Neutral Citation Number: [2019] EWHC 2173 (Admin)

Case No: CO/4753/2018

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT
ON APPEAL FROM THE FITNESS TO PRACTISE PANEL OF THE MEDICAL PRACTITIONERS TRIBUNAL SERVICE

Manchester Civil & Family Justice Centre
1 Bridge Street, Manchester M60 9DJ

Date: 07/08/2019

Before :

THE HON. MR JUSTICE PEPPERALL

- -

Between :

DR SYED AHMED

Appellant

- and -

THE GENERAL MEDICAL COUNCIL **Respondent**

- -

Andrew Colman (instructed by **Radcliffes Le Brasseur**) for the **Appellant**
Alexis Hearnden (instructed by the **General Medical Council**) for the **Respondent**

Hearing dates: 27 February 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

THE HONOURABLE MR JUSTICE PEPPERALL:

1. Dr Syed Ahmed is a Consultant in Acute Medicine. He qualified as a doctor in Pakistan in 1985 and became fully registered with the General Medical Council ("the GMC") in 1996. Between January 2007 and February 2016, he was employed by the Stockport NHS Foundation Trust as a consultant at the trust's Stepping Hill Hospital. In addition to his work on the Acute Medicine Unit, between March and May 2015 he provided consultant cover on additional wards, known as escalation wards, including A14 and C5.

2. In 2015, irregularities were identified in respect of Dr Ahmed's claims for payment for work done on the escalation wards. After internal investigation, Dr Ahmed was dismissed for gross misconduct and his case referred to the GMC.

3. Dr Ahmed was required to attend before a Fitness to Practise Panel of the Medical Practitioners Tribunal in order to answer allegations of professional misconduct. His case was heard over 16 days between 8 October and 1 November 2018. The tribunal found a number of allegations to have been proven. It concluded that Dr Ahmed's fitness to practise was impaired and directed that his name be erased from the medical register.

4. Dr Ahmed now appeals to this court pursuant to s.40 of the Medical Act 1983. He argues that the tribunal was wrong to find that he made knowingly false statements and that he acted dishonestly. He accepts, however, that if the tribunal's findings of fact stand then there are no separate grounds for challenging either its finding that his fitness to practise was impaired or the sanction imposed.

THE LAW

THE REGULATION OF DOCTORS

5. Public protection is at the heart of the regulation of doctors. Section 1(1A) of the Medical Act 1983 provides:

> "The over-arching objective of the General Council in exercising their functions is the protection of the public."

6. Section 1(1B) adds:

> "The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives-
>
> (a) to protect, promote and maintain the health, safety and well-being of the public;
>
> (b) to promote and maintain public confidence in the medical profession; and
>
> (c) to promote and maintain proper professional standards and conduct for members of that profession."

7. Allegations of professional misconduct are referred to a Fitness to Practise Panel of the Medical Practitioners Tribunal. The central question for the tribunal is whether the doctor's

fitness to practise is impaired: s.35D of the Medical Act 1983. Misconduct was considered by the Court of Appeal in R (Remedy UK Ltd) v. The General Medical Council [2010] EWCA Civ 1245. Elias LJ said, at [37]:

> "Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will occur outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession."

8. In the event that some impairment is found, s.35D(2) of the Act provides that the tribunal may, if it considers it appropriate, direct erasure, suspension for up to 12 months, the imposition of conditions for up to 3 years or the issue of a warning.

APPEALS

9. By section 40 of the Act, a doctor can appeal to the High Court against directions for erasure, suspension or the imposition of conditions. In Bhatt v. The General Medical Council [2011] EWHC 783, at [9], and in Yassin v. The General Medical Council [2015] EWHC 2955 (Admin), at [32], Langstaff and Cranston JJ respectively explained the proper approach to appeals under the 1983 Act. In Yassin, Cranston J said, at [32]:

