Neutral Citation Number: [2021] EWHC 2109 (Admin)

Case No: CO/155/2021

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27/07/2021

Before :

THE HONOURABLE MRS JUSTICE COLLINS RICE

- -

Between :

(1) THE GENERAL MEDICAL COUNCIL
(2) THE PROFESSIONAL STANDARDS AUTHORITY
FOR HEALTH AND SOCIAL CARE

- **Appellants**

and -

MR SIMON BRAMHALL

Respondent

- -
- -

Ms Jenni Richards QC (instructed by GMC Legal) for the **First Appellant**
Ms Fenella Morris QC (instructed by Browne Jacobson LLP) for the **Second Appellant**
Mr Jonathan Holl-Allen QC (instructed by Radcliffes LeBrasseur) for the **Respondent**

Hearing date: 13th July 2021

- -

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.

.....

MRS JUSTICE COLLINS RICE

Mrs Justice Collins Rice:

Introduction

1. The General Medical Council (GMC) brings this appeal under section 40A of the Medical Act 1983. The Professional Standards Authority for Health and Social Care (PSAHSC) is a party further to section 40B of the 1983 Act. They challenge a Medical Practitioners Tribunal (MPT) decision of 18th December 2020 to impose a suspension of five months on Mr Bramhall's medical registration. They say this sanction is insufficient to maintain public confidence in the profession and/or to maintain proper professional standards and conduct for the profession.

Background

2. Mr Bramhall was a transplant surgeon at the University Hospitals Birmingham NHS Foundation Trust. He pleaded guilty at the Crown Court in Birmingham in December 2017 to two counts of assault by battery, committed six months apart in 2013 against patients under general anaesthesia during transplant surgery. He had marked his initials on their livers with an argon beam coagulator, a surgical instrument used for cauterisation.

3. The offences came to light when the second patient was subject to further liver surgery shortly afterwards by another surgeon who observed and photographed the marks and reported the matter to the Trust's medical director. Mr Bramhall admitted his responsibility. The Trust conducted an investigation in 2013/14 before referring the matter to the police, who conducted their own investigation. Mr Bramhall's responsiveness to these investigations is raised as an issue in this appeal, but essentially he said he could not remember any other incidents, without seeking to challenge the accounts of witnesses among his colleagues who came forward to say they had seen him do it before. A consultant anaesthetist who witnessed Mr Bramhall initial the first patient's liver in February 2013 brought that incident to light. A surgical nurse present at the second patient's transplant operation in August 2013 said that, when Mr Bramhall became aware she was watching him mark his initials on the liver, he told her "I do this".

4. Mr Bramhall was sentenced on 12th January 2018 by HHJ Farrer QC at Birmingham Crown Court, applying the Sentencing Council's definitive guideline for offences of assault by beating (physical assault). That requires the Judge to consider 'culpability' and 'harm' by reference to specified criteria. The Judge said this:

> "So far as culpability is concerned, this was conduct borne of professional arrogance of such magnitude that it strayed into criminal behaviour. It was not isolated conduct, it involved assaulting two of your patients in the space of just over six

> months. Those patients were unconscious and as such were vulnerable, and you targeted them in that knowledge. You conduct surgical procedures within the limits of your patients' consent and you were well aware that these two patients had not consented to you burning your initials onto their livers. What you did was an abuse of power and a betrayal of the trust that these patients had invested in you.
>
> While opinions may differ, within at least a section of society your actions will inevitably have a corrosive effect upon the essential bond of trust which exists between a patient and their doctor. Balancing these factors, I conclude that within the definitive guideline, this is a case of higher culpability.
>
> So far as harm is concerned, as I have already observed, Patient A was unconscious and therefore particularly vulnerable. Whilst not conclusive, that is, in itself, a factor indicative of greater harm. I accept that you did not intend or foresee that anything other than the most trivial degree of harm would be caused to your victims. … In accepting guilty pleas to assault by beating, the prosecution accept that this damage was, in itself, no more than transient or trifling.
>
> However, for the purposes of sentence, this court is entitled to consider the wider impact of your offending upon your victim, including such emotional or psychological harm as you caused. Regrettably, the emotional impact of your offending upon Patient A has been extreme. As such I conclude that count 2 is an offence evidencing greater harm, and is therefore a category 1 offence within the definitive guideline."

