. He stated that it is agreed that it was appropriate to examine Patient D’s chest and listen for heart sounds and that Dr Singh accepts responsibility that he failed to explain to Patient D where he would be examining. In relation to paragraphs 20 and 22 of the allegation, Mr Larkin reminded the Tribunal that the experts agree that, opening the buttons of her polo top gave implied consent and that there is insufficient evidence that this clinical examination required either consent or a chaperone. He reminded the Tribunal of Patient D’s oral evidence where she stated that if the procedure has been explained to her properly and, had there been a chaperone, that ‘we wouldn’t be here today’. He submitted that this was consistent with the evidence she provided at the Crown Court and meant her complaint referred to the unexpected and shocking nature of the examination rather than the manner of the examination itself.

On behalf of the GMC

13. Ms Hudson referred the Tribunal to the case of Husband V GDC [2019] EWHC2210 (Admin) which confirms that it is incumbent on the decision maker to consider the whole of the evidence which has been produced at the stage of the no case to answer application and the ‘task is to decide whether the charge could not whether it would be made out’. She reminded the Tribunal that at this stage it is not for them to consider whether they accept the evidence of the three patients and find it credible but whether their evidence, taken together with the expert evidence of Dr G and Dr H is sufficient and could support the charges to the civil standard of proof.

14. In relation to Patient A, Ms Hudson submitted that she has consistently maintained in her evidence that she was sexually assaulted by Dr Singh. She referred the Tribunal to the explanation as to why she did not call out to her partner and submitted that this is a matter for analysis of credibility at the conclusion of the case and does not amount to patient A’s evidence being so flawed as to be incapable
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of belief. Ms Hudson referred the Tribunal to the evidence of the telephone calls. Patient A’s evidence is that the telephone calls were inappropriately sexual. There is a note from Dr E which refers to the telephone call. Dr Singh has not disputed that one or more calls were made but he made no record of the calls. Ms Hudson submitted that there is a conflict of evidence on this issue and therefore Dr Singh has a case to answer. She submitted that taking the phrase ‘prosecution case at its highest’ the Tribunal should assume Patient A is telling the truth and the Heads of Charge should be allowed to proceed.

15. In relation to Patient C, Ms Hudson submitted she has given evidence that the touching of her breast during the consultation was not accidental and she has consistently maintained that she was sexually assaulted. Ms Hudson submitted that the Tribunal could find the charge proved on the basis of Patient C’s evidence, taken at its highest. She submitted that an assessment of whether Dr Singh’s actions were not deliberate should be done at the end of stage 1 when Dr Singh has given his evidence. She further submitted that it would be artificial to separate allegation 18a and 18b.

16. In relation to Patient D, Ms Hudson submitted that there is a conflict between the evidence of Patient D and Dr Singh’s assertions of the consultation. She submitted that the GMC’s evidence, taken at its highest is that Patient D had the stethoscope placed directly on her nipple and that he touched her nipple with his finger. In Patient D’s view, this was sexual therefore Ms Hudson submitted that there is a case to answer.

17. Further, Ms Hudson submitted that the allegations are cross admissible and that the evidence in respect of one patient is admissible in evidence on others. She stated that it would be a matter for the Tribunal at the end of stage 1 to consider the degree of similarity between three women independently making allegations of sexual impropriety against Dr Singh.

18. In conclusion, taking the GMC case at its highest, Ms Hudson submitted that nothing has been adduced in cross examination that mandates the dismissal of any of the allegations. She stated that sexual motivation is a matter for the Tribunals assessment of the entirety of the evidence and the reasonable inferences that could be drawn from it. She stated that clinically indicated examinations do not preclude sexual motivation and the perception of the patients is not determinative but is an important factor in favour of the case proceeding at this stage. Further, she submitted that the evidence adduced is reasonably capable of supporting a finding on a rational basis that these charges are proven.
The Tribunal’s Approach

19. The Tribunal has accepted the submission of Mr Larkin and the advice of the Legally Qualified Chair who referred it to the terms of rule 17(2)(g) of the Rules and to the principles derived from the case of *R v. Galbraith [1981] 1 WLR 1039* which are set out in detail in Mr Larkin’s submission above. The Tribunal has also taken into account Ms Hudson’s submission and referred to the case of *Husband V GDC [2019] EWHC2210 (Admin)*.

