PRIMARY HEALTH LISTS

The Tribunal Procedure (First-Tier Tribunal) (Health, Education and Social Care) Rules 2008

IN THE MATTER OF THE NATIONAL HEALTH SERVICE (PERFORMERS LISTS) (ENGLAND) REGULATIONS 2013

CASE NO [2017] 3049.PHL

Heard on 12 - 13 & 19 - 22 February 2018 at the Royal Courts of Justice, London

BEFORE:
Mr H Khan (Judge)
Dr E Walsh-Heggie (Specialist Member)
Mr M Cann (Lay Member)

BETWEEN:

Dr Ferdinand Cruz

Appellant

-v-

NHS Commissioning Board (NHS England)

Respondent

DECISION

The Appeal

1. This is an appeal by Dr Ferdinand Cruz ("The Appellant") made pursuant to Regulation 17 of The National Health Service (Performers Lists) (England) Regulations 2013 ("the 2013 Regulations") against a decision made by the Performers List Decision Panel ("PLDP") on 26 May 2017 to remove him from the NHS Performers List.

Attendance

2. The Appellant was represented by Mr Andrew Hockton (Counsel). The Appellant attended throughout the hearing and gave evidence. The Appellant called Professor Ian Wall as a witness.

3. The Respondent was represented by Mr George Thomas (Counsel). The Respondent called the following witnesses. We have referred to the witnesses (Patient A, Patient B and BF) as requested by the Respondent and not objected to by the Appellant. We have listed them in the order in which they gave their evidence; Patient B, BF (Patient B's father), Ms T Galloway, Dr S El Obaidi, Dr H Spiteri and Patient A.

The Hearing

4. The hearing took place on 12-13 and on 19-22 February 2018. Following the hearing, the Tribunal directed that the parties file written submissions and the last of these was received on 2 March 2018. The panel reconvened on 19 March 2018.

Reporting Restriction

5. On 9 August 2017, an order was made under Rule 14 of the Tribunal Procedure (First-Tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 ("2008 Rules") to prohibit the publication of the names of any person who have received care from the Appellant.

Late Evidence

6. The Tribunal was asked to admit additional evidence by the Parties including notes from the Queens Hospital and an extract from Ilford Recorder dated 23 January 2015.

7. We admitted the late evidence as its admission was agreed between the parties and it was relevant to the issues in dispute.

8. In considering any late evidence, the Tribunal applied rule 15 and took into account the overriding objective as set out in rule 2 of the Tribunal Procedure (First Tier Tribunal) (Health Education and Social Care Chamber) Rules 2008.

Background

9. The Appellant is a Registered Medical Practitioner. He qualified as a doctor in 1994.

10. From 13 October 2008 - 21 October 2013, he was employed as a salaried GP at the Doctor's House Surgery, 40 Cameron Road, Ilford IG3 8LF ("the

Surgery"). In practical terms, he stopped working at the Surgery after his arrest on 15 July 2013.

11. The Surgery has a list size of approximately 9000 patients and holds a General Medical Services contract with NHS England. There are 16 members of staff employed at the Practice. This consists of six doctors, two of whom are partners (Dr S El Obaidi & Dr H P Spiteri) and two trainee doctors. It employs five administration staff, five receptionists and one nurse.

12. In around July 2013, the Respondent received concerns in respect of the Appellant's treatment of a patient referred to in these proceedings as Patient A. As a result of those concerns, previous concerns identified in relation to another patient, and his arrest on 15 July 2013, the Respondent convened a PLDP panel on 31 July 2013 in order to consider his immediate suspension from the National Medical Performers List ("NMPL"). The PLDP determined that the Appellant should be suspended immediately and he has remained suspended since.

13. On 8 October 2013 the Appellant was charged with three accounts of sexual assault on a male patient over the age of 16 years contrary to the Sexual Offences Act 2003 in relation to Patient A.

14. The General Medical Council ("the GMC") imposed interim conditions upon the Appellant's registration on 23 October 2013 (extended to 2 April 2017). The conditions included a restriction against undertaking intimate examinations with male patients without a trained chaperone present.

15. The Appellant's first criminal trial took place in June 2014. The jury was unable to reach a verdict and a retrial was ordered. His second trial took place in January 2015 and resulted in his acquittal.

16. On 18 May 2015, the Respondent was notified by the police that they had arrested the Appellant following allegations of a sexual assault by a further complainant, also a patient of his, Patient B, who at the time of the assault was a minor. The Police progressed the investigations as a child abuse and sexual offence case. The third criminal trial took place in November 2016 and resulted in the Appellant's acquittal.

17. The GMC notified the Appellant on 8 March 2016 (in relation to Patient A) and 17 January 2018 (in relation to Patient B) that it had considered the information and decided to conclude its cases with no further action. There is no involvement at present from the GMC.

The Agreed Issues for the Tribunal

18. The allegations against the Appellant in these proceedings relate to allegations made by two male patients (Patient B & Patient A) that the Appellant touched them in an inappropriate and sexual manner during

consultations at the Surgery. During these consultations, it was alleged that he masturbated them or assisted/encouraged them to masturbate.

19. The issues for the Tribunal were agreed between the parties and set out in the agreed Scott Schedule. The issue for Tribunal was whether the Appellant acted as alleged by his former patients.

20. The agreed Scott Schedule set out the questions to determine as;

20.1. During a consultation with Patient B on 27th May 2010 did the Appellant:

a) Tell Patient B that his penis needed to be erect in order for him to examine it?
b) Tell Patient B that his penis needed to be erect in order to take a sample of fluid from his prostate?
c) Encourage Patient B to masturbate?
d) Allow Patient B to masturbate?
e) Masturbate Patient B?

20.1.1. During consultations with Patient A in 2011 did the Appellant :

a) Tell Patient A that he needed to see him masturbate?
b) Tell Patient A to masturbate in front of him?
c) Allow Patient A to masturbate?
d) Masturbate Patient A?
e) Touch Patient A testicles?
f) Touch Patient A between his testicles and his anus?

20.1.2. In relation to any questions above to which the answer may be 'yes', were the actions of Appellant clinically appropriate or were they inappropriate?

20.1.3. On the basis of the factual findings above, was the Appellant a suitable person to remain on the performer's list?

21. There was no dispute between the parties' that if the Appellant acted as alleged, his behaviour was highly inappropriate and there was no clinical basis for acting as he did. It was effectively conceded that the grounds for removal would be met. It was also agreed that, if, on the other hand, he did not act as alleged, there was no other basis on which is removal is alleged to be necessary.

The PLDP Decision

22. In pursuance of its duty to patients, the Respondent separately took formal action against the Appellant under the 2013 Regulations. At the PLDP hearing, the Respondent did not seek his removal on any other grounds (such as efficiency). The written accounts of the patients, including some,

but not all the transcripts of evidence at the previous criminal trial were considered. None of the former patients attended to give evidence.

