Neutral Citation Number [2024] UKUT 408 (AAC) **Appeal No. UA-2023-000571-V**

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Between:

AK

Appellant

- v -

Disclosure and Barring Service

Respondent

Before: Upper Tribunal Judge Church and Tribunal Members Heggie and Jacoby
Hearing date: 19 November 2024
Mode of hearing: Oral Hearing at Field House, London

Representation:
Appellant: Anthony Haycroft of counsel, instructed by Weightmans LLP
Respondent: Simon Lewis of counsel, instructed by DLA Piper LLP

On appeal from:
Tribunal: The Disclosure and Barring Service
Customer ID No: P000565FZMH
DBS Ref No: DBS6191
Decision Date: 27 March 2023

RULE 14 Order

Pursuant to rule 14(1) of the Tribunal Procedure (Upper Tribunal) Rules 2008, it is prohibited for any person to disclose or publish any matter likely to lead members of the public to identify the appellant in these proceedings.
This order does not apply to: (a) the appellant; (b) any person to whom the appellant discloses such a matter or who learns of it through publication by the appellant; or (c) any person exercising statutory (including judicial) functions where knowledge of the matter is reasonably necessary for the proper exercise of the functions.
Any breach of this order is liable to be treated as a contempt of court and punished accordingly (see section 25 of the Tribunals, Courts and Enforcement Act 2007).

SUMMARY OF DECISION

SAFEGUARDING VULNERABLE GROUPS (65)

The Appellant was a doctor working in the emergency department of a hospital. Allegations were made by three patients that the Appellant sexually assaulted them under the guise of a medical examination.

The Appellant was charged with sexual assault, but the CPS issued a notice of discontinuance in relation to the charges, although the case was not closed by the police.

The DBS decided to place the Appellant's name on both barred lists on the basis that he had engaged in 'regulated activity' in his role as a doctor, and he had sexually assaulted 3 patients in his care, and this amounted to 'relevant conduct' in relation both to children and vulnerable adults.

The evidence relied upon by DBS in finding that the Appellant sexually assaulted the patients under his care was very weak, being untested second or third hand hearsay. It didn't even have the complainants' ABE interviews.

AK gave oral evidence before the Upper Tribunal, which was tested under cross-examination.

In the light of the fresh evidence before it, the Upper Tribunal found that the DBS had based its decision to bar the Appellant on material mistakes of fact. It accepted the Appellant's evidence that, while he had touched each patient close to her breasts and had touched her pubic bone, this was part of a standard systemic examination appropriate to the symptoms with which they had presented and was not sexually motivated.

It directed the DBS to remove the Appellant's name from both barred lists.

Please note the Summary of Decision is included for the convenience of readers. It does not form part of the decision. The Decision and Reasons of the judge follow.

DECISION

The decision of the Upper Tribunal is to allow the appeal. The First-tier Tribunal made mistakes in the findings of fact on which its decision was based. Pursuant to Section 4(6)(a) of the Safeguarding Vulnerable Groups Act 2006 (**"SVGA"**) the Upper Tribunal directs the Disclosure and Barring Service to remove the Appellant's name from both the children's barred list and the adults' barred list.

REASONS FOR DECISION

The decision under appeal

1. On or about 27 March 2023 the Disclosure and Barring Service (**"DBS"**) decided that it was appropriate and proportionate to include AK's name in both the adults' barred list and the children's barred list (the **"Barring Decision"**). It informed AK of the Barring Decision by a 'Final Decision Letter' dated 27 March 2023.

2. That Final Decision Letter explained that the Barring Decision was based on the following findings made by the DBS:

> "We are satisfied that you meet the criteria for regulated activity. This is because of your time working in the NHS as a Doctor.
>
> We have considered all the information we hold and are satisfied of the following:
>
> - On 20/06/2019 while obtaining the Mental Health history of a patient you touched her genitals, breasts and buttocks.
>
> - On 10/06/2020 on 2 occasions you sexually touched 2 female patients during physical medical examinations while working in A&E."

2. Because what the Upper Tribunal needs to decide is so narrow (for the reasons explained under "What we must now decide" below) there is no need to reproduce the Barring Decision here.

The factual background

3. AK is a male doctor (now aged 31). He was accused by 3 separate female patients of sexually assaulting or otherwise inappropriately touching the patients while ostensibly performing a clinical examination in the course of his work as a medical doctor.

4. The first allegation (described in the first bullet point in paragraph 2 above) is no longer relied upon by the DBS, so there is no need to recount the detail of that allegation here.

5. The second allegation was that in the late morning of 10 June 2020, while AK was working as a locum doctor within a hospital accident and emergency department and ostensibly carrying out a triage assessment on a patient who had complained of abdominal issues (**"Patient 2"**), AK sexually touched Patient 2 (**"Incident 2"**).

6. The third allegation was that, almost immediately after the alleged assault on Patient 2, in the same examination room and in similar circumstances, AK sexually touched another patient who had complained of chest pains and of whom he was ostensibly carrying out a triage assessment (**"Patient 3"**; **"Incident 3"**).