20. The Tribunal distinguished between its approach to the evidence at this stage of the proceedings and the approach to be taken at the end of the fact-finding stage. It bore in mind that its role at this stage is not to make findings of fact but to determine whether the evidence heard in the GMC’s case, taken at its highest, is such that the Tribunal could find an alleged fact proved on the balance of probabilities. The Tribunal bore in mind that if it finds that there is sufficient evidence for the hearing to proceed on a particular paragraph, it will have to decide in the light of all the evidence before it at the end of the fact-finding stage, whether that paragraph has in fact been found proved or not.

21. Having regard to the principle of cross admissibility advanced by Ms Hudson, in respect of each of the allegations by Patient’s A and D and Ms C, the Tribunal considered whether each was sufficiently similar to the others to support those allegations.

The Tribunal’s Decision

**Patient A**

22. The Tribunal first concluded that the only evidence in relation to the physical examinations alleged in paragraphs 2-11 of the Allegation is provided by Patient A and set out in her GMC witness statement, police statement and the evidence that she gave to the Crown Court. Patient A also gave oral evidence at this hearing. The Tribunal therefore considered it necessary to assess the overall credibility and reliability of Patient A’s evidence, including that given orally to the Tribunal.

23. The Tribunal took into account the considerable passage of time since the alleged events (including the time that elapsed between the indexed events and her police statement) together with Patient A’s memory problems which are well documented in the medical evidence. The Tribunal had regard to the fact that whilst someone might not remember certain details after the amount of time that had elapsed, it noted that the details given by Patient A have developed over time and is concerned about the reliability of her recollections. Thus, for example, the Tribunal noted that the details of what took place at each of the alleged examinations varied to an extent in each of her accounts. The Tribunal were concerned that when
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confronted with contemporaneous medical records that she had been subject to at least four physical examinations by various clinicians at the Kings Mill Hospital before she saw Dr Singh, in her oral evidence, she maintained that the only person to physically examine her was Dr Singh. More significantly, the Tribunal noted that her account of what she told Dr E at a GP consultation with him on 30 October 2000, a week after she last saw Dr Singh as an out-patient, is directly contradicted by Dr E in his written statements, evidence to the Crown Court and oral evidence before the Tribunal. The Tribunal noted that his accounts were supported by contemporaneous written notes of that consultation. As an example of Patient A’s tendency to develop her accounts, the Tribunal noted that she mentions ‘groaning’ in the telephone calls in her evidence to the Crown Court and noted this was not present in her witness statement to the police. In her oral evidence to this Tribunal, Patient A, for the first time, referred to ‘masturbation’.

24. The Tribunal took the view that Patient A’s recollection of events are inconsistent with documented, contemporaneous records which the Tribunal considered the most reliable evidence. The Tribunal also bore in mind Patient A’s consistent evidence that she told ‘anyone who would listen’. It noted the considerable and multiple interactions she had with various clinicians and therapists who all made detailed notes of their meetings and consultations but which do not mention any complaint of an inappropriate sexual examination by Dr Singh. Because of certain comments that Patient A made in her oral evidence, the Tribunal was also concerned about Patient A’s motivation for making the complaints of sexual assault against Dr Singh.

25. For these reasons, in the absence of other supporting evidence, the Tribunal did not find Patient A to be an entirely credible, plausible or reliable witness.

Paragraph 2 – Application upheld

26. The Tribunal considered the evidence in relation to Patient A’s consultation with Dr Singh on 10 October 2000. In her GMC witness statement, Patient A confirmed she did ‘not remember any of the dates or times’ of her consultations with Dr Singh. She recalled meeting Dr Singh for the first time on the Ward at Millbrook whilst she was with her mum, sister and possibly her partner, Adult B. Further, she stated that she does not remember the date or time of the first consultation with Dr Singh but it was at this first consultation, in a room just off the in-patient ward, that she alleges that the first sexual assault took place. She stated that she went to this consultation alone. In her statement to the police, she stated that the first time she saw Dr Singh was on the ward with her family present and that it was after this initial meeting, at the first consultation where she was sexually assaulted.