23. The decision was made following an oral hearing before the PLDP which took place on 15, 16, 17, and 19 May 2017. Following the oral hearing, the panel decided to remove the Appellant from the NHS Performers List on the grounds of suitability. The decision was communicated to the Appellant by way of a letter dated 26 May 2017. This is the Appellant's appeal against the removal decision.

The Appellant's position in respect of the allegations

24. The Appellant denies the allegations made in their entirety and he disputes the accounts made by the complainants to various organisations including the police.

The Regulatory Framework

25. In order to work as a General Practitioner within the NHS England a Medical Practitioner must be on the "Medical Performers List" maintained by NHS England. The 2013 Regulations govern the eligibility to apply, application by medical performers for inclusion on the list and the removal of the medical performers from the list.

26. This is an "unsuitability case". The Respondent does not seek removal conditions on any other ground.

27. Regulation 14 of the 2013 Regulations provides:

> **14 Removal from a Performers List**
>
> … (3) The Board may remove a Practitioner from a performers list where any one of the following is satisfied—
> …
> (d) the Practitioner is unsuitable to be included in that performers list ("an unsuitability case").

28. Regulation 15 sets out a number of matters that are to be considered when deciding whether the criteria for removal are met. The matters include regulation 15 (2) (a), the nature of any event which gives rise as to the suitability of the Practitioner to be included in the performers list and 15(2) (d), the relevance of the event to the Practitioner's performance of the services which those included in the relevant performers list perform, and, any likely risk to any patients or to public finances.

29. The appeal is governed by Regulation 17 of the 2013 Regulations and procedurally by the Tribunal Procedure (First-Tier Tribunal) (Health, Education and Social Care) Rules 2008 ("the 2008 Rules"). Regulation

17(4) provides that on appeal the First-tier Tribunal may make any decision which the Board could have made. It is common ground that the First-tier Tribunal is not required to review the decision and reasons of the PLDP. It is required to make a fresh decision in light of all the information before it, which includes new information not available to the PLDP.

30. The burden of proof lies on the Respondent and the standard of proof is the balance of probabilities.

Evidence

31. The Tribunal had in evidence before it 3 lever arch files of documentary evidence, which it had read in advance of the hearing, and which was enlarged upon in oral evidence. The parties also made oral and written submissions to the Tribunal.

Patient B

32. Patient B confirmed that he had made three statements. He had provided two statements in criminal proceedings and a statement for the purpose of these proceedings. He confirmed that in his initial statement dated 13 March 2015, he identified January 2012 as the date on which the alleged incident took place.

33. His second statement dated 24 June 2016 was made after he was shown the medical notes by the police although he now stated that he was only looking for the last date that he had visited the Appellant. He confirmed that in the second statement, he identified 9 February 2012 as the date on which the incident took place.

34. His most recent statement, made in December 2017 but signed on 12 February 2018 (at the hearing), confirmed that he had read the medical notes before identifying 27 May 2010 as the date on which the incident took place.

35. Patient B acknowledged that his memory was poor. However, he wanted to make it clear that at the time he made the statements, he thought that the dates he identified were the correct ones. He acknowledged that a lot of years had passed since the incident.

36. Patient B acknowledged that in his first statement to the police made on 13 March 2015, he referred to a urinary tract infection and that there was no mention of penile discharge. He confirmed that his parents normally took him to the doctors' appointments until he was aged around 16. This was normally his dad. His dad would normally remain in the room for the discussion but would leave if any intimate examination was required. Patient B could not recall the consultation on 20 May 2010 in great detail. However, he was clear that his father attended.

37. Patient B was now confident that the incident took place on 27 May 2010. He had looked through the medical records in a more careful manner and this appeared to be the consultation that fitted in with his recollection. He recalled that he was accompanied by his dad. However, he acknowledged that the medical notes did not refer to his dad leaving the consultation but he was sure that his dad left the consultation after the initial discussion.

38. Patient B then went on to describe the incident on 27 May 2010. He linked this to some significant events in his life. This included the fact that his sister been in a car crash in December 2010 when her fiancé had died. Patient B confirmed that the reason he went to see the doctor on 27 May 2010 was due to a recurring urinary tract infection. He had suffered with Urinary Tract Infections (UTI). The symptoms of which were blood in his urine. He confirmed that there was no blood in his semen at the time.

39. Patient B described the incident. He attended the room upstairs at the Surgery. The appointment was with the Appellant. He described his problems to the Appellant including reporting penile discharge. Patient B recalled that the Appellant may have drawn a diagram about what the potential problem could be. He remembers describing to the Appellant that he was getting yellow discharge from his penis when it was erect.

40. The Appellant explained to Patient B that he would have to examine his penis. After the discussion, his dad left the consultation room before the physical examination. His dad waited outside. He could not remember if the doctor asked him to leave or whether his father left of his own accord. Patient B himself recalled that he personally was more comfortable if his dad was not there for the physical examination.

41. Patient B did not think that the Appellant expressly said that his penis needed to be erect in order for him to examine it. Patient B claimed that he couldn't remember. He assumed or inferred that that was the case as he described the problem (penile discharge) had been present when he was erect. He stated that he did not think the Appellant said that his penis needed to be erect in order to take a sample of fluid from his prostate.

42. Patient B then stated that he laid down on the examination couch. The Appellant pulled the curtain across. Patient B pulled his trousers down and put his hands on his penis and started to masturbate. However, he found it strange. He could not get his penis erect. He tried for about 2 or 3 minutes without any success.

43. The Appellant then joined him and said something to him but he could not remember what. Patient B then explained to the Appellant that he could not get an erection. The Appellant then put his hands around the shaft of Patient B's penis and started to move up and down towards the head of the penis. This went on for about five minutes. Patient B couldn't get erect. The Appellant then told him it didn't matter and that he could get the sample another way.

44. The Appellant produced a medical implement. Patient B did not know what this was called but everyone he knew called it the "*umbrella*". He confirmed that the term *"umbrella"* was a term he picked up at school. He couldn't remember in what context it was mentioned. However, he now acknowledged that an umbrella was a four inch stick with a cotton swab at the top. This was then inserted into his penis and a swab was taken. That was the end of the examination. Patient B recalls being prescribed some sort of antibiotics. He then left and went home with his dad. The appointment with the doctor lasted around 20 to 25 minutes.

45. He accepted that since the incident, he had been to see the Appellant on a number of occasions. From the medical records, Patient B confirmed that he had been to see the Appellant on 20 May 2010, 27th May 2010, 8 June 2010, 30th June 2010 and 13 July 2010. However, the Appellant had not done anything or said anything inappropriate either before or after the 27 May 2010. Since the incident on 27 May 2010, Patient B had never thought about what had happened and it had never crossed his mind. He had gone to see the Appellant after the 27 May 2010 and had his genitalia examined by the Appellant and did not think anything of it.