> "Appeals under section 40 of the Medical Act 1983 are by way of re-hearing (CPR PD52D, [19]) so that the court can only allow an appeal where the Panel's decision was wrong or unjust because of a serious procedural or other irregularity in its proceedings: CPR 52.11. The authorities establish the following propositions:
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> i) The Panel's decision is correct unless and until the contrary is shown: Siddiqui v. General Medical Council [2015] EWHC 1996 (Admin) , per Hickinbottom J, citing Laws LJ in Subesh v. Secretary of State for the Home Department [2004] EWCA Civ 56 at [44];
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> ii) The court must have in mind and must give such weight as appropriate in that the Panel is a specialist tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserves respect: Gosalakkal v. General Medical Council [2015] EWHC 2445 (Admin);
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> iii) The Panel has the benefit of hearing and seeing the witnesses on both sides, which the Court of Appeal does not;
>
> iv) The questions of primary and secondary facts and the over-all value judgment made by the Panel, especially the last, are akin to jury questions to which there may reasonably be different answers: Meadows v. General Medical Council [197], per Auld LJ;
>
> v) The test for deciding whether a finding of fact is against the evidence is whether that finding exceeds the generous ambit within which reasonable disagreement about the conclusions to be drawn from the evidence is possible: Assucurazioni Generali SpA v. Arab Insurance Group [2003] 1 W.L.R. 577, [197], per Ward LJ;
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> vi) Findings of primary fact, particularly founded upon an assessment of the credibility of witnesses, will be virtually unassailable: Southall v. General Medical

Council [2010] EWCA Civ 407, [47] per Leveson LJ with whom Waller and Dyson LJJ agreed;

vii) If the court is asked to draw an inference, or question any secondary finding of fact, it will give significant deference to the decision of the Panel, and will only find it to be wrong if there are objective grounds for that conclusion: Siddiqui, paragraph [30](iii);

viii) Reasons in straightforward cases will generally be sufficient in setting out the facts to be proved and finding them proved or not; with exceptional cases, while a lengthy judgment is not required, the reasons will need to contain a few sentences dealing with the salient issues: Southall v. General Medical Council [2010] EWCA Civ 407, [55]-[56];

ix) A principal purpose of the Panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the medical profession so particular force is given to the need to accord special respect to its judgment: Fatnani & Raschid v. General Medical Council [2007] EWCA Civ 46, [19], per Laws LJ."

10. Appeals challenging the tribunal's findings of fact pose particular difficulties for appellants. Leveson LJ observed in Southall v. The General Medical Council:

> "… as a matter of general law, it is very well established that findings of primary fact, particularly if founded upon an assessment of the credibility of witnesses, are virtually unassailable (see Benmax v. Austin Motor Co. Ltd [1955] A.C. 370); more recently, the test has been put that an appellant must establish that the fact-finder was plainly wrong (per Stuart-Smith LJ in National Justice Cia Naviera SA v. Prudential Assurance Co. Ltd (The Ikarian Reefer) [1995] 1 Lloyd's Rep. 455 at 458). Further, the court should only reverse a finding on the facts if it 'can be shown that the findings … were sufficiently out of tune with the evidence to indicate with reasonable certainty that the evidence had been misread' (per Lord Hailsham of St Marylebone LC in Libman v. General Medical Council [1972] A.C. 217 221F more recently confirmed in R (Campbell) v. General Medical Council [2005] 1 W.L.R. 3488 at [23] per Judge LJ)."

11. In Gupta v. The General Medical Council [2002] 1 W.L.R. 1691 Lord Rodger said, at [10]:

> "In all such cases the appeal court readily acknowledges that the first instance body enjoys an advantage which the appeal court does not have, precisely because that body is in a better position to judge the credibility and reliability of the evidence given by the witnesses. In some appeals that advantage may not be significant since the witnesses' credibility and reliability are not in issue. But in many cases the advantage is very significant and the appeal court recognises that it should accordingly be slow to interfere with the decisions on matters of fact taken by the first instance body. This reluctance to interfere is not due to any lack of jurisdiction to do so. Rather, in exercising its full jurisdiction, the appeal court acknowledges that, if the first instance body has observed the witnesses and weighed their evidence, its decision on such matters is more likely to be correct than any decision of a court which cannot deploy those factors when assessing the position."

DISHONESTY

12. This case concerns allegations of dishonest claims for payment by a senior clinician. When assessing an allegation of dishonesty, a tribunal should follow the guidance given by Lord Hughes in Ivey v. Genting Casinos (UK) Ltd [2017] UKSC 67; [2018] A.C. 391, at [74]:

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

13. While the burden of proof remains the civil standard, namely the balance of probabilities, the tribunal should have in mind the inherent implausibility of fraud. This question was considered by the House of Lords in Re H (Minors) (Sexual Abuse: Standard of Proof) [1996] A.C. 563 and in Re B (Children) (Care Proceedings: Standard of Proof) [2009] A.C. 11. Lord Nicholls said in Re H, at 586:

> "When assessing the probabilities, the court will have in mind as a factor, to whatever extent is appropriate in the particular case, that the more serious the allegation the less likely it is that the event occurred and, hence, the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability. Fraud is usually less likely than negligence."