7. There was a police investigation into the allegations, which were treated as allegations of sexual assault. AK was charged in relation to Incident 2 and Incident 3, but a "notice of discontinuance" was subsequently issued by the Crown Prosecution Service in relation to those charges on the basis that there was then insufficient evidence. However, the case has not been closed and the police say that the matter is "live and ongoing". This has had the unfortunate consequence that neither the DBS nor AK has had access to evidence relevant to the allegations, including the ABE interviews that the complainants gave in the course of the investigation.

8. AK referred himself to his regulator, the General Medical Council (**"GMC"**), in connection with the allegations against him. The Interim Orders Tribunal made interim orders (first imposing conditions on AK's practice, then suspending him from practice, then permitting him to practise subject to conditions again) pending the outcome of substantive proceedings before the Medical Practitioners Tribunal Service, which appear still to be at an early stage.

9. The allegations were referred to DBS, which informed AK of the allegations in a 'Early Warning Letter' dated 4 February 2022 and invited him to make representations. AK made written representations on 16 March 2023 denying the allegations against him, but on 27 March 2023 the DBS made the Barring Decision, which it communicated to AK by way of the Final Decision Letter.

The appeal to the Upper Tribunal

10. AK disagreed with the Barring Decision and completed a UT10 appeal form, which he sent to the Upper Tribunal. In that form he argued that the Barring Decision involved mistakes of law in that it had:

    a. applied a reversed burden of proof (requiring AK to “explain” and provide “mitigation” based on an apparent assumption that he had engaged in the conduct that was alleged),

    b. misunderstood the nature of a GMC interim order of conditions, and

    c. made a decision that was premature, given that the GMC fitness to practise proceedings had not concluded and it was unclear whether criminal proceedings would be pursued).

11. AK also maintained that the Barring Decision involved material mistakes of fact, namely DBS had mistakenly found that AK had sexually touched three patients, when he says he did no such thing, and the balance of the evidence doesn’t support that he did.

12. On 16 April 2024 I granted AK permission to appeal on the papers. In my grant of permission I said:

    “15. The Applicant has made several criticisms of the way that the DBS carried out its decision making. At the heart of this application, though, is the Applicant's spirited denial that he did the things that the DBS have found that he did.

    16. The DBS has said in its written submissions on this application that it made no material mistake of fact. However, it said it "does not seek to defend its findings" in relation to the first alleged incident. It appears to accept that it may well have been mistaken in its finding that that alleged incident occurred as alleged, but maintains that such a mistake would not have been material, because the DBS would still have placed the Applicant's name on both barred lists had it not made such a mistake. It maintains that its findings in relation to the second and third alleged incidents were not mistaken and the Barring Decision involved no error of law.

    17. The DBS made the Barring Decision based on the written evidence only, and before the Applicant's professional conduct proceedings before the GMC had concluded. I am not persuaded that it is arguable that the DBS's decision to reach a final decision in those circumstances was itself an error of law but, given the Applicant's willingness to give oral evidence at a hearing and to make himself available for cross examination by the DBS's counsel and to be questioned by the panel, it is likely that if permission were to be granted the Upper Tribunal would hear significant new evidence on the allegations (namely the Applicant's own account). The Upper

> Tribunal would be entitled to take into account such new evidence when assessing whether the Barring Decision was based on a material mistake of fact.
>
> 18. I am persuaded that this makes it appropriate for permission to be granted to appeal the Barring Decision to the Upper Tribunal. Since I am granting permission, I need not deal at this stage with the other grounds argued in the Applicant's amended grounds of appeal. Although I am currently unpersuaded that any of them is arguable, I give permission for them to be aired and relied upon at the substantive appeal hearing, if desired."

13. I made case management directions and directed an oral hearing of the substantive appeal.

What we must now decide

14. The parties, in accordance with their duty to help the Upper Tribunal to further the overriding objective under rule 2 of the Tribunal Procedure (Upper Tribunal) Rules 2008 (the **"UT Rules"**), co-operated with each other to narrow the issues ahead of the substantive appeal hearing.

15. AK narrowed the focus of his appeal, and by the date of the hearing he sought to rely only on the mistake of fact ground.

16. DBS agreed the expert report of Mr P. Burdett-Smith (a consultant in emergency medicine) adduced by AK, making it unnecessary for him to attend to be cross-examined.

17. The co-operative spirit in which this case was conducted by the parties and their representatives greatly assisted the Upper Tribunal and allowed the hearing to run smoothly and to time. The panel is grateful to all involved.

18. This all meant that we had only one issue to decide: "Was the DBS mistaken in its finding that AK touched Patient 2 and Patient 3 sexually?" Put another way: "Did he do it?"