46. The matter had only come to light when his father sent him a WhatsApp message on 31 January 2015. He was on an overseas posting in America with the Army at the time. His dad had asked him "*did anything weird go on when you went to see Dr Cruz*". It got him thinking. He thought that his father would not ask such questions if it wasn't serious. He had replied yes. That was the very first time that he had reflected that something untoward may have happened to him. He remembered that the fact that he felt he had to be erect during the exam was because that is what he thought he had to do. He recalled that the Appellant also explained that there were sensitive areas such as under the testicles between the back of the testicles and the rectum.

47. Patient B confirmed that the Appellant did not tell him that his penis needed to be erect in order for him to examine it. Patient B had assumed that this was the case. He had done so on the basis that he had told the Appellant that his problems occurred when he was erect and therefore he had thought that that is what the Appellant was asking him to do. He also stated that the Appellant did not tell him that his penis needed to be erect in order to take a sample of fluid from his prostate.

BF

48. BF confirmed that he was Patient B's father. Patient B had told him that he was worried about seeing blood in his semen. He told him to see a doctor. He did not remember the details very well as it happened a while ago. He accepted that there was a confusion regarding the dates in the criminal trials. However, BF was sure that he only went on one occasion with Patient B to see the Appellant although there was mention of him at a number of consultations. This was on 27 May 2010. On that occasion, he recalled the Appellant asking Patient B if he would feel more comfortable

talking about his problems if BF was not in the room. BF then went back downstairs and waited for him. He recalled the wait being around 20 minutes. After the consultation, he asked Patient B whether the doctor had taken a sample. Patient B told him that despite trying a couple of times he couldn't do it. Patient B hadn't elaborated on what he meant by this.

49. BF had been contacted by members of his family to ask if they had seen media articles regarding the Appellant. He looked at the Ilford Recorder and this carried a photograph of the Appellant. However, he wasn't sure whether this was Patient B's former doctor as he didn't recognise him. Patient B was in America at this time on an army posting. He sent a message over WhatsApp asking Patient B "*did anything dodgy happened to you when you went to see Dr Cruz at the Doctor's House Surgery"* followed by a message later saying *"did anything weird go on when you saw Dr Cruz"*. Patient B told him that he had concerns about the consultation and wished to pursue them. He accepted that he had made reference to seeing a solicitor rather than the police initially but this was to get advice regarding the process. He denied that he and Patient B had colluded in relation to the evidence.

50. BF had used the term *"umbrella"* to describe the four inch stick with a cotton swab at the top used to take a sample. The *"umbrella"* was a term that he had heard at school many years ago but he could not remember in what context.

Dr S El Obaidi

51. Dr El Obaidi worked at the Surgery. She confirmed that she had made the entry in Patient A's medical records on the 25 May 2010. The entry referred to Patient A not trusting Dr El Obaidi's opinion and her explaining to him not to book with her again. However, Dr El Obaidi could not be sure why she had asked him not to book with her again. She thought that this may have been written that way due to her having a bad day or may have actually happened. She could not be sure.

Dr H Spiteri

52. Dr Spiteri's evidence focused on the Chaperone Policy at the Surgery. He confirmed that the policy had been reviewed in 2012 by the Medical Director. At the time of the alleged incidents, there was a chaperone available who was the full-time nurse. However, the nurse wasn't a dedicated chaperone and this had to be fitted in around her daily work. The doctors could each ask another doctor to act as a chaperone but this would depend if they were available and in practical terms would take them away from the patients. Dr Spiteri accepted that there were not many staff who would be able to act as a chaperone at the time. He confirmed that all staff were made aware of the Chaperone Policy and it was included in the Locum Induction pack. However, Dr Spiteri acknowledged that the practice of recording whether or not a chaperone was offered varied across the Surgery. The practice of recording whether or not a patient was offered a

chaperone and declined also varied. Some doctors did it whilst others did not. Dr Spiteri confirmed that an audit had not been done so see if the Chaperone Policy was being complied with but this was something that the Surgery could consider in the future.

53. Dr Spiteri described the EMIS booking system. When a patient arrived, he would be marked with an *"A"* denoting arrival. When the doctor brought up the record on the screen, he would mark it with an *"S"* denoting seen. This would mean that the patient would be then seen and the receptionist would send the patient up. Dr Spiteri confirmed that an entry on the computer system regarding the length of the consultation did not mean that this was how long the patient spent with the doctor. The entry referred to when the doctor filed his notes. This could be done immediately as soon as the patient had left, or it could also be filed much later, for example, after the doctor had seen another patient or even after a lunch break. Each doctor could also open two records at one time.

Ms T Galloway

54. Ms Galloway confirmed that she first became involved in the Appellant's case on 27 June 2013. The Nursing Director of NHS England (London Region) had been contacted regarding concerns about the Appellant's management of Patient A. She had met with Patient A.

55. On 15 July 2013, Ms Galloway attended the Appellant's former Practice. This was on the day he was arrested by the Police and taken for questioning. The Appellant signed a voluntary undertaking provided by Ms Galloway not to practice as an NHS GP for a period of two weeks.

56. She confirmed that as at the date of the hearing, the GMC were no longer involved with any matters concerning the Appellant. There were no conditions imposed. They had closed the cases in respect of both Patient B and Patient A. This was due to the non co-operation from the two witnesses.

57. Ms Galloway confirmed that in August 2014, the first-tier Tribunal made a consent order extending the Appellant's suspension and this had been extended since. Since June 2013, Ms Galloway had been assisting with preparing the Respondent's case to oppose the appeal. This included contacting each of the witnesses in this appeal.

Patient A

58. Patient A confirmed he had made two statements in relation to the Appellant. The first statement dated 11 July 2013 was made in the criminal proceedings. The second statement dated 15 December 2017 was made for the purposes of these proceedings. His statement in these proceedings was made after he had had the opportunity of reading and considering an extract from his GP records.

59. Patient A confirmed that his general ability in retaining dates was poor. This was due in part to the overwhelming embarrassment and humiliation arising from these incidents. However, he was clear in his mind as to what happened at three separate consultations with the Appellant.

60. Patient A described his background. He came from a conservative Muslim family. He had attended a number of boarding schools (including one in Bangladesh) and confirmed that at no time during his education did he receive formal sex education or indeed any scientific-based biological studies.

61. Patient A disclosed that one of the pivotal points in his life was his pilgrimage to Saudi Arabia during March/April 2012. He used that as a point of reference for events which occurred before he went. He accepted that he could not recall the precise date upon which the appointments took place. He was sure they occurred before he went to Saudi Arabia. He relied on the medical records to the extent that they actually recorded his attendance.

62. Patient A described three occasions when he visited the Appellant in 2011. However, he made it clear that he could not remember the dates but he could remember what happened. Patient A explained that it was sometime around late 2011 and early 2012 that he discovered that he had a rash on the tip of his penis. He was clear that this was before March 2012.