14. In Re B, Lord Hoffmann added, at [15]:

> "There is only one rule of law, namely that the occurrence of the fact in issue must be proved to have been more probable than not. Common sense, not law, requires that in deciding this question, regard should be had, to whatever extent appropriate, to inherent probabilities."

15. Applying these principles in Braganza v. BP Shipping Ltd [2015] UKSC 17; [2015] 1 W.L.R. 1661, Baroness Hale said, at [35]:

> "Some things are inherently a great deal less likely than others. The more unlikely something is, the more cogent must be the evidence required to persuade the decision-maker that it has indeed happened …
>
> Thus, for example, most parents do not sexually abuse their children. Cogent evidence is therefore required to establish that sexual abuse is more likely than not to have happened. But once it is clear that such abuse has happened, the threshold of incredulity has been surmounted …"

16. In Sharma v. The General Medical Council [2014] EWHC 1471 (Admin), His Honour Judge Pelling QC was critical of the legal assessor for failing to draw the principles in Re H to the attention of the tribunal.

THE FACTS

17. Dr Ahmed was employed under the terms of a job plan under which he was required to work 11.625 programmed activities of 4 hours (each a "PA") per week. The job plan identified discrete periods of time for:

    17.1 direct clinical care (abbreviated to "DCC"), being his duties on ward A1, the Acute Medicine Unit (the "AMU") and the Acute Assessment Unit (the "AAU");

    17.2 supported programmed activity (or "SPA"), being time allocated to Dr Ahmed's own professional development and his supervision of trainees; and

    17.3 clinical administrative work, being time spent on administrative duties in support of his DCC.

18. Dr Ahmed's work schedule was as follows:

<table>
<tr><th>Day</th><th>08:00-12:00</th><th>12:00-16:00</th><th>16:00-19:00</th></tr>
<tr><td>Monday</td><td>DCC (A1)</td><td>SPA</td><td>-</td></tr>
<tr><td>Tuesday</td><td>DCC (A1)</td><td>SPA</td><td>-</td></tr>
<tr><td>Wednesday</td><td>DCC (A1)</td><td>DCC (Admin)</td><td>-</td></tr>
<tr><td>Thursday</td><td>DCC (A1)</td><td colspan="2">DCC (AAU)</td></tr>
<tr><td>Friday</td><td rowspan="2">DCC (A1)</td><td>DCC (AMU)</td><td>-</td></tr>
<tr><td>Friday (alternate weeks)</td><td colspan="2">DCC (AAU)</td></tr>
</table>

    In addition, he was required to work an additional half PA per week (being 2 hours) of SPA.

19. As part of the trust's waiting-list initiative, between March and May 2015 the hospital operated the escalation wards since the number of patients requiring in-patient treatment exceeded the beds normally available. During this period, Dr Ahmed and other consultants provided cover for patients on the escalation wards. In order to claim for time worked on the escalation wards, doctors were required to complete a claim form. The claim form contained the following declaration:

    > "I have performed the above duties outside my regular contractual entitlement"

20. In May 2015, a clinical director at the trust, Dr Kong, became aware that Dr Ahmed had been rostered to cover the escalation ward A14 on 18-19 May despite being on study leave. This incident and other apparent irregularities in respect of Dr Ahmed's claims for payment for work on the escalation wards were investigated.

21. Before the tribunal, the GMC alleged that Dr Ahmed had dishonestly claimed additional remuneration for working on the escalation wards during times when he was already being paid for either DCC or SPA. Specifically, it was alleged that he knew that his declarations on the claim forms that his work on the escalation wards had been performed outside of his

regular contractual commitment were untrue. In addition, it was alleged that Dr Ahmed had submitted duplicate claims for payment on five days, and that he had claimed payment for 18-19 May 2015 both for working on ward A14 and for scheduled study leave. Finally, there was an allegation that he had breached trust policy by sending a colleague an e-mail from his personal e-mail account in which he had identified personal patient data.