5. The Judge had heard that the second patient had suffered an "extreme and enduring emotional reaction" to his offence; she was experiencing many of the symptoms of Post-Traumatic Stress Disorder. She did not meet the diagnostic criteria for PTSD only because the causative event, the initialling of her liver, was not directly witnessed by her and did not involve threat of death or serious injury.

6. The Judge's analysis placed Mr Bramhall's offending in the most serious category within the spectrum of the offence. He was then required to consider mitigating factors. He accepted the extensive testimonials to Mr Bramhall's character as "kind, gifted, committed, caring, compassionate, insightful and a man of integrity and outstanding character". The Judge paid tribute to his record as a dedicated and highly talented surgeon who over many years had undoubtedly saved numerous lives and improved the quality of life of many other individuals. He had worked tirelessly for the public good, the wellbeing of his patients and the training and teaching of colleagues. His professional reputation had been shattered, and a lucrative private practice lost. The Judge accepted he was remorseful and would never behave similarly in future. He passed concurrent community sentences and imposed a fine.

The Regulatory Proceedings

7. The GMC brought regulatory proceedings against Mr Bramhall following his conviction. The case came before the MPT as a 'conviction case' in December 2020. The facts were admitted. The GMC sought his erasure from the medical register.

8. The MPT found Mr Bramhall's fitness to practise impaired by reason of his convictions. It found he had breached the following paragraphs of *Good Medical Practice*:

> 17. You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.
>
> 47. You must treat patients as individuals and respect their dignity and privacy.
>
> 65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

It considered Mr Bramhall's convictions so serious that public confidence in the profession would be undermined unless a finding of impairment were made. A finding of impairment was required to reaffirm to the public and doctors the standard of conduct expected of them. It was necessary, in other words, to maintain public confidence in the medical profession and to uphold proper professional standards and conduct for members of the medical profession.

9. Proceeding to the question of sanction, the MPT directed itself to the GMC's *Sanctions Guidance* and to the assistance of the decided case law in applying it. It identified aggravating factors: repeated criminal behaviour in a clinical context, committed against unconscious patients in theatre, each constituting a significant breach of trust and of key tenets of the medical profession by amounting to significant departures from *Good Medical Practice*. It "gave particular weight to the impact on public confidence in the medical profession of such grave breaches of professional conduct and abuse of trust".

10. It identified mitigating factors: the numerous testimonials to Mr Bramhall's dedication to patients and exceptional clinical skills; his long unblemished record; his "full acceptance of wrongdoing"; that he "had demonstrated genuine remorse" and "developed significant insight into the reasons for his offences and completed remediation"; that "his actions were seen by colleagues as out of character at a time of work-related stress".

11. Addressing itself to sanction, starting with the least severe and working up, the MPT came to this conclusion:

> The Tribunal considered factors in the Sanctions Guidance relevant to suspension including the need in this case to mark the seriousness of his offences to Mr Bramhall, other doctors and the public. Mr Bramhall has acknowledged his fault and the Tribunal is satisfied that his behaviour is unlikely to be repeated.

> There is no evidence of repetition since 2013 and the level of insight and remorse demonstrated indicates a low risk of future breaches of *Good Medical Practice*.
>
> …
>
> However, his offences represent a serious breach of *Good Medical Practice* and any sanction lower than suspension would be insufficient to maintain public confidence in the profession and to uphold standards. It has determined to impose a five month suspension order, with a review shortly before expiry.
>
> The Tribunal determined that Mr Bramhall's assault convictions in 2013 are not fundamentally incompatible with continued registration, taking account of all the circumstances, guidance and relevant principles. It thus did not consider erasure to be an appropriate or proportionate response."

Grounds of Appeal

12. The GMC appeals on the grounds that:

(1) The Tribunal failed to consider relevant parts of the Sanctions Guidance and/or departed from the Sanctions Guidance by failing to direct erasure without giving any, or any adequate, reasons.

(2) The Tribunal erred in its assessment of the inherent seriousness of the misconduct.

(3) The Tribunal failed to address the attitudinal issues underlying the misconduct.

(4) The Tribunal failed to take into account the Registrant's lack of candour and/or inconsistencies in respect of the February 2013 charge.

