IN THE UPPER TRIBUNAL **Appeal No. UA-2023-000688-V**
ADMINISTRATIVE APPEALS CHAMBER **[2024] UKUT 177 (AAC)**

The Upper Tribunal has ordered that there is to be no disclosure or publication of any matter likely to lead members of the public to identify AT or his wife

Between:

AT

Appellant

- v –

Disclosure and Barring Service

Respondent

Before: Upper Tribunal Judge Citron, Ms Heggie and Ms Smith

Decided following an oral hearing at Field House, Breams Buildings, London EC4 on 14 May 2024

Representation:

Appellant: by Betsan Criddle KC of counsel, instructed by Hempsons
Respondent: by Tim Wilkinson of counsel, instructed by DBS Legal

DECISION

The decision of the Upper Tribunal is to allow the appeal. The Respondent made mistakes in the findings of fact it made and on which its decision of 22 March 2023 (reference DBS6191 00991160608) to include AT in the children's and adults' barred lists was based. The Upper Tribunal directs the Respondent to remove AT from both barred lists.

REASONS FOR DECISION

This appeal

1. This is an appeal against the decision (the "**decision**") of the Respondent ("**DBS**") dated 22 March 2023 to include AT in the children's and adults' barred lists.

The decision

2. The decision was made under paragraphs 3 and 9 of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006 (the "**Act**"). These provide (in very similar terms as regards both children and vulnerable adults) that DBS must include a person in the relevant barred list if
    a. it is satisfied that the person has engaged in relevant conduct,
    b. it has reason to believe that the person is, or has been, or might in the future be, engaged in regulated activity relating to children/vulnerable adults, and
    c. it is satisfied that it is appropriate to include the person in the list.
3. Under paragraphs 4 and 10, "relevant conduct" includes, amongst other things, conduct which endangers a child/vulnerable adult or is likely to endanger a child/vulnerable adult, or which, if repeated against or in relation to a child/vulnerable adult, would endanger them or would be likely to endanger them; and a person's conduct "endangers" a child/vulnerable adult if he (amongst other things)
    a. harms them or
    b. causes them to be harmed or
    c. puts them at risk of harm.
4. The letter conveying the decision (the "**decision letter**"):
    i. found that AT was, at the relevant time, working as a locum consultant cardiologist with an NHS foundation trust in England;
    ii. found that on 14 February 2022, whilst carrying out a cardiology assessment, AT
        a. examined Patient A's breasts without a medical need to do so
        b. examined Patient A's groin without a medical need to do so
        c. gently smacked and rubbed Patient A's buttocks without a medical need to do so; and
        d. made a domiciliary visit (the "**home visit**") to Patient A following her clinical appointment to examine a rash; whilst at her home, AT touched Patient A's breasts without a medical need to do so;
    iii. stated that DBS was satisfied that AT had engaged in relevant conduct in relation to vulnerable adults, on the basis that he had engaged in

conduct which endangered a vulnerable adult or was likely to endanger a vulnerable adult;

iv. stated that DBS considered that AT had engaged in relevant conduct in relation to children: conduct which, if repeated against or in relation to a child, would endanger that child or would be likely to endanger them;

v. stated that DBS had found Patient A credible based on multiple factors, including

a. the consistency in the disclosures made by Patient A

b. Patient A did not appear to have any reason to make false allegations

c. Patient A spoke kindly and positively about AT; she did not give any indication that she disliked AT

d. Patient A did not want to make a disclosure initially but after talking with family members felt it was best to protect anyone else going forward; once she had made her disclosure and spoke with various professionals, she decided that she did not want to make a formal complaint as she felt she had disclosed it to enough people

e. DBS could see no logical reason in the evidence to suggest that Patient A would have anything to gain by making false allegations;

vi. noted, in considering why Patient A agreed to the home visit if she had been unhappy about the way the examination by AT earlier in the day had been conducted, that the evidence suggested that Patient A felt some things at the examination earlier in the day had been "a bit odd" but she thought there "may have been a medical reason behind it"; it was only after AT's "behaviours" at the home visit that Patient A questioned his actions

vii. stated that some aspects of what AT "shared" cast some doubt on the sincerity of his account:

a. DBS saw no logical reason for the home visit, given that AT was aware that home visits were rarely done;

b. DBS considered that, had the home visit been necessary, AT would have recorded it in the paperwork; however he did not;

c. as for AT's suggestion that he chose to do a home visit because he didn't think doctors in the 'same day emergency clinic' would appreciate his concerns on wanting to see Patient A the same day – DBS observed that if it was necessary that Patient A be seen the same day to assess the rash in connection to her heart

palpitations, other doctors would have shared the same concerns. The fact that AT suggested that they would not, brings into question to the urgency of Patient A needing to be seen (and so why AT thought it necessary to conduct a home visit);