22. The tribunal heard evidence from 17 witnesses; 12 called by the GMC, Dr Ahmed in his own defence and 4 further witnesses called on his behalf. In addition, the tribunal considered an additional witness statement on the papers. Having heard submissions from both parties, it gave its determination upon the allegations on 24 October 2018.

THE TRIBUNAL'S DECISION

23. By its 22-page determination, the tribunal summarised the allegations, the evidence and the parties' submissions before setting out its approach to the fact-finding exercise and then providing its detailed findings. The tribunal rejected the allegations in respect of 25 and 31 March 2015 but found that dishonest claims had been made for work done during Dr Ahmed's contractual hours on thirty days between 1 April and 22 May 2015. Further, it found that dishonest duplicate claims had been made in respect of additional work done on four occasions. In addition, it found that a dishonest claim had been made for payment for work on an escalation ward on 18-19 May when Dr Ahmed was in any event being paid for study leave.

24. Dr Ahmed had admitted the allegation that he had sent an e-mail to another clinician from a personal e-mail account that contained identifying personal patient data in breach of the trust's Acceptable Use and Information Security Policies. While the tribunal subsequently found that this was misconduct, it concluded that Dr Ahmed's fitness to practise was not thereby impaired. Accordingly, since this proven misconduct was not taken into account in either the finding of impairment or directing the erasure of Dr Ahmed's name from the register, it is not relevant upon this appeal.

THIS APPEAL

25. Andrew Colman, who appears for Dr Ahmed as he did before the tribunal, accepts that this appeal is a "full-frontal attack" on the tribunal's findings of fact. He contends that the tribunal appeared "wilfully deaf" to the defence case. In his oral submissions, Mr Colman frankly concedes the obvious difficulty in arguing such an appeal but submits that since the credibility issue at the heart of this case did not arise in respect of a medical issue, this is not a case in which this appeal court should pay particular deference to the assessment of the specialist tribunal.

26. Alexis Hearnden, who appears for the GMC on this appeal, cautions against the appellant's attempt to submit the tribunal's decision to a close-textured analysis. She argues that the tribunal's findings were not "out of tune" with the evidence and that there is no proper basis for interfering with the tribunal's careful findings of fact after a hearing at which it had the advantage of hearing the witnesses.

CREDIBILITY

27. Mr Colman criticises the tribunal's assessment of Dr Ahmed's credibility, arguing that insufficient allowance was made for the fact that English is not his first language. He argues that, in finding Dr Ahmed to have been evasive, the tribunal resorted to formulaic findings that are commonly made against registrants by citing his repeated requests for Ms Fairley, counsel for the GMC below, to rephrase a question and by its criticism that he frequently answered direct questions by saying "Let me explain" and then giving a convoluted statement about his general position rather than a clear answer.

28. In response, Ms Hearnden argues that there is nothing in the English language point. There was no suggestion before the tribunal that any allowance was necessary and there were no apparent instances of any linguistic misunderstanding. I agree. There is no evidence that any allowance was required for Dr Ahmed's English.

29. More generally, Ms Hearnden argues that the tribunal had the advantage of hearing Dr Ahmed and sixteen other witnesses over the course of a long hearing. Having done so, it was for the tribunal to assess the evidence and to decide which witnesses were reliable and which were evasive or untruthful.

30. Notwithstanding Mr Colman's submissions and his detailed analysis of the six occasions on which Dr Ahmed asked for a question to be rephrased and the eight occasions when he gave an additional explanation, the starting point must be that the tribunal had the considerable advantage of hearing the witnesses over the course of this hearing. As I have already explained, the proper approach is to treat the tribunal's assessment of credibility as virtually unassailable. In my judgment, the arguments on this appeal fall short of the compelling case that would be required to persuade the appeal court that the tribunal had erred in its assessment of the witnesses. Indeed, for the reasons set out below, I am satisfied that there was proper material on which the tribunal rejected Dr Ahmed's evidence and found these allegations to have been proven.

FAILURE TO HAVE REGARD TO SUPPORTIVE EVIDENCE

31. Mr Colman argues that the tribunal failed to have proper regard to evidence that supported the defence case as to the practice of displacing DCC time, and particularly to the evidence of Drs Bonny, Ali and Dizayee who, he argues, essentially worked in the same way as Dr Ahmed. Ms Hearnden responds that the points now advanced were made in Mr Colman's closing submissions below.