(5) Alternatively, the Tribunal erred in not imposing the maximum (or a longer) period of suspension and/or by failing to provide any, or any adequate, reasons for its decision that five months was sufficient.

(6) In the further alternative, the Tribunal failed to give adequate reasons for its decision.

13. The PSAHSC adopts and 'strongly supports' these grounds. It also advances a further ground of appeal under section 40B(2)-(5) of the Medical Act 1983. It says as follows:

> The Authority by way of its further ground of appeal submits that the GMC failed to present to the Tribunal all the statements made by the Registrant in its possession – particularly those made in the initial investigation by the NHS Trust which employed him, and his representations to the GMC – and then

> compare them to the statements he made in his police interview and his letter to the [sentencing] Judge. Reading all of the Registrant's statements together is revealing: they were inconsistent and lacked candour; sought to minimise his misconduct; focused on the negative impact on him rather than the patients; and were tailored to avoid making admissions while at the same time attempting to demonstrate insight. The Registrant's statements taken together reveal deep-seated attitudinal issues which could well have led the Tribunal to reach a different conclusion as to sanction. The GMC also failed to show the Tribunal the statements it had obtained from clinicians who had seen the Registrant in surgery, in particular where they contradicted his account that they sniggered at his misconduct.

The Legal and Regulatory Framework

(i) Appeals from the Medical Practitioners Tribunal under s.40A

14. Section 40A of the Medical Act 1983 provides the GMC with a right of appeal from a MPT decision on sanction if they consider it not sufficient for the protection of the public. By section 40A(4):

> Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient –
>
> (a) to protect the health, safety and well-being of the public;
>
> (b) to maintain public confidence in the medical profession; and
>
> (c) to maintain proper professional standards and conduct for members of that profession.

In this case the GMC relies on subparagraphs (b) and (c).

15. The correct approach of an appellate court on such an appeal was summarised at Divisional Court level in *GMC v Jagjivan* [2017] EWHC 1247 (Admin), [2017] 1 WLR 4438, at paragraphs 39-40. This is an appeal governed by CPR Part 52, and subject to the test of whether the decision appealed is either wrong, or unjust because of a serious procedural or other irregularity. Since the appellate court lacks the MPT's professional expertise, it must approach the MPT's determinations about what is necessary to maintain public confidence and proper standards in the profession with 'diffidence'. But there may be matters (dishonesty or sexual misconduct are examples) where the court is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself, and thus attach less weight to the expertise of the MPT. In such cases the court will afford an appropriate measure of respect to the MPT's decision, but not more than is warranted by the circumstances. Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice, because the overarching

concern of the professional regulatory is the protection of the public. A failure of the MPT to provide adequate reasons may constitute a serious procedural irregularity rendering a decision unjust.

16. Further guidance is provided by the Court of Appeal in *Bawa-Garba v GMC* [2018] EWCA Civ 1879; [2019] 1 WLR 1929, at paragraphs 60-67. A sanction decision of the MPT is an evaluative decision based on many factors – a 'multifactorial decision' involving a mixture of fact and law. The appellate court has limited scope for overturning such a decision. Its approach should be conditioned by the extent to which it is at a relative disadvantage. It should interfere only if it identifies an error of principle by the MPT in carrying out the evaluation, or the evaluation was wrong because it fell outside the bounds of what the MPT could properly and reasonably decide.

17. By section 40A(6) of the 1983 Act, the powers of the appellate court include dismissal of the appeal; allowing the appeal and quashing the relevant decision; substituting for the relevant decision any other decision which could have been made by the MPT; or remitting the case back to the MPT for determination.

(ii) The Sanctions Guidance

18. The powers of the MPT to impose sanction are conferred by section 35D of the 1983 Act. In exercising these powers, MPTs are required to have regard to the overarching statutory objective of protecting the public (section 35E(3A)). On that basis, the GMC issues Sanctions Guidance to assist MPTs, placing the sanctions regime within that overarching objective. By section 1 of the 1983 Act, that involves the pursuit of the three-fold objectives of protecting, promoting and maintaining the health, safety and well-being of the public; promoting and maintaining public confidence in the medical profession; and promoting and maintaining proper professional standards and conduct for members of that profession. The Guidance indicates that although the MPT should make sure that the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.