19. This appeal is all about the evidence.

Legal framework

<u>The statutory scheme</u>

20. There are multiple gateways under Schedule 3 to the SVGA to a person's name being included on a barred list.

The 'relevant conduct' gateway

21. In this case the DBS relied upon the "relevant conduct" gateway. That required the DBS to be 'satisfied' of three things:

    a. that AK was at the relevant time, had in the past been, or might in future be 'engaged' in, 'regulated activity' in relation to children and/or vulnerable adults (see paragraphs 3(3)(aa) (in relation to children) and 9(3)(aa)(in relation to vulnerable adults) of Schedule 3 to the SVGA);

    b. that AK had 'engaged' in (see paragraphs 3(3)(a) (in relation to children) and 9(3)(a) (in relation to vulnerable adults) of Schedule 3 to the SVGA) 'relevant conduct' (defined in paragraph 4 (in relation to children) and paragraph 10 (in relation to vulnerable adults); and

    c. that it was 'appropriate' (and proportionate) to include AK on the barred list(s) (see paragraph 3(3)(b) (in relation to children) and 9(30(b) (in relation to vulnerable adults) of Schedule 3 to the SVGA).

22. If the DBS was satisfied of all three matters above, it was required to place AK's name on both barred lists.

23. AK accepts that the 'regulated activity' requirement is met in this case by reason of his work as a doctor, so a. is not in issue.

24. Whether AK engaged in 'relevant conduct' in relation to vulnerable adults is the key issue in this appeal.

25. Although AK says that it was neither appropriate nor proportionate to place his name on any barred list, he does not dispute that the conduct that the DBS found him to have engaged in would make barring appropriate and proportionate. However, his case is that he didn't engage in 'relevant conduct' because he didn't act as the DBS found him to have acted.

26. Those unfamiliar with this jurisdiction may wonder why the DBS argues that AK engaged in 'relevant conduct' in relation to children, given that the allegations relate to adult women in their 30s. The reason for this is the way that 'relevant conduct' in relation to children is defined in paragraph 4 of Schedule 3 to the SVGA. That definition includes "conduct which, <u>if repeated against or in relation to a child</u>, would endanger that child or would be likely to endanger him" (see

paragraph 4(1)(b) of Schedule 3 to the SVGA, emphasis added). There doesn't need to be any conduct that has actually involved children.

The Upper Tribunal's jurisdiction under the SVGA

27. Section 4 of the SVGA sets out the circumstances in which an individual may appeal against the inclusion of their name in the barred lists or either of them. An appeal may be made only on grounds that the DBS has made a mistake on any point of law or in any finding of fact which it has made and on which the barring decision was made (see section 4(1) and (2) of the SVGA).

28. An appeal under section 4 SVGA may only be made with the permission of the Upper Tribunal (see section 4(4) SVGA).

29. Unless the Upper Tribunal finds that the DBS has made a mistake of law or fact it must confirm the decision of the DBS (see section 4(5) of the SVGA). If the Upper Tribunal finds that the DBS has made such a mistake it must either direct the DBS to remove the person from the list or remit the matter to DBS for a new decision.

30. If the Upper Tribunal remits a matter to DBS under section 4(6)(b) the Upper Tribunal may set out any findings of fact which it has made (and on which the DBS must base its new decision) and the person must be removed from the list until the DBS makes its new decision, unless the Upper Tribunal directs otherwise.

31. Section 4(3) SVGA provides that, for the purposes of section 4(2) SVGA, whether or not it is 'appropriate' for an individual to be included in a barred list is "not a question of law or fact".

The relevant authorities

32. There was no dispute on the authorities applicable to the Upper Tribunal's mistake of fact jurisdiction. However, to help readers unfamiliar with this area I set out a summary of the current state of the case law, which was agreed by the parties:

33. The relevant principles regarding factual mistakes have been set out in several recent decisions of the Court of Appeal (see *PF v DBS* [2020] UKUT 256 (AAC); *DBS v JHB* [2023] EWCA Civ 982; *Kihembo v DBS* [2023] EWCA Civ 1547; and

DBS v RI [2024] EWCA Civ 95). These decisions are binding on the Upper Tribunal.

34. In relation to whether it is “appropriate” to include a person in a barred list, the Upper Tribunal has only limited powers to intervene. This is clear from the section 4(3) SVGA and relevant case law. The scope for challenge by way of an appeal is effectively limited to a challenge on proportionality or rationality grounds. The DBS is well-equipped to make safeguarding decisions of this kind (*DBS v AB* [2021] EWCA Civ 1575 (paras 43-44, 55, 66-75)).

35. At paragraph [55] of *DBS v AB*, the Court cautioned: “[The Upper Tribunal] will need to distinguish carefully a finding of fact from value judgments or evaluations of the relevance or weight to be given to the fact in assessing appropriateness. The Upper Tribunal may do the former but not the latter…”. At paragraph [43], the Court stated: “…unless the decision of the DBS is legally or factually flawed, the assessment of the risk presented by the person concerned, and the appropriateness of including him in a list barring him from regulated activity…, is a matter for the DBS”.

36. In the subsequent Upper Tribunal case, *AB v DBS* [2022] UKUT 134 (AAC), the Upper Tribunal decided (albeit in the context of a case that was based on the “risk of harm” rather than the ‘relevant conduct’ gateway) that *DBS v AB* meant that the Upper Tribunal could consider, on appeal under the SVGA, a finding of fact by DBS that an individual poses “a risk” of harm but not a DBS assessment of the “level of the risk posed” (see [49]-[52] and [64]).