63. At the time, he was having a sexual relationship with his girlfriend and was also having problems relating to premature ejaculation and maintaining an erection. He decided to book an appointment with his GP to have the rash looked at. His appointment was with the Appellant. On the first appointment the Appellant examined the rash on his penis and gave him some cream for it and booked another appointment one or two weeks later.

64. Patient A attended for the second appointment, Patient A explained that the Appellant examined him once again and found that the rash was beginning to clear up. It was at this appointment that he felt the courage to speak to the Appellant about the problems he was having maintaining an erection and his problems with premature ejaculation. He set out that he felt confident to talk about this issue due to him seeing a poster on the wall at the surgery about erectile dysfunction.

65. Patient A set out that the Appellant asked him personal questions including whether he drank, smoked, was in a relationship, masturbated or watched porn. He answered the questions as honestly as he could. The Appellant then examined this penis and during this examination the Appellant wore gloves. He was given more cream and then attended for a further appointment about a week or two later.

66. On his third appointment, the Appellant examined the rash on his penis which had mostly cleared up. The Appellant asked more questions about his private life and whether he had sexual relationships with multiple partners, whether he had anal sex, how often he had sex and how often he

masturbated. It was at this appointment that the Appellant told him that he needed to examine his penis again. Patient A stated that the Appellant told him that he would need to see him masturbate. Patient A felt very uncomfortable when the Appellant said this. However, the Appellant reassured him that a lot of people went through the same thing. The Appellant asked him whether he wanted someone else in the room as a chaperone. He declined as he didn't want anyone else to know about his issue.

67. The Appellant then asked him to go behind a curtain which was in the room and take down his trousers and under garments to his knees, which he did. The Appellant then closed the curtain and examined his penis and testicles. The Appellant then told him to masturbate in front of him so that he could see how he masturbated and ejaculated. The Appellant explained that this was so he could see what the dysfunction was. Although Patient A felt uncomfortable, he tried to masturbate but at the same time covered his face with his arm. However, Patient A was unable to get an erection because of how uncomfortable the Appellant was making him.

68. Patient A stated that the Appellant then asked him if he would like the Appellant to help. Patient A stated that he was confused and just said yes. He then claimed that the Appellant took hold of his penis and began to masturbate him. However, whilst he was unable to get a full erection he did produce some ejaculate.

69. Patient A stated that the whole process lasted about five minutes. He felt disgusted and embarrassed. The Appellant then explained to him that he hadn't ejaculated properly as he didn't get a full erection so would need to come back for another appointment. Patient A claimed that the Appellant then booked him in for a further appointment about a week later. However, Patient A did not attend that appointment as he felt "uncomfortable".

70. Around a month later, Patient A felt pain in his genitalia. So he decided to book another appointment. He saw the Appellant. He explained to the Appellant that he suffered a lot of pain during sexual intercourse and he was having problems with maintaining an erection. The Appellant told him that he needed to see him masturbate and asked him to go behind the curtain and take down his trousers and under garments. He felt uneasy about it but due to the pain he had experienced, he was determined to get it sorted out. The Appellant joined him behind the curtain and asked him to masturbate. He was unable to do so. The Appellant asked if he wanted him to assist Patient A. He replied yes. The Appellant then masturbated him again and this time he was able to get a slightly harder erection and ejaculated a bit more. This lasted five minutes. He felt embarrassed and humiliated. The Appellant told him to try various techniques when masturbating including the “start stop technique” and Patient A claims told him to watch porn. The Appellant then booked him in for another appointment.

71. On the third appointment, the Appellant examined him again. The symptoms were the same. The Appellant asked if he could help him again. The

Appellant began to masturbate him, however on this occasion, he was not wearing gloves. The Appellant also began to stroke his scrotum. He was using his left hand to masturbate him and his right hand to stroke his scrotum. The Appellant then told him to lie on his left side so that his back was now to the Appellant. Patient A stated that with his left hand, he continued to masturbate the Appellant and that with his right hand, he reached his hand between his legs from behind and began to stroke the area between his testicles and his anus. The Appellant explained to him that this was a sensitive area and wanted to see what reaction Patient A would get from it. Patient A alleged that the Appellant then began to slide his fingers closer to his anus. Patient A flinched and pushed his hand off. However, the Appellant continued to masturbate him and stroke the area between his scrotum and anus. Patient A ejaculated. Patient A alleged that the Appellant explained that his penis was bigger than average and even though he had ejaculated, it was not enough and there should have been more. The Appellant asked Patient A to come back for a further appointment following this incident.

72. However, Patient A claimed that he began to feel depressed and isolated himself. A few weeks later, he decided to book a flight to Saudi Arabia for a pilgrimage. Patient A acknowledged that when he returned from Saudi Arabia, he began to feel better. However, a month later the rash came back and he booked another appointment with the Appellant. On this appointment, the Appellant made no further suggestion or attempt to masturbate him.

73. He saw the Appellant on a number of occasions and under cross examination could not rule out whether an incident had occurred after he had returned from his pilgrimage in March 2012.

74. In April/May 2013, Patient A noticed that the rash on his penis had come back again. He then did some research on the Internet and contacted the Loxford Polyclinic who advised him to go to Queens Hospital. He then booked an appointment over the phone with a sexual health department.

75. In early May 2013, he had his appointment with another doctor at Queens Hospital. It was during this appointment that he explained to them what happened. He explained to those doctors what the Appellant had done to him during his appointments. The doctors were shocked and the police were then involved.

76. Under cross-examination, Patient A accepted that he could not remember the exact dates for each incident. However, in his mind he was clear that it happened three occasions. However, he accepted that he could not remember the sequence in which the incidents occurred. Patient A was clear that on three occasions he was told by the Appellant that he needed to see him masturbate. However, he wasn't sure whether the Appellant had masturbated him on the first of those three occasions. He could not recall whether or not the Appellant had seen him ejaculate on the first of those

three occasions. He was linking them to what the Appellant had done to him (i.e. touching between the testicles and the anus).

77. Patient A stated that the Appellant had told him penis was bigger than average (as set out in the statement dated 11 July 2013) and more than average "for an Asian person" at the hearing.

78. He acknowledged that he did not mention the ultra sound scans that the Appellant had arranged for him as part of the consultations in his police statement. This was due to him focusing on the main issues and which was whether or not the Appellant had asked to him to masturbate.

79. Patient A agreed with the symptoms and description of the medical records for 28 December 2012. Patient A accepted that he had been to see the Appellant after he returned from Saudi Arabia in March/April 2012. He accepted that this included intimate examinations. He set out that this was because he did not recognise what the Appellant did was wrong. He believed it was linked to his medical problems. It was only when he attended Queens Hospital and they called it inappropriate that he then realised that it was totally inappropriate.