19. The Guidance directs the MPT to approach any sanctions decision by considering all the sanctions available to it, starting with the least restrictive. It should have regard to the principle of proportionality, weighing the interests of the public against those of the doctor. However, once the MPT has decided that a certain sanction is the minimum necessary to protect the public, that sanction must be imposed even where it may lead to difficulties for the doctor. Examples are given of mitigating factors which may be taken into account, including evidence that a doctor understands the problem, has insight, and attempts to address or remediate it.

20. The Guidance provides that suspension of a doctor's registration will be appropriate for misconduct that is 'serious but falls short of being fundamentally incompatible with continued registration'. Examples are given, including of circumstances where there has been acknowledgment of fault and the MPT is satisfied that the doctor has taken steps to mitigate; where there is no evidence to suggest remediation is unlikely to be successful (eg because of previous unsuccessful attempts or a doctor's unwillingness to engage); where there is no evidence of repetition of similar behaviour after an incident;

and where the MPT is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.

21. The Guidance provides that erasure from the medical register will be appropriate where this is the only means of protecting the public. Erasure may be necessary, even where a doctor does not present a risk to patient safety, to maintain public confidence in the profession, for example where a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession.

22. Paragraph 109 of the Guidance provides that the presence of *any* of a non-exhaustive list of factors may indicate that erasure is appropriate. That list includes:

    a. A particularly serious departure from the principles set out in *Good Medical Practice* where the behaviour is fundamentally incompatible with being a doctor.

    b. A deliberate or reckless disregard for the principles set out in *Good Medical Practice* and/or patient safety.

    c. Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients.

    d. Abuse of position/trust (see *Good Medical Practice* paragraph 65: '*You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession*')

    e. Violation of a patient's rights/exploiting vulnerable people…

    f. …

    g. Offences involving violence.

    h. …

    i. …

    j. Persistent lack of insight into the seriousness of their actions or the consequences.

23. The Guidance makes further provision regarding conviction cases. It emphasises that the MPT should bear in mind that the criminal sanction imposed is not necessarily a definitive guide to the seriousness of the offence. There may have been personal circumstances that led the court to be lenient (including the prospect of erasure).

(iii) Applying the Sanctions Guidance

24. The MPT in this case referred to two authorities on how to direct itself to the Sanctions Guidance. *CRHP v GMC & Leeper* [2004] EWHC 319 was cited for the proposition that the aim of the Guidance is to promote the consistency and transparency of Tribunal decisions – a matter to which it must have regard although each case will depend on its own facts. The Court of Appeal in *PSA v HCPC & Doree* [2017] EWCA Civ 319 was cited for the principle that departure from the Guidance must be explained. A Tribunal should have proper regard to the Guidance, and apply it as its own terms suggest, unless it has sound reasons for departing from it – in which case it has to state those reasons clearly in its decision. Again, however, a degree of flexibility and fact-sensitivity is acknowledged.

25. The High Court in *GMC v Khetyar* [2018] EWHC 813 had before it the particular issue of applying the Guidance in determining suspension rather than erasure. It characterised the Guidance as an '*authoritative steer*' as to the application of the principle of proportionality in balancing the public interest against the interest of the individual professional. Accordingly, '*a proper conclusion that suspension is sufficient cannot be reached without reference to and careful consideration of advice in the Guidance that erasure may be or is likely to be appropriate where that advice is pertinent to the facts of a particular case*'. The Court said this (paragraph 22):

> Again, of course, it remains advice and not prescription: tribunals must ultimately judge each case on its own merits, and are entitled in principle to depart from that steer. Doing so, however, requires careful and substantial case-specific justification. A "generalised assertion that erasure would be a disproportionate sanction and that the doctor's conduct was not incompatible with his continued registration", where the Guidance gives a clear steer towards erasure, properly considering what is says about important features of the case in question, will be inadequate and will justify the conclusion that a tribunal has not properly understood the gravity of the case before it: see *GMC v Stone* [2017] EWHC 2534 (Admin) at [53].

26. The error identified in *Stone* was failure properly to consider the objective features of the case, to demonstrate that their gravity had been fully understood, and then to address and explain how the available mitigation operated to justify the imposition of the sanction of suspension. The court emphasised that this is not elevating form over substance; proper regard to the Guidance is important in its own right, and giving clear reasons for divergence is part of the MPT's functions in articulating in the public domain how its determinations properly serve the overarching objective.