27. The Tribunal went on to consider the medical notes relating to the consultations between Dr Singh and Patient A. These indicate a considerable discrepancy in Patient A’s recollection of the timing of events. For example, the
medical notes indicate that Patient A’s first consultation with Dr Singh was on the ward on 9 October 2000 when a history was taken and a plan made. However, there is no indication in the notes of Patient A’s family being present. The Tribunal noted that in the subsequent medical notes relating to a consultation on 10 October 2000, these refer to Patient A’s family and boyfriend being present at the consultation. There is no record of any physical examinations in the medical notes from the 9 and 10 October 2000. The Tribunal considered Dr Singh’s medical notes to be thorough and consistent with the notes of other professionals in relation to Patient A and the Tribunal has already indicated that it places weight on contemporaneous written evidence.

28. The Tribunal had regard to Patient A’s medical notes which confirm that she had undergone at least four examinations of chest and abdomen following her admission to Kings Mill Hospital. The Tribunal heard expert evidence from Dr H, the GMC expert, in which it was confirmed that an abdominal examination would include examining the area below the waistline. However, in her oral evidence, the Tribunal noted Patient A denied that she had been physically examined by any other doctor during the hospital stay. The Tribunal next had regard to the inconsistencies in Patient A’s evidence to the police, and her GMC statement regarding the examination of her pubic area at the consultation on 10 October 2000. In her GMC statement, Patient A stated that Dr Singh put his hands in her trousers at the first consultation. This was not detailed in her statement to the police. In her oral evidence to the Tribunal, she stated that she did tell the police officer however they ‘must have forgot to write it down’. The Tribunal is concerned that this is an example of Patient A developing her evidence over time.

29. The Tribunal noted Patient A’s comments that she ‘told anyone who would listen’ about the sexual assault. The Tribunal had regard to the nursing notes from 9 and 10 October 2000. The note from 9 October 2000 stated ‘appears settled on the ward. She appears happy to be here’. The note from 10 October at 12:35 states that she ‘appeared settled’. The note from 20:10 on 10 October 2000 refers to the fact that Patient A declined leaving the hospital as she wanted to ‘find herself’. The Tribunal noted that there was no reference in these nursing notes to her complaining of a sexual assault by Dr Singh and it determined that it could not rely on Patient A’s evidence that she told ‘anyone who would listen’.

30. The Tribunal also placed significant weight on the evidence of Dr E, who had been Patient A’s GP for a number of years prior to Patient A’s consultations with Dr Singh and continued as her GP afterwards. Contemporaneous medical notes made by Dr E indicate that he saw Patient A on 13 October 2000 (the day after her discharge and her last consultation with Dr Singh as an in-patient) and again on 20 and 30 October 2000. In none of the records of his consultations with Patient A is there any mention of physical, sexual assaults by Dr Singh. Consistently, in his evidence to the Crown Court and to the Tribunal, Dr E confirmed that Patient A had never mentioned to him that Dr Singh had inappropriately touched her neck,
breasts, pubic or buttock areas and that, had she made such allegations, he would have taken advice and escalated them. The Tribunal noted Patient A’s evidence that on this consultation and at the others, where she alleges being sexually assaulted, that she told Dr Singh to stop and fended him off and that she took her partner as a chaperone to later examinations. The Tribunal considered that these actions demonstrated that she would have recognised Dr Singh’s actions as sexual assaults and the Tribunal considered it therefore inconceivable that when she reported the telephone calls by Dr Singh to Dr E on the 30 October 2000, that she would not have mentioned any physical assaults.

31. The Tribunal noted from Patient A’s medical records that she attended a series of sessions with the Community Practice Nurse in 2000 and 2001 after the alleged assaults by Dr Singh. The notes on these sessions are detailed and the contents consistent with those of other clinicians. There is no mention of any assaults notwithstanding her firm written and oral evidence that she had ‘told anyone who would listen’.