37. When considering appeals of this nature, the Upper Tribunal “must focus on the substance, not the form, and the appeal is against the decision as a whole and not the decision letter, let alone one paragraph…taken in isolation”: *XY v ISA* [2011] UKUT 289 (AAC), [2012] AACR 13 (at [40]).

38. When considering the Barring Decision, the Upper Tribunal may need to consider both the Final Decision Letter and the document headed ‘Barring Decision Summary’ that is generated by DBS in the course of its decision-making process. The two together, in effect, set out the overall substantive decision and reasons (see *AB v DBS* [2016] UKUT 386 (AAC) at [35] and *Khakh v ISA* [2013] EWCA Civ 1341 at [6], [20] and [22]).

39. The statement of law in *R (Iran) v Secretary of State for the Home Department* [2005] EWCA Civ 982 indicates that materiality and procedural fairness are

essential features of an error of law and there is nothing in the SVGA which provides a basis for departing from that general principle (*CD v DBS* [2020] UKUT 219 (AAC)).

40. DBS is not a court of law. Reasons need only be sufficient/adequate. DBS does not need to engage with every potential issue raised. There are limits, too, as to how far DBS needs to go in terms of any duty to "investigate" matters or to gather further information for itself, but it must carry out its role in a way that is procedurally fair.

41. If the Upper Tribunal finds that the DBS made a material mistake of fact or law under section 4(2) of the Act, it is required under section 4(6) SVGA to either (i) direct that DBS removes the person from the relevant list(s) or (ii) remit the matter to DBS for a new decision. Following *AB*, the usual order will be remission back to DBS unless no decision other than removal is possible on the facts.

The hearing before the Upper Tribunal

<u>AK's oral evidence</u>

42. At the hearing AK gave oral evidence and he made himself available for cross-examination by Mr Lewis, for the DBS, and the panel.

43. In his evidence, AK described working conditions at the hospital at the time of the alleged incidents, which was during the height of the Covid pandemic. He said the Accident & Emergency Department was busy and, due to the need for there to be segregation between patients with Covid and patients without Covid, it was understaffed. PPE clothing was required to be worn, and the specific requirements for PPE changed frequently by reason not only of policy changes but also what was available within the trust. He described wearing PPE (a mask, apron and gloves) as being uncomfortable, and he said wearing masks could give rise to breathing issues.

44. He described the room in which he had carried out the examinations of Patient 2 and Patient 3: on entering through the door there was a computer station on the left with a chair. On the right side there was a sink, a chair for the patient and an examination couch which was a "thin bed-like structure". He said the room was perhaps a quarter the size of the courtroom, so perhaps 20' x 20'.

45. Under cross-examination AK said he had no reason to believe that Patient 2 and Patient 3 knew each other, but he hadn't observed them closely. He said he did

not doubt that they had attended the Emergency Department with genuine medical concerns. He said that when he examined Patient 2 and Patient 3 on each occasion it was just him and the patient present. It was the same with the meetings with Patient 2 and Patient 3 when he explained their respective test results, 'red flags' and treatment plan.

46. AK described performing "standard systemic examinations" of both Patient 2 and Patient 3.

AK's evidence on his interactions with Patient 2

47. AK's evidence in relation to his interactions with Patient 2 was that she presented in the emergency department with abdominal pain and he saw her shortly before 11:35am. Blood and urine samples were taken. AK performed an abdominal examination which went "as high as the top of the abdomen" under Patient 2's chest, and "as low as the pubic bone". AK said that sometimes when performing an abdominal examination, a patient requires their clothing to be adjusted if it comes up too high, and that in such a case he would ask the patient to lower their clothing down to their hip. He insisted that when examining Patient 2 his hand hadn't gone below her pubic bone.

48. AK said he used his stethoscope to listen to Patient 2's chest and he checked her "apex beat". This involved him feeling for the beat with his hand just below Patient 2's left breast. AK said his hand would have gone "close to the breast" when performing this examination.

49. AK's evidence was that after the examination Patient 2 returned to the waiting area when AK wrote up Patient 2's electronic patient record of the examination. Patient 2 had to wait some time for her test results to come back and for AK to speak to his consultant. AK saw Patient 2 again for about 5 minutes at about 15:00, when he gave her the test results, removed her canular, explained what 'red flags' would indicate that a return visit to hospital was warranted, and explained the treatment plan. AK said that Patient 2 was discharged at 15:05, as shown in her patient record.

50. AK explained that he had made entries on the electronic patient record during the course of the morning on a more or less contemporaneous basis. The record indicates the times the record was updated (that time being recorded automatically), although it doesn't show which entries were added when. AK said he updated the records after seeing each patient on each occasion.

