Neutral Citation Number: [2024] EWHC 1217 (Admin)

Case No: AC-2023-LDS-000295
and Case No: AC-2023-LDS-000296

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

Leeds Combined Courts
2 Oxford Row
Leeds

Date: 23/05/2024

Before :

Her Honour Judge Belcher

- -

Between :

Ashish Dutta	**Appellant**
- and -	
General Medical Council	**Respondent**

- -
- -

Mr James Counsell KC (instructed by **Morris Law**) for the **Appellant**
Miss Alexis Hearnden (instructed by **General Medical Council**) for the **Respondent**

Hearing dates: 30 April 2024

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Approved Judgment

This judgment was handed down remotely at 10.00am on 23 May 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Her Honour Judge Belcher:

1. This matter comprises two sets of proceedings. By case number AC-2023-LDS-000295, pursuant to Section 40 Medical Act 1983 ("the Act"), Dr Ashish Dutta appeals a decision of the Medical Practitioners Tribunal ("the MPT") made on 24 November 2023. The MPT made various findings of fact against him, made a determination of impairment, and directed that his name be erased from the register. By case number AC-2023-LDS-000296, Dr Dutta made an application under Section 38(8) of the Act for the termination of the immediate order of suspension imposed on him by the MPT, pending determination of his appeal. Mr Counsell KC, counsel for Mr Dutta, accepted that the application under Section 38(8) had become academic given the listing and hearing of Dr Dutta's appeal before me.

2. I was provided with a number of bundles. References to the appeal bundle in this judgment will be by the Tab number and page number in square brackets, for example, **[4/276].** References to the authorities bundle will be by capital letters AB, Tab number and page number in square brackets, for example **[AB/16/329]**.

The Facts

3. The following facts, which are not in dispute, are drawn largely from Mr Counsell's skeleton. I record here my appreciation of the very helpful skeletons provided to me by both Counsel. Dr Dutta graduated in 1986 with a Bachelor of Medicine and Bachelor of Surgery degree at Calcutta University, before moving to England and passing the Professional and Linguistic Assessment Board test, entitling him to practise as a doctor in the UK. He obtained a number of UK medical qualifications and obtained full GMC registration in 1994. He qualified as a GP in 1996 and became a member of the Royal College of General Practitioners in 2001.

4. He commenced practising cosmetic surgery in the private sector in 2000, but also continued to work as a GP until 2005, after which he undertook a further year of additional cosmetic-specific surgical training and became a cosmetic surgeon full-time. Dr Dutta opened Aesthetic Beauty Centre ("ABC) in Sunderland in 2000, and a second centre in Newcastle in 2004.

5. In April 2002, cosmetic procedures became regulated under the Care Standards Act 2000. From 1 April 2009 the Care Quality Commission ("CQC") became the regulator for cosmetic procedures comprising regulated activities.

6. On 22 March 2019, Dr Dutta was performing a procedure at ABC Newcastle on Patient A. The procedure was to correct a deformity to the right cheek. During the procedure the patient suffered excessive blood loss, Dr Dutta suspended the procedure, and the patient was transferred to hospital in Newcastle. Whilst at the hospital, unfortunately, Patient A suffered a cardiac arrest, but he was successfully resuscitated, and his facial wound treated. Dr Dutta reported this incident to the GMC because he was the subject of conditions on his registration in connection with an unrelated matter.

7. On 20 September 2019, Dr Dutta was undertaking a male breast reduction procedure on Patient C under local anaesthetic and sedation, with the help of an anaesthetist and a nurse. The patient's heart rate slowed significantly, and the procedure was terminated.

An ambulance was called by the anaesthetist and the patient was transferred to hospital where he was successfully treated.

8. As a result of these incidents, the CQC undertook an urgent review and visited ABC in Newcastle on 27 September 2019. On 4 October 2019, the CQC imposed a condition on the ABC Newcastle premises that any surgical procedures which required local anaesthetic or sedation should immediately be suspended. After a review of the Sunderland clinic, the CQC imposed a similar condition on the Sunderland clinic.

9. In March 2020, the COVID-19 pandemic struck, and restrictions of movement were imposed shortly afterwards. The CQC asked all providers to send it a COVID policy. ABC sent its policy on 31 March 2020, which policy included the following:

> "**Patient Safety and Support**
>
> The primary concern of the practice is to ensure the continuing care of patients…[and] … the need to balance the care and safety of all staff at the practice.
>
> As such all face-to-face consultations have been suspended until further notice in line with the Governments (sic) recommendations on non-essential travel and social distancing". **[4/325]**
>
> and
>
> **"Staffing**
>
> At present all staff have been instructed to remain at home and the clinics have been closed. No new patients are being considered and the centres in Sunderland and Newcastle will remain closed until the Covid 19 crisis has been resolved or instructions from Government has changed." **[4/326]**

10. On 4 April 2020, the conditions imposed on the two clinics by the CQC (set out in Paragraph 8 above) expired. By letter dated 14 April 2020 the CQC wrote to ABC stating that under normal circumstances they would have extended the conditions, but that they had decided that "…. because you have provided CQC with assurance that you will not be carrying on face-to-face consultations and surgical procedures we will monitor your improvement steps through regular engagement" **[4/330].** The letter stated that in reaching that decision they had taken into consideration ABC's Covid-19 strategy document, and in particular the paragraph on **"Staffing"** set out in Paragraph 9 above **[4/331]**. The letter continued as follows:

> "**Action we need you to take**
>
> ……. We require further assurance from you that no surgical procedures are being undertaken…..
>
> ….. We would also ask you to formally advise CQC two weeks **before** you commence any face-to-face contact with clients or

> carry out any surgical procedures so that CQC can arrange a further comprehensive inspection of both locations." **[4/331]**

11. On 2 May 2020, the CQC sent a Notification of Dormancy to ABC in relation to both clinic locations. That notification included the following:

> "I write in relation to the provision of Surgical procedures, Diagnostic and screening procedures, and Treatment of disease, disorder or injury……
>
> We believe, following your latest inspection and information you provided that you are not providing the above regulated activity at the above locations. We have therefore made these regulated activities and locations dormant on the register…..
>
> If you are aware of the date you will commence delivering the activity can you also please let us know." **[4/333-334]**

12. That document included a response slip to confirm dormancy and reasons, which response slip was completed and returned by Mrs Wendy Dutta. Her return, dated 1 June 2020, states that the date the clinics intend to start delivering a regulated activity is 1 July 2020. In the table below, the following dormant regulated activities are again identified as: "Treatment of disease, disorder or injury; Surgical procedures and Diagnostic and screening procedures" **[4/335-336].** The effect of the dormancy notice was that the CQC did not need to carry out inspections of the clinics as no regulated activities were being undertaken.

13. In June and July 2020, Dr Dutta carried out three office based procedures at the clinics:

    i) on 23 June 2020, the removal of a cyst on Patient D;

    ii) on 30 June 2020, the removal of two lesions on Patient E; and

    iii) On 15 July 2020, the removal of a mole on Patient F.

    A sample of the mole removed from Patient F was sent for testing, and the histology results confirmed the presence of a malignancy.

The GMC Investigation

14. All references to Rule or Rules in this judgment are references to the General Medical Council (Fitness to Practise) Rules 2004 as amended, unless otherwise indicated.

15. The following is taken from Miss Hearnden's skeleton. In March 2019 Dr Dutta reported the incident with Patient A to the GMC, and the GMC opened an investigation into that in April 2019. In September 2019, Dr Dutta contacted the GMC in respect of Patient C. The Newcastle upon Tyne Hospital NHS Foundation Trust ("the Trust") contacted both the GMC and the CQC in respect of Patient C.

16. Between September 2019 and January 2020 there were CQC inspections/engagement with Dr Dutta. It will be necessary to consider those in more detail when I turn to the Grounds of Appeal later in this judgment. On 1 May 2020 the Medical Practitioners

Interim Orders Tribunal ("IOT") imposed conditions on Dr Dutta's registration. On 30 July 2021, a Rule 7 letter was sent to Dr Dutta, setting out the allegations and inviting his response. He responded on 23 September 2021. On 19 May 2022 the Case Examiner decided pursuant to Rule 8 that the allegations should be referred to the Medical Practitioners Tribunal Service ("MPTS"), for them to arrange a hearing in front of the MPT.

17. On 11 January 2023, a Case Examiner's Rule 28 decision was issued and 22 of the original allegations were withdrawn, with the balance to proceed to an MPT hearing. As a consequence of that decision, on 1 February 2023, Dr Dutta applied for postponement of the MPT hearing which at that time was listed for hearing in March 2023. The MPTS granted that postponement, and the matter was relisted for hearing in November 2023, with a Pre-Hearing Meeting ("PHM") to take place on 3 August 2023.

18. On 24 July 2023 a draft hearing bundle was sent to Dr Dutta. At all times throughout this process, he was legally represented. At the PHM the deadline for defence evidence was extended to 9 October 2023. During September 2023 there were Counsel to Counsel discussions on redactions to the bundle. On 13 October 2023 the defence expert report of Mr Percival was disclosed. A joint expert meeting was arranged for 22 October 2023, with the joint expert report being received on 26 October 2023. Prior to receipt of the joint expert report, on 25 October 2023 the GMC bundle was agreed and was uploaded to the MPTS case management system.

19. In the light of the joint expert report, on 31 October 2023 the GMC made a fresh Rule 28 referral to the Case Examiner. On 3 November 2023, a further Rule 28 decision was issued withdrawing allegations 1 to 5 which related to the standard of care provided to Patient A. The remaining allegations, 6 -15, were to proceed to the MPT hearing. The hearing commenced on 6 November 2023, and only at the hearing were the tribunal members notified that allegations 1 to 5 were to be withdrawn.

Proceedings before the MPT.

20. It will be necessary to consider some detail of what occurred before the MPT when I turn to the Grounds of Appeal. Here I simply adopt the following summary from Miss Hearnden's skeleton.

21. The Appellant attended the hearing and was legally represented throughout. No application was made to adjourn the proceedings or for a stay on the basis of an abuse of process. There was no suggestion that the Appellant wished to judicially review the Rule 28 decision. Instead, the hearing proceeded, and he gave evidence at the facts stage and again at the impairment stage. The MPT found that through his actions and by virtue of his dishonesty the Appellant had breached fundamental tenets of the medical profession and concluded there was a significant risk of repetition as a result of his lack of insight. The MPT directed that the Appellant's name be erased from the register.

The Law

22. Section 40 of the Act provides a right of appeal to this court against a sanction imposed by the MPT. By virtue of CPR PD52D, such appeals are by way of rehearing, although it is a rehearing without hearing evidence, instead relying on transcripts of evidence

where appropriate. By CPR 52.21, this court should allow the appeal if the decision of the MPT was wrong or unjust because of serious procedural or other irregularity.