d. as for AT saying that his wife was outside in the car during the home visit, DBS observed that AT's wife would not have witnessed what happened within Patient A's home; DBS observed that AT's wife's knowing that AT was doing a home visit and being outside "does not add any weight to the evidence";

viii. stated that, considering

a. the doubt surrounding the plausibility of some of AT's explanations,

b. that there did not appear to be anything for Patient A to gain by making up false allegations and

c. that AT had failed to take accountability for his actions,

DBS was of the view that AT could repeat his actions in the future if he was to find himself sexually attracted to a patient;

ix. referred to AT having crossed a serious boundary by intimately touching someone with no medical reason to do so..

Jurisdiction of the Upper Tribunal

5. Section 4(2) of the Act confers a right of appeal to the Upper Tribunal against a decision by DBS under paragraphs 3 and 9 of Schedule 3 (amongst other provisions) only on grounds that DBS has made a mistake

a. on any point of law; or

b. in any finding of fact on which the decision was based.

6. The Act says that "the decision whether or not it is appropriate for an individual to be included in a barred list is not a question of law or fact" (section 4(3)).

The Upper Tribunal proceedings

7. Permission to appeal on grounds that DBS had made mistakes both in findings of fact on which its decision was based, and on points of law, was given by the Upper Tribunal in a decision issued on 12 February 2024.

8. Both AT and his wife submitted witness statements and, at the hearing, gave oral evidence, including under cross examination. More is said about their evidence in the discussion below.

9. Most of the documentary evidence about what happened in the incidents in question was contained in an investigation report by the NHS foundation trust for which AT was working at the relevant time, dated 22 July 2022.

Background facts

10. The following background facts were not in contention:

    a. AT was registered with a licence to practice with the General Medical Council; he qualified as a doctor (outside the UK) in 1997 and moved to the UK in 2018.

    b. Patient A was 45 at the time and had diagnoses of fibromyalgia, endometriosis and 'palpitations on propranolol'. She was referred (to the cardiology clinic) for chest pain and palpitations.

    c. The NHS trust's investigation report found the following to be established:

        (i) at the hospital clinic, AT offered Patient A a chaperone; she declined; this was not documented, though

        (ii) the hospital consultation involved appropriate history-taking and a number of direct clinical examinations

        (iii) the immediate outcome of the consultation was an intention to arrange further investigations

        (iv) the hospital records and correspondence make no reference to examination of Patient A's breasts or bottom

        (v) breast and bottom examinations would have been clinically inappropriate

        (vi) the home visit took place in the early evening

        (vii) a neighbour (of Patient A's) was present for a short time during the home visit, and then left to take Patient A's dog for a walk whilst the visit took place

        (viii) no arrangements were made for a chaperone to be present at the home visit; it would have been very appropriate to propose a chaperone for the home visit

        (ix) there was no documentation of the home visit

        (x) per expert medical opinion, a home visit would be unusual; there would need to be a clear question to resolve. Normal practice in the event that a consultant believed they may have overlooked something would be to invite the patient to return to a 'same day emergency clinic'; AT would have been familiar with that clinic. The expert could identify no clinical imperative that would necessitate an urgent domiciliary visit in the circumstances described.

    d. AT's letter to Patient A's GP following the clinic on 14 February 2022 ended with him saying he was going to arrange for a CT coronary angiogram, "Holter" and echocardiogram. The letter also said this:

> "On a separate note, patient mentioned, she is noted to have some rashes on her palm, hands, arm, forearm and body. I did look through her rashes, with my limited understanding on rashes, it appears are xerotic skin ? eczematous rashes. I was concerned as it was started around the time when patient was started on

> propranolol. I was pleased to hear that these rashes are getting better and there is a plan in place to be referred to dermatology"

e. AT drove to the home visit on his way home from work, with his wife in the car; his wife stayed outside in the car whilst AT went into Patient A's home for the home visit.

Context for evidence in the NHS trust's investigation report

11. The NHS trust's investigation was carried out under the "Managing Performance Concerns for Medical and Dental Staff Policy".

12. As part of the investigation, the following were interviewed (between 13 and 27 June 2022): three people who had spoken with Patient A (the NHS trust's 'patient experience manager', Patient A's GP, and the NHS trust's 'nurse consultant safeguarding lead'); a consultant cardiologist (as an expert and as someone who had worked with AT); and AT.

13. Patient A spoke (anonymously at that point) with the NHS trust's 'patient experience manager' by phone on 15 and 16 February 2022 voicing concerns about what had happened (on 14 February) and "making allegations of sexual assault".

14. Patient A's GP contacted the NHS trust on 7 April 2022 to say that Patient A had (that day) spoke to her about what happened with AT; at this point, AT was identified.