AK's evidence on his interactions with Patient 3

51. AK said he first saw Patient 3 at shortly before 12:29. He was informed by the triage nurse that Patient 3 had complained of central chest pain, palpitations, and left arm numbness. AK explained that he was concerned because these symptoms were consistent with a heart attack. AK took a history from Patient 3, whom he understood to be a woman in her 30s probably from Romania or another East European country. He said her English was "fairly OK", but it was obvious that English was not her first language.

52. Urine and blood samples were taken and sent for testing, and Patient 3 was also given an echocardiogram.

53. AK said he performed an examination of Patient 3 that was "more or less the same" as the examination he had performed on Patient 2, except that in the case of Patient 3 AK also palpated either side of the sternum (breastbone) to check for costochondritis (which was a differential diagnosis for chest pain). When asked why nothing was recorded on the electronic patient notes about this part of the examination, AK said he would have recorded if he had found anything, but there was nothing to report.

54. When asked under cross examination what "palpate" meant, AK demonstrated by pressing the palm of one hand briefly with two fingers of his other hand. He agreed with Mr Lewis's suggestion that he had demonstrated a "relatively short, light touch", and agreed that this was "very different from a massage". AK said he didn't touch either Patient 2 or Patient 3's breasts, except as he had described in his account of the examinations.

55. AK said that while he was waiting for the test results to come back, he met with the Emergency Department consultant, Dr Johal, to discuss that day's cases (including Patients 2 and 3). This was, he thought, around 12:30-1:00pm.

56. When the test results came back AK was "relieved and reassured" that Patient 3's symptoms did not indicate a heart attack. AK spoke to Dr Johal again after the tests came back.

57. Immediately after AK had spoken to Patient 2 and discharged her (which took about 5 minutes), he called Patient 3 from the waiting area and they went (alone) to a room where he told her the results of the tests, explained the treatment plan and explained the "red flag" symptoms that Patient 3 should look out for and that

would indicate that a return to hospital was warranted. This meeting also took about 5 minutes and at 15:10 AK discharged Patient 3, as indicated on the electronic patient records.

58. AK said the document at pages 410-415 of the appeal bundle was a report he wrote on the evening of 10 June 2020 (the day of the alleged incidents) on the advice of Dr Johal and other consultants. AK said that after the police had visited the ward, the consultants said he should write down everything he remembered about the incidents. He said this account was written from memory.

59. AK explained that the document at pages 419 – 421 of the appeal bundle was a report written by Dr Helen Parker, one of the other consultants, and had been written by her in the context of a complaint that Patient 2 later made to the hospital trust. He said the information in that report was largely a cut and paste from Patient 2's patient record.

60. AK said that the document at pages 339 – 386 was a record of his police interview on 26 June 2020. He explained he had only one police interview, with a short break in between, and that the reference to a different date on page 387 must be in error.

61. AK said he answered the questions in the police interview honestly, but he was now less sure about whether he was in fact wearing gloves when he examined Patients 2 and 3. He explained that while pre-Covid he wouldn't necessarily have worn gloves for such an examination, it was the practice at the time of the alleged incidents for him to wear gloves, and that was why he was so confident when interviewed by the police that he had worn them. However, he later remembered that he had not worn gloves when dealing with an incident on the ward involving a patient with mental health problems, so he couldn't now be sure whether he wore gloves when examining Patients 2 and 3. He couldn't say one way or the other as he had no specific recollection.

62. When asked about the comments alleged to have been made by the male patient with the initials KS who interacted with Patient 2 in the waiting area, AK said he didn't know whom the "crazy guy" KS referred to was, and he couldn't confirm whether it was the patient whom he had referred to as having mental health problems.

63. When it was put to AK that witness KS had reported being told by Patient 2 that the doctor had "touched her in different ways", and had "touched her leg, back

and chest" despite her only having reporting pain in her stomach, he said it was true that he had touched Patient 2's legs, back and chest, as that was part of the standard systemic examination. He said he also touched Patient 2's belly. When asked about KS's report that Patient 2 had spoken of the doctor trying to go down with his "hand towards her private parts", he said he had put his hand down "towards" her private parts, but insisted that he had gone down no further than Patient 2's pubic bone, and that this was again part of the standard abdominal examination.

64. It was put to AK that KS had reported Patient 2 as having said that the doctor "had gone behind her and hugged her". AK said he did not do this. AK said Patient 2 had been lying on the examination couch, which was against a wall on the left hand side, while AK was standing to the right of the patient, with her head to his left and propped up. AK said he performed the examination while Patient 2 was in this position and it wouldn't have been possible for him to have done what was described. He said he didn't do what was described.

65. When it was put to AK that witness KS had reported Patient 2 as having said that she said to AK "what are you doing? I have pain in my stomach, not my back" and that she had told KS that the doctor "was touching her in the wrong way", AK said Patient 2 had not asked "what are you doing" and he didn't remember her saying that he was touching her "in the wrong way".

66. It was put to AK that KS had reported "another lady" (Patient 3) saying that the Asian doctor "was misbehaving to her", and that she told him she had pain in her chest and the doctor "opened her pants and touched her back". AK said that Patient 3's pants could have been opened, and that he asked her to lower her trousers. He said there was no need to go inside the underwear, but he had touched Patient 3's back as part of the examination.