23. In *Sastry v General Medical Council* [2021] EWCA Civ 623 Nicola Davies LJ, giving the judgment of the court, confirmed, at Paragraph 102 of her judgment, that the jurisdiction in this type of appeal is appellate and not supervisory; that the appeal is by way of a rehearing in which the court is fully entitled to substitute its own decision for that of the Tribunal; that the appellate court will not defer to the judgment of the Tribunal more than is warranted by the circumstances; that the appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate; and in the latter event, the appellate court should substitute some other penalty or remit the case to the Tribunal for reconsideration.

24. Mr Counsell submitted that the approach the appellate court should consider on an appeal from the MPT is best encapsulated by the judgment of Cranston J in the cases of *Meadow v GMC* [2007] QB 462 and *Raschid v GMC* [2007] 1WLR 1460. Miss Hearnden relied on a more recent decision of Cranston J in *Yassin v GMC* [2015] EWHC 2955 (Admin) in which he set out a number of propositions based on the authorities. There is no difference of substance in these decisions. I find the more recent decision more helpful for the way it sets out numbered propositions in Paragraph 32 of the judgment, as follows:

"Appeals under section 40 of the Medical Act 1983 are by way of rehearing (CPR PD52D) 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 52.21. The authorities establish the following propositions:

i.) The Panel's decision is correct unless and until the contrary is shown: *Siddiqui v. General Medical Council [2015] EWHC 1996 (Admin)*, per Hickinbotham J, citing Laws LJ in *Subesh v Secretary of State for the Home Department [2004] EWCA Civ 56* at [44];

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);*

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: *Assucurazione Generali SpA v Arab Insurance Group [2003] 1WLR 577*, [197] per Ward LJ;

vi.) The 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 LJ J 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 and Raschid v General Medical Council [2007] EWCA Civ 46*, [19], per Laws LJ.

25. Miss Hearnden also referred me to the judgment of Warby J (as he then was) in *Dutta v General Medical Council* [2020] EWHC 1974 (Admin) at Paragraph 21 where he said this in relation to challenges to findings of fact:

> "…(3) a court asked to interfere with findings of fact made by a lower court or Tribunal may only do so in limited circumstances. Although this Court has the same documents as the Tribunal, the oral evidence is before this court in the form of transcripts, rather than live evidence. The appeal Court must bear in mind the advantages which the Tribunal has of hearing and seeing the witnesses, and should be slow to interfere. See *Gupta* [10], *Casey* [6a] and *Yassin* [32(iii)].
>
> (4) Where there is no question of a misdirection, an appellate court should not come to a different conclusion from the tribunal of fact unless it is satisfied that any advantage enjoyed by the lower court or tribunal by reason of seeing and hearing the witnesses could not be sufficient to explain or justify its conclusions: *Casey* [6a] .
>
> (5) In this context 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: *Yassin* [32(v)].

> (6) The appeal Court should only draw an inference which differs from that of the Tribunal, or interfere with a finding of secondary fact, if there are objective grounds to justify this: *Yassin* [32(vii)] for
>
> (7) But the appeal Court will not defer to the judgment of the tribunal of fact more than is warranted by the circumstances; it may be satisfied that the tribunal has not taken proper advantage of the benefits it has, either because reasons given are not satisfactory, or because it unmistakably so appears from the evidence: *Casey* [6a] and cases there cited, which include *Raschid* and *Gupta* (above)and *Meadow* [125-126], [97] (Auld LJ). Another way of putting the matter is that the appeal court may interfere if the finding of fact is "so out of tune with the evidence properly read as to be unreasonable": *Casey* [6c], citing *Southall* [47] (Leveson LJ)"

26. Miss Hearnden also reminded me of the test for dishonesty as set out in the Supreme Court decision in *Ivey v Genting Casinos UK* [2017] UKSC 67. Put shortly, the first step is to establish the actual state of the individual's knowledge or belief as to the relevant facts. Having determined that, the question whether his conduct was honest or dishonest is to be determined by applying the (objective) standard of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.

The Grounds of Appeal

27. There are 10 Grounds of Appeal in the Amended Grounds of Appeal **[2/18-20]**. For the purposes of his skeleton and in argument before me, Mr Counsell grouped the Grounds of Appeal into four Grounds:

> "(1) First, it was not possible for Dr Dutta to receive a fair trial in the light of the very substantial and inexcusable delay in proceeding with these allegations;
>
> (2) Secondly, the lateness of requesting a second case examiner to make a decision on cancellation meant that the Tribunal had been provided with a very substantial quantity of highly prejudicial material which would not have been in the bundle had the case examiner been able to make their decision sufficiently in advance of the hearing, the effect of which was that Dr Dutta did not receive a fair hearing;
>
> (3) Next, the decision made by the tribunal in respect of each of the remaining individual allegations was contrary to the evidence or the weight of the evidence; and
>
> (4) Lastly and, in any event, the decision to raise Dr Dutta from the register was excessive and disproportionate."

Both Counsel addressed me on that approach, and that is the approach I shall adopt in this judgment.

Ground 1: Delay Prevented a Fair Trial

28. There is no dispute that Article 6 of the European Convention on Human Rights (incorporated into UK law by the Human Rights Act 1998) establishes the right to a fair trial, which includes the right to expect the hearing will take place within a reasonable time. Mr Counsell submitted that the delay in bringing this case to trial was, on any view, inordinate and inexcusable. The hearing in November 2023 was 4 ½ years after the first incident with Patient A, and four years since the second incident with patient C. Mr Counsell submitted that there had never been an explanation for the lengthy delay although he conceded, in response to a point from me, that the difficulties caused by the Covid 19 pandemic will inevitably have had some impact in this case.

29. In response to questions from me, and to me pointing out that no application had been made to stay the proceedings as an abuse of process, this challenge evolved into a challenge on the basis that no proper and sufficiently robust direction as to the impact of delay was given by the legally qualified chair ("LQC") to the Tribunal. That, Mr Counsell submitted, was particularly important in this case where the allegations relied heavily on witnesses' recollection of single words, phrases or brief exchanges during inspection visits in September and December 2019. Mr Counsell said that witnesses reiterated that the time which had elapsed was causing them difficulties in recollection and by way of example, he pointed to the evidence of Victoria Head, a CQC Inspector, who made the difficulty clear when she said "I am saying this to the best of my ability, considering this was three years ago…." **[7/1178 at letter A]**.

30. Mr Counsell referred to the judgment of Blair J in *Hutchinson v General Dental Council* [2008] EWHC 2896 (Admin) ("*Hutchinson*") at Paragraph 19 where he said this:

> "Given that a stay on grounds of abuse of process will be rare, the important thing in cases like this, in my judgment, is that the tribunal should reach its finding on the evidence with possible prejudice to the practitioner caused by factors such as delay and lack of specificity firmly in mind. To take the analogy of a criminal trial, on facts like these an express direction to the jury as to the necessity to guard against the potential prejudice caused by delay would be essential."

31. In his skeleton Mr Counsell states that no such direction was given in this case. In his oral submissions he accepted that a direction on delay was given. It was given in the following terms:

> "…. The Tribunal should note that when considering the evidence of any witness in this case, it should also bear in mind the extent to which the passage of time may have affected the memory of the witness, and the Tribunal should be aware from its own experience that memories can fade with the passage of time and that recollections may change or may become confused as to what did or did not happen at a particular time and the Tribunal should make due allowance for the way in which the

passage of time may have affected the recollection of any witness." **[7/1310 at letter D]**

32. Mr Counsell submitted that direction might be sufficient in other cases, but that it was nowhere near adequate in this case. He submitted the direction should have reminded them to look at the individual allegations and the extent to which a recollection is not supported by the records and the extent to which it is supported by or contradicted by other evidence.

33. Mr Counsell further submitted that the delay prejudiced Dr Dutta in other ways. Dr Dutta's defence was conducted with funding from his insurers but with an upper financial limit. Right up to the last minute, when allegations 1 to 5 were withdrawn, Dr Dutta had to prepare a defence to clinical matters, resulting Mr Counsell said, in funding being used up on allegations which did not proceed. Dr Dutta then had to fund his own representation. In an attempt to save costs, Dr Dutta's then solicitors did not attend and participate in the final hearing, leaving Dr Dutta's counsel to deal with the matter unassisted, something Mr Counsell described as far from satisfactory for either Dr Dutta or his Counsel.

34. Miss Hearnden submitted that the observations of Blair J in *Hutchinson* must be viewed in context. In that case the GDC's committee had refused an abuse of process application, and had proceeded with the hearing, and no direction about delay was given. Here, Dr Dutta was represented by experienced regulatory counsel before the MPT, and no application was made for an adjournment or a stay on the basis of delay/abuse of process. She pointed to the fact that the effect of delay was acknowledged in written submissions on behalf of the parties, and she relied on the direction given as being adequate to acknowledge a delay in the circumstances.

35. Miss Hearnden noted that regrettably the stress of proceedings and degradation of memory is not uncommon in fitness to practise proceedings, and those matters by themselves do not render a fair trial impossible. So far as the impact on Dr Dutta's funding is concerned, Miss Hearnden submitted that the impact on his funding does not on its own reveal serious procedural unfairness. She pointed to the fact that many registrants, lacking the benefit of legal funding, appear before fitness to practise committees without the benefit of legal representation and that is not a breach of their Article 6 rights.

36. To rely on the funding position, if taken to its logical conclusion, would mean, that once somebody runs out of legal funding, they cannot have a fair trial, even where that is not a result of delay but results from the sheer volume of the allegations and work involved. To put this another way, it would involve arguing that Dr Dutta could only have a fair trial in relation to allegations of a nature which could not exceed his legal funding. That plainly cannot be right. In any event, Miss Hearnden pointed to the fact that Dr Dutta remained legally represented by an experienced team before the MPT (even if the solicitor was not actually present). He now has new representation from different solicitors and leading counsel in this appeal. In my judgment, the impact on his legal funding has no relevance in this case.

37. In my judgment it is significant that Dr Dutta does not identify any specific evidence or witnesses lost as a consequence of the time delay. He points to no specific prejudice over and above the impact of the passage of time on the memory of witnesses,

something plainly dealt with by the LQC in the direction he gave, and which is set out in Paragraph 31 above. Miss Hearnden reminded me that delay and its effect on witness recollection impacted on witnesses on both sides. If Dr Dutta had been suggesting that delay deprived him of specific evidence or witnesses, or, for example, of the possibility of investigating and raising an alibi, some specific reference to the consequences of that delay, and in particular the prejudicial effect of that for him defending himself, might have been appropriate. This was not such a case. Mr Counsell very fairly and properly acknowledged that the direction given about delay might be sufficient in certain cases. What I cannot accept is his further submission that on the facts of this case the direction needed to go further. I am satisfied the direction given in this case was sufficient, and this Ground of Appeal therefore fails.

Ground 2: Admissibility of Evidence Relating to Clinical Allegations and Other Criticisms.