Consideration

(i) Introductory

27. This is a case with a public profile. Its facts are highly unusual and attracted considerable public attention and reaction at the time. Unique circumstances always

pose a challenge for applying general principles and rules not drawn up with such facts in mind. There is also a profound ambivalence to be confronted about how Mr Bramhall and his actions should properly be regarded by authorities responsible, each in its different way, for considering the public interest – police, prosecutors, criminal courts, professional regulatory bodies, disciplinary tribunals and appellate courts.

28. On the one hand, what Mr Bramhall did was calculatedly harmless, since no physical damage beyond the 'transient and trifling' was done. It was also calculatedly inconsequential: the patients were not to know, and although done in a clinical context, these were acts quite distinct from and incapable of affecting the performance of his technical clinical functions to the highest standards; they posed no risk to the clinical outcomes for patients. And if it was an invasive act, that has to be seen in the radically invasive context that is transplant surgery itself.

29. But on the other hand, this was a criminal, non-consensual physical interference. It had to be sentenced as one of the most serious forms of common assault because of the multiplicity of aggravating features. One of his victims was certainly traumatised, writing powerfully to the sentencing court of her experience of being physically 'violated' in a sense she compared to sexual abuse or rape. Of course, it might be said this was 'only because' she had come by knowledge she was never intended to have. But it was knowledge of an intimate non-consensual physical act. And there is further ambivalence about whether the acts themselves were conceived as being intensely private or whether there was knowing entertainment of the risk of discovery (the two are not mutually exclusive, of course). These were acts performed in a busy operating theatre, with other health professionals going about their duties.

30. Then there are Mr Bramhall's own explanations for what he did. He denied 'personal gratification'. He accepted 'arrogance' as one explanation: the literal signing-off of his bravura handiwork perhaps. He also spoke of tension: the effects of pressure of work on his own judgment, and wishing to relieve the intensity of the theatre atmosphere with a jocular gesture of technical skill for the amusement of staff. The latter account is regarded by the Appellants in this case as troubling in its own right (apart from what they say is its lack of explanatory power, their view is that it has scant evidential support from his colleagues).

31. There are therefore competing high-level narratives available about this case from a public point of view. Perhaps a respected and admired expert to whom lives are owed has already lost much through a silly and hubristic mistake, and the public would be the substantial loser in being deprived of his services. Perhaps it is every patient's worst nightmare: a surgeon perpetrating an act of personal power, violation and appropriation, contemptuous of the autonomy and integrity of the body, exploiting the helplessly vulnerable and seriously ill, and indecently disrespectful of the altruistic act of organ donation (often in tragic circumstances) – an exercise of power extending to the theatre colleagues who may have to witness this act and live with any conflicted feelings (human and professional) about their own position in relation to a perpetrator of such seniority and reputation. As the sentencing Judge said, opinions may differ.

32. It is not my task to offer an opinion. I am not rehearing the case. I am considering whether the MPT did its job properly. That job was to give a fair, informed, objective and definitive answer to the question of what was necessary to maintain *public* confidence in the medical profession in this case. That has to reflect the views of an

informed and reasonable member of the public; it must be assessed by reference to the standard of the ordinary intelligent citizen who appreciates the seriousness of the proposed sanction and the other issues involved in the case (*Bawa-Garba* paragraph 96). The MPT, an expert tribunal on which the public relies, was tasked with putting its finger on precisely what was and was not wrong with Mr Bramhall's conduct and how serious it was or was not, and sanctioning accordingly. It had to be fair to him, and to hold in mind that the reputation of the profession as a whole was more important than the interests of any individual professional.

33. Unusual facts call for the particularly thoughtful and responsive application of general rules. At the same time, it is precisely where principles and rules are most challenged by unique and ambivalent facts, that procedure and guidance may have the most important work to do in achieving the outcomes, for the individual and for the public, for which they were designed.