32. At the heart of this case was the question of the proper basis on which consultants were paid for work done on the escalation wards:

    32.1 The GMC submitted that a consultant could only claim for work done on the escalation wards during time for which he/she was not already being paid. It argued that work done on another ward, including the escalation wards, during normal clinical hours could not attract additional payment. Accordingly, payment could only be claimed for work done on the escalation wards:

        a) outside of the doctor's contractual hours; or

b) during scheduled SPA or administrative time which was in turn displaced into the consultant's private time.

32.2 Against this, Dr Ahmed argued that consultants were entitled to payment for taking on additional responsibilities, even when the work was done during DCC for which the doctor was already being paid.

33. In my judgment, the tribunal considered the evidence telling both ways on this issue:

33.1 First, at paragraphs 60-67 of the decision, it referred to the evidence of trust managers (Philip Harwood, David Taylor and Jane Drummond) and fellow consultants (Drs Ngai Kong, Shivakumar Krishnamoorthy, Chaminda Jayawarna and Simon Hodgson) that they would not expect consultants to displace DCC or to submit claims for working on the escalation wards during time that was already being paid as part of the doctor's DCC.

33.2 At paragraph 70, the tribunal referred to the evidence of Dr Stephen Bonny that it was "common practice" to use some DCC time to work on a second ward. Dr Bonny said that he claimed payment for doing so. The tribunal added, however, that it bore in mind that:

> "Dr Bonny's job plan was different to that of Dr Ahmed, that [Bonny] performed extra duty on the escalation wards on only four separate occasions over a four-month period, and that, when he did so, he stated that he worked for at least 20 more hours per week."

33.3 Further, at paragraph 71, the tribunal considered Mr Colman's submission that Dr Ahmed had worked in the same way as Dr Dizayee. As to that, it said:

> "However, [the tribunal] concluded that Dr Dizayee's work in the Care of the Elderly Department was very different from Dr Ahmed's work in the ACU department, that Dr Dizayee had specific DCC 'administration time' incorporated in his ward round in a way which Dr Ahmed did not, and that, crucially, Dr Dizayee started his scheduled work at 09:00. When asked if he would have done escalation ward work if his contractual hours had started at 08:00, he replied 'no'."

34. The tribunal then concluded, at paragraphs 72-73:

> "72. … the weight of the evidence, despite there being no Trust policy explicitly forbidding double payment for the same period of time, was that consultants were not expected to perform additional cover responsibilities at the time they were scheduled to undertake their 'regular contractual commitment' as outlined in their job plans.
>
> 73. … the Tribunal concluded that Dr Ahmed was not working 'in accordance with the common practice of his colleagues', but was working his scheduled duties simultaneously with additional cover responsibilities repeatedly – in fact almost continually over a period of approximately two months. The Tribunal accepted the evidence of the GMC witnesses that it was for the Consultants themselves to know whether or not they were free and able to undertake additional work.
>
> 74. The Tribunal therefore concluded that Dr Ahmed's confirmation, by signature on the relevant claim forms, to the effect that his additional work was

'performed outside my regular contractual commitment' was knowingly untrue."

35. The tribunal then concluded at paragraphs 117-118:

> "117. However, as the Tribunal has already set out, the consistent and compelling evidence of the majority of the GMC witnesses was that practitioners could not use DCC time in order to perform additional duties for additional remuneration, and that displacement of DCC admin and/or SPA was subject to a widely held understanding that extra payment would only be legitimately afforded if the times displaced were completed, for example, by staying late or completing SPA at home. Given the extent to which Dr Ahmed committed himself to additional duties, as the Tribunal earlier concluded, he could not have had sufficient administrative or SPA PAs to displace legitimately.
>
> 118. The Tribunal therefore concluded that on multiple occasions, Dr Ahmed must have known he was committing himself to additional work at times when – whether 'AM', 'PM' or 'AM/PM' – he was scheduled to undertake his normal, regular DCC and/or his DCC admin and SPA sessions without being able to complete those sessions at other times."

36. In my judgment, the tribunal properly engaged with the evidence both for and against Dr Ahmed. I accept Ms Hearnden's submission that the tribunal was "not blinkered to the fact that there was a lack of unanimity but took a view as to the prevailing understanding." It was entitled to do so and there is no proper basis upon which this court could interfere with the tribunal's conclusion that consultants were not entitled to displace DCC.