38. The thrust of Ground 2 is that the hearing bundles considered by the MPT contained inadmissible evidence comprising evidence relating to the withdrawn allegations, numbers 1 to 5, and further prejudicial and critical matter which Mr Counsell submitted was irrelevant. He submitted that none of this material should have been seen by the tribunal members and that very large amounts of prejudicial evidence had been read by the tribunal in advance of the hearing. Mr Counsell submitted that the prejudice caused by the material which had been read was incurable, and made the more so by the fact that evidence which related to the withdrawn allegations was evidence which Dr Dutta would not have been able to respond to when giving evidence as the tribunal would have stopped that evidence as no longer being relevant.

39. As set out in Paragraph 18 above, the agreed bundle was uploaded by the GMC on 25 October 2023, the day before the joint expert report was received. In his skeleton Mr Counsell states that what was uploaded was the GMC evidence, and none of the defence bundle, which was not uploaded until 3 November 2023, three days before the start of the hearing. The defence cannot upload its own documents to the MPTS platform, and the defence is reliant on the GMC to upload its bundles. Having said that, the chronology prepared by Miss Hearnden, and which was not challenged, is that the defence disclosure, including Dr Dutta's statement and the testimonials he relied upon, was only provided on 3 November 2023. In those circumstances there is no room for complaint about the date of the uploading of that material.

40. Mr Counsell referred me to Rule 28(2) and in particular the fact that the Registrar may refer the matter for a Rule 28 decision if "…..it appears to the Registrar that a matter (or part of it) should not be considered by an MPT.." **[AB/16/329].** He stressed the importance of the words "should not be considered by an MPT". That he submitted must extend to any evidence in support of matters that are withdrawn.

41. I was provided with a copy of the MPTS guidance on hearing bundles for MPT hearings. It provides guidance for decision-makers, parties and representatives. Mr Counsell referred me to the following passages in the guidance:

> Under the heading **Introduction**:
>
> "To help in the efficient running of our hearings, we require hearing bundles to be made available to tribunal members in

> advance of all MPT hearings so that they can familiarise themselves with the contents before the hearing starts. This removes or significantly reduces the reading time required during the hearing, resulting in time and cost savings." **[AB/17/344]**
>
> "Under the heading **What happens where the parties are unable to comply with a direction to provide hearing bundles in advance?**
>
> "…. They must urgently inform the MPTS Case Management Team as soon as they identify that they are unable to comply with the direction and set out in writing their reasons for being unable to comply with the direction and their proposals for the case management direction to be varied or set aside" **[AB/17/350]**

42. Whilst the agreed GMC bundle in this case was uploaded before the joint expert report was received, Mr Counsell submitted that as soon as it was appreciated that a second Rule 28 referral for a decision as to whether or not the matter or part of it should be withdrawn, the GMC should have contacted the Case Manager for directions. He submitted it should have sought a direction that the bundle should not go to the tribunal members until the outcome of the rule 28 decision or if the bundle had already gone to members, there might have been the possibility of stopping members doing any reading until further notice, or of switching the tribunal members if they had already read the bundles, or part of them. He submitted that where, as here, the Rule 28 decision was not made until the very last day before the hearing, the Case Manager would have directed that the first day of the hearing should be a reading day and the GMC could then have removed all irrelevant and prejudicial material. This was a case listed for 20 days, and Mr Counsell submitted that there was no pressing need to begin on the first day. He told me that in any event the hearing did not commence until day 2 of its listing.

43. The tribunal was not told until the morning of day 2 that allegations 1 to 5 were to be withdrawn. Thus, the bundles contained all the evidence in relation to allegations 1 to 5 which were allegations relating to clinical practice in relation to Patient A. Mr Counsell made the point that at no stage during the hearing did the Chair, either at the prompting of GMC Counsel or in any event, direct the other members that they should ignore evidence relating to the withdrawn allegations, nor did any determinations record that as having happened.

44. Further, Mr Counsell provided by way of appendix to his skeleton, a summary of the evidence which he described as prejudicial and inadmissible, but which the tribunal had also read. He submitted the material should have been redacted and would have been but for the delay. He submitted that the material would give the lasting impression to any reader, reading, as he put it, this one-sided account, that Dr Dutta was a doctor:

    i) who was not competent (or even properly qualified) to perform numerous cosmetic procedures, which were criticised in the inadmissible evidence, to the extent the patients were put at avoidable risk of harm;

ii) who was responsible for two clinics, whose facilities were dangerously inadequate and unsafe and which he allowed to operate without proper inspections;

iii) who carried out procedures in those clinics which could only be safely carried out in hospital and for which he was not registered;

iv) whose record keeping was inadequate;

v) who was willing to withhold records from his regulator;

vi) who gave pre-treatment advice to patients which was inappropriate and led to a seriously dangerous outcome;

vii) who was not up to speed with his regulatory obligations;

viii) who minimised the seriousness of the outcome when treatment did not go according to plan; and

ix) finally, and in Mr Counsell's words, "Perhaps most importantly, in view of the nature of the remaining allegations", who had been dishonest in his dealings with a patient and with the CQC on occasions which did not form part of the allegations which remained.

45. Mr Counsell submitted there was no basis for any of those criticisms, as demonstrated by the fact that no allegations were made in respect of those matters and they were not proceeded with. He submitted that none of this evidence should have been before the tribunal, and he pointed out this was not just one piece of inadmissible evidence which had slipped through the redaction net, but a very large quantity of highly prejudicial material.

46. He further submitted that the sheer volume of prejudicial material and the seriousness of the unfounded criticisms contained therein would have required lay judges to perform an impossibly difficult feat of mental gymnastics to try and put that all to one side, even if they had been directed to ignore the material. Whilst professional judges are expected to be able to put out of their minds inadmissible material, a judge in that situation will specifically indicate such evidence has played no part in the final determination. Mr Counsell submitted there is no such indication given by the tribunal in this case.

47. The tribunal was made up of the LQC, one medical member and one lay member. Mr Counsell made it clear he did not intend to slight or criticise lay members by suggesting they could not reasonably be expected to disregard this volume of material, even if they had been given such a direction. He pointed to the fact that lay magistrates will be disqualified from adjudicating the trial of a defendant if they have knowledge of the defendant's previous convictions, and he submitted that part time non legal members are no different. He submitted they could not possibly have put this material out of their minds, and that there is a very real risk that their findings were influenced by the significant quantity of prejudicial material before them.

48. Mr Counsell pointed to the fact that the Chair of this Tribunal was very much alive to the risk that a tribunal can be prejudiced by reading material which was not relevant to the allegations, as evidenced by the steps he took to avoid this happening in respect of evidence provided for the first time during the hearing. On Day 2 of the hearing, it was agreed that the defence would introduce a new bundle. Counsel for the GMC raised a concern that the bundle should not be seen by the tribunal until redactions had been agreed, and the Chair confirmed none of the panel had had the opportunity to look at the bundle and gave an undertaking not to look at it until it had been cleared with the tribunal clerk that it is ready for them to access **[7/1055]**.

49. The following day, there was discussion to ensure that the tribunal was working from the second and redacted version of the Defendant's supplemental bundle. It appears that the bundle retained a patient's address which should have been redacted. In the course of the discussion the Chair asked "Is the nature of the redaction a matter of privacy or is it something that puts the tribunal at some kind of risk if we see it? **[7/1080 at letter D]**. Having established the issue concerned a redaction to remove the witnesses address for confidentiality reasons, the LQC said "That's something we can quickly forget" **[7/1081 at letter C].** In response to an enquiry from the tribunal clerk as to whether proceedings should be paused to go through the documents, the Chair pointed out that the witness was present adding "… If we're not concerned that there is something which might be prejudicial in the bundle then I think we can proceed and then settle that matter later" **[7/1081 at letter A]**, a course of action to which the parties agreed.

50. Mr Counsell relies on these exchanges and submitted that despite the parties and the Tribunal Chair taking great care that prejudicial material should not accidentally be put before the tribunal during the hearing, very large amounts of prejudicial evidence had already been read by the tribunal in advance. He submitted the sheer quantity of prejudicial material was not something the tribunal could "quickly forget" and, in the Chair's words, "put the tribunal at risk".

51. Mr Counsell also referred me to Rule 34(1) which provides that "The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law" **[AB/16/331]**. Anticipating the inevitable point to be made that there could have been an application to exclude the prejudicial evidence and/or for an adjournment to a hearing with bundles not containing that evidence, Mr Counsell submitted it was hardly surprising that no application to exclude the material was made at the hearing itself as such an application would simply draw attention to the prejudicial material, broadcast its prejudicial significance and give the impression that Dr Dutta had something to hide.

52. In terms of the possibility of an adjournment for a fresh panel with appropriate evidence excluded, something I raised with Mr Counsell, he pointed to the fact that would involve further delay at a time when Dr Dutta was subject to IOT conditions. Mr Counsell and those instructing him were not representing Dr Dutta at the Tribunal, and they cannot say whether these matters were explored and what if any tactical decisions were made in those respects. Indeed, Dr Dutta would not be required to waive any privilege in relation to any such discussions.

53. Mr Counsell submitted that the evidence relating to the withdrawn allegations and all of the prejudicial material was left "hanging in the air" for tribunal members to make what they wanted of it. They were not directed to disregard it and on the contrary, he

submitted the tribunal recorded that it had received evidence from a list of witnesses both orally and in writing without making any distinction between those parts of their evidence which were admissible and those which were not **[3/47, paragraphs 10 and 11]**. Indeed, the tribunal made clear it had regard to the written GMC witness statements including all of the exhibits **[3/48, paragraph 14]**. Mr Counsell submitted that whilst it is clear from comments made by the Chair that he appreciated the need to ignore irrelevant evidence, it is not known whether the other members were aware of this given there is no mention of this in the Tribunal's determinations.

54. In response to these points, Miss Hearnden pointed out that Rule 34(9) provides that unless otherwise agreed between the parties or directed by a Case Manager, each party shall provide a list of documents and copies as requested, not less than 28 days before the date of the hearing. She submitted that there is a process involving a Case Manager and that there was significant collaboration in relation to case management in this case, with both sides having experienced legal representation. She reminded me that for an appeal to succeed it would need to be shown that the decision of the MPT was wrong or unjust, and that the court is therefore looking for a breach of fairness or natural justice. Miss Hearnden submitted that the gap in Mr Counsell's submissions is that he has not identified any way in which the material he now objects to impacted unfairly on the decisions made.

55. In her skeleton, Miss Hearnden described this tribunal as an experienced panel. That was challenged by Mr Counsell on the basis that there is no information about the panel, how many times members had sat in matters of that sort. In her oral submissions Miss Hearnden told me that she maintained her submission that the panel was experienced. She had no details of how many occasions panel members had sat on a panel, but she relied on the fact that the panel comprised an LQC, a medically qualified member and a lay member. The members of the panel have been trained and they receive guidance from the chair. Whilst I recognise that panel members are trained, in my judgment that, of itself, does not make them experienced. It makes them trained. Experience is earned over time. I have no basis for saying that this tribunal was an experienced one.

