Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 11/03/2019 - 19/03/2019
Medical Practitioner’s name: Mr Pagulu PRASAD
GMC reference number: 4569354
Primary medical qualification: MB BS 1993 Bangalore
Type of case: Misconduct
Outcome on impairment: Not impaired

Summary of outcome
Not impaired, no warning issued

Tribunal:

<table>
<thead>
<tr>
<th>Legally Qualified Chair</th>
<th>Mr Graham White</th>
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<tbody>
<tr>
<td>Lay Tribunal Member:</td>
<td>Mr Andrew Waite</td>
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<td>Medical Tribunal Member:</td>
<td>Dr Joanne Topping</td>
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<td>Tribunal Clerk:</td>
<td>Ms Lauren Culkin</td>
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</table>

Attendance and Representation:

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<thead>
<tr>
<th>Medical Practitioner:</th>
<th>Present and represented</th>
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</thead>
<tbody>
<tr>
<td>Medical Practitioner’s Representative:</td>
<td>Mr Anthony Haycroft, Counsel, instructed by Radcliffes Le Brasseur</td>
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<td>GMC Representative:</td>
<td>Mr Ciaran Rankin, 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.
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 & Impairment- 19/03/2019

FACTS

Background

1. Mr Prasad qualified in India in 1989, and prior to the events which are the subject of the hearing, he moved to the UK in 1996 where he worked in various hospital posts in Orthopaedics. He obtained a Certificate of Completion of Training in 2010 and attained the post of Consultant Orthopaedic & Spine Surgeon at Southend University NHS Trust (‘the Trust’). In between November 2011 and May 2012, Mr Prasad worked as an Honorary Fellow at the Royal National Orthopaedic Hospital in London, and then went on to be an Honorary Consultant for the Nottingham University Hospital NHS Trust. From February 2016 to August 2017, Mr Prasad returned to India where he worked in Honorary Clinical attachment roles. Between October 2017 and April 2018, he worked at the Spinal Unit of the Royal National Orthopaedic Hospital. In June 2018, he completed a one month locum post at the Whipps Cross University Hospital Orthopaedic & Trauma department in London. At present, Mr Prasad is not working.

2. On 3 June 2013 Mr Prasad performed L2/3 bilateral revision decompression surgery on Patient A.

3. The Allegation in this case relates to post-operative care provided by Mr Prasad to Patient A whilst she was an inpatient between 4 and 18 June 2013 (‘the Period’), and on 23 July 2013 when she was an outpatient.

The Outcome of Applications Made during the Facts Stage

4. The Tribunal granted the GMC’s application, made pursuant to Rule 34(13) of the General Medical Council (Fitness to Practise Rules) 2004 as amended (‘the Rules’), for Ms B to give her witness evidence via video-link. Mr Haycroft supported the application which the Tribunal concluded was in the interests of justice.

5. The Tribunal granted Mr Haycroft’s application made on behalf of Mr Prasad, pursuant to Rule 17(2)(g) of the Rules, that insufficient evidence had been adduced on which the facts in respect of all the disputed allegations could be proved. The Tribunal’s full decision on the application is included at ‘Annex A’.
The Allegation and the Doctor’s Response

6. The Allegation made against Mr Prasad is as follows:

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

1. Between 4 June 2013 and 18 June 2013 ('the Period'), you provided post-operative care to Patient A following L2/3 bilateral revision decompression surgery you carried out on 3 June 2013. **Admitted and found proved**

2. On one or more occasion during the Period, you:
   a. stroked Patient A’s legs; **Admitted and found proved**
   b. inappropriately pushed your groin against Patient A’s hip. **Dismissed under Rule 17(2)(g)**

3. On one occasion during the Period, Patient A consented to a rectal examination and you: **Dismissed under Rule 17(2)(g)**
   a. failed to offer Patient A a chaperone; **Dismissed under Rule 17(2)(g)**
   b. inserted your finger(s) into Patient A’s vagina:
      i. without Patient A’s consent; **Dismissed under Rule 17(2)(g)**
      ii. when a vaginal examination was not clinically indicated; **Dismissed under Rule 17(2)(g)**
   c. failed to document a vaginal examination in Patient A’s medical records; **Dismissed under Rule 17(2)(g)**
   d. failed to carry out a rectal examination. **Dismissed under Rule 17(2)(g)**