(ii) Applying the Sanctions Guidance

34. I have considered the MPT's sanctions decision in its full context, including its determination on impairment, reading these together with the transcripts of the whole proceedings. An appellate court must avoid narrow textual analysis when considering the reasoning of any tribunal, especially one not composed of professional judges, and must not expect 'slavish recitation' of the Guidance (*GMC v Awan* [2020] EWHC 1553 (Admin), paragraph 26, 44). The determination must be read fairly, as a whole, to understand and assess its reasoning. A number of points arise on that basis.

35. First, I cannot regard this sanctions decision as anything other than a departure from the Sanctions Guidance. Mr Bramhall had been convicted of more than one offence of deliberate violence. He was sentenced on the basis that his offences had targeted patients who were particularly vulnerable because of their personal circumstances; that his acts were an abuse of power and of a position of trust; and that he had caused serious and lasting harm to one of his victims (albeit unintentionally). The Guidance provides at paragraph 109 that any one of those factors on its own may indicate that erasure is appropriate. Here, multiple factors were present. Other indicators of erasure in paragraph 109 were potentially engaged also on the MPT's own assessment of seriousness. The 'authoritative steer' of the Guidance was plainly towards the proportionality of erasure.

36. Second, while that does not necessarily constrain a tribunal's final decision, it does properly engage a duty to state clear reasons for departure (*Doree*) in the form of a careful and substantial case-specific justification (*Khetyar*). This requires something more (a) clear, (b) substantial and (c) specific in the way of reasons than would be required if the steer of the Guidance were being followed. This determination does not provide that. While the GMC's submissions were noted, the engagement of the erasure indicators is not even acknowledged as such in the MPT's reasoned determination. That is remarkable in a case brought *on the basis of* convictions for crimes of violence, an express indicator in its own right that erasure may be required, not least where committed in a clinical setting. Failure to deal with erasure indicators where they are engaged produces determinations which are simply incomplete. There is an important part of the picture missing, or a 'missing link' (*GMC v Mmono* [2018] EWHC 3512 (Admin) paragraph 27). That is a fundamental flaw – an error of principle. The decision does not fully make sense and the reader cannot see how it is proportionate.

37. Third, I firmly agree with the court in ***Khetyar*** that a *proper* conclusion that suspension is sufficient cannot be reached in a case like this without reference to, and careful consideration of, advice in the Guidance that erasure may be appropriate on the facts. The established and properly cautious discipline of considering possible sanctions from the bottom up does not permit a tribunal to 'stop at suspension' simply on the basis that it thinks it has before it '*a serious breach of Good Medical Practice but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest´* (Sanctions Guidance paragraph 97a). To 'stop at suspension' without addressing indications of erasure – and therefore without addressing what the Guidance says about when misconduct *is* 'fundamentally incompatible' – is to make the error of principle the appellate courts have consistently identified as such. It is an error which leads to generalised assertion that erasure would be a disproportionate sanction and that a doctor's conduct is not incompatible with continued registration. That is insufficient. It substitutes a vague or subjective approach to proportionality for the structured and objective 'authoritative steer' of the Guidance.

38. The sanctions determination in the present case does not persuade me that it has avoided this error. It appears to 'stop at suspension'. It concludes with a generalised assertion that Mr Bramhall's convictions were not fundamentally incompatible with continued registration, and that it 'thus' did not consider erasure proportionate or appropriate. An informed reader does not in these circumstances know *why* suspension (in principle, and for five months in particular) *rather than* erasure is sufficient to maintain public confidence in the medical profession and to maintain proper professional standards and conduct for members of that profession. It is asserted, not demonstrated.

39. Close reading of the entirety of the proceedings does not supply the deficiency. The Tribunal said it gave 'particular weight' to the impact on public confidence in the medical profession of such grave breaches of professional conduct and abuse of trust. How it did that is not explained or apparent. A reasonable reader might well infer that *determinative* countervailing weight was, nevertheless, given to the matters of personal mitigation noted: Mr Bramhall's past reputation and record and the effects on him of its loss, the wealth of testimonials, his remorse and the low risk of repetition. That in itself is indicative of error of principle, since the Guidance and the case law caution against giving *determinative* weight to such matters; they are relevant but can only ever be part of the story. In any event, the comparatively vestigial attention given in the determination to the public and professional confidence dimension of this criminal conviction case does not enable a fair-minded reader to understand it, and be reassured that, however imperfectly expressed, it reflects a job properly done.