56. Miss Hearnden referred me to the Court of Appeal decision in R *(Mahfouz) v the Professional Conduct Committee of the General Medical Council* [2004] EWCA Civ 233 ("*Mahfouz*"). In *Mahfouz* the appellant doctor challenged a ruling of the professional conduct committee of the GMC in circumstances where, after the first day of the hearing, four of the five members of the committee had seen prejudicial material about the doctor which was published in the newspapers and would not otherwise have been seen in evidence before them. An application was made on behalf of the doctor for the committee to discharge itself, which application was unsuccessful.

57. Dealing with the issue of prejudicial publicity, at paragraph 22 Carnwath LJ (with whom the other Lord Justices agreed) said the following:

> "The problem of prejudicial publicity "including reference to previous convictions" is one which may arise in any court or tribunal considering criminal or disciplinary charges, but the law's response to the problem will vary depending on the nature and experience of the tribunal concerned. There is no absolute rule that knowledge of such material is fatal to the fairness of the proceedings."

He went on to describe the jury as at one end of the spectrum of tribunals in that members will generally have no previous experience of court procedures and practices. He noted that further along the line are magistrates' courts where the justices, although not legally qualified, should, by virtue of their training and experience, be better able to put out of their mind matters that are irrelevant.

58. At Paragraph 24, Carnwath LJ noted that the committee members in *Mahfouz* included two professionals and three lay members selected from a panel of persons chosen as having experience in public life. The court was told that the panel included retired judges, justices of the peace, barristers, solicitors and academics, and Lord Carnwath said they can be assumed to understand the proper approach to issues of law and be aware of the need to disregard irrelevant material.

59. In this case of course there is an LQC. Miss Hearnden submitted it can be assumed that the tribunal, including lay members trained specifically for the purposes of sitting in the tribunal, would be aware of the need to disregard irrelevant material. That submission I can accept.

60. Miss Hearnden referred me to the observations of Lord Hoffman in *Piglowska v Piglowski* [1999] 1 WLR 1360 ("*Piglowska*") at 1372G:

> "The exigencies of daily courtroom life are such that reasons for judgement will always be capable of having been better expressed. This is particularly true of an unreserved judgment such as the judge gave in this case but also the reserved judgment based upon notes, such as was given by the district judge. These reasons should be read on the assumption that, unless he has demonstrated the contrary, the judge knew how he should perform his functions and which matters he should take into account".

In *Khan v General Medical Council* [2021] EWHC 374 (Admin) ("*Khan*") Julian Knowles J applied those principles in the disciplinary context, noting at paragraph 89 that as a general rule, it is not readily to be assumed that a judge at first instance has failed to apply well understood principles even when they are not directly set out in his/her judgment. She submitted that Judges should be trusted to do their job, and that this tribunal would know to ignore irrelevant material.

61. Mr Counsell submitted that the situation here is quite different to the situation in those two cases. In *Piglowska* the court was dealing with an appeal from an ancillary relief hearing heard by a full-time District Judge sitting in the principal Registry of the Family Division. It was alleged that the District Judge had failed to take account of the provisions of Section 25 (2) Matrimonial Causes Act 1973, which sets out the factors to which the court is to have regard when considering ancillary relief in matrimonial cases. That section applies in every ancillary relief case and Lord Hoffman concluded that the judge could be expected to know those provisions, particularly when they are so well-known. In *Khan* the challenge was to the tribunal's failure to expressly set out that it had taken into account a good character. There were agreed written directions of law which the tribunal had, and both counsel in their submissions referred to the relevance of good character. Further the LQC had given a direction to the tribunal as to how good character was to be approached. In those circumstances Julian Knowles J

found it was impossible to infer that the tribunal must then have wholly left it out of account.

62. Mr Counsell submitted that this case is wholly different. He points to the fact the court is not considering a decision of a full-time District Judge who would be highly unlikely to forget something as basic as the factors to be taken into account in ancillary relief proceedings, nor is it dealing with a case where proper directions on good character had been given and agreed with counsel. Instead, he submitted, this tribunal was presented with a huge volume of irrelevant and highly prejudiced material which it had been required to read and was given no guidance whatsoever as to how it should approach this information.

63. Dealing first of all with the evidence relating to allegations 1 to 5, Miss Hearnden submitted that this Tribunal was able to put the evidence in relation to those allegations out of its mind. Allegations 1 to 5 were clinical allegations relating to a single patient and the care delivered to that patient. None of the remaining allegations relates to the standard of care provided by Dr Dutta to any other patient. In those circumstances Miss Hearnden submitted the evidence in relation to allegations 1 to 5 could have no subconscious or cumulative impact on the remaining allegations which were of a totally different nature.

64. Further she submitted that no specific direction was necessary as it is clear that everyone ignored the allegations and the evidence relating to them. In closing on behalf of the GMC no mention was made of anything to do with allegations 1 to 5. Counsel for the GMC went through the allegations in chronological order, starting with Allegation 6 [**7/1290**]. In closing submissions on behalf of Dr Dutta, his Counsel also went through the allegations starting at Allegation 6. Defence counsel in the tribunal did refer to the fact that about half of Dr Dutta's Witness Statement dealt with allegations 1 to 5, and that previously other misplaced allegations including a fundamental attack on his competence in qualification as a surgeon had all been dropped following a previous Rule 28 application. This discussion took place in the context of providing an explanation as to why Dr Dutta did not focus on the evidence as soon as he might have done, and Counsel invited the tribunal not to draw any adverse conclusion from his lack of timely preparation, or his change of account in respect of Charge 6 **[7/1302 at letter F-1303 at letter B]**.

65. In those circumstances, Miss Hearnden submitted that the Chair did not need to give an express direction discounting the evidence in relation to allegations 1 to 5. It was known to the tribunal that those allegations had been withdrawn. They were known to be of a wholly separate nature to the remaining allegations. They were not referred to save in the context set out above. I accept those submissions. In my judgment there is nothing from which it could properly be inferred that the allegations and the associated evidence relating to standards of clinical care which were withdrawn and not referred to again, did or could have influenced the Tribunal's findings on wholly unrelated allegations, none of which included an allegation relating to Dr Dutta's standards of clinical care.

66. In relation to the wider prejudicial material objected to by Mr Counsell, Miss Hearnden fairly acknowledged that some of it says negative things about Dr Dutta. However, she submitted that it was relevant to the overall picture being presented to the MPT, in particular so that the tribunal could understand the state of relations between Dr Dutta

and the CQC and could understand the context in which the CQC asked questions of him, and the significance of any answers. She submitted that it showed the background, explained why things were tense, and that it would have been very difficult for the MPT to understand what was going on, or the mischief addressed in the allegations if the evidence could not be seated in the broader investigations. Mr Counsell challenged this as speculation and submitted that in any event it would not explain the admission of most of the prejudicial material. Further he submitted that there was no evidence that the relationship between Dr Dutta and the CQC inspectors was strained in any way. He pointed to the evidence of the CQC's Inspector Angie Brown who accepted that the CQC got the assistance it needed from the provider when conducting her inspection **[7/1094 at letter C],** and that Jill Atkinson, another CQC Inspector, expressly indicated that she didn't believe at the time of her inspection that anything Dr Dutta had said to her was untrue **[7/1161 at letter H]**.

67. Miss Hearnden reminded me that the bundles including this material were agreed, and this at a time when Dr Dutta had competent and experienced legal representation. The material challenged in this respect is unaffected by the inclusion or otherwise of allegations 1 to 5 in relation to the care provided to Patient A. She submitted there was no concern from the defence about this material being included in the agreed bundle, regardless of the material in relation to Patient A.

68. Miss Hearnden pointed to the fact that the bundle was not an unfiltered bundle and that there were significant agreed redactions. An obvious example is that at **[4/235- 236]**, and a quick flick through the bundle shows many redactions including in some instances whole pages **[4/404-406].** Miss Hearnden said the bundle went back-and-forth between lawyers to refine it. She submitted that what should or should not go in the agreed bundle is a judgement call, and the Appellant is not saying that the legal representation below was so incompetent as to render the tribunal hearing unfair. She submitted that it cannot be said that there was a procedural irregularity which resulted in unfairness.

69. She submitted that what is going on here is the situation warned against by Choudhury J in *Ahmed v General Medical Council* [2022] EWHC 424 (Admin) at paragraph 75 in his judgment:

> "Section 40 appellants need to be aware that the circumstances in which it is shown that professional representatives acted in a manner giving rise to some serious irregularity in the proceedings so as to render the outcome unjust are likely to be very rare, and the fact that the appeal court conducts a rehearing is not licence to include a ground of appeal founded on hindsight based disagreement with the way in which representation was conducted before the Tribunal."

70. Miss Hearnden invited me to look at the determination and reminded me that Mr Counsell points to no examples where it is suggested that irrelevant or prejudicial material has impacted on the minds of the tribunal members. The Chair's questions to Dr Dutta are all directed to the remaining issues in the case, and no mention is made of allegations 1 to 5 or any of the background material which Mr Counsell now challenges **[7/1260-1262].** The same is true of the questions asked by panel member Dr Brooke **[7/1265-1267]**. The lay member, Ms Daughters, asked Dr Dutta a question as to what he thought made the CQC cancel his registration just six days after the CQC was told

that the clinic was doing "lumps and bumps". Unsurprisingly counsel for Dr Dutta objected that Dr Dutta could not explain why he thinks the CQC cancelled his registration, particularly as it was a decision he did not agree with, and which he then appealed. Counsel suggested it was perhaps a futile line of enquiry. Miss Hearnden submitted this was the closest anyone gets to looking at any of the background information, and that everything else is focused on the allegations.

71. Ms Hearnden made the point that no application was made at the start of the tribunal hearing to redact or exclude further evidence. She submitted that the fact that his new legal team would have drawn the line for redactions in a different place and would have sought to redact additional evidence is insufficient to show that his earlier representation took such decisions or acted in a way which no reasonable advocate might reasonably have been expected to act.

72. I accept those submissions. The test to be applied on Ground 2 is whether the decision of the tribunal was unjust because of a serious procedural or other irregularity in the proceedings in the tribunal. It is hardly surprising that there is no reference in the tribunal's directions to the need to ignore any of this material in circumstances where it appears in an agreed bundle, and neither counsel suggested it should be ignored. Mr Counsell's suggestion that the reason for that is to avoid drawing further attention to prejudicial material is pure speculation. In my judgment, Ground 2 amounts to little more than a disagreement with any tactical decisions which may have been made, (such as not seeking a further adjournment and/or further redaction of material), or with decisions of judgement as to what should or should not be included in the bundle to go before the tribunal.