15. The NHS trust's 'safeguarding lead' spoke with Patient A's about what happened, on 14 April 2022.

16. The GP and the 'safeguarding lead' both thought Patient A was being honest, both observing that they had no reason to doubt her.

17. Patient A indicated (by email on 26 April 2022) that she was unwilling to be interviewed in relation to the allegations about AT; she cited the impact on her health and a feeling that she had already reported her allegations on a number of occasions.

Discussion

18. In our view, the principal issue in this appeal is whether DBS made mistakes in the findings of fact on which its decision to bar AT was based. The point of contention is whether AT examined Patient A's breasts, groin and/or buttocks at the hospital cardiology clinic, or during the home visit, on 14 February 2022.

19. DBS's findings of fact, to the effect that AT *did* so examine Patient A, were made on the basis of the documentary evidence before DBS at the time of its decision; essentially, the NHS investigation report of 22 July 2022 and AT's written representations to DBS of 10 March 2023.

20. We had, in addition to this, AT's witness statement and oral evidence at the hearing (as well as that of AT's wife), including under cross examination.

21. This tribunal's jurisdiction in "mistake of fact" cases, where (as here) "new" evidence has been put before the tribunal that was not available to DBS, has recently been clarified in *DBS v RI* [2024] EWCA Civ 95. What follows is our assessment of all the evidence, following the principles as clarified in that case.

The "new" evidence

22. AT's witness statement and oral evidence was broadly the same as his earlier, documented evidence (in the NHS trust's investigation report and in his representations to DBS): in all his evidence, he said that he had examined Patient A from a cardiological point of view, which had not required touching her breasts, her groin, or her buttocks – and that he had not done so.

23. AT's witness statement and oral evidence did include "new" evidence about the unusual level of scrutiny he felt he was under at work and how he had started to practice what he called "defensive" medicine and "over investigating": he was being "hammered" (by colleagues) at work, was how AT put it in his oral evidence; AT gave this evidence in the context of his trying to explain why he took the unusual step of arranging the home visit. The reason for going into such matters was that DBS's case, expressly or implicitly, was that the "unusualness" or "illogicality" of AT's making the home visit was evidence supportive of the finding that AT *did* touch Patient A's breasts, groin and buttocks (the implication being that AT 'engineered' the home visit to create an opportunity to touch Patient A inappropriately (as, per the allegations, he had done in the hospital clinic earlier that day)).

24. AT's witness statement contained a number of other details, including about the layout of the hospital cardiology clinic, and about how doctors conduct cardiology clinics with patients. In terms of his physical contact with Patient A at the clinic, AT said he listened to her heart and lungs using a stethoscope over her clothing; he then applied gentle pressure on her sternum and chest with the forefingers of his right hand to determine if her pain was "reproducible".

25. As for the 'immediate' reasons for his undertaking the home visit, AT said that, at the end of his hospital clinic for that day, reflecting on the day's patients, he became concerned that he had not responded to Patient A having expressed concerns about a skin rash. AT said he became worried that he might have missed a "differential diagnosis" about "sarcoidosis": Patient A's "palpitations" could be symptoms of "cardiac sarcoid", he thought. Due to those concerns, AT telephoned Patient A, saying he wanted to have another look at the rash. He said he could see her on a home visit on his drive home for work; or he could book her another appointment. AT's evidence was that he considered referring Patient A to the 'same day emergency clinic', but he did not do this as he thought the "junior" doctors, and nurses, on duty there would not be able to address his concern about Patient A's rash and "sarcoidosis". AT's evidence was that he now regretted arranging the home visit: he said his arranging it was because of the stress of work colleagues scrutinising his work – he did not want to "get something wrong". AT's evidence was that, during the home visit, he examined Patient A's hands and concluded that the rashes were not "sarcoidosis" but rather dry skin (and so not, as he feared, related to Patient A's heart medication, propranolol). He said that Patient A asked him again about her chest pains; in response, he gently pressed on her sternum area using his right-hand finger over her clothing, and noted this made her pain slightly more intense, so confirming (he said) that it was a muscle tenderness problem (as opposed to something more cardiologically serious).

26. AT was cross examined about the reasons for the (unusual) home visit; why no chaperone had been offered for the home visit; why there was no documentation

of the home visit; what "options" he had given Patient A on the telephone, apart from the home visit. It seemed from the questioning that the panel was being invited to infer that the true reason for the home visit was to enable Dr AT to carry out inappropriate sexual touching. AT was also questioned as to why he had not mentioned the point about being "hammered" by colleagues at work, earlier (to the NHS trust investigator or to DBS) – it seemed this was aimed at inviting the panel to conclude that this element of AT's evidence was "made up". There was also questioning about how "closed" the door was to the hospital clinic room where AT had examined Patient A (as AT had been suggesting that nurses and other staff could, and did, fairly easily "walk in" on cardiologists during their clinics with patients).