(iii) Assessing Gravity

40. Underlying the problems with the sanctions analysis by the MPT in this case are indications of error of principle at a deeper level, similar to that in ***Stone***, namely a failure properly to assess and/or articulate the gravity of conduct before it, and hence correctly to apply itself to the question of sanction. That was the essence of the task before it.

41. I have suggested there are competing narratives on the available facts of this case about how truly serious Mr Bramhall's behaviour should be considered, when all of its features are properly considered in context. The Appellants in this case are in no doubt

that it was deeply serious and deeply troubling for a number of reasons. The MPT was (rightly or wrongly) obviously less sure of that. Mr Bramhall himself is in a difficult position; it is not in his interests either to overstate or to understate the gravity of his conduct. So this is no doubt an evaluative matter for the MPT in the end.

42. The discipline of fully addressing the application of the Sanctions Guidance to the facts, and clearly articulating reasons for any departure determined upon, is itself the surest route to a secure assessment of gravity of misconduct and hence of proportionality. Shortcuts must be resisted, particularly where they risk being – or, as importantly, being seen to be – unduly influenced by considerations of personal mitigation.

43. In a conviction case, particularly where the conviction is for repeated offences of violence against patients in a clinical context, it is also important for a tribunal not to lose sight of what the criminal law, criminal procedure and the principles of sentencing law and practice have already had to say about the public interest considerations which should properly be brought to bear in considering gravity. Certainly, the differences between criminal and regulatory proceedings are crucial; their purposes and procedures are different, and the relevance, combination and weighting of any common factors are different also. But the Sanctions Guidance expressly and properly indicates the *relevance* of the *fact* that misconduct has passed the threshold of criminality to the determination of sanction. To that might be added the relevance of the sentencing guideline's classification of the inherent seriousness of the offence and of the offending (in terms of culpability and harm, based on evidence established to the criminal standard of proof) before allowance is made for matters particular to the offender.

44. It is not necessarily determinative; the weight to be given to these matters will vary from case to case as they are assessed in context. But it is important for an MPT determination of sanction in a conviction case – especially where offences of violence and abuse of trust in a clinical context are involved – to grapple with the *criminal quality* of the misconduct as a public interest consideration *in its own right*. That steer is clearly given by paragraph 109g of the Guidance. A failure to do so is likely to lead to (or constitute) the error of principle of failing to make a proper assessment of gravity. That error is indicated in this case. It is a particularly unfortunate error in a case where there is an acute public interest in understanding from an expert tribunal how serious a conviction case with an unusual and ambivalent factual matrix really is for the position of a senior professional and for the public at large.

'Attitudinal' Issues

45. Mr Bramhall's perspective on his own conduct, and his engagement with the various procedures examining and responding to it, are matters of potential relevance to the determination of sanction. As a point of principle, '*the way in which a healthcare professional reacts to the discovery of their misconduct is an important part of the assessment of their attitude, their insight into the wrongdoing and effects on a victim, and the sanction necessary in the public interest*' (*PSAHSC v HCPC & Wood* [2019] EWHC 2819 (Admin) at paragraph 73). Moreover, this is a case in which, on the facts, *motivation* presents itself as an acute regulatory question. Again, '*the reasons why a person acts in a particular way, or their motivation for acting, are significant in evaluating (a) the true seriousness of their behaviour and (b) what the appropriate sanction should be*' (*Wood* paragraph 56). Motivation, in other words, potentially goes to gravity and also to insight and remediability.

46. Motivation remains something of an under-explored and unresolved issue in this case. The act was unusual, transgressive, invasive and proprietorial. The imbalance of power was extreme. It was not an isolated incident; as well as the double convictions, the unchallenged evidence of the theatre nurse, which was before the MPT, that Mr Bramhall responded to discovery in the act with "I do this", hangs in the air. The MPT did not on the face of its determination get to close grips with these issues or make clear and reasoned findings about them. That is a problem for its determination, and also leaves the reader in something of an unsatisfactory limbo.

47. Two issues arise in particular. The first is the importance of demonstrable analytical clarity about what is being considered and why. *Candour* is a continuing professional obligation of openness and honesty, embracing full and proactive co-operation with regulatory and other investigative action, and putting self-interest behind that of the patient. It has potential relevance beyond particular incidents. The Appellants consider it to be in issue in this case, with unresolved issues about how forthcoming Mr Bramhall was in the accounts he gave when first confronted with his behaviour, about the consistency of those accounts, and about whether they cross a line between the advisedly circumspect and the self-serving.