73. Undoubtedly, Dr Dutta's current legal team would have done things differently. That does not mean that the hearing in front of the tribunal was unjust because of serious procedural or other irregularity. In my judgment it is highly relevant that the inclusion of the material now challenged by Mr Counsell was agreed by lawyers acting for Dr Dutta at a time when all of the allegations were expected to be before the Tribunal. The material challenged is not limited to the allegations withdrawn and was plainly, therefore, accepted as having wider relevance, whatever that relevance may have been. In my judgment this Gound of Appeal must also fail.

Ground 3: Findings of Fact Which Were Wrong

Allegation 8- Cardiac Arrest.

74. Allegation 8 is that between December 2019 and January 2020, on one or more occasions Dr Dutta told the CQC inspector(s) that 'Patient C did not have a cardiac arrest at ABC', or words to that effect, which was untrue and which he knew to be untrue. To prove this allegation, it would be necessary to establish that Patient C had a cardiac arrest at ABC; that Dr Dutta told CQC inspectors that Patient C did not have a cardiac arrest; and that in making that statement Dr Dutta knew it was untrue. This allegation related to the bilateral gynaecomastia excision (or male breast reduction procedure) carried out on Patient C on 20 September 2019 at ABC Newcastle.

75. In his Witness Statement dated 3 November 2003 Dr Dutta accepted that he advised the CQC inspectors that Patient C had bradycardia and did not have a cardiac arrest at the clinic. He states the reason that he advised the CQC inspectors of this is because Patient

C did not, in fact, have a cardiac arrest. He had bradycardia (in other words a slower than normal heart rate). He goes on to say he has reviewed the cardiac science report which confirms that Patient C had bradycardia (rather than a cardiac arrest) and that this was also confirmed to him by the anaesthetist in the serious incident investigation. **[5/625, paragraph 23]**.

76. Mr Counsell submitted that there was no proper basis on which the tribunal could have been satisfied that Patient C suffered a cardiac arrest. There was no evidence before the MPT from a cardiologist as to whether the patient suffered a cardiac arrest or simply bradycardia. The expert witnesses were both plastic surgeons and both made clear they had no cardiological expertise. Dr Heaton, the expert called by the GMC, emphasised he was not a cardiologist but he accepted that it would be incumbent upon him to be able to recognise a cardiac arrest and institute appropriate measures, and that exactly the same would be true for Dr Dutta **[7/1111 at letter D]**.

77. Mr Counsell pointed out that in the course of examination in chief, it became clear that Dr Heaton's conclusion that there was a cardiac arrest was largely based on the fact that the anaesthetist, Dr Jagannathan, had commenced CPR and in a call to the ambulance service had said that the patient had suffered a cardiac arrest **[7/1104 at letter G]**. Mr Counsell submitted that Dr Heaton appeared to have overlooked or disregarded the fact that the anaesthetist had also said, on two separate documented occasions, that the patient suffered bradycardia: (i) in the medical advisory meeting dated 23 September 2019 three days after the event **[5/711]** and (ii) in a Statement of Fact dated 11 October 2019 **[5/734 at point E, and at paragraph 34]**, where Dr Jagannathan referred in each case to severe bradycardia.

78. In re-examination on these issues Dr Heaton said that standing in that operation at the time and given that the anaesthetist said he could not feel a pulse and that there was bradycardia, Dr Heaton would have considered that to be a cardiac arrest. Asked whether his opinion would have been the same two weeks later, he said it was difficult to say particularly with the analysis from the machine [**7/1127 at letters A-C**]. Mr Counsell submitted that was a reference to the definitive evidence of the heart trace showing the heart did not stop, and that based on that, Mr Heaton could not say if there was a cardiac arrest or bradycardia.

79. He further submitted that given its importance, it was extraordinary that the tribunal failed to mention this evidence in its determination and that it was incumbent on the tribunal to explain why it had reached a finding that the patient had had a cardiac arrest, and why it was appropriate to ignore all of the other evidence to the contrary. He submitted the Tribunal gave no reasons for selecting the parts of the evidence that supported the allegations and ignoring those that assisted the defence. The GMC did not call Dr Jagannathan to explain why he told the hospital there was a cardiac arrest but was later recording this as bradycardia or severe bradycardia. Mr Counsell submitted that without that explanation, there could be no safe basis for a finding that Patient C had a cardiac arrest simply on the basis of Dr Jagannathan's calls to the ambulance service.

80. In its determination the tribunal accepted the definition of a cardiac arrest given by the experts in their joint report, namely:

> "The term cardiac arrest can be used to describe a clinical condition when the heart stops beating or a clinical state when the heart slows to a rate that leads to circulatory collapse". **[3/52, paragraph 23]**

The tribunal then went on to note that the defence expert, Mr Percival, defined bradycardia as 'a slowing down of the heart, medically defined as below 60 bpm'; that Dr Dutta accepted that patient C's heart rate fell to 30 bpm ; that the anaesthetist stated that 'at the point of commencement of CPR I was not sure if the patient had a pulse or not', and referred to a return of spontaneous circulation (ROSC). All this indicated to the Tribunal that at some point the anaesthetist could not find evidence of circulation, CPR was initiated and was successful **[3/52, paragraph 24].** I am aware the later heart trace data shows a drop to 36bpm, rather than 30, but as bradycardia is defined as below 60bpm, it seems to me that nothing turns on this.

81. In my judgment it is clear from that paragraph that the Tribunal relied on the second part of the definition, namely a clinical state when the heart slows to a rate that leads to a circulatory collapse. Insofar as Mr Counsell submits that only a cardiologist could properly give a definition of what amounts to a cardiac arrest, on the facts of this particular case I am unpersuaded by that. As set out in Paragraph 76 above, Dr Heaton, accepted that it would be incumbent upon him to be able to recognise a cardiac arrest and to institute appropriate measures, and that exactly the same would be true for Dr Dutta. Importantly, in his evidence, in response to questions from the Chair, Dr Dutta accepted the definition given in the joint expert report **[7/1261 at letter C-D]**. In those circumstances, in my judgment, the Tribunal was entitled to proceed on that basis. The real issue, in my judgment, is whether there was evidence from which the Tribunal could properly conclude that there was a circulatory collapse.

82. As regards this issue, in my judgment, there is more force in the suggestion that evidence was required from a cardiologist. Dr Dutta's position at all times before the tribunal was that, notwithstanding the bradycardia, Patient C had a heartbeat as shown on the monitor. In answer to questions from the chair, Dr Dutta said that he did not think there was a circulatory collapse in relation to Patient C. He added that after the patient was finished, they looked back on the monitor and looked back on the defib and there was no mention on the defib that there was shockable rhythm, and the monitor was still showing that his heart was beating and everything was back to normal. **[7/1261, letters B-F]**.

83. Ms Hearnden relies on the following evidence in support of her submission that the MPT was entitled to find, on the balance of probabilities, that Patient C's heart had slowed to a rate that leads to circulatory collapse:

i) The evidence of the defence expert, Mr Percival, that he did not think there was any doubt about whether there was, as described in the joint report, circulatory collapse or inadequate circulation **[7/1282]**.

ii) His further evidence that bradycardia on its own was not an adequate explanation for the condition of patient C, and that he thought it would be reasonable to say the patient had severe bradycardia with a circulatory collapse **[7/1287]**.

iii) Dr Heaton's conclusions in his reports that the anaesthetist's inability to find a palpable pulse was indicative that the individual was in cardiac arrest **[6/919 - 920]** and that the fact that the consultant anaesthetist referred to a return of spontaneous circulation suggested that Patient C suffered a cardiac arrest **[6/955 and 974]**.

iv) Dr Heaton's evidence in chief, again referencing that the patient did not have any palpable pulses and that effectively the heart was beating so slowly that it was not sufficient to enable circulation to be maintained **[7/1106-1107]**, and his evidence, under cross-examination, that although the defibrillator data did not show the heart actually stopping, his view that it had slowed to a point where there was no detectable peripheral circulation, although he acknowledged that there was doubt about what was detectable **[7/1112]**.

v) Mr Percival's evidence that circulatory collapse could mean either a total absence of circulation or inadequate circulation, describing effectively a change from the normal situation where there is an adequacy of circulation to a situation where relatively rapidly there is an inadequate circulation". He also indicated that a pulse rate of 30 (recorded by the anaesthetist) is slow and that it is not surprising that it was inadequate to maintain circulation **[7/1277-1278]**.

vi) The joint expert report which notes there is conflicting information in the record as to whether Patient C suffered an absolute cessation of cardiac function or a severe bradycardia with circulatory collapse, **[6/1021]**, from which it can be inferred that it was one of the other, not simply bradycardia.

84. Mr Counsell submitted that the real difficulty here is that nobody has got to grips with what is meant by "circulatory collapse", and that there should have been expert cardiology evidence to deal with that issue. Mr Counsell points out that as a result, the experts have said different things at different times, although he does not criticise them for doing their best to give evidence about something which is not their area of expertise. I have already referred in Paragraph 78 above to Dr Heaton's evidence that whilst in the immediacy of the procedure his view would have been that there was a cardiac arrest, it was difficult to say whether his opinion would have been the same two weeks later, particularly with the analysis from the machine. Whilst not criticising him for what was plainly a very fair answer, it is an answer which in my judgment undermines Miss Hearnden's reliance on his principal conclusions both in his report and in his evidence.

85. I also have concerns that his evidence is based on the notes of the anaesthetist Dr Jagannathan, whose own views on whether there had been a cardiac arrest appear to have changed once the heart trace information had been reviewed. Dr Jagannathan was not a witness before the GMC despite the reliance on his notes during the procedure. That is particularly surprising when he also appears to have volunteered a different opinion (bradycardia rather than cardiac arrest) on 2 later dates as set out in Paragraph 77 above. Dr Heaton makes no mention of those but does make the concession set out in Paragraphs 78 and 84 above, that his opinion might not have been the same 2 weeks later with the benefit of the machine data. There is no mention of any of those matters in the Tribunal decision and Mr Counsell submitted that Dr Dutta is entitled to know why that evidence was rejected in favour of other evidence. In my judgment this is particularly important when the tribunal decision itself relies heavily on Dr Jagannathan's notes at the time of the procedure.

86. I accept Mr Counsell's submissions that it was incumbent upon the tribunal to explain why it reached a finding that Patient C had had a cardiac arrest without dealing with the evidence which suggested the contrary. No reasons at all are given for selecting those parts of the evidence that supported the allegation that this was a cardiac arrest, and

more importantly the reasons to the contrary are simply not referred to. If I ask myself the question as to whether the conclusion on this issue could be said to be so out of tune with the evidence as to justify interference, my answer has to be yes. I conclude that the tribunal's finding that Patient C had suffered a cardiac arrest was wrong in circumstances where it appears to have been reached based on selective parts of the evidence only.