80. Patient A accepted under cross examination that the Appellant had referred to a Polyclinic. He had initially said he had not. The Appellant had talked about referring him to such a clinic but Patient A claimed that the Appellant had assured him that he had treated others in a similar situation to him and that he could deal with it. Patient A took the view that he did not need to attend elsewhere if the matter could be dealt with at his Surgery. He also set out that he did not want to go and talk about his personal issues with another doctor. The Appellant could also observe whether or not the rash was getting better having previously seen it. He did not realise what the Appellant had done was wrong and he had not discussed the matter with anyone else. He came from conservative family and found it uncomfortable to discuss this issue with anyone.

81. Patient A acknowledged that he had been a youth worker at the time and had undertaken some safeguarding training. However, he did not link his treatment by the Appellant to any safeguarding issues until he visited Queens Hospital. He personally did not think it was wrong at the time although it made him feel uncomfortable.

82. Patient A confirmed that on one occasion, the Appellant discussed the start stop technique. This was to help him ensure that he would not ejaculate prematurely. In a follow up consultation, the Appellant had asked him how he was getting on with that.

<u>The Appellant</u>

83. The Appellant's position was that he denied the allegations made in their entirety and disputed the accounts made by the complainants to various organisations including the police.

84. The Appellant stated that he was a registered General Practitioner and, during the period in question, he worked at the Surgery. He confirmed that in 1994 he obtained his undergraduate qualification in the Philippines and in the final year of his undergraduate training, he undertook a rotation in four major specialities, internal medicine, paediatrics, obstetrics and gynaecology and surgery (which included the sub- speciality of urology). He had also worked in Cambodia.

85. He moved to the UK in 2000 and worked in various hospital posts. In 2005, he began his specialist GP training at Old Church Hospital for two years before undertaking his GP Registrar year in Romford. In 2006/2007, he completed his examinations for Membership of the Royal College of General Practitioners and the Diploma for the Faculty of Sexual and Reproductive Healthcare (DFSRH). He obtained a full GMC registration as a GP in February 2007. He had also worked at the Queens Hospital.

86. The Appellant explained how he would carry out intimate examinations of patients presenting with problems relating to their genitalia. He confirmed that he was taught the intimate examination techniques by senior consultants in the Philippines. He would ask questions initially. He would then do a full examination of the genitalia. However, before he examined any patients intimately, he would obtain consent to examine them. He would offer also a chaperone.

87. He confirmed that the examination was a relatively quick process He would ask patients to go and lay on the examination couch and expose their abdomen and genitalia. He would explain what he would do. He would palpate the 4 quadrants of the abdomen. Then he would inspect the genitalia for anything obvious, whilst always talking to the patient for example *"I'll be performing this now"* etc. He would hold the penis and examine it.

88. He would examine the penis before the scrotum. He would likely start at the top and work his way down. He would need to touch all the penis to examine it, this included the glans and the shaft.

89. He would usually ask the patient to retract the foreskin but if they could not do it then he would ask them if he could do it. He would then examine the glans, press a bit to open the urethral orifice to look for condylomata or discharge. He would press the shaft of the penis so discharge could appear and be seen and collect a sample of discharge.

90. He would then examine the scrotum, the skin and look for irregularity or lesions and then examine the testicles. He would roll the testicle between his fingers to check size, how firm, if it was smooth all over. He would examine both testicles. He would also examine behind the testicles to make sure there was no tenderness or infection. He then made sure the Vas Deferens was normal and would then check the inguinal region for nodes. He would look for spots or lesions over or inside the thighs.

91. He would examine the testicles and the epididymus in order to check for tenderness, texture and whether or not there was any swelling. He would also check both sides of the groin looking for any abnormalities.

92. He would normally wear gloves but there would be few occasions when he would not wear gloves. This was, for example, when he was looking for tiny lumps that he could not feel with the gloves

93. He accepted that on some occasions male patient patients could get an erection. It had happened to him on some occasions but never with Patient A or Patient B. In such circumstances, he would pause the examination until the patient's erection subsided.

94. He confirmed that he used a swab. He would take a swab from the urethra. He would take a sample of the discharge. The swab had a cotton bud at the end of it. He was not aware of anyone referring to it as an "*umbrella*". He explained that some patients found the process uncomfortable but others were okay with it.

95. He described the Surgery. His room was located upstairs. He had transferred rooms on occasions. He described the booking system. When a patient arrived, he would be marked with an "A" denoting arrival. When the doctor brought up the record on the screen, he would mark it with an "S" denoting seen. This would mean that the patient would be then seen. The doctor would press the bell to request that the patient is sent through and the receptionist would look at the screen and send the relevant patient up. The patient record would be closed after the consultation had been filed. The Appellant stated that the consultation could be filed immediately after the patient left or sometime thereafter. It did not follow that the record would be filed as soon as the patient left. The doctors could open two records at one time. The Appellant tried to ensure that it was filed as soon as possible but this was not always the case. For example, the record might be filed after a break.

Appellants Position - Patient B

96. The Appellant confirmed on 9 February 2016, he was interviewed at Woodford Police Station following an allegation of sexual assault made by Patient B. Patient B alleged that the Appellant had masturbated him during a consultation at the surgery. The Appellant denied that he sexually assaulted Patient B.

97. The Appellant confirmed that Patient B had attended the surgery on 27 May 2010 with his father. He had previously attended on 20 May 2010. The Appellant had considered him to be Gillick competent.

98. The entry on the medical notes for Patient B on 27 May 2010 indicated that dad was worried about STI and Patient B was still having dysuria. The urine

results were discussed and Patient B was worried about discharge. The Appellant confirmed that the Patient B told him that if he had an erection, he got a "*yellowy discharge*". Patient B wanted to show him the discharge.

99. The Appellant decided to take a urethral swab to test for chlamydia and gonorrhoea. In order to take the urethral swab, the Appellant pressed gently on the shaft of Patient B's penis with his thumb, middle and index finger to see if the discharge was expressed from the urethra. This would indicate the presence of an infection. The Appellant was unable to obtain evidence of any discharge, however, Patient B was insistent that there was discharge and wanted to show him. The Appellant explained to him that he had not obtained any evidence of the discharge but that Patient B could try using the same technique, to see if he could *"milk/express"* any out. At this point, the Appellant went to prepare a swab. As there was no discharge, the Appellant then inserted the swab into the urethra and the swab was placed in a sealed bag and sent to the local laboratory to be tested. A report was returned on the 28 May 2010, confirming that the results were normal. He denied the allegations as they were set out in relation to Patient B.

100. The Appellant confirmed that after that consultation on 27 May 2010, Patient B made further appointments to see him in relation to matters including his genitalia on 8 June 2010, 30 June 2010, 13 July 2010, 24 January 2011, 21 September 2011, 28 September 2011, 18 October 2011 and 9 February 2012. This included further intimate examinations.