32. The Tribunal considered Patient A’s evidence so inconsistent with other reliable witness evidence and contemporaneous written records adduced by the GMC in relation to this consultation as to call into question her credibility and reliability on the facts alleged concerning an assault. Accordingly, the Tribunal was unable to place any weight on Patient A’s evidence. The Tribunal concluded that, taking the GMC’s evidence as a whole and at its highest, it was so inconsistent, weak and unreliable that no Tribunal properly directed could find that a physical examination took place on 10 October 2000 by Dr Singh. Accordingly, the Tribunal determined that there was no case to answer in respect of paragraph 2 of the Allegation.

Paragraph 3, 4 and 5 – Application upheld

33. In light of its findings that there was not a physical examination of Patient A on 10 October 2000, the Tribunal determined that there is no case to answer in respect of paragraphs 3, 4 and 5 of the Allegation.

Paragraph 6(a-f)- Application upheld

34. The Tribunal had regard to Patient A’s statement to the police, the GMC and the evidence she provided to the Crown Court in relation to the consultation on 12 October 2000. The Tribunal took the view that her evidence is consistent in that she states that her partner, Adult B, was initially present at this consultation but was asked to leave the room by Dr Singh. The Tribunal went on to consider the medical notes that Dr Singh had made in respect of this consultation. It noted that there was no reference to Adult B being present at the consultation. There were no notes to indicate that a physical examination had taken place.
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35. The Tribunal went on to consider again Patient A’s consultation with her GP, Dr E on 13 October 2000. In her evidence to this Tribunal, Patient A maintained that she told Dr E about this assault and the others and that he had written it all down. As indicated above in respect of paragraph 2 of the Allegation, the Tribunal noted that Dr E denied that he was ever told about a physical assault by Dr Singh. The Tribunal took the view that Dr E was consistent in his evidence, he relied on his extensive medical records and the Tribunal found him to be an entirely credible witness.

36. Given its earlier comments, the Tribunal was unable to place any weight on Patient A’s evidence. The Tribunal determined that the GMC has not adduced any sufficient satisfactory evidence on which a Tribunal could find that a physical examination took place. Accordingly, the Tribunal determined that there was no case to answer in respect of paragraph 6(a-f) of the Allegation.

Paragraph 6(g)- Application upheld

37. In relation to paragraph 6(g) of the Allegation relating to a further consultation by Dr Singh at Millbrook, the Tribunal had regard to Patient A’s statement to the police and the GMC where she stated, 'Dr Singh then began to ask questions about my sex life with Adult B and I felt this entirely inappropriate'. In her evidence to the Crown Court, the Tribunal noted that Patient A stated that Dr Singh had not asked her about her sex life prior to the outpatient appointment. Having examined the medical notes of 12 October 2000 completed by Dr Singh, the Tribunal noted that these do not indicate that she was asked any questions about her sex life at that consultation. However, the Tribunal observed that Dr Singh had made the following note in her records from the 9 October 2000, 'not having good sexual relationship with partner because he suffers sciatica'. Further, the Tribunal noted that this observation recorded by Dr Singh was consistent with that of other clinicians who had seen Patient A, including her own GP, Dr E. In the medical notes for a consultation on 20 October 2000 he recorded the following, 'it appeared that relationship with partner is at the route of problem but difficult to talk owing to partners continued presence'. The Tribunal also noted the medical notes of Dr N who saw her on 12 November 2000 where he mentions relationship problems in similar terms. This consultation was not with Dr Singh as Patient A alleges. The Tribunal determined this was another example demonstrating the inconsistencies between Patient A’s different accounts and the documented records.

38. The Tribunal next considered the report of the GMC psychiatric expert, Dr G, in which he confirms that asking Patient A about her sex life would not be inappropriate. The Tribunal determined that no reasonable Tribunal, taking the GMC’s evidence at its highest, could conclude that this sub paragraph is capable of amounting to statutory misconduct. Accordingly, the Tribunal determined that there was no case to answer in respect of paragraph 6(g) of the Allegation.
Paragraphs 7 & 8 – Application upheld

39. In light of its findings that there was not a physical examination of Patient A on 12 October 2000, the Tribunal determined that there is no case to answer in respect of paragraphs 7 and 8 of the Allegation.