87. However, if I am wrong about that, I have no hesitation at all in concluding that the tribunal was wrong, in the sense that it could not properly have found, that Dr Dutta was being dishonest when he said the patient had not had a cardiac arrest. When asked that question by CQC inspectors, unsurprisingly there was no discussion as to the precise meaning of the term "cardiac arrest", or the difference between a cardiac arrest as in the heart stopping completely, and the situation of a heart slowing to such an extent that it resulted in circulatory collapse. Giving the words cardiac arrest their natural meaning they mean that the heart has stopped. Whilst accepting the definition of the experts at the tribunal hearing, Dr Dutta's evidence was that when he told the CQC inspectors that there was no cardiac arrest, but rather bradycardia, he was relying on the cardiac science report which confirms that Patient C had bradycardia (rather than a cardiac arrest) and that this was also confirmed to him by the anaesthetist in the serious incident investigation. **[5/625, paragraph 23]**.

88. Further, the tribunal made no mention of Dr Percival's clarification in his oral evidence of the definition of cardiac arrest. In his oral evidence he stated that some people may consider that the term "cardiac arrest" means an absolute cessation of heart function, and that others may have a broader term. Both he and Mr Heaton agreed that they felt a broader term of reduction in cardiac function leading to circulatory collapse or inadequate circulation would cover the term of "cardiac arrest" as well, and then he said this:

> "But I understand that different people may consider that one or other term is more appropriate. Some people may consider that cardiac arrest means an absolute cessation of heart function." **[7/1281 at letters B-C]**

89. I appreciate that in cross examination Dr Dutta accepted the broader definition put forward by experts. Given that concession, in her submissions Miss Hearnden formulated the issue as to whether there was evidence from which the tribunal could properly conclude that there was a circulatory collapse, in other words an absence of pulse. That was her choice of words, but nowhere in the evidence is the absence of a pulse said to be the definition of circulatory collapse, and Dr Dutta did not accept that there was a circulatory collapse. Nor did he accept that there was no pulse, as opposed to no palpable pulse which he pointed out could mean that there was a weak but non-detectable pulse, and he relied upon the fact that the monitor showed that there was always a heartbeat. There was some discussion as to whether there could be a heartbeat, some electrical function of the heart with no pulse, but none of that was put to Dr Dutta and in any event, it would clearly require proper cardiology evidence for that to be the basis of any conclusions against Dr Dutta in the case.

90. Furthermore, in my judgement it is significant that at the point that Dr Dutta told CQC inspectors that Patient C had suffered bradycardia and not a cardiac arrest, he had information from the consultant anaesthetist present at the procedure, that this was a

case of bradycardia. It is hard to see how the tribunal could reach a conclusion that he was acting dishonestly when he was relying upon the opinion expressed by the anaesthetist who was present at the procedure. Whilst Dr Jagannathan may have thought there was a cardiac arrest at the time of the procedure, having had sight of the AED rescue report, it appears he formed the view that this was bradycardia. Dr Heaton did not feel able to say that that was wrong, and in those circumstances, it is very hard to see how the tribunal could have concluded that Dr Dutta was being so economical with the truth as to represent a deliberate attempt to downplay the severity of the incident.

91. The tribunal comments that the term bradycardia was offered as an alternative to cardiac arrest with no qualification or further expansion **[3/51, paragraph 26]**. The same was true of Dr Jagannathan's reports, the very same doctor whose earlier statements made during the procedure are relied upon to support the findings of cardiac arrest. I have no hesitation in concluding that this conclusion was not properly open to this Tribunal on the evidence before them. Again on this issue, no mention was made in the determination of the points of evidence in Dr Dutta's favour, and no reasons at all were given for rejecting that evidence. In my judgment the conclusion on this issue was so out of tune with the evidence as to justify interference with the finding of fact.

92. It follows that the tribunal's determination on Allegation 8 must be quashed.

<u>Allegation 9- Procedures at ABC Sunderland</u>

93. Allegation 9 is that between September and December 2019 on one or more occasions Dr Dutta made assurances to the CQC that he was not undertaking procedures at ABC Sunderland, assurances which it is alleged were untrue, and which he knew to be untrue. To prove this allegation, it would be necessary to establish that the assurance was given; that the assurance was untrue; and that Dr Dutta knew it to be untrue.

94. Mr Counsell's first line of attack is to the finding that such assurances were given. Dr Dutta's case is that what he told inspectors was that procedures involving sedation or general anaesthetic were not carried out at ABC Sunderland, although they were at Newcastle. Mr Counsell made the point that the CQC would have known this in any event from regular inspections carried out by it and in accordance with ABC Sunderland's Statements of Purpose, copies of which were provided to the Tribunal.

95. Mr Counsell further submitted that the CQC Inspector, Miss Atkinson's Witness Statement itself did not support the allegation. In her Witness Statement Miss Atkinson said that Dr Dutta had said that no procedures under sedation and anaesthetic were being carried out at Sunderland **[4/103, paragraph 25]**. He submitted that it must follow the allegation as worded in paragraph 9 cannot be made out on the evidence and cannot stand.

96. Whilst Miss Atkinson did state that in her Witness Statement, in my judgment that sentence needs to be put into the context of the paragraph as a whole which reads as follows:

> "I have been asked by the GMC why we only inspected the Newcastle premises of ABC, following the call from the Trust. The first inspection in September 2019 was an initial response.

> During this inspection and the inspection in December both Dr Dutta and Mrs Dutta made assurances that the Sunderland premises did not have any procedures being undertaken under sedation or anaesthetic. We were told it was a consulting room only and therefore we did not believe there was a need to inspect the Sunderland facility. During our inspection in December 2019, I viewed the diaries for Sunderland and Newcastle locations and these showed some surgical procedures booked at Sunderland. I attach a copy of the diary entries that showed procedures booked in Sunderland between October and December 2019….."**[4/103]**

There is no dispute that the procedures which had taken place in Sunderland in that period were those alleged in Allegation 11, namely the removal of a cyst; two lesion removals; and a mole removal.

97. Dr Dutta's case was that he had given a narrower assurance to the CQC, namely that he was not carrying out procedures involving sedation or **general** anaesthetic, (my emphasis added), but that the CQC knew that minor surgical procedures, including those under local anaesthetic were being carried out at the Sunderland premises. This was put to Miss Atkinson in cross examination, and she did not accept this, and maintained that she was told that no procedures at all were being carried out at Sunderland. In giving that answer she refers to the fact that the assurances included that Sunderland was a consulting room only and was registered as a consulting room. **[7/1138]**. She was taken to the statements of purpose for ABC Sunderland, but she maintained that inspectors were told that no procedures were being carried out at all at Sunderland **[7/1166]**.

98. Miss Atkinson was asked to provide any notes she may have made of her conversations with Dr and Mrs Dutta. When she provided those notes the following day, there is no mention of the alleged conversation. Mr Counsell made the point that this is to be contrasted with the very detailed notes of other conversations in that document **[541-546].** Mr Counsell submitted that, in the absence of any note, it would have been a nonsense to suggest that Miss Atkinson could accurately recall whether Dr Dutta had said (as he claims) that there were no procedures under sedation or general anaesthetic, or that there were no procedures under sedation and anaesthetic (a difference of a single word), at a meeting which took place more than four years before the hearing.

99. Miss Atkinson's evidence was that they did not believe it was necessary to carry out an inspection at Sunderland because they were told it was a consulting room only. Once they became aware of the procedures booked in Sunderland between October and December 2019, an inspection was carried out at Sunderland in January 2020 which confirmed those procedures had actually been carried out **[4/103]**. Mr Counsell challenged the tribunal's acceptance of Miss Atkinson's inferential recollection that Dr Dutta must have said that there were no procedures at all because the CQC did not then go on to carry out an inspection. He pointed to the fact that the tribunal did not give itself a direction about the risks of accepting evidence of a conversation where there is a difference only of a few words and the conversation is not recorded. He suggested the much more likely explanation was that the two parties to the exchange were at cross purposes.

100. Miss Hearnden submitted that the MPT was entitled to find on the balance of probabilities, in reliance on the evidence of Miss Atkinson, that the broad assurance alleged had been given. She submitted that finding was not against the evidence and did not exceed the generous ambit within which reasonable disagreement about the conclusions to be drawn from the evidence is possible.

101. Miss Atkinson was previously known as Miss Bullimore. The MPT found that her evidence was consistent with the related and accepted facts. They point to the fact that once the CQC became aware of procedures being carried out at Sunderland, this triggered an urgent inspection from the CQC. They considered the statement of purpose for ABC clinic Sunderland to be of limited significance for reasons given, and the tribunal concluded it was satisfied on the balance of probabilities that Miss Bullimore's evidence was accurate. **[3/52, Paragraphs 29-30].** The tribunal of course had the benefit of seeing and hearing from the witnesses which this court does not have. Whilst there is no express mention of the lack of a note of the conversation, the tribunal considered the evidence in the context of the related and accepted facts which they plainly concluded supported Miss Atkinson's evidence.

102. In my judgment Mr Counsell's submissions amount to a disagreement with the findings reached by the tribunal rather than providing a basis for concluding that the tribunal could not properly have reached the conclusion it reached. When considering the full context of the paragraph of Miss Atkinson's Witness Statement (as set out in Paragraph 96 above), the reasons that Miss Atkinson gave for her recollections are, as the tribunal found consistent. Mr Counsell did not seek to challenge the further finding that Dr Dutta knew that the assurances he gave were untrue. It follows that the appeal against the finding on Allegation 9 fails.

<u>Allegation 10 - Brazilian Butt lift ("BBL")</u>

103. Allegation 10 is that between September and December 2019 Dr Dutta told the CQC's Inspector that he had stopped doing BBL procedures a while ago which was untrue and which he knew to be untrue as he had more than one booked in the diary. To establish this allegation, it would be necessary to prove that Dr Dutta had made the statement; that it was untrue; and that he knew it was untrue.

104. Dr Dutta accepted that he said this during an inspection visit on 9 December 2019, as recorded by CQC Inspector, Angie Brown in answer to a question from Mr Ali Soueid, an adviser who had attended the visit with Miss Brown. The reply was recorded in Miss Brown's notes and appears at **[4/486]**. That note also records that it was pointed out to Dr Dutta that he had a BBL listed in October, but that Dr Dutta did not respond. There is a photograph of the diary at **[4/214].** It shows a BBL at 9am on 9 October 2019. At the top of that page, in different coloured pen, are the words "Informed no surgery". It was Dr Dutta's case that that appointment was cancelled because, prior to the date of the appointment, clinics had been told not to perform this operation because of concerns about its safety. The records show that the last time Dr Dutta had undertaken the procedure was on 5 August 2019. Mr Counsell submitted that was entirely consistent with Dr Dutta telling Mr Soueid that he had stopped doing such procedures "a while ago". In her evidence Miss Brown said that she did not believe the October procedure went ahead and she accepted that Dr Dutta's statement made in December 2019 would not be inaccurate if he had last undertaken a BBL on 5 August 2019 **[7/1093, letters A – E]**.