67. When asked whether he locked the door to the examination room, AK said that his usual practice "if I remember to" was to lock the door, explaining that he was doing so for the patient's privacy because he was going to examine her, and the room in which he was to perform the examination didn't have curtains around the examination couch. He said he couldn't recall whether he had done so when examining Patient 2 or Patient 3. AK said it wouldn't have been strange for him to have locked the door. He explained that the door does not lock with a key, but rather it is the kind of lock that is activated by turning a knob, so the patient would be able to unlock it by turning the knob the other way and would not be "trapped".

68. AK denied getting Patient 2 to stand up during her examination, and he denied going behind her to touch her buttocks. He denied palpating Patient 2's breasts or feeling them "in a non-medical way". He denied making contact with Patient 2 with his genital area, pressing into her from behind, as had been alleged.

69. AK denied putting his hand inside Patient 3's underwear, touching Patient 3's bottom, touching Patient 3's nipples, touching Patient 3's vulva or looking at her genitals, and he denied making contact with Patient 3 with his penis/groin through his clothes. AK said none of these things would have been part of the examination and none of them would have been clinically justified.

70. When it was put to him that the vulva was "a reasonable distance" from the pubic bone, "perhaps 3 to 4 inches", AK said that the human anatomy differed from person to person, and it may be as little as "3 to 4 centimetres". He said his hand would have been palpating the bladder, so to the patient it would feel close to the genitals.

71. When asked about his allegedly touching the buttocks of the patients he said that they were sitting down so he wouldn't have been able to do that. However, he said that when examining her back he did press the sacral area, just above the buttocks. He said he would have been able to touch the buttocks if they were standing up, but denied standing either patient up during their examination.

72. AK said that about half-way through his examination of Patient 3 he became aware that she was not wearing a bra. He said that, in retrospect, he should have asked for a chaperone once he realised the patient was not wearing a bra, but because the examination he was carrying out was not classed as an "intimate" examination, trust policy did not require a chaperone.

73. AK denied having an erection or a semi-erection during either alleged incident. He denied massaging either patient's breasts or breathing heavily, and he denied that he had sought sexual gratification from the examinations.

74. Mr Lewis put to AK that there was a big difference between his account of what happened and the accounts of Patient 2 and Patient 3. He said it was difficult to see that they might have misinterpreted the examination he had conducted. AK said that what Patients 2 and 3 had said initially was in fact very close to what he had said happened.

75. It was put to AK that the nurse who was on duty at the time of the incidents (with initials AE) had been interviewed by the police and made a witness statement reporting that Patient 2 had approached him in the waiting area after having been examined by AK, and had said that she didn't like the doctor and didn't want to be examined by him again, that Patient 3 said she didn't like the doctor either, and the nurse reported that he brought to AK's attention that neither patient wanted to see him again.

76. AK confirmed it was brought to his attention that the patients didn't want to be seen and he said it didn't surprise him, because patients get tired of waiting and want to go home. He said he told them he was waiting for their results and they would probably be discharged once the results came in. When asked whether the nurse had said that the patients "don't want to be seen by you?" (emphasising the last two words), AK said he couldn't remember, and could remember only being told that they didn't want to be seen.

77. When AK was asked by Mr Lewis whether, looking back, he would have done anything differently, he said he would have asked for a chaperone. He said he would also like to apologise to the patients if his examination of them made them uncomfortable, and he said he now understood the importance of communicating clearly with patients, especially if they don't have English as their first language. He said this was especially important where a patient may be confused because an examination went beyond the areas where they had reported pain. He said he had not explained to Patient 2 or 3 why he was touching them in those other areas, and that he should have done.

78. AK said he only became aware that complaints had been made about him at about 5pm on the day of the alleged incidents, when police officers attended the ward. He said he wasn't aware that one of the patients had telephoned the police after being examined by him but before meeting with him the second time to get her test results.

79. AK said that he was not currently working in a medical capacity, but rather was doing part time academic work.

The evidence before the DBS when it made the Barring Decision

80. The DBS made the Barring Decision based on paper evidence only. It did not hear live evidence either from AK or from any other witness. Further, it did not have the benefit of considering the ABE interviews of either Patient 2 or Patient

3 because these had not been disclosed by the police (and indeed they have still not been disclosed).

81. It is not entirely clear what evidence the DBS based its finding on, because it is not referenced in the 'Barring Decision Summary' document. Reference is made to allegations which are attributed to Patient 2 and Patient 3 but the provenance of the allegations is not explained. It appears to have relied in large part on the record of the police interview with AK (at pages 339-396 of the appeal bundle), in which allegations were put to him, the police 'Case File Summary – Police Report' (see pages 397-402 of the appeal bundle).