48. *Insight* goes to the subsequent development of fair, objective understanding of the nature and gravity of the misconduct. It typically requires demonstration of a degree of empathetic identification with the perspective of others: victims, professional colleagues, the public (including other patients and organ donors, actual and potential). It is a necessary precondition of *remorse*, or genuine regret for the impact on others. It is distinguishable from willingness to offer an apology, from the development of self-serving narrative, and from chagrin at the personal consequences of public exposure and regulatory and criminal justice action. Again, the Appellants say that all of this is properly in issue in the present case.

49. These are issues which were certainly considered to at least some degree, both in the criminal proceedings and in the regulatory proceedings preceding the sanctions determination. On its face, the MPT sanctions determination took an overwhelmingly positive view of the attitudinal issues. It did have evidence to support that before it. But Counsel for the GMC had also raised countervailing issues in his submissions on impairment, including that Mr Bramhall had not in fact made a prompt clean breast of things, and that the particularity of his account of the first offence given in his submissions on sentencing were in contrast to the declared uncertainty of his recollections up until then. The MPT dealt with these only briefly and summarily by allowing for the potential effects of stress on memory.

50. The 'attitudinal' concerns were not demonstrably interrogated by the MPT to any degree. I am not persuaded that, reading the proceedings as a whole, the MPT showed itself sufficiently astute to the potential relevance of these issues for the determination of sanction; to maintaining appropriate clarity about the distinctions between them; and to the need to assess and weigh them and explain its conclusions. Error of principle is disclosed in this also.

51. There is a second and related issue. This concerns the material which forms the substance of the PSAHSC's additional ground of appeal. This is material which it says goes particularly to the issue of candour, relating as it does to some of Mr Bramhall's early reactions to being confronted with his conduct. It says that this is material which

the GMC properly ought to have brought to the attention of the MPT, which would then have produced a clearer focus on the nature and relevance of the attitudinal issues which the MPT needed to address, and which was capable of affecting its decision on sanction. It says that the failure to do so constituted, or led to, further error of principle, procedural irregularity and an unjust outcome.

52. I agree that the material with which the PSAHSC is now concerned is potentially relevant to the issue of Mr Bramhall's attitude in general and his candour in particular. These in turn are relevant to the issue of sanction. In view of my conclusions about the errors of principle in the MPT's determination, it would be speculative to say what difference if any the materials in question might have made to the MPT's approach and determination. Nevertheless, a tribunal should always be placed in the best reasonably possible evidential position to consider all the relevant facts. The GMC ought to have done so in this case by taking the MPT to these materials.

Conclusions

53. I remind myself of the appropriate diffidence I must show before thinking of interfering in an MPT decision. Here, the appellate function is properly engaged: not with a reassessment of the MPT's decision on sanction on its merits, but with its failure to demonstrate convincingly that it has made a proper assessment of sanction, one which the public and the profession can fully understand and have confidence in, at all. It is my conclusion for the reasons given that the MPT in this case made errors of principle in its sanctions evaluation, resulting in, and including, an insufficiency of reasons for departure from the Sanctions Guidance. These constitute serious irregularity in the conduct of its functions, vitiating the justice of its conclusion. The MPT did not put its finger on precisely what was and was not wrong with Mr Bramhall's conduct and sanction accordingly. It did not do full justice to this unique case. I allow this appeal on that basis.

54. The unusual features of this case (not to say anything of its public prominence) make it especially important that a careful, structured, and transparently accessible approach to regulatory decision-making is demonstrably taken. The same unusual features potentially call for the Sanctions Guidance to be applied particularly sensitively and thoughtfully, and possibly flexibly, to the facts. That is because of some of the ambivalence I have already alluded to in the factual matrix, and because the public and professional confidence issues may, on proper examination, turn out to pull in different directions. In these circumstances, I am satisfied that the right way forward is to quash the sanctions determination and remit the case for a fresh determination by a differently constituted tribunal. That will enable what may or may not be a difficult decision, when correctly approached, to be considered fully and in the round by the body Parliament has primarily entrusted with that responsibility.