105. In her evidence, Jill Atkinson said that Dr Dutta had said the same thing to her at an earlier inspection visit on 27 September 2019. Mr Counsell made a number of points in relation to this. Miss Atkinson made a CQC statement in November 2019 which makes no mention at all of such a conversation. In her Witness Statement dated 14 May 2020, Ms Atkinson, when referring to the September inspection, stated that Dr Dutta said he had not done a BBL "in a long time". She stated there was one listed for the following day, with others included in the list of procedures **[4/104]**.

106. Mr Counsell submitted that recollection could not be correct for a number of reasons. Firstly, there was no evidence of any BBL in the diary for the following day, 28 September 2019. He submitted the only procedure recorded after the time of her inspection was the one in the diary on 9 October 2019 which according to Dr Dutta had already been cancelled by the time of the September CQC inspection.

107. He also submitted that Miss Atkinson's recollection that Dr Dutta said he had not done a BBL in a long time was inconsistent with the fact that his diary showed that he had done one in early August, less than two months before the September CQC visit. In her oral evidence, she said that Dr Dutta told her that he had stopped a while ago, although she then reverted back to "not done in a long while", saying that it was to Mr Soueid that Dr Dutta had said that he hadn't done one in a while. She denied the suggestion that the question was not asked, and said she thought the question would be in her inspection notes. **[7/1142]**.

108. The following day Miss Atkinson provided her inspection notes which are at **[4/541-546]**. They make no mention of any such conversation. Mr Counsell submitted that this conversation would have been noted by Miss Atkinson if it had taken place. He also submitted that Allegation 10 related to a single conversation, unlike Allegation 9 which expressly referred to assurances made on one or more occasions. He submitted Allegation 10 must have referred to the December conversation, in which case it plainly could not be proved.

109. Miss Hearnden submitted that the MPT was entitled to reach the factual conclusion it did on Allegation 10. Whilst accepting that Miss Atkinson's notes did not expressly record this conversation, they did note "Sunday list planned" **[4/543]** which was two days after the inspection. Details of that Sunday list on 29 September 2019 show it included an appointment for buttock augmentation **[4/529].** Miss Hearnden further submitted that was consistent with the CQC's decision tree which records "There was a BBL planned for the weekend after our first inspection in September 2019" **[4/206]**.

110. During the course of the hearing in front of me, and when I was looking at the diary entries for 9 October 2019, I asked about the reference on the left hand page to "buttock augmentation", and whether that was the same as a BBL. I was told by both Counsel that I could not make that assumption. However, it appears that the CQC inspectors have assumed that "buttock augmentation" is the same as BBL, since the Sunday list refers only to buttock augmentation, not to BBL It is a distinction referred to by Dr Dutta in his witness statement. He acknowledges that further BBL consultations had been marked in the diary but states that no procedures were performed. He states there were other less risky procedures that might have been suitable for the patients as the clinic had by this time made a decision to stop offering BBLs. This time must refer to September 2019 when looked at in its context of the previous paragraph, notwithstanding later changes to his evidence about the dates (see below). He states

the patient would be counselled about the fat transfer and its risks, then they could go for filler or implant if they decided **[5/626, paragraph 27]**.

111. Having said that, I note that in its determination the MPT refers only to the BBL booked on for 9 October 2019 and makes no mention of the buttock augmentation procedure booked in the Sunday list on 29 September 2019. Further there was discussion of the different procedures in the evidence, and it was made clear that the only relevant procedure is one specifically labelled BBL **[7/1232 – 123]**. Whilst Miss Atkinson may have treated these as the same, there is no evidence that the MPT did so. However, the "Sunday list planned" evidence is supportive of Miss Atkinson's recollection that the conversation in question took place in September 2019, something the MPT was entitled to take into account.

112. Miss Hearnden also relied upon the fact that in his first Witness Statement dated 3 November 2023, Dr Dutta recounted a conversation about BBLs with a female inspector when they were discussing a procedure performed about four weeks earlier. He accepted that at about the time of that conversation it was correct that there was some further BBL consultations that had been marked in the diary **[5/626 paragraph 26-27]**. In his supplemental statement dated 6 November 2023 he corrected this evidence to say that he must have been referring to a procedure nine rather than four weeks earlier **[5/696, paragraphs 10-11]**. That evidence ties in with the BBL performed on 5 August 2019, with the conversation taking place at the September inspection, and also refers to a conversation with a woman inspector which would tie in with the September inspection, rather than the December inspection. Dr Dutta was asked about these dates by tribunal member Dr Brooke, and Counsel explained that at the time of making the statements they were unclear as to the date the conversation with the CQC was alleged to have taken place, and the nine weeks was counting back from 9 October (the diarised procedure) to 5th August. Dr Dutta then said the period of time should be corrected to 12 to 14 weeks (i.e. from the December inspection back to August).

113. In its decision, the MPT noted Dr Dutta's reference to a conversation with an inspector described as 'she', and the inconsistency with his oral evidence suggesting the conversation was in December, when both surgeon specialist advisers were male. They stated that Dr Dutta was unclear as to why further BBLs were cancelled, and they found on the balance of probabilities that Dr Dutta had booked a patient in for a BBL in October 2019 **[3/54, Paragraph 37]**.

114. In my judgment that finding is unassailable and is clearly a finding it was open to the tribunal to make on the evidence before it. The real issue, in my judgment, was whether the patient booked in for October had been cancelled by the time of the CQC inspection in September. This goes to the issue of whether Dr Dutta was truthful in stating that he had had stopped doing BBLs.

115. The MPT's determination acknowledges that the procedure on 9 October 2019 was cancelled but asserts that on the day of the CQC's inspection [in September] it was booked in. Dr Dutta's Witness Statement indicated that ABC had decided not to do further BBL procedures but does not address when the procedure booked for 9 October was cancelled. Mr Counsell submitted that the MPT has assumed, without any evidence to support it, that the photograph of the diary for 9 October showing the BBL had been cancelled was taken at the inspection in December, rather than at the inspection in

September. If taken in September, it would have shown the future procedure had been cancelled and Mr Counsell submitted that would be consistent with what Dr Dutta was saying and could not be said to be dishonest.

116. It is correct that the determination does not address when that photograph was taken. However, in Paragraph 37 of the determination the tribunal deals with Dr Dutta's evidence about when concerns were raised about the safety of BBLs. They refer to the evidence which he gave that concerns came out in the newspapers in October and November, and that before that doctors knew there was risk involved, risk they explained to the patients but there was no public knowledge of BBL being discouraged to be done and there was never a ban in this country **[7/1235].** In its determination the tribunal described Dr Dutta's evidence as inconsistent and concluded that the appointment on 9 October was still booked in (and therefore not cancelled) as at the inspection in September. Unsurprisingly, this was not based simply on the photograph or diary entry, but on the MPT's assessment of the evidence as a whole. The tribunal noted that Dr Dutta was unclear why other BBLs booked in were cancelled, and they noted that an urgent notice issued by the CQC on 4 October 2019 required the provider to cease carrying out any surgical procedures under local anaesthetic and sedation.

117. As is inevitable, the reasons are given in fairly short form, but in summary they show that the tribunal rejected Dr Dutta's evidence and found on the balance of probabilities that the statement was made at the CQC's inspection in September and at a time when Dr Dutta had not yet decided to cease carrying out BBLs. That is entirely consistent with his evidence that it was only in October and November that concerns about BBL's became more prominent, in which case there would have been no reason for him to have cancelled it in September. The Tribunal had the benefit of seeing and hearing the witnesses and in my judgment, there is no basis for saying the conclusions they reached in this respect are wrong. In my judgment the findings made by the Tribunal were open to them on the evidence before them, and they cannot be said to be so out of tune with the evidence as to justify interference on appeal. The appeal in relation to Allegation 10 fails.

Allegation 13 – Acted contrary to an assurance given to and a notice provided by the CQC and in breach of an IOT condition.

118. There is no dispute that Dr Dutta undertook the following procedures: (a) on 23 June 2020, removal of a cyst on the patient D; (b) on 30 June 2020, removal of two lesions on patient E; and (c) on 15 July 2020, removal of a mole on patient F. By Allegation 13 it is alleged that undertaking those procedures put Dr Dutta in breach of breach of (a) assurances given by him to the CQC; (b) a Dormancy Notice and (c) conditions on his GMC registration issued by the IOT. I shall deal with each in turn.

119. The assurances were written assurances provided to the CQC on 31 March 2020 as part of ABC's Covid pandemic policy. The assurance said to have been breached (set out in full in paragraph 9 above) is that "… the centres in Sunderland and Newcastle will remain closed until the Covid19 crisis has been resolved or instructions from Government has changed".

120. As set out in paragraph 10 above, the CQC wrote to ABC on 14 April 2020 stating that it would have continued the conditions but had decided instead to monitor improvement through regular engagement because ABC had provided an assurance that they would

not be carrying out face-to-face consultations and surgical procedures. The letter further asked ABC to formally advise the CQC two weeks before commencing any face-to-face contact with clients or carrying out any surgical procedures so that CQC could arrange a further comprehensive inspection of both locations.

121. Mr Counsell submitted that there is no breach of the assurance. By the time the procedures were carried out Government instructions had changed, and small clinics were permitted to reopen (Evidence of Dr Dutta **[5/628]**), and he submitted the assurance had, therefore, ceased to operate. He further submitted the fact that the CQC had requested they be notified about procedures two weeks before they recommenced formed no part of the time-limited assurance given by ABC.

122. Miss Hearnden submitted that the assurances had to be read having regard to the overarching ways in which the CQC sought to safeguard public safety in the first half of 2020 and the interrelationship between the assurances given, the Dormancy notice and the IOT conditions imposed by the GMC, in seeking to achieve that aim. She submitted the assurance was not time-limited and also included the line that face-to-face consultation would cease "until further notice". In fact, the full wording is that face-to-face consultation would cease "until further notice in line with Government recommendations". Miss Hearndon further submitted that it was relevant that the Dormancy Notice was in place preventing ABC from undertaking regulated activities. That, of course is charged as a separate breach.

123. In my judgment Mr Counsell's submissions in this respect are correct. The assurance was expressly until any change in Government regulations. Whilst the CQC asked for two weeks' notice before the re-commencement of face-to-face contact with clients or the carrying out of surgical procedures, ABC did not give assurances to that effect, and nor was it asked to do so. ABC was aware that conditions preventing the carrying out of procedures would have been extended in April, but the decision not to do so was entirely one for the CQC. If ABC commenced face-to-face contact with clients/carrying out of surgical procedures without giving two weeks notice, whilst that would undoubtedly evidence a lack of cooperation with the CQC's clear expectations, that is not the allegation. The allegation is a breach of the assurance, and in my judgment the tribunal was wrong to find the assurance had been breached. In my judgement the assurance had plainly expired, notwithstanding the presence of the Dormancy Notice and IOT conditions which might quite separately have impacted on the same matters.