Appellants Position - Patient A

101. The Appellant confirmed that on 15 July 2013, he was interviewed at Ilford Police Station following an allegation made by Patient A. He was interviewed under caution and provided a written statement to the police.

102. He denied that he asked Patient A to masturbate himself. He also denied that he masturbated Patient A during any examination. He also denied asking Patient A to let the Appellant see him ejaculate and stated that at no time did Patient A ever ejaculate during a consultation with him

103. The Appellant confirmed that he first became aware of the complaint of Patient A after he had received a letter from the GMC on 10 July 2013. That letter was received by him on 11 July 2013. On the following day, he viewed and printed Patient A's electronic GP records for the period during which he worked at the Surgery. Those records confirm that Patient A consulted with him on 12 occasions between June 2009 and January 2013. He was aware that Patient A had complained about a number of consultations with him at which he alleged that the Appellant had asked him to masturbate and assisted with that until he ejaculated. He denied the allegations that he masturbated Patient A, asked him to masturbate himself in his presence or observed him ejaculate.

104. The Appellant confirmed that Patient A attended consultations with him on a number of occasions regarding genital complaints. He confirmed that he

had seen Patient A in relation to issues about his genitalia on number of occasions including 6 October 2010, 16 May 2011, 20 May 2011, 14 October 2011, 12 December 2011, 29 December 2011, 22 May 2012, 28 December 2012 and for the last time on 14 January 2013. Many of these consultations were lengthy discussions with Patient A about his concerns. It was not possible to have shorter appointments with Patient A as he was a patient who liked to discuss matters at length. During the period, that he treated Patient A, he presented with complaints including pain on urination, a discharge from his penis, penile discomfort, possible sexually transmitted infections (STI's), aches and "pressure" in his scrotum, premature ejaculation and a rash around his penis.

105. As a result of Patients A's medical complaints, it was necessary for the Appellant to physically examine Patient A's genitals. The Appellant accepted that he would have physically examined Patient A's genitals, including his penis, scrotum and testicles on a number of occasions. However, he had done so for clinical reasons and would not have asked him to masturbate or masturbated him.

106. The Appellant confirmed that he would have asked Patient A questions about his sexual practice and sexual history which he would have done sensitively due to the intimate nature of these enquiries. This included discussing techniques with Patient A such as on 20 May 2011 when he discussed Patient A's worries about premature ejaculation and advised him about the "start stop technique". This was a way in which Patient A could stop himself ejaculating too quickly. The Appellant stated that he did so by using a diagram to demonstrate how it worked.

107. These examinations were undertaken in accordance with his routine clinical practice and were clinically appropriate. On none of these occasions did the Appellant masturbate Patient A or ask him to masturbate in front of him.

108. He confirmed that his routine practice for examining a male patients genitals depended upon the nature of the presenting symptoms. Given the symptoms that Patient A presented with, it would have been clinically necessary for him to examine his genitalia. These examinations were noted in the contemporaneous medical records and had been undertaken in accordance with the routine practice of explaining to the patient of the need to undertake an examination and obtain their consent to proceed.

109. He confirmed that he would routinely offer a chaperone for intimate examinations although he did not record this on every occasion at that time. The Appellant's approach was that he did record the offer of a chaperone for female patients but not for male patients. However, he stressed that a chaperone would be offered. This was in line with the practice at the Surgery at the time.

110. The Appellant confirmed that the medical records of his consultations with Patient A confirm that he undertook urine dipstick testing, screening for chlamydia, a urethral swab for chlamydia and gonorrhoea and on two

separate occasions a referral for an ultrasound scan of his scrotum and testicles. He also confirmed that he prescribed topical treatment for Patient A on a number of occasions for the rash on his penis.

111. The Appellant set out that Patient A refused to attend for an ultrasound scan at the local hospitals despite his symptoms continuing and the Appellant providing him two separate referrals. Furthermore, after a number of detailed conversations with Patient A, he declined his offer of psycho-sexual counselling. In those circumstances, the Appellant felt that he was unable to treat those specific symptoms.

112. The Appellant explained that on 28 December 2012, he urged Patient A to accept his referrals for ultrasound scanning and counselling. In those circumstances, he told him that as Patient A had refused to accept a scan and psychosexual counselling, the Appellant was unable to offer any further treatment on that specific issue. He also described how Patient A had attended a final consultation with him in January 2013 with ongoing psychosexual concerns. There was no further treatment that the Appellant could provide him with and Patient A did not consult him again.

113. He had asked Patient A to see another doctor at the Surgery as he could no longer help him. He accepted that he did not record this in the medical notes as he had seen patients of other doctors without such notes being present. In hindsight, he accepted he should have recorded it.

114. The Appellant confirmed that he may not have recorded each occasion that Patient A was offered a chaperone. However this was not an unusual practice at the Surgery at the time. He also confirmed that he may have spoken to him regarding his premature ejaculation and that this was not documented after the initial discussion 20 May 2011. However, the Appellant had reviewed Patient A's previous notes and had asked him how he was getting on with it.

Professor Ian Wall

115. Professor Ian Wall confirmed that he was instructed to prepare a report on behalf of the Appellant. He had reviewed the records of both Patient A and Patient B. This included the medical notes. He had read the witness statements of the Appellant and was of the opinion that from what he had read, the Appellant had acted in accordance with acceptable and recognised practice and that his history taking was of an acceptable standard. In his opinion, the Appellant had carried out the appropriate examinations for the symptoms recorded in both patients' medical records.

116. Professor Wall stated that was still is difficult to reconcile Patient A's account with the medical records. Professor Wall set out that there was a lack of correlation between the date stated in Patient B's witness statement in relation to his complaint of 9 February 2012 and the probable relevant consultation of 20 May 2010 or 27 May 2010. In his view, the initial account

could not be reconciled with the medical records but the new date of 27 May 2010 was *"a slightly better association"* but still not a good reconciliation with medical records.

117. Professor Wall confirmed that he had looked at lots of medical records. The Appellants standard of record keeping was in line with, if not better, than a reasonable body of GPs.

118. He confirmed that premature ejaculation is a condition where ejaculation occurs earlier than is desired (before or soon after penetration). Various treatments can help this condition including the "start stop technique".

119. Professor Wall was of the opinion that examination findings by the Appellant were appropriately recorded but that GMC guidance on the use of a chaperone was not always followed or recorded. However, he concluded that it was not unusual to not record the presence or absence of a chaperone, or the offer of one, when the doctor is of the same gender as a patient.

120. Further, Professor Wall specified that the wearing of gloves was not always undertaken for external intimate examination but was when swabs were taken and this was appropriate and in accordance with World Health Organisation guidance.

The Tribunals Conclusions with Reasons

121. We took into account all the evidence that was included in the hearing bundle, presented at the hearing, including the respective submissions.