37. Equally, the tribunal clearly considered the fact that Dr Ahmed was of positively good character. Indeed, it referred to the supportive character evidence of Drs Bonny, Ali, Akram and Hasan, and of Ms Farley directly at paragraph 113. While it did not also expressly refer in that passage to the further written testimonials, I accept Ms Hearnden's submission that this was part of the documentary evidence which the tribunal had already recorded that it had regard to. Even if I am wrong about that, any failure to take into account yet further positive character evidence did not render the tribunal's decision either wrong or unjust.

IMPLAUSIBILITY OF FRAUD

38. Mr Colman argues that the legal assessor failed to advise the tribunal as to the principle set out in Sharma and Re H. Ms Hearnden points out that Mr Colman raised such failure with the assessor who responded that he had nothing to add but that he had the caselaw available if the panel required further advice on the point.

39. I readily accept that most consultants do not make dishonest claims for payment. I am, however, satisfied that the tribunal had the issue of implausibility firmly in mind in determining whether Dr Ahmed had acted dishonestly in this case:

    39.1 The point had been made in Mr Colman's closing arguments.

    39.2 Such submission had been emphasised by the exchange with the legal assessor.

39.3 The tribunal directly recorded the argument in its review of Mr Colman's submissions by setting out his argument, at paragraph 23 of the decision, that:

> "… the Tribunal 'must take into account the inherent improbability of a well-respected and established consultant physician placing his professional reputation and his very livelihood at risk by committing fraud in pursuit of a limited amount of financial gain'."

Such summary of Mr Colman's submission amalgamated two points, namely the inherent improbability of fraud and the fact that someone of good character is less likely to have committed fraud.

39.4 Further, the former point was repeated at paragraph 113 of the decision when the tribunal said that it "bore in mind Mr Colman's submission to the effect that 'fraud is usually less likely than negligence'." The latter point as to propensity was also addressed by the tribunal at paragraphs 34(b) and 113. In addition, the tribunal bore in mind Dr Ahmed's good character in assessing his credibility: see paragraph 34(a).

40. Accordingly, there is no merit in the argument that the tribunal was not properly directed or that it failed properly to consider the inherent implausibility of fraud. This was, in my judgment, a case where notwithstanding such argument and Dr Ahmed's positively good character, it was open to the tribunal to find dishonesty on the balance of probabilities.

THE FINDING OF DISHONESTY

41. Mr Colman points out that this is not a case of moonlighting, but rather of a doctor who worked in two capacities for the same employer with the trust's full knowledge. He argues that Dr Ahmed fitted the additional duties around his existing commitments by working extra hours, displacing non-patient-facing activities to his own time and by utilising periods when he had completed all of his DCC obligations to his patients. He contends that this approach was implicitly accepted by the trust.

42. Mr Colman argues that the tribunal was wrong to reject Dr Ahmed's account of his movements on 18 May 2015 and to ignore his evidence about having worked yet further sessions for which he had overlooked his entitlement to claim payment.

43. Mr Colman argues that the trust did not have either a written policy for the payment of work done by consultants on the escalation wards or specific claim forms for such work. Instead, the doctors were asked to complete forms designed for junior doctors claiming for work done as locums. There was no space or requirement upon such forms to declare the hours worked but, in any event, Dr Ahmed was paid by sessions of PA and not by the hour.

44. Ms Hearnden points to the scale on which Dr Ahmed worked on the escalation wards and argues that he had systematically overcommitted to such an extent that he simply could not have completed his duties on the escalation wards without intruding into hours that could not have been displaced.

45. In considering the issues, the tribunal first found that Dr Ahmed had claimed payment for working on the escalation wards on a number of Wednesdays, Thursdays and Fridays. As noted above, Dr Ahmed was already required to work on Wednesday mornings on the ward providing DCC, although the trust accepted that his administrative time on Wednesday afternoons could be displaced. He was, however, already committed to providing DCC from 08:00 to 19:00 on Thursdays and alternate Fridays with a clinical commitment from 08:00 to 16:00 on the other Fridays. Accordingly, there was very little scope for Dr Ahmed to provide additional cover for the escalation wards on these days.