124. In relation to the Dormancy Notice and the IOT conditions, there was no dispute that the carrying out of the three procedures constituted a breach of each of those. The issue before the tribunal was whether or not Dr Dutta did this deliberately or inadvertently and that was the issue that both parties invited the tribunal to rule upon. The evidence in relation to this matter focused on whether in June/July 2020 Dr Dutta had understood which type of procedures fell within the scope of the Dormancy Notice. The tribunal came to the conclusion that Dr Dutta's actions were deliberate, and that is the ruling challenged in this appeal.

125. The Dormancy Notice (as set out in Paragraph 11 above) refers to the provision of Surgical procedures, Diagnostic and screening procedures, and Treatment of disease disorder or injury; refers to the fact that the above regulated activity is not being carried out at the ABC clinics; and states that the CQC have therefore made these "regulated

activities" and locations dormant on the register. Mr Counsell made the point that the Dormancy Notice could only relate to regulated activities as the CQC could have no jurisdiction in respect of any activities performed by Dr Dutta which were not regulated. That is plainly right, and indeed the Dormancy Notice itself expressly made "these regulated activities" dormant on the register.

126. It appears that the evidence before the tribunal focused largely on mole removal and whether it would fall under "surgical procedures" and constitute a regulated activity. Mr Counsell submitted that to seek to establish that these procedures were regulated, the GMC relied upon the evidence of the CQC Inspector Miss Victoria Head. In her second Witness Statement she referred to the CQC Scope of registration document dated March 2015, and to what she described as its "definition" of Surgical procedures **[4/124]**. The 62 page Scope of registration document was not put before the tribunal, although it is in the appeal bundle at **[1451].** At paragraph 20 of that Witness Statement Victoria Head stated as follows

> "The CQC scope of registration (March 2015) defines Surgical procedures as:
>
> a. The surgical removal of the mole in cases where the removal is carried on by a healthcare professional for the purposes of treating disease, disorder or injury, or for cosmetic purposes, where the procedure involves the use of instruments or equipment which are inserted into the body. Using an instrument such as a scalpel to cut the skin would be considered by the CQC to amount to involving an instrument or equipment being inserted into the body.
>
> b. If a medical practitioner removes a skin lesion by curettage, cautery or cryocautery and the removal is not carried out under general anaesthesia (so for example by using local anaesthesia) then it is not within CQC scope for the regulated activity of surgical procedures". **[4/124]**

127. In opening the case to the tribunal GMC Counsel opened the case by reference to that paragraph and as if quoting from the guidance **[7/1049].** Mr Counsell submitted that the word "mole" does not appear anywhere in the Scope of registration document, and that nowhere is there any reference to "instruments or equipment being inserted into the body". He submitted that Miss Head's "definition" was in fact her amalgam of differing parts of the guidance. I have not read the 62 page scope of registration document but these submissions were not challenged by Miss Hearnden.

128. In fact, the CQC guidance on surgical procedures deals with the exception for skin lesions (of which a mole is one type) in the following terms (so far as relevant to this case):

> "The activity does not cover the following surgical procedures if they are carried out using local anaesthesia or no anaesthesia: ….. Curettage (scraping), cautery (burning), or cryocautery cautery (freezing) of warts, verrucae or other skin lesions carried out by a medical practitioner …." **[5/777]**.

129. In her Witness Statement dated 16 August 2022 the CQC Inspector Miss Atkinson stated that mole removal was an unregulated activity and not in the CQC remit **[4/99, paragraph 6]**. In her oral evidence she explained that that was her belief at the time, but since then there had been considerable change and learning throughout the CQC, the methodology has changed, and mole removal is a regulated activity **[7/1131].** In an email dated 9/11/23 she confirmed to the GMC that the evidence in her Witness Statement was her understanding at that time, **[4/618]**, in other words in August 2022. The MPT was considering the position in June and July 2020.

130. The MPT had evidence from four different practitioners each of whom believed that mole removals were not procedures which required surgical registration. Dr Dutta's supervisor for his GMC conditions, Mr Christopher Inglefield, set out his belief that mole removals were not procedures requiring surgical registration, and said that he was "stunned" to hear that the CQC was now suggesting that they were. He also explained that mole removals were not carried out in an operating theatre, but are office-based procedures, regularly undertaken by GPs and nurses **[5/776].** A Witness Statement from Mr Hugh Prior, a witness who provided training for CQC inspectors **[5/768]** describes the position as follows:

> "A mole removal is a skin lesion but this does not mean all mole removals are exempt. There are three categories:"
>
> (a) **No CQC Registration Required**. Simple mole removals using burning, freezing, scraping using local or no anaesthesia are exempt and not a regulated activity;
>
> (b) **Screening and Diagnostics CQC.** Registration is required if the mole is sent for biopsy then it is the sending of the mole for biopsy which is a regulated activity under the screening and diagnostics aspect of the registration. I do not think the removal of the role becomes a regulated activity.
>
> (c) **Surgical CQC Registration Required.** There is a rare circumstance in which a surgical registration is required and that is where a patient needed more than local anaesthetic. For example, if you have an extremely nervous patient and needed sedation then this would be a regulated activity and a surgical registration would be needed." **[5/769]**

131. In its determination, the tribunal concluded that the procedures were surgical, but that even if they did not constitute surgery, the removal of a lesion via an incision, the subsequent stitching of the wound and sending of the excised legion for histology clearly fell within "Treatment of disease, disorder or injury" or "Diagnostic and screening procedures". Miss Hearnden submitted that finding was plainly open to the tribunal, and it is consistent with the evidence of Mr Inglefield and Mr Prior whose evidence is that only the simple removal of a mole by burning, freezing or scraping with local or no anaesthesia which would be exempt.

132. Mr Counsell made the point that whilst sending the mole of Patient F for histology would be a regulated activity, that he is submitted is not the allegation which is specifically charged as the removal of the mole. However, there was clearly an incision

and stitching of a wound. Even if the charge was not carrying out of diagnostic and screening procedures, and even if that finding was therefore wrong, I accept Miss Hearnden's submissions that the procedure described was covered by the umbrella term of "Treatment of disease, disorder or injury. In my judgment the tribunal was entitled to reach that conclusion on the evidence before it.

133. However, the tribunal went further and concluded on the balance of probabilities that Dr Dutta was aware of the terms of the Dormancy Notice and that his contravention was deliberate. That comes back to the issue of whether Dr Dutta believed he was breaching the terms of the Dormancy Notice. Mr Counsell relies on the opinions of CQC Inspector Miss Atkinson, Dr Dutta and his supporting witnesses to the effect that they did not believe that mole removal was a regulated activity. He points out that in dealing with that evidence (which was specifically dealt with by the MPT in relation to allegations 13c but equally applies here) the Tribunal referred to the evidence provided by Dr Dutta that others were confused as to whether the procedures constituted surgery. The determination then notes that the witnesses were not called and not cross examined, and that the tribunal had the agreed view of the two experts that such procedures as these were clearly surgical in nature **[3/53]**.

134. Mr Counsell made the point that the witnesses were not called because their evidence was unchallenged, it having been made clear that the witnesses' evidence was relied upon as to the state of their belief, rather than the factual issue as to whether these were surgical procedures. In the final sentence of Paragraph 53 of the determination the MPT fails to distinguish between two separate issues, that is agreement by the experts that these were surgical in nature, and the question of what Dr Dutta believed.

135. The determination appears to simply reject the unchallenged evidence of the supporting witnesses as to their beliefs. There was no basis for the wholesale rejection of that evidence, and I accept Mr Counsell's submissions that to reject that evidence on the ground that the witnesses were not cross examined was wrong and unfair and a material irregularity. I appreciate that the evidence of the beliefs and understandings of others including Miss Atkinson related only to mole removal, but findings as to Dr Dutta's belief in respect of those matters might have affected the Tribunal's view of his evidence in relation to the skin tag removal and the removal of other lesions if indeed they were not moles. None of this was addressed in the decision, which simply asserted that Dr Dutta's contravention was deliberate.

136. Furthermore, in the middle of Paragraph 53 of the determination **[3/57]**, having referred to the note of a telephone call from Dr Dutta to the GMC on 5 August 2020 and the details of that call, the determination states this: "Whilst this suggests that Dr Dutta did not appreciate the procedures he performed were classed as surgical procedures,… The tribunal noticed this information was provided after the procedures had already taken place and shortly after the CQC had visited his premises". It is unclear whether the point being made there is that the information should have been provided before commencing surgical procedures, or whether it is suggested that this was an attempt after the event to minimise his understanding. Whichever it is, the question of whether or not Dr Dutta was acting dishonestly was fundamental and the tribunal needed to address this fully and properly.

137. I can deal very briefly with the breach of IOT condition. Neither the GMC nor the MPTS has a definition of "surgical procedures" nor any guidance as to the meaning of

surgical procedures. This seems startling when the IOT is imposing conditions preventing the carrying out of surgical procedures. However, the procedures were admitted to be in breach of the IOT conditions, and again the issue was one of dishonesty. The evidence before the tribunal in this case shows the obvious difficulties which can arise from there being no proper guidance or definition of surgical procedures.

138. However, in so far as the allegation of dishonesty is concerned, the same points arise as are set out in Paragraphs 133 -136 above. In my judgment when considering the issue of whether Dr Dutta's breaches were deliberate and dishonest, it was incumbent upon the tribunal to deal with all of the evidence both for and against him on that issue and to explain its reasons for rejecting evidence in his favour. It failed to do so and in my judgement the appeal on Allegations 13b and 13c also succeeds.

Allegation 14.

139. It is right that I should mention Allegation 14. At the outset of the hearing, I indicated to Mr Counsell that even if I was in his favour on the specific factual matters, the finding on Allegation 14 would remain as the detail of it is not challenged. He asked for the opportunity to check this, and later told me that his case on Allegation 14 is that allegation 14 is caught by the more general grounds in Grounds 1 and 2, that is the effect of delay and the effect of prejudicial evidence. I have rejected those Grounds and therefore the finding on Allegation 14 stands.

Summary of Findings

140. It is perhaps convenient for me to summarise my findings. I reject the general Grounds as to the effect of delay and prejudicial evidence on the fairness of the MPT decision and which formed Grounds 1 and 2 of the Appeal as argued before me. In terms of the challenges to the findings of fact, I allow the appeal in relation to the findings on Allegations 8 and 13 which must therefore be quashed. I reject the appeal in relation to the findings on Allegations 9 and 10 and those findings stand. The finding in connection with Allegation 14 also stands since the only challenge to it was on the more general Grounds which I have rejected. It follows that this matter will have to be remitted to the MPT for reconsideration of the determinations on fitness to practice and sanction based on the remaining findings.