82. It is not entirely clear to us whether the DBS had before it the police statements of:

    a. DK (the male patient present in the waiting area at the relevant time) (at pages 757-758 of the appeal bundle);

    b. AE (the nurse on duty in the Emergency Department at the time of the alleged incidents, and who spoke to Patient 2 and Patient 3) (see page 718 of the appeal bundle);

    c. husband of Patient 3 (translation at page 759 of the appeal bundle); and

    d. AY, the police officer who attended at the hospital to collect DNA evidence (see page 736 of the appeal bundle).

83. Whether it did or not, we have them now and we are entitled to take them into account.

84. Whether or not the DBS had access to the documents listed in paragraph 82, it is plain that the Barring Decision placed heavy reliance on untested hearsay evidence, and in large part on untested second or third hand hearsay evidence. There is no direct account from Patient 2 or Patient 3 of the allegations which are referred to by the officers who conducted the police interview of AK (save the victim impact statement that was made long after the alleged incidents and which does not provide significant detail), so the DBS has relied principally on what the police officers interviewing AK suggest that Patient 2 and Patient 3 had alleged, and possibly what DK, AE, Patient 3's husband reported them as having said.

The parties' submissions

85. Mr Lewis, for the DBS argued that this was a binary case: either AK was right and he performed a legitimate clinical examination, and Patient 2 and Patient 3 were both lying, or Patient 2 and Patient 3 were telling the truth and AK was lying.

86. He argued that, given the nature of the allegations made by Patient 2 and Patient 3 (i.e. that AK engaged in overtly sexual touching by massaging their breasts, pressing his erect or semi-erect penis into them from behind and, in the case of Patient 3, touching her nipples and vulva and looking at her vulva) this was not a case that could be explained in terms of Patient 2 and Patient 3 misunderstanding, misremembering or misinterpreting matters.

87. He argued that it was inherently unlikely that Patient 2 and Patient 3, who do not appear to have known each other, would have engaged in a conspiracy to make false allegations against AK.

88. Mr Haycroft, for AK, encouraged us to give weight to the evidence that AK gave, which was the only evidence that had been tested. He said AK's case was simple: he didn't do it.

Our assessment of the evidence

89. Unlike the decision makers at the DBS, we had the opportunity to hear AK's live evidence tested under cross-examination. AK was forthcoming, and it was apparent that he had reflected on the situation and had learned from it.

90. He acknowledged that, in retrospect:

    a. he should have explained to Patient 2 and Patient 3 in advance what his examination would involve, and why; and

    b. he should have asked for a chaperone for his examination of Patient 3 once he discovered that she was not wearing a bra.

91. We considered AK's evidence at the hearing alongside all the other evidence. We found the evidential value of the untested hearsay statements relied upon by the DBS to be low and we felt able to give them little weight.

92. We found AK to be a compelling witness. Other than in relation to the issue of whether he wore gloves when he examined Patient 2 and Patient 3, the evidence he gave was consistent with what he had written in his clinical notes and in the

report he wrote on the day of the alleged incidents when they were fresh in his mind, as well as what he had said in his police interview.

93. We were not troubled by AK's change in his evidence as to whether he wore gloves when he conducted the examinations of Patient 2 and Patient 3. We accept his explanation that he was confident at the time of his police interview that he had worn gloves because that was at the time his normal practice due to Covid PPE policies, but he now accepts that he may not have done. He couldn't remember one way or the other. We do not find that either this inconsistency or AK's admitted uncertainty makes his evidence unreliable.

94. AK's evidence at the hearing was (save in respect of the wearing of gloves) consistent with what he had said himself in his police interview and in his written account on the day of the allegations. Consistency by itself does not establish either truthfulness or accuracy: a witness may be inconsistent but still honest, just as he may be wholly consistent but untruthful and unreliable. However, AK's oral evidence was largely consistent not only with what is recorded of his other statements, but also with what is recorded of the first accounts of each of the relevant witnesses:

    a. AK, the male patient present in the waiting area said that one female patient complained that the "doctor's no good" and that he had been "touching her in different ways" He says that she reported having stomach pain but complained that the doctor had "touched her leg, back and chest" and "belly" and tried to "go down with his hand towards her private parts". He said that the other female patient said that the Asian doctor had "done the same thing" to her, that she had a pain in her chest but he opened her pants and touched her back. See pages 757-758 of the appeal bundle).

    b. The nurse present in the waiting room said that one of the female patients had told him that she didn't want to be examined by AK again, but didn't say why, and the other female patient overheard this and said that she also didn't want to be examined by AK again. He said that he told them that he would tell the doctor that they didn't want to see him again, and he told AK that (see page 718 of the appeal bundle).

    c. Police officer AY, who attended to collect evidence. She says that she "swabbed the skin around [the complainant's] breasts and the top of her pubic bone with wet and dry swabs as these were the areas that had

been touched extensively in her account" She explained that this was "to ascertain traces of [AK's] DNA on her skin which would have been transferred if he had not been wearing gloves" (see page 736 of the appeal bundle).

d. Patient 3's husband's account of his telephone call with his wife was that she said that the doctor had "touched [her] 'tits' – her breasts – when he was behind her".