Paragraph 9(a-e) – Application upheld

40. The Tribunal considered Patient A’s evidence in respect of the out-patients consultation on 23 October. Her evidence is that her partner was present at this appointment and Dr Singh’s notes are consistent with this. The Tribunal noted that again there is no reference to a physical examination on this date in Patient A’s medical notes. The Tribunal considered it significant that, in her evidence, she has forgotten or overlooked the fact that this was the final appointment with Dr Singh and that it was not him who she saw after this. In addition to other evidence of confusion, Patient A has not correctly identified the doctor on the final outpatient appointment as Dr N but maintains that it was definitely Dr Singh. The medical notes and letter from Dr N, dated 14 November 2000 make clear her error. The medical notes and letter from Dr N, dated 14 November 2000 make clear her error.

41. Given its earlier comments, the Tribunal was unable to place more than minimal weight on Patient A’s evidence. The Tribunal determined that the GMC has not adduced sufficient evidence that, taken at its highest, the facts in question could be found proved to the appropriate standard. Accordingly, there was no case to answer in respect of paragraph 9(a-e) of the Allegation.

Paragraph 9(f) - Application upheld

42. The Tribunal first of all noted Patient A’s evidence in relation to this Allegation. It then considered the medical notes written by Dr Singh dated 23 October 2000 which included references to difficulty in her relationship and ‘partner having treatment for sciatica’. It then noted the content of a subsequent letter that Dr Singh sent to Dr E dated 24 October 2000. In his letter it is noted ‘her present partner...is having secondary impotency due to his back pain and sciatica’. The Tribunal next considered the letter Dr N sent to Dr E, dated 14 November 2000, following a consultation he had with Patient A on 13 November 2000. This letter also refers to ‘difficulties in her current relationship’. There is a clear pattern in the medical notes of previous discussion around this area. The Tribunal took note of its earlier reference to the evidence of the GMC expert, Dr G, that such questions were not inappropriate. The Tribunal determined that the GMC has not adduced any evidence that demonstrates these questions were inappropriate.

43. The Tribunal could not conclude that this was inappropriate. Accordingly, taking the GMC evidence at its highest, the Tribunal concluded that no Tribunal
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could find, on the balance of probabilities, that the questioning alleged in paragraph 9(f) of the Allegation was so inappropriate as to amount to serious misconduct.

Paragraph 10 & 11- Application upheld

44. In light of its findings that there was not a physical examination of Patient A on 23 October 2000, the Tribunal determined that there is no case to answer in respect of paragraph 10 of the Allegation in so far as it relates to paragraph 9 (a-e) or in relation to paragraph 11 of the Allegation. In light of its findings that the GMC has not adduced any evidence so that it could find 9(f) proved, there is no case to answer in so far as 10 relates to 9(f).

Paragraph 12- Application upheld

45. In Patient A’s written and oral evidence, the Tribunal noted that she maintains that some 4-6 weeks after her last consultation with Dr Singh as an out-patient, she was telephoned by Dr Singh. The Tribunal had regard to Dr E’s contemporaneous notes and evidence which confirm that Patient A complained to him on 30 October 2000 about phone calls from Dr Singh. Patient A’s evidence, when taken at its highest was therefore consistent with Dr E’s notes. The Tribunal noted that, although he said in his written evidence that he does not remember them, Dr Singh has not denied that he made one or more phone calls to Patient A. The Tribunal then had regard to the GMC expert, Dr G’s evidence in which he stated that any contact with the patient should be detailed in the medical notes. However, Dr G describes the absence of this note to be a ‘minor matter of recordkeeping which would not fall seriously below the standard of a medical practitioner’. In the light of that expert opinion, the Tribunal had no evidence before it capable of proving misconduct but not serious misconduct on the balance of probabilities and therefore the application of a no case to answer in respect of paragraph 12 is upheld.