4. On one occasion during the Period you attended upon Patient A and you:
   a. failed to obtain informed consent in that you did not tell Patient A you were going to carry out an intimate
Record of Determinations –
Medical Practitioners Tribunal

examination; Dismissed under Rule 17(2)(g)
b. stroked Patient A’s legs; Admitted and found proved
c. failed to offer Patient A a chaperone; Dismissed under Rule 17(2)(g)
d. inserted your finger(s) into Patient A’s vagina: Dismissed under Rule 17(2)(g)
i. without Patient A’s consent; Dismissed under Rule 17(2)(g)
ii. when a vaginal examination was not clinically indicated; Dismissed under Rule 17(2)(g)
e. stated to Patient A, ‘What does that feel like?’, or words to that effect; Dismissed under Rule 17(2)(g)
f. failed to document a vaginal examination in Patient A’s medical records. Dismissed under Rule 17(2)(g)

5. During the Period, you failed to carry out a rectal examination when this was clinically indicated. Admitted and found proved

6. On 23 July 2013, at an outpatient appointment, you advised Patient A that you needed to do an internal examination and you:

a. failed to offer Patient A a chaperone; Dismissed under Rule 17(2)(g)

b. inserted your finger(s) into Patient A’s vagina: Dismissed under Rule 17(2)(g)

i. without Patient A’s informed consent; Dismissed under Rule 17(2)(g)
ii. when a vaginal examination was not clinically indicated; Dismissed under Rule 17(2)(g)

c. failed to document a vaginal examination in Patient A’s medical records. Dismissed under Rule 17(2)(g)
Record of Determinations –
Medical Practitioners Tribunal

7. Your actions in respect of paragraphs 2, 3a, 3b, 4b, 4c, 4d, 4e, 6a and 6b were sexually motivated: **Dismissed under Rule 17(2)(g)**

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

**The Admitted Facts**

7. At the outset of these proceedings, through his Counsel Mr Haycroft, Mr Prasad made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced paragraphs and sub-paragraphs of the Allegation as admitted and found proved as follows:- 1, 2(a), 4(b) and 5.

**MISCONDUCT & IMPAIRMENT**

8. The Tribunal went on to consider in accordance with Rule 17(2)(l) of the Rules, whether on the basis of the facts which have been found proved by way of Mr Prasad’s admission as set out above, Mr Prasad’s fitness to practise is impaired by reason of misconduct.

**Factual Witness Evidence**

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

- Patient A, the complainant, orally and by her written statement dated 23 April 2018;
- Ms B, Head of Risk & Patient Safety at the Trust, orally by video-link and by her written statement dated 11 April 2018.

10. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses:

- Dr E, Medical Director and Responsible Officer ('RO') of the Trust, dated 8 May 2018;

11. Mr Prasad provided his own witness statements, dated 6 February and 18 March 2019; he also gave oral evidence.

**Expert Witness Evidence**
Record of Determinations –
Medical Practitioners Tribunal

12. The Tribunal also received evidence from two expert witnesses, namely Mr C, Consultant Orthopaedic & Spinal Surgeon, on behalf of the GMC; and Mr D, Consultant Spinal Specialist, on behalf of Mr Prasad.

13. Both expert witnesses gave evidence in person and in written reports. Mr C’s initial expert report was dated 6 June 2018, and his supplementary report was dated 26 February 2019; Mr D’s expert report was dated 2 January 2019. There was a joint expert statement by both dated 28 February 2019.

Documentary Evidence

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

- Chronological letter by Patient A, dated 23 September 2013;
- Letter from the Trust to Patient A, dated 13 September 2016;
- Various e-mails between Patient A and the Trust;
- Emails from Ms B to Dr E, dated 10 March 2017;
- Letter from Dr E to Dr Prasad, dated 10 April 2017;
- Redacted transcript of meeting in the matter of Patient A’s care, dated 12 April 2017;
- Various extracts from Patient A’s medical records.