95. We found it significant there is no reference in AK's statement to Patient 3 alleging that AK looked at or touched her genitals, or of either patient complaining of AK massaging or otherwise inappropriately touching their breasts, or of pressing his erect or semi-erect penis into them.

96. We find it highly significant that police officer AY who carried out the swabbing, did not report swabbing the breasts themselves or below the complainant's pubic bone, which she would surely have done had the complainant alleged that she had been touched by AK in those places too. It appears that swabs were taken in relation to both complainants, but these were not sent for testing because it was considered that the results would have no evidential value as AK could have touched the areas swabbed as part of a legitimate examination. This indicates that at that stage no allegation had been made of AK touching either patient's vulva.

97. While Patient 3's husband did refer to his wife reporting that the doctor had touched her breasts, there is no mention of any allegation that he looked at or touched her genitals or that he massaged her breasts or that he had an erect or semi-erect penis or pressed his penis into her.

98. While Patient 3 was reported by her husband to have referred to the doctor having "touched [her] tits", we note that she was not wearing a bra when she was examined. We think it likely that she felt vulnerable as a result and may have experienced AK feeling for her apex beat near her left breast and palpating either side of her breastbone, as him touching her breasts.

99. We do not accept that the two alternative explanations proposed by Mr Lewis are the only ones. Another possible explanation is that:

a. AK carried out clinical examinations of Patient 2 and Patient 3 just as he described in his evidence;

b. Patient 2 and Patient 3 were each surprised and distressed to be touched and examined in places other than where they had complained of pain (i.e. their abdomen and chest, respectively), including being touched close to their breasts and their pubic bone (near to their genitals);

c. Patient 2 and Patient 3 believed the examination to have been inappropriate and sexual in nature, and were distressed by this; and

d. Patient 2 and Patient 3 gave honest initial accounts of their experiences.

100. In the absence of direct evidence from Patient 2 and Patient 3, it is very difficult to know what they said. It is possible that, having given honest and largely accurate initial accounts, they later added to that evidence in the way that the line of questioning in AK's police interview suggests they did. If they did, it may well be that that later evidence amounts to a "gilding" of their initial accounts for fear that what they had initially alleged (touching of the leg, back, chest and belly and going down towards their "private parts") would not be taken seriously, or it may be that their allegations were misdescribed by the officers conducting the interview with AK, and it could have been inaccurately summarised in the police "summary of evidence". We note also that Patient 2 and Patient 3 appear to have been interviewed together, so there is a risk that hearing each other's accounts might have influenced what they described.

101. We feel bound to resolve these uncertainties in favour of AK, given that his evidence was tested while the evidence of Patient 2 and Patient 3 is second or third hand hearsay which has not been tested.

102. We do not require to find either that the complainants were part of a dishonest conspiracy against AK or that AK was lying. It is much more likely that the complainants genuinely believed that they had experienced inappropriate sexual touching, but we are persuaded by AK's evidence at the hearing and by our review of the evidence as a whole, that the DBS was mistaken in its finding that AK "sexually touched 2 female patients during physical medical examinations while working in A&E" (see the Final Decision Letter).

103. Considering all the evidence before us in the round, we find that:

a. AK performed a standard systemic examination of Patient 2, which involved touching near her breast and touching her pubic bone;

b. AK performed a standard systemic examination of Patient 3 which involved touching near her breast, palpating either side of her sternum and touching her pubic bone;

c. AK did not touch either patient's breasts except possibly accidental touching incidental to his feeling for an apex beat;

d. AK did not look at or touch either patient's genitals;

e. AK did not touch either patient's bottom; and

f. AK's examination of each patient was motivated by his professional concern and not by any sexual interest.

104. The upshot of Mr Burdett-Smith's expert evidence, which was not challenged by the DBS, was that what AK had described doing in his examination of Patient 2 and Patient 3 would have amounted to an appropriate clinical examination given the presenting complaints (although the examination of Patient 3 should have been carried out over her clothes given that she was not wearing a bra, or with a chaperone present), but the alleged massaging of breasts and looking at and touching of the vulva, would not form part of an appropriate clinical examination in this context. We accept AK's evidence as to what he did and did not do. As such we find that his examination of both Patient 2 and Patient 3 was clinically appropriate albeit that, as AK now accepts, he should have asked for a chaperone for his examination of Patient 3 when he became aware that she was not wearing a bra.

105. We therefore conclude that the Barring Decision was based on a material mistake of fact.

106. Because we have found that the DBS was mistaken in its findings as described above, we find that AK did not engage in any relevant conduct for the purposes of the SVGA.

107. As such, there was no basis for AK's name being included in any barred list.

Conclusion

108. The appeal is allowed.

109. The DBS made mistakes in the findings of fact on which its decision was based.

110. Pursuant to Section 4(6)(a) of the SVGA the Upper Tribunal directs the DBS to remove AK's name from both the children's barred list and the adults' barred list.

Thomas Church
Judge of the Upper Tribunal
Tribunal Member Jo Heggie
Tribunal Member Suzanna Jacoby

Authorised by the Judge for issue on 10 December 2024