122. We acknowledge the courage and difficulties involved in individuals talking about experiences, involving matters of an intimate nature, in a public setting. We wish to place on record our gratitude to all the witnesses for attending the hearing and in particular, Patient A for attending the hearing venue when technical difficulties arose in relation to the video link. Patient A attended the Royal Courts of Justice voluntarily and gave his evidence from behind a screen despite there being an earlier order allowing for his evidence to be heard from an alternative venue by video link. This allowed the Tribunal to continue with the hearing and maintain the hearing timetable.

123. We acknowledge that the case as presented before the Tribunal was somewhat different to that considered by the PLDP. There was evidence before the PLDP panel which was not placed before this Tribunal. In these proceedings, the Respondent sought to rely on the evidence of two complainants, Patient B and Patient A, who both attended the hearing and gave evidence.

124. It was agreed by the parties that the Tribunal was to put out of its mind any reference to or consideration of concerns raised by patients other than Patient B and Patient A. We noted that the bundle, despite being redacted in places, still contained reference to other patients but we can confirm that

in reaching our decision, as agreed between the parties, we put out of our mind any reference to or consideration of concerns raised by patients other than Patient B and Patient A.

125. We were grateful to both Mr Hockton and Mr Thomas for their assistance at the hearing. In particular, for agreeing a Scott Schedule identifying the issues which the Tribunal needed to determine. The Respondent as part of its closing submissions proposed new issues relating to the WhatsApp exchange between Patient B and BF on 31st January and when Patient B became aware of the allegations of sexually inappropriate behaviour made against the Appellant. However, we considered this to be somewhat unfair to the Appellant as this was raised after the oral evidence had been heard and after the Appellant had filed its closing submissions. We have considered them insofar as they are relevant to the issues identified on the Scott Schedule. We have addressed our minds to the issues which we were informed were agreed and set out in the Scott Schedule.

126. We reminded ourselves that as this was a redetermination, it remained for the Respondent, to prove its case for removal under Regulation 14 of the 2013 Regulations. The standard of proof is the balance of probabilities.

127. The parties agree that the Appellant does not have to prove anything. In particular, he does not have to prove a reason as to why patients might make allegations against him that are untrue. We accepted, as the Respondent acknowledged, that if there were a credible reasons why this might be the case, that such an explanation would be potentially significant. Equally, if we cannot identify any reason why either complainant would invent that account, this may be a factor in accepting their account.

128. It is clear that the allegations were of an extremely serious nature. They are one of the most serious allegations that can be made against a professional person. The consequence for the Appellant were the Tribunal to find them proven were very serious, he would, in effect, be unable to practice as a medical practitioner within the NHS.

129. We found the Respondents witnesses Dr Obaidi, Dr Spiteri and Ms Galloway to be credible. None of those individuals witnessed any of the alleged incidents directly and their evidence was consistent and credible. We found the evidence of Professor Wall to be particularly persuasive. Professor Wall provided a clear and well-reasoned basis for his observations and these were set out in his report dated 11 May 2017 and expanded upon at the hearing. We concluded that although he was instructed by the Appellant's representatives, his evidence was very fairly presented. Our observations regarding Patient B, BF and Patient A are set out below.

130. Overall, we found the Appellant to be consistent and credible. He was measured in his replies and provided a credible explanation for the entries on the medical records of both Patient B and Patient A. We found that he Appellant's evidence has been consistent in the criminal proceedings (as evidenced through the transcripts provided) and in the proceedings before

us. We acknowledge that he had access to the medical records but his explanations in relation to what occurred are consistent with the contemporaneous medical records.

Patient B

131. We concluded that, based on the evidence before us, we were not persuaded that, on the balance of probabilities that during a consultation with Patient B on 27th May 2010 the Appellant did tell Patient B that his penis needed to be erect in order for him to examine it, tell Patient B that his penis needed to be erect in order to take a sample of fluid from his prostate, encourage Patient B to masturbate, allow Patient B to masturbate and masturbate Patient B. Our reasons for doing so are set out below.

132. We found that Patient B gave a confusing and unclear account about the incident although we did not consider this to be deliberate. In fairness to Patient B, he made it clear that he cannot remember the exact date as it was a long time ago. It is clear that there have been a number of dates put forward by Patient B as dates on which the alleged incident took place. There were three dates, these being January 2012, 9 February 2012 and for these proceedings, 27 May 2010.

133. We noted that Patient B's first statement, which identified January 2012, dated 13 March 2015 was made without the benefit of seeing his medical records.

134. His second statement dated 24 June 2016, was made after he was shown a copy of his medical records. The witness statement makes it clear that "*upon reading my medical records, I now believe that the date that Dr Cruz assaulted me was when he examined me on 9 February 2012*". This was, by his account after he had seen his medical records. This is recognised in his statement made for the purpose of these proceedings, and signed on 12 February 2018, that those earlier statements contained the incorrect dates and he apologises for those errors. Patient B now states that he reviewed the medical records only to the extent that he was looking for the date of the last visit to the Appellant. We were concerned that given the nature and seriousness of the allegations, the statement made in criminal proceedings when read as it does suggests that he had read the medical records and determined that was the alleged date, not the last date that Patient B had seen the Appellant.

135. Patient B in his statement made in these proceedings states that *"having carefully on this occasion read a copy of the medical records, I am sure reading the description of the consultation and examination that the correct date for the alleged incident was in fact 27 May 2010."* However, Patient B acknowledged that his memory was poor, his *"memory of specific dates is not good"* and that a lot of years have passed since the incident. Furthermore, he accepted that with the passage of time, the dates have become even more confused. For example, he could not even recall seeing the Appellant again after he attended for his employment medical

examination, yet it is evident from the medical records shared with him that he saw the Appellant on 9 February 2012. Patient B also appeared to have little recollection of the consultation on 20 May 2010 which provides a context for the consultation which took place on 27 May 2010.

136. Furthermore, in oral evidence, Patient B accepted that the Appellant did not tell him that his penis needed to be erect in order for him to examine it. Patient B had assumed this to be the case. He acknowledged that this was on the basis that he had told the Appellant that his problems occurred when he was erect and therefore he had inferred that this is what the Appellant was asking him to do. Patient B also accepted that the Appellant did not say that his penis needed to be erect in order to take a sample of fluid from his prostate. However, this is contradicted by his statement dated 13 March 2015, where he stated that *"Dr Cruz explained to me that he would need my penis to be erect to examine me. He said that he needed a sample of fluid from my prostate and that this could only be done if my penis was erect"*

137. We also noted that there was an inconsistency between the evidence of BF and Patient B. Patient B made it clear that his parents normally took him to the doctors' appointments until he was aged around 16. He made it clear that this was normally his dad. Patient B suggested that there were two occasions when his father left the room during examinations. However, his father was adamant he only attended on one occasion.

138. However, BF was equally sure that he attended with Patient B to see the Appellant on one occasion. Furthermore, there was also an inconsistency in the account between Patient B and BF as to the reason for the visit. Patient B confirmed that he did not have blood in his semen whereas BF stated Patient B had told him that he was worried about seeing blood in his semen. BF had then suggested he went and saw the doctor.