Submissions

15. Mr Rankin submitted with regard to misconduct that the only allegation to consider was the failing at Paragraph 5. He reminded the Tribunal of the expert evidence which confirmed that Mr Prasad failed to carry out a rectal examination following her surgery during the Period. Mr Rankin confirmed that the GMC’s position was neutral as to whether or not Mr Prasad is currently impaired.

16. Mr Haycroft submitted that Mr Prasad’s fitness to practise is not impaired by reason of misconduct, as the remaining allegation does not pass the threshold. Other professionals would not regard this as deplorable. Of the outstanding allegations, 1 is a matter of fact, 2(a) and 4(b) only stood if sexual motivation had been proven. Mr Haycroft accepted that paragraph 5 was a breach of duty by Mr Prasad. Both experts had stated it was below the standard required, not far below or seriously below and it was a single error.

17. Mr Haycroft further submitted that Mr Prasad acknowledged his failings, and has been co-operative throughout. He admitted all the allegations found proved. This case dates back to June 2013 and subsequently Mr Prasad has altered his practice. So the issues of insight and risk of repetition have already been addressed. Finally, Mr Haycroft submitted that Mr Prasad has made appropriate apologies in his
Record of Determinations –
Medical Practitioners Tribunal

statements, through his Counsel, at the outset of the proceedings; and directly to
Patient A.

The Relevant Legal Principles

18. In reaching its decision at this stage of the proceedings, the Tribunal has borne in
mind that there is no burden or standard of proof and the decision of impairment is a
matter entirely for the Tribunal’s judgement alone.

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

Misconduct:

20. The Chair reminded the Tribunal of the relevant legal principles. So far as
misconduct is concerned this included:

Roylance vs GMC (2) [2000]1AC311:

‘Misconduct is a word of general effect involving some act or omission which
falls short of what would be proper in the circumstances. The standard of
propriety may often be found by reference to the rules and standards
ordinarily required to be followed by a medical practitioner in the particular
circumstances.’

Nandi v GMC [2004] EWHC 2317 (Admin):

‘What amounts to professional misconduct ... “a falling short by omission or
commission of the standards of conduct expected among medical
practitioners, and such falling short must be serious”. The adjective "serious"
must be given its proper weight, and in other contexts there has been
reference to conduct which would be regarded as deplorable by fellow
practitioners. It is of course possible for negligent conduct to amount to
serious professional misconduct, but the negligence must be to a high
degree.’

Calhaem, R (on the application of) v GMC [2007] EWHC 2606 (Admin):

‘A single negligent act or omission is less likely to cross the threshold of
"misconduct" than multiple acts or omissions. Nevertheless, and depending upon
the circumstances, a single negligent act or omission, if particularly grave, could be
characterised as "misconduct".’
21. The Chair further reminded the Tribunal that there are two principal kinds of misconduct.

- The first may involve sufficiently serious misconduct in the exercise of professional practice. This is relevant to Mr Prasad’s case, in so far as findings have been made that, in the context of his clinical performance, he failed to carry out a rectal examination of Patient A when this was clinically indicated. That finding was made by his admission at the outset of the hearing.

- The second may involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outside the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession. On the basis of the facts found proved, this kind of misconduct is clearly not relevant to Mr Prasad’s case. The Tribunal has found that the admitted and therefore proved stroking of Patient A’s legs on more than one occasion was not sexually motivated or otherwise inappropriate but, on the contrary, in each case clinically necessary.

22. The Tribunal had regard to GMP (2013 version (updated April 2014)), in particular where it states:

'15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a) adequately assess the patient’s conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient

b) promptly provide or arrange suitable advice, investigations or treatment where necessary

c) refer a patient to another practitioner when this serves the patient’s needs.’

23. By way of summary therefore, in order to make a finding of misconduct, the Tribunal would have to determine that the facts found proved constitute a serious departure from the standards of conduct expected of a medical practitioner.

24. If the Tribunal does not find misconduct it cannot find Mr Prasad’s fitness to practice impaired. If it does find misconduct in this case, it should then go on to consider whether or not Mr Prasad’s fitness to practice is currently impaired.