Paragraph 13 (a) – Application upheld

46. The Tribunal had regard to the police and GMC statement of Patient A. It noted that both statements are consistent in that Patient A described Dr Singh asking, ‘if she was alone in the house’ and if she was ‘stood up or sat down’. The Tribunal noted that the GMC has not adduced any evidence of impropriety in relation to these questions. The Tribunal therefore determined that the GMC had adduced evidence capable of proving misconduct on the balance of probabilities therefore the application of a no case to answer in respect of paragraph 13(a) is upheld.
Paragraph 13 (b)- Application rejected

47. The Tribunal had regard to both Patient A’s and Dr E’s evidence in relation to the telephone call. In relation to this allegation, the Tribunal noted that Patient A’s evidence was supported by other accounts. Dr E made reference to a ‘suggestion of an inappropriate examination’ in the medical notes. In his evidence at the Crown Court, Dr E referred to ‘the patient being asked to give details of a sort of internal examination’. In his oral evidence he clarified that Patient A had confirmed that Dr Singh had not examined her but made reference to a possible physical examination that could take place in the future. The Tribunal noted that Dr E must have been concerned enough about the contents of the telephone calls as he reported this to Dr J who was the consultant responsible for Dr Singh and with whom he records a long discussion.

48. The Tribunal took into account the fact that Dr E had known Patient A for a number of years prior to her consultations with Dr Singh. The Tribunal concluded that there is some evidence, taking it at its highest, to support Patient A in respect of this allegation and considered that there was evidence on which it could find this allegation proved. Accordingly, the application in relation to 13(b) is rejected.

Paragraph 14- Application upheld in relation to paragraph 13(a) but rejected in relation to 13(b)

49. In the light of its findings in respect of paragraph 13(a) of the Allegation the Tribunal determined that there is no case to answer in so far as paragraph 14 relates to paragraph 13(a). In the light of its finding in respect of paragraph 13(b), the application is rejected in so far as paragraph 14 relates to 13(b).

Paragraph 15 – Application upheld

50. The Tribunal mirrored the approach it took in respect of paragraph 12 of the Allegation. It took the view that on the basis of the GMC’s expert evidence, the failure to make adequate records is not capable of being found to be serious misconduct therefore the application of no case to answer in respect of paragraph 15 is upheld.

Paragraph 16 & 17 – Application rejected

51. The Tribunal mirrored the view it took in relation to paragraph 13(b). Taking into account the evidence from Dr E, it determined that there was sufficient
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evidence such that the facts in question could, on one view of the evidence, be found proved. Accordingly, the application in respect of paragraphs 16 and 17 was rejected.

Ms C

**Paragraph 18(a)- Application upheld**

52. The Tribunal had regard to the statements that Ms C provided to the police and the GMC, together with the evidence she provided to the Crown Court in relation to the consultation with Dr Singh. The Tribunal noted that she gave a consistent account of the consultation in her oral evidence to this Tribunal. The Tribunal considered her to be a straightforward, credible and reliable witness. The Tribunal noted that Ms C has consistently stated that the only physical examination of child B involved a stethoscope. This account is inconsistent with the medical notes by Dr Singh which indicate that a more thorough physical examination took place. The Tribunal reminded itself that there is no charge in respect of Dr Singh falsifying his notes.

53. The Tribunal noted that Ms C consistently indicates that she felt Dr Singh was dismissive of her. In her statement to the GMC she described Dr Singh to be ‘patronising, intimidating and rude’. The Tribunal noted Dr Singh’s comments at the Crown Court where he described the consultation by stating ’it was not a perfect consultation. It didn’t go as I wanted...I might have come across as rude. I apologise for that and I still apologise for that”. The Tribunal next had regard to Dr H’s supplemental report to the GMC dated 24 April 2019. Dr H states that ‘if Ms C’s account is accepted in my opinion Dr Singh’s actions fell below the standard expected...as no reasonable competent general practitioner would behave in this way to a concerned parent of an ill child. Dr Singh’s actions were not seriously below the standard expected because his behaviour did not affect the clinical care he provided to the child’. The Tribunal therefore determined that whilst inappropriate, given the evidence of the GMC expert, taking the evidence at its highest, this Allegation, if proven on the balance of probabilities is not capable of amounting to serious misconduct.

54. Accordingly, the Tribunal determined that there was no case to answer in respect of paragraph 18(a) of the Allegation.