27. AT's wife's evidence was largely on matters that were not in dispute (essentially, that she drove with AT to the home visit and stayed outside in the car whilst it was going on). She was cross examined on why, if she knew about AT being subject to unusual scrutiny at work (being "hammered", as he put it), she did not urge him to tell the NHS investigators, and DBS, about this.

Assessment of all the evidence

28. The evidence before the UT (in its totality) was contradictory as regards the issue in contention: did AT examine Patient A's breasts, groin and/or buttocks, in the course of the hospital cardiology clinic and home visit on 14 February 2022?

29. There was no direct, third party evidence of what happened: no film or recording; and only AT and Patient A were present at the time.

30. We found AT to be a straightforward witness who was not seeking to mislead the tribunal. We do not think it necessary to make findings on every topic pursued in the evidence and cross examination, as much of it was quite removed from the core question before us, and was aimed at giving us some indirect reason either to believe, or to disbelieve, the evidence on the key point. It suffices to say that we are satisfied that the home visit was *not* a ploy to enable AT to be alone with Patient A in order to touch her inappropriately; rather, it was a clinical decision, albeit, quite possibly, a wrong one. Similarly, in not documenting the home visit (properly or at all), we are satisfied that AT was not trying to "cover up" the fact that he had touched Patient A in the course of the home visit, though it is certainly possible that the reason for not documenting it was that AT wanted to "cover up" (i.e. hide from his colleagues) the whole episode of AT having doubts after the hospital clinic about Patient A's rash, setting up a (very unusual) home visit, and then concluding there was no reason for (medical) concern about the rash.

31. We are also satisfied that AT's wife was being straightforward and thus that she was able to corroborate the point about AT being "hammered" at work.

32. As Patient A was not presented as a witness, we were unable to hear her version of events first-hand and ask questions about the elements of it that were strange or incongruous. These elements included: why she consented to AT coming to do the home visit, if he had touched her, sexually and inappropriately, earlier in the day at the hospital clinic (we were aware of the written evidence that Patient A had not at that point "clicked" that the doctor was behaving wrongly – but that would have been a point about which we would want to hear more from Patient A); and, from a similar angle, why she sent away the dog-walking neighbour, just as AT arrived for the home visit (did it not occur to her to ask them to stay, perhaps

in the next room, as a safeguard?). Apart from these sort of queries we ourselves had, we also did not have the opportunity to hear Patient A being cross examined by counsel, and assess her answers.

33. It follows that, upon balancing the strengths and weaknesses of all the evidence before us, we have concluded that DBS's factual findings were mistaken: on the balance of probabilities, AT did not examine Patient A's breasts, groin or buttocks, either in the hospital or at patient A's home.

34. As an aside, we note that we asked DBS's counsel at the hearing, why DBS had not arranged for Patient A to attend and give evidence to the tribunal; we were told the reason was a very general one, that DBS had concerns that if such patients or victims are brought to the tribunal to give evidence, it might be a deterrent to others "coming forward" (i.e. informing employers and/or DBS of events giving rise to safeguarding concerns). This seemed to us no answer at all, *as regards this* (or really any) *particular case*. It also seemed surprising in the light of the many (and well-publicised) things that the tribunal can do to ensure (in a case like this) that women can feel safe in participating in the judicial process and are protected against unjustified intrusive questioning: see the *Equal Treatment Bench Book* at paragraph 92 and following, and the references there to "tools" available to tribunals such as the Advocate's Gateway Toolkits; the making of anonymity orders; the giving of evidence by video link; and having hearings in private.

Result

35. Given our finding that DBS's factual findings were mistaken, it seems to us the only decision that DBS could lawfully reach would be to remove AT from both barred lists. Indeed, this case is on all fours with the example given by the Court of Appeal in *DBS v AB* [2021] EWCA Civ 1575 at [73]

> … The DBS may have considered that a person had been found to have engaged in sexually inappropriate conduct on one occasion with a child. If, on the facts, it transpired that the conduct had not in fact occurred (or the respondent had wrongly been identified as the person responsible) and the person had not been guilty of the conduct, there would be no basis for including that person in a barred list and the Upper Tribunal could direct removal. …

36. It follows that we have directed DBS to removed AT from the barred lists.

37. In light of this result, it seems to us unnecessary to consider the mistakes on points of law contended for by AT's counsel; we therefore forbear from doing so.

Zachary Citron
Judge of the Upper Tribunal

Josephine Heggie
Rachael Smith
Members of the Upper Tribunal

Approved for release on 14 June 2024