The Tribunal’s Determination of Misconduct & Impairment
Record of Determinations –
Medical Practitioners Tribunal

Paragraph 1

25. The Tribunal considered this paragraph to be an uncontroversial factual statement setting out the dates when Patient A was an inpatient at the Trust, where she received post-operative care from Mr Prasad following L2/3 bilateral revision decompression surgery, performed by him on 3 June 2013.

Paragraphs 2(a) and 4(b)

26. Paragraphs 2(a) and 4(b) refer to allegations admitted by Mr Prasad that he stroked Patient A’s legs whilst she was an inpatient during the Period. Mr Prasad said that this was a clinically indicated medical procedure. Both expert witnesses agreed that leg stroking as described by Patient A was clinically indicated as part of the neurological examination that was carried out by Mr Prasad.

27. The Tribunal therefore found that the stroking of Patient A’s legs could not amount to misconduct.

Paragraph 5

28. The Tribunal finally considered Mr Prasad’s admission to the allegation that during the Period, he failed to carry out a rectal examination when this was clinically indicated.

29. In his oral evidence the expert witness, Mr C explained that there are reversible causes of Cauda Equina Syndrome, such as a post-operative bleed and that delaying appropriate investigations for 7 days to confirm/ refute the presence of a haematoma, could mean that damage is already done, meaning a potential reversible cause cannot be adequately treated; and stated: “In this case, he got away with it.”

30. The Tribunal had regard to the expert witness evidence, in which there was no dispute, that as acknowledged by Mr Prasad, he should have conducted this examination following Patient A’s surgery, as explained in Mr C’s expert report:

‘When assessing a patient who has gone into retention, who has had to be catheterised, and who has developed new increased postoperative lower limb numbness, particularly in the perineal region, in my opinion a rectal examination should have formed part of the postoperative neurological assessment as soon as such symptoms became apparent. Delaying such a rectal examination until the postoperative clinic is below a reasonable standard of care.’

31. The Tribunal had regard to Mr C’s further assessment of Mr Prasad’s care, in which he stated:
Record of Determinations –
Medical Practitioners Tribunal

'However, in all other aspects Mr Prasad responded well to the postoperative complication that became apparent. This response included an MRI scan which excluded any cauda equina compression. Therefore, even if the rectal examination had been positive (in other words demonstrated the reduced perineal sensation and reduced anal tone that was seen when she came to clinic in July) his management would not have been changed in any way. It is therefore my opinion that this failure to perform a prompt rectal examination was below, but not seriously below a reasonable standard of care.’

This was supported by Mr D who in his report stated:

'...there is much evidence of a generally good standard of care delivered by Mr Prasad to Patient A during her in-patient stay and as an outpatient after discharged.’

There is agreement from both experts that this was a single error that was below but not seriously below a reasonable standard of care.

32. The Tribunal considered that this was a single negligent omission. It had regard to the case of Calhaem vs GMC that that a single negligent act or omission is less likely to cross the threshold to misconduct.

33. The Tribunal concluded that this omission did not constitute misconduct.

Conclusion

34. The Tribunal concluded that having found no misconduct, it follows that Mr Prasad’s fitness to practise cannot be found impaired.

Determination on Warning - 19/03/2019

1. Having concluded that Mr Prasad’s fitness to practise is not impaired, the Tribunal went on to consider under 17(2)(m) of the Rules, the question of whether a warning should be imposed.

Submissions

2. On behalf of the GMC, Mr Rankin submitted that on considering “everything in the round”, the GMC’s position is neutral as to whether or not a warning should be issued.

3. On behalf of Mr Prasad, Mr Haycroft submitted that a warning was not justified.
Record of Determinations –
Medical Practitioners Tribunal

The Tribunal’s Determination on Warning

4. The Tribunal determined that, as the GMC were neutral and had made no submission regarding a warning, it was not minded to proceed further.

Confirmed
Date 19 March 2019

Mr Graham White, Chair

ANNEX A – 15/03/2019

Application under Rule 17(2)(g)

1. At the close of the first stage of the case, Mr Haycroft made an application under Rule 17(2)(g) of the Rules, which states:

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

Submissions on behalf of Mr Prasad

2. Mr Haycroft referred to the leading criminal case of R v Galbraith [1981] 2 All ER 1060 per Lord Lane CJ as applied to regulatory cases. He submitted that there is insufficient evidence to prove any of the non-admitted allegations under limb 2, applying the test as follows:

"How then should the judge approach a submission of 'no case'?