**Paragraph 18(b)- Application upheld**

55. The Tribunal considered the evidence adduced by the GMC in relation to Dr Singh sliding his hand across the left breast of Ms C. It noted that Ms C had been consistent in her evidence in that Dr Singh’s hand had come into contact with her breast during the examination of Child B. The Tribunal noted that Dr Singh had previously conceded this possibility and had apologised for any accidental touching.
56. The Tribunal next considered the evidence adduced in relation to whether the touching of the breast was intentional. Her police witness statement states ‘I think the touching of my breast was intentional...I can’t remember much of it, I was in shock’. At the Crown Court, Ms C was asked why she was convinced that it was not accidental in which she responded, ‘Because he didn’t give me any warning that he was going to check [Child B]’. Following the incident, Ms C raised her concerns with the Practice Manager, Mr F. The Tribunal noted that in Mr F’s witness statement, Ms C had told him that ‘she did not know’ if the touching of the breast had been deliberate.

57. The Tribunal had regard to the expert report prepared by Dr H for the GMC, dated 11 November 2018. In her report she stated that ‘it is not unusual for a doctor to come into contact with the person who is holding the child when carrying out an examination and sometimes this is unavoidable’.

58. The Tribunal did not consider that there were features in Patient A and Patient D’s allegations of significant similarity with Ms C’s to assist in its determination of this allegation.

59. The Tribunal determined that the GMC has not adduced sufficient evidence that, when taken at its highest, it could conclude that Dr Singh intentionally slid his hand across the left breast of Ms C. Accordingly, the Tribunal determined that there was no case to answer in respect of paragraph 18(b) of the Allegation.

Patient D

Paragraph 19— Application rejected

60. The Tribunal considered the evidence provided by Patient D. It took the view that Patient D had been consistent in her statements to the police, the GMC and during her evidence at the Crown Court Trial. In her oral evidence to this Tribunal, it found her to be a credible and reliable witness. It noted the only discrepancy related to Dr Singh’s finger touching the left nipple. This is noted in her GMC statement but she did not say this in her police statement or imply it in her evidence at the Crown Court. The Tribunal noted that, to her credit, she accepted that she had changed her evidence and qualified her answer to say that she maybe meant ‘areola’.

61. The Tribunal had regard to the expert evidence adduced by the GMC. Although it was agreed that the examination of the chest and heart was clinically indicated, Dr H stated in her oral evidence that the technique used by Dr Singh was ‘unusual’.
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62. The Tribunal took the view that, taking the GMC evidence at its highest, there is a case to answer in respect of the appropriateness of the manner in which examination was conducted. Accordingly, the application in respect of paragraph 19 is rejected.

Paragraph 20 & 22 – Application rejected

63. Given its findings in respect of paragraph 19, the Tribunal determined that there was a case to answer in respect of paragraphs 20 and 22. The Tribunal took into account the joint expert report of Dr H and Dr I, the defence General Practitioner expert, dated 2 September 2019. In relation to the issue of consent and offering a chaperone, both experts agreed that 'if Dr Singh was intending to touch the nipple then implied consent was not sufficient and his actions would fall seriously below the standard expected of a reasonably competent general practitioner’ and ‘if Dr Singh’s intention was to touch the nipple and feel the breast...then a chaperone should have been offered’.

64. The Tribunal considers there is sufficient evidence that is not of such a tenuous character that a Tribunal, properly directed, could find the facts proved. Accordingly, the application in respect of paragraphs 20 and 22 is rejected.

Paragraph 23 – Application upheld in so far as it relates to paragraphs 2, 6, 9 and 18(b) of the Allegation. Application rejected in so far as it relates to paragraphs 13, 16 and 19.

65. Given its earlier findings that there is no case to answer in respect of paragraphs 2, 6, 9 and 18(b) of the Allegation the application is upheld in respect of paragraph 23 in so far as it relates to paragraphs 2, 6, 9 and 18(b).

66. Given its earlier finding that there is a case to answer in respect of paragraphs 13, 16 and 19 the application is rejected in respect of paragraph 23 in so far as it relates to paragraphs 13(b), 16 and 19.

67. The following paragraphs remain to be determined: 13(b), 14 (in so far that it relates to 13(b)), 16, 17, 19, 20, 22 and 23 (in so far that it relates to paragraphs 13(b), 16, and 19).