46. The tribunal found that, with the exception of Wednesday 25 March 2015, Dr Ahmed had wrongly used his scheduled DCC time on Wednesdays, Thursdays and Fridays to work on the escalation wards on twenty days between 1 April and 22 May 2015.

47. Further, the tribunal found that Dr Ahmed had displaced either his DCC or SPA time on ten Mondays and Tuesdays between 7 April and 12 May 2015 in order to work on the escalation wards. The tribunal also found that Dr Ahmed had made dishonest duplicate claims for payment for work done on 8, 9, 13 and 14 April 2015.

48. The tribunal found that Dr Ahmed dishonestly endorsed a number of claims for payment for work done on the escalation wards on Wednesdays, Thursdays and Fridays with a comment that he would displace SPA time. Rejecting Dr Ahmed's claim that he was taking a weekly view of the displacement of SPA, the tribunal said, at paragraph 98:

> "The Tribunal was satisfied, having regard to Dr Ahmed's overall engagement with additional work on the escalation wards, that he could not possibly have displaced sufficient SPA time in order to work so frequently and so consistently on those wards. He had no SPA time scheduled in his work plan on the dates listed in Schedule 4, and even considering his assertion about a generalised 'weekly' endorsement he did not, in the Tribunal's view, have sufficient SPA time to displace in order to provide the availability to undertake escalation ward cover on all the dates that he did. Furthermore, the Tribunal considered it more likely than not that Dr Ahmed knew he had insufficient SPA time to displace when he endorsed the claim forms as he did."

49. Noting that Dr Ahmed was often contacted by text to work on the escalation wards just before 08:00 when he was due to start work in any event on the AMU, the tribunal rejected the suggestion that he had "come in early."

50. On 18-19 May 2015, Dr Ahmed took two days' study leave to attend a conference in Manchester. Despite his leave, he worked on the escalation ward on both days. Rejecting Dr Ahmed's evidence that he had forgotten that he was on study leave until arriving at work on 18th and that he muddled through rather than admit his embarrassment, the tribunal concluded, at paragraph 109, that Dr Ahmed had "knowingly set out to combine paid study leave with additional and simultaneous work on Ward 14." It found such conduct to have been dishonest at paragraphs 125-127.

51. I have already found that the tribunal properly considered:

51.1 Dr Ahmed's good character both in assessing his credibility and as evidence on the issue of propensity; and

51.2 the inherent implausibility of fraud.

52. Having done so, and having properly directed itself in accordance with Ivey, I am satisfied that it was properly open to the tribunal on this evidence to find that Dr Ahmed had been dishonest. Indeed, the following features of this case supported the finding of dishonesty:

52.1 The sheer scale of Dr Ahmed's additional work done on the escalation wards meant that it was impossible for him to have fitted in these duties by simply displacing SPA and administrative time.

52.2 The balance of the evidence supported the tribunal's finding that doctors could not displace DCC and that they were not entitled to additional payment for work done on the escalation wards during hours that they were already contracted to work for the trust.

52.3 The evidence that Dr Ahmed often accepted an offer of work on an escalation ward between 07:45 and 08:00 meant that there were little or no time for him to attend the escalation ward before starting work at 08:00.

52.4 Accordingly, the declarations made by Dr Ahmed in signing the claim forms that he was claiming for additional work "performed outside [his] regular contractual commitment" were plainly false.

52.5 The evidence of duplicated claims.

52.6 The evidence of events on 18-19 May 2015 when Dr Ahmed claimed both study leave and additional payment for work during the same hours on an escalation ward.

53. Accordingly, the tribunal's conclusions were not "out of tune" with the evidence and were, in my judgment, properly open to it. There are no grounds, in my judgment, for this court to interfere with the tribunal's findings.

GENERAL FAIRNESS

54. Finally, Mr Colman makes a general complaint that the hearing was unfair. I detect no evidence of bias or general unfairness in the tribunal's conduct of this case. Indeed, while the tribunal made serious findings against Dr Ahmed, it dismissed other allegations and took considerable care to analyse the evidence and arguments before it. In my judgment, the evidence before me falls a long way short of that required to make good such argument.

OUTCOME

55. Accordingly, this appeal must be dismissed. I regret the time that it has taken me to hand down this judgment. Unfortunately, I was not provided with the correct bundles in advance of the hearing and it was therefore necessary to find the time around other judicial commitments to consider the 820-page bundle after the hearing.