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

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

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

(b) Where however the Crown’s evidence is such that its strength or weakness depends on the view to be taken of a witness’s 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 a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.”

3. Mr Haycroft submitted that this approach has been adopted by and adapted for regulatory cases as in case law of: R (On the Application of Dr Tutin) v GMC [2009] EWHC 553 (Admin) per McCombe J, R (on the application of Sharaf) v MPTS [2013] EWHC 3332 (Admin) Carr J, where it was pointed out that the civil standard applied.

4. Mr Haycroft submitted that whilst there is “some evidence” to support the allegations in the form of Patient A’s assertions, her evidence is of such a "tenuous character... because of inherent weakness or vagueness [and] because it is inconsistent with other evidence”. There were inconsistencies in her own evidence. Her evidence was also inconsistent with the contemporaneous notes of professionals, and the evidence of Ms B and Dr E. Accordingly he submitted that no Tribunal "properly directed could ... properly convict on it”, applying the civil standard.

5. Mr Haycroft drew the Tribunal’s attention to the fact that unfortunately Patient A has endured back problems since 1987, had surgeries from 1995 and she has acknowledged that she has therefore seen many doctors and had countless appointments. It is also now more than five and a half years since her operation by Mr Prasad in June 2013, and Mr Haycroft submitted that her memory had likely been affected by both of these factors.

6. Mr Haycroft referred to inconsistencies in Patient A’s evidence, such as her detailed complaint letter dated 23 September 2013, drafted for the purpose of possible civil proceedings. In it Patient A made no mention of any wrong doing on Mr Prasad’s part, despite recounting what happened when she had been an inpatient at the Trust in June 2013 and also at her outpatient appointment of 23 July 2013. In this letter, she had described Mr Prasad as being “polite” as opposed to her written statement dated 23 April 2018 where she has referred to Mr Prasad as "strange” and “familiar”.

7. Mr Haycroft acknowledged that there can be various reasons as to why someone may delay in making a complaint but submitted that regarding her other complaints Patient A had made to the Trust about her treatment, she had not been
Record of Determinations – Medical Practitioners Tribunal

slow; e.g. about the commotion on the undignified ward she was on, or her wristband not being checked.

8. Patient A chose not to pursue a clinical negligence claim following her operation and subsequent condition, later diagnosed as Cauda Equina Syndrome, following advice from solicitors. Mr Haycroft highlighted that throughout the written documentation regarding this, there is no allegation by Patient A of a sexual nature. Mr Haycroft additionally referred to two occasions in May 2016, where Patient A’s daughter complained to the Trust’s Patient Advice & Liaison Service (‘PALS’) about Patient A’s stoma alone and not to the alleged sexual assault by Mr Prasad; and Patient A’s complaint to her MP about the tardiness of the Trust, but again there were no allegations of a sexual nature. Furthermore, in October 2016 Patient A sent a list of questions to the Trust but again did not refer to these matters.

9. Mr Haycroft submitted that when Patient A finally complained about Mr Prasad’s behaviour on 10 February 2017 some three and half years after the events, she did not provide an explanation as to what prompted her to make the complaint. He maintained this further undermined her evidence.

10. Mr Haycroft submitted that in her oral evidence Patient A stated that she knew in June 2013 that what Mr Prasad had done was “wrong”. Yet she contradicted herself by stating that it was not until years later when she had received her medical records from the Trust and noted the absence of any reference to vaginal penetration, that she knew this had been wrong. When questioned by the Tribunal, Patient A could give no explanation for this contradiction.

11. Mr Haycroft submitted that Patient A had read a sinister connotation into Mr Prasad’s clinically justified actions, e.g. the stroking her legs; getting her to remove her stockings and walk bare foot; getting her to close her eyes; and the need for a clinician to be in “close” proximity to examine her.

Conclusion

12. In summary, Mr Haycroft submitted that the evidence overall cannot be regarded as in any way reliable and that it does not reach the standard required for a case to answer.

Submissions on behalf of the GMC

13. Mr Rankin acknowledged that the case law referred to by Mr Haycroft correctly set out the test to be applied. He submitted however that this case falls into the category “where the prosecution evidence is such, that its strength or weakness depends on the view to be taken of a witness’s reliability, or other matters which are generally speaking within the province of the jury, and where on one possible view of the facts there is evidence upon which a jury could properly come
to the conclusion that the defendant is guilty, … then the judge should allow the matter to be tried by the jury.”

14. Regarding the delay of Patient A’s complaint, Mr Rankin submitted that experience shows that people react differently to the trauma of a serious sexual assault and that there is no one “classic” response. He also submitted that whilst some may complain immediately, there are others who do not due to feelings of shame and shock, and that a late complaint does not necessarily mean a false complaint.

15. Mr Rankin submitted that what may have been the “catalyst” for Patient A in making her complaint of the sexual allegation against Mr Prasad was when she received and reviewed her medical notes from the Trust, which may have been around early 2017. Mr Rankin submitted that this would have been the first occasion where Patient A realised there had been no details of her vaginal examinations in the medical notes and she complained very quickly thereafter.

16. Mr Rankin submitted it made sense for Patient A not to have referred to any part of the sexual assault allegations in her negligence complaint as such allegations were not clinically-related.

17. Mr Rankin submitted that since early 2017, Patient A has been consistent with regard to the central issue in this case that she was penetrated digitally by the doctor vaginally and rectally.

18. Mr Rankin pointed out that Patient A was also able to provide a level of detail that would be remarkable if she was merely a confused elderly lady who had wrongly interpreted clinically indicated examinations. For example, the following paragraphs in her written statement:

'20. The first time he came in he said he would check the feeling in my legs and using his fingertips he stroked down my legs, first going down on the outside of my thighs and then going up on the inside of my thighs. He asked me if I could feel what he was doing. I felt that Dr Prasad had a very strange manner when he was doing this and he was also pushed up against me. Dr Prasad was to my right as I was lying in the bed which was pushed up against a big wardrobe. I felt Dr Prasad’s groin was pushed up against my hip as he stroked up and down my legs. He would do this 3-4 times on each leg. He was always telling me to take my surgical stockings off and then the nurses made me put them back on. When I think back, I can still smell his aftershave as he was pushed up so close to me.'
23. Dr Prasad was standing really close behind me and was pushed up against me. I could feel him pushed up against my lower back. I couldn’t see what Dr Prasad was doing as he was behind me but he did not carry out a rectal examination he just inserted his fingers into my vagina. Dr Prasad did not say anything when he did this. I have had vaginal examinations before and this didn’t feel like that type of examination. Dr Prasad used what felt like his two fingers. I didn’t notice him putting on any gloves beforehand. He inserted his fingers into my vagina and he went in and out of my vagina with his fingers a couple of times in a backwards and forwards motion. This took about 20 seconds. That was the end of the examination. Once the examination was over Dr Prasad then left. He didn’t even tell me what he was doing it for.

...  

27. On this particular occasion the curtain was drawn. There was no chaperone offered and the same thing happened. Dr Prasad said he needed to examine me but he didn’t specify that this was a rectal examination this time or anything else. I was turned onto my left hand side with my knees up. Dr Prasad was again pushed up against my lower back although I am not sure what part of him it was as he was behind me. Dr Prasad then inserted what felt like a couple of fingers into my vagina. He then proceeded to push his fingers in and out a couple of times in my vagina in a backwards and forwards motion. While he was doing this Dr Prasad said ‘What does that feel like?’ Those were his exact words. I froze. I just asked Dr Prasad, ‘Well is there any change?’ as I didn’t know what to say. Dr Prasad said no. I didn’t tell him that I could feel exactly what he was doing. Although I am numb on the outside, I still have feeling and on the inside I am really sensitive and I can feel someone that is pushing. It is not an actual sensation, as in you didn’t get stimulation but you can feel what is happening.’

19. Mr Rankin submitted that as the expert evidence was not conclusive, it had not undermined Patient A’s ability to discern if there had been any penetration of either her vagina or rectum due to her lack of sensitivity. He further submitted that there can be varying degrees of loss of sensitivity which is reflected in the expert evidence.

20. Mr Rankin submitted that ultimately Patient A’s subjective view of what occurred cannot be completely undermined by an objective analysis of the medical notes.

Conclusion
Record of Determinations – Medical Practitioners Tribunal

21. Mr Rankin stated that it is for these reasons the GMC submit that sufficient evidence has been adduced and that the application should be rejected.

Rebuttal by Mr Haycroft

22. In response to Mr Rankin’s submission that a late complaint does not necessarily mean it is a false complaint, Mr Haycroft submitted that it would be irrelevant for the Tribunal to consider whether Patient A is honest or not, as he acknowledged that there is no doubt she is honest in her complaint, as well as the fact that she has been adamantly consistent in her “protestations” overall.

23. In relation to the evidence of the expert witnesses, Mr Haycroft clarified that the clear evidence from both of them was that on the balance of probabilities it was unlikely that Patient A would have been able to differentiate between penetration of the rectal and vaginal area, although they acknowledged it was not impossible.

24. Regarding Mr Rankin’s submission that Patient A has been consistent with regards to the central point in this case that she was penetrated digitally by the doctor vaginally and rectally; Mr Haycroft acknowledged she has been consistent throughout with her complaint of sexual assault since making it, but invited the Tribunal to look in detail at the circumstances in which Patient A was contradictory and inconsistent.

The Tribunal’s Approach

25. The Legally Qualified Chair (LQC) of the Tribunal acknowledged that in accordance with the provision of Rule 17(2)(g), the Tribunal has to consider whether sufficient evidence has been adduced to find some or all of the facts proved; and as it has the power to decide whether the hearing should proceed any further or not.

26. The LQC indicated to both parties that the case law in this area (second limb of Galbraith, R (on the application of Sharaf) v MPTS [2013] EWHC 3332 (Admin) and R v Shippey [1988] Crim LR 767) is well settled. Much of the legal principle had been set out correctly by Mr Haycroft and agreed by Mr Rankin. The Tribunal was cognisant that where there was some evidence it had to evaluate some evidence to support an allegation of any inherent weakness, vagueness or inconsistencies, taking the evidence at its highest but not "taking out the plums and leaving the duff behind”.

27. The Tribunal therefore was mindful that it’s remit at this stage was to determine whether or not in respect of each of the disputed particular, there was sufficient evidence for there to be a case to answer, on the balance of probabilities.

The Tribunal’s Decision
Record of Determinations –
Medical Practitioners Tribunal

28. The Tribunal considered each of the outstanding paragraphs of the Allegation in turn.

Paragraph 2(b)

29. The Tribunal considered carefully Patient A’s evidence regarding the occasions when Mr Prasad checked if there was any feeling in her legs by stroking them. Patient A explained that on the hospital bed she would be lying down on her back each time this occurred. She also recalled that this bed was pushed up against a wardrobe on one side and therefore Mr Prasad would stand on her right side.

30. The Tribunal had regard to the expert witness evidence where both experts confirmed that light-touch stroking was clinically necessary and that during this procedure a doctor would have to lean across a patient. Therefore some contact between a doctor’s body and that of the patient would be unavoidable.

31. The Tribunal concluded that there was no evidence that any of the unavoidable contact had been inappropriate. Therefore the Tribunal was not persuaded that a reasonable Tribunal properly directed could, on the balance of probabilities, find the facts proved as alleged.

Paragraph 3 in its entirety

32. There is no documentary evidence of Mr Prasad carrying out a rectal examination on Patient A whilst she was an inpatient at the Trust during the Period. Mr Prasad admitted at the outset of the hearing that he had undertaken one rectal examination on Patient A whilst an outpatient on 23 July 2013. This examination was clinically indicated, consent was obtained and the examination was recorded.

33. In considering the issue of whether or not Mr Prasad performed any intimate examination of Patient A whilst an inpatient at the Trust, the Tribunal considered the evidence of Patient A. Patient A said Mr Prasad saw her every day at the hospital always alone and that only he and no one else had conducted an intimate examination on her during this time.

34. Hospital records show that Mr Prasad was often accompanied by other health professionals on the many occasions he saw her. The records also showed the only record of an intimate examination of Patient A whilst she was an inpatient was carried out by another doctor on the Neurology team on 10 June 2013.

35. The Tribunal considered Patient A’s evidence to be inconsistent with these facts and that it was unreliable. It concluded that her evidence was so tenuous that, in the absence of any other evidence, no reasonable Tribunal properly directed could find any of the particulars under Paragraph 3 proved. Accordingly it found that there was no case to answer in respect of the entirety of particular 3.
Paragraph 4(d)

36. The Tribunal first considered particular 4(d), namely an allegation that Mr Prasad inserted his finger(s) into Patient A’s vagina. The only evidence of such an act is Patient A’s assertion that it occurred.

37. The Tribunal concluded as with Paragraph 3 that the evidence was so tenuous that no reasonable Tribunal properly directed could find on the balance of probabilities that any ‘intimate examination’ was conducted by Mr Prasad on Patient A whilst she was an inpatient at the Trust.

38. Having found Patient A’s evidence to have been inconsistent and unreliable, the Tribunal concluded that the no case to answer test had been met in respect of 4(d). Having reached this conclusion there can be no case to answer in respect of the entirety of 4(a), 4(c), 4(d), 4(e) and 4(f).

Paragraph 6(a)

39. Mr Prasad admitted he had carried out a rectal examination on Patient A on 23 July 2013, this examination was clinically indicated, consented and recorded. The Tribunal had regard to Patient A’s evidence where she stated during her outpatient appointment with Mr Prasad, that there had been a nurse present who had been going in and out of the room.

40. Patient A did not refer to the nurse as a chaperone. Ms B said it was noted that a chaperone was present. She confirmed these were her words and not Patient A’s, in that Patient A did not refer to the nurse as being a chaperone. But Ms B confirmed in her oral evidence that a nurse would be regarded as a chaperone.

41. The Tribunal considered Patient A stating at one stage the nurse left the room and locked the door from the outside. There was no other evidence to suggest that happened nor a reason as to why a nurse would decide to do that.

42. The Tribunal noted there was no dispute that a nurse was present during the appointment. There was no evidence to contradict Patient A’s assertion that the nurse went in and out of the room. However it considered it implausible that the nurse would have locked the door, which Ms B stated was not usual practise.

43. The Tribunal was not persuaded that a reasonable Tribunal properly directed could, on the balance of probabilities, find the facts proved as alleged.

Paragraph 6(b)
Record of Determinations –
Medical Practitioners Tribunal

44. The agreed evidence of both experts was that having "a well documented numb perineum post operatively and on the balance of probabilities she would therefore have struggled to differentiate with any clarity between a rectal examination and a vaginal examination." In answer to questions from the Tribunal, Mr D stated that as to any feeling at all of digital penetration either could generate some diffuse visceral feeling. In his opinion, the fact that Patient A does not have a uterus would reduce the likelihood of any feeling.

45. It was clear from Patient A’s own evidence was that she was lying on her left side on the examination couch covered by a sheet with the doctor standing behind her, accordingly it follows that she could not have viewed any penetration.

46. The Tribunal was not persuaded that a reasonable Tribunal properly directed could, on the balance of probabilities, find the facts proved as alleged.

Paragraph 6(c)

47. Having reached the conclusion of no case to answer on allegation 6(b), the Tribunal concluded that there can be no case to answer in respect of 6(c).

Paragraph 7

48. By reason of the above mentioned findings, the Tribunal determined the only actions which remain for consideration as to sexual motivation are: 2(a) namely that Mr Prasad stroked Patient A’s legs, and 4(b) that on another occasion he stroked Patient A’s legs.

49. In the light of the agreed expert evidence that such stroking is an integral part of a neurological examination which was clinically indicated, a reasonable Tribunal properly directed could not conclude in this case that either action was sexually motivated.

Conclusion

50. As such, the Tribunal has determined to grant Mr Haycroft’s application made under Rule 17(2)(g) of the Rules. It has concluded that taken at its highest, the GMC evidence in respect of all the disputed allegations is such that a Tribunal properly directed could not find the Allegation proved.

51. Accordingly, the hearing will proceed only in respect of those matters admitted and found proved, namely 1, 2(a), 4(b) and 5.