139. We acknowledged that although Patient B and BF informed us that they did not discuss the matter when it first arose other than on WhatsApp, we could not be certain that this was the case. Both BF and Patient B used the term *"umbrella"* to describe the four-inch stick with a cotton swab at the top. Both explained in oral evidence that this was a term that they had heard used at school but neither could explain the context in which it had arisen.

140. Furthermore, BF in his statement dated 28 October 2015 stated that he didn't remember discussing with Patient B what the Appellant had done after the appointment and didn't remember any follow up appointments. However, BF's later statement dated 10 April 2017, made for these proceedings, suggests there was a discussion which involved him asking Patient B whether the Appellant had taken a sample. Patient B had told him that despite trying a couple of times he couldn't do it but Patient B hadn't elaborated on what he meant by this.

141. We acknowledge that Patient B was only 15 at the time and may not have appreciated the seriousness of what he now alleges. However, The Appellant confirmed that after that consultation on 27 May 2010, Patient B

made further appointments to see him in relation to matters including his genitalia including on 8 June 2010, 30 June 2010, 13 July 2010, 24 January 2011, 21 September 2011, 28 September 2011, 18 October 2011 and 9 February 2012. This included further intimate examinations. Patient B confirmed that in all the years after, until his father's WhatsApp message, he had not thought about the incident or considered it inappropriate.

142. We acknowledge the WhatsApp evidence. It sets out what was discussed. Patient B himself, in oral evidence contradicted what he said in the message as he accepted that the Appellant did not say that his penis needed to be erect in order to examine it or to take a sample of fluid from his prostate. Furthermore, we observed that the first suggestion regarding masturbation came from BF who attributed it to Patient B's mum and there is no reference in the WhatsApp message to any dates for the incident.

143. We preferred the evidence of the Appellant in relation to the consultation which took place on 27 May 2010. The earlier note for 20 May 2010 states that the Appellant felt that Patient B had sufficient maturity and understanding to continue the consultation on his own i.e. he was Gillick competent. The Appellant's version was clear and was consistent with the medical notes produced. It is clear that a swab was taken as a medical records indicate that on 28 May 2010, the lab results for chlamydia were received and logged onto medical records. Furthermore, we accepted the evidence of Professor Wall that for the symptoms recorded in the notes, an examination of the penis and scrotum was appropriate as was taking a urethral swab and arranging an ultrasound scan. Professor Wall also confirmed that the providing Patient B with the opportunity to milk/express his penis to produce any discharge was appropriate so long as it did not amount to advising Patient B to masturbate to do this.

144. We concluded that having heard and considered the evidence including the oral testimony from both Patient B, BF and the Appellant, that based on the evidence before us, we were not persuaded that, on the balance of probabilities that during a consultation with Patient B on 27th May 2010 the Appellant did tell Patient B that his penis needed to be erect in order for him to examine it, tell Patient B that his penis needed to be erect in order to take a sample of fluid from his prostate, encourage Patient B to masturbate, allow Patient B to masturbate and masturbate Patient B.

Patient A

145. We considered the position in relation to Patient A. The Scott Schedule identified the questions we need to address in relation to Patient A. We concluded that, based on the evidence before us, we were not persuaded that, on the balance of probabilities, that that during consultations with Patient A in 2011, that the Appellant did tell Patient A that he needed to see him masturbate, tell Patient A to masturbate in front of him, allow Patient A to masturbate and masturbate Patient A. We concluded that the Appellant did touch Patient A's testicles and the area between his testicles and anus but only insofar as it related to the symptoms presented and in accordance

with acceptable and recognised practice. Our reasons for reaching our conclusions are set out below.

146. We acknowledge that the matters concerned events which occurred some time ago and memories fade with the passage of time. However, in our view, Patient A's account of what happened, when it happened and how often it happened has been inconsistent throughout the various proceedings. Patient A stated that one of the pivotal point in his life was his pilgrimage to Saudi Arabia during March/April 2012. He used that as a focal point. He thought the incidents occurred before he went to Saudi Arabia. In evidence to the Tribunal, Patient A accepted that he could not even remember the sequence of events but insisted that he was clear as to what had happened. At one stage he accepted that one of the incidents may have happened after he returned from pilgrimage in 2012.

147. Patient A accepted that he could not recall the precise date upon which the appointments took place and relies on the medical records to the extent that they may actually record his attendance. Patient A, in the main, accepted the medical notes recorded what had occurred at the examination. The issue concerned what wasn't recorded i.e. the alleged incidents. Patient A could not tell the Tribunal exactly when this happened as he could not remember the dates. He could not even remember the sequence of how the incidents occurred.

148. Patient A accepted that his previous statement, made in the criminal proceedings, (dated 11 July 2013) he did not expressly set out specific dates upon which he believed he was sexually assaulted. This was due to the time between the incidents and the preparation of this statement in the criminal proceedings. We agreed with his assessment that his recollection at the time of his first statement dated 11 July 2013 is more likely to be accurate than now given the passage of time. However, even that statement is incorrect in relation to his attendance to see the Appellant at the Surgery. The Respondent accepts that Patient A made a mistake in that statement. Patient A had asserted that, while he returned to see the Appellant on one occasion after his return from Saudi Arabia, with a rash on his penis, he did not go back to see the Appellant again. However, it is clear from the medical records that this is incorrect as he actually returned on three occasions in relation to his genitals.

149. Patient A's account of how many incidents occurred was also inconsistent. Patient A described the Appellant asking him to masturbate on two occasions (at one point the Appellant is said to have masturbated him) in the note recorded by the Queens Hospital under the entry dated 3 May 2013. He informed Ms Galloway that "*there were more than three and less than 10*" and referred to 3 incidents in the police statement. It was clear from his oral evidence that he appeared confused as to the total number of incidents that he alleged. It varied from 2 to 3 incidents.

150. Patient A's evidence was also inconsistent in other aspects. For example, he denied that the Appellant had referred him to the Polyclinic but later, under

cross examination, accepted that this was the case. Patient A was also inconsistent in describing what the Appellant is alleged to have said in relation to the size of his penis after one of the incidents. In the police statement, Patient A stated that the Appellant was purported to have commented that his penis was bigger than average and he should have ejaculated more. His evidence to the Tribunal gave a different account about this discussion. He described the Appellant as saying that he had a more than average penis "for an Asian person" and bigger than average for the person of his size.

151. We acknowledge that Patient A may have believed that his treatment by the Appellant was appropriate at the time, but we concluded that it was difficult to reconcile Patient A's alleged treatment by the Appellant and his subsequent actions. Patient A states that he masturbated himself and was masturbated by the Appellant without considering this to be in any way clinically untoward but continued to return to the Appellant for further treatment. The Queen's Hospital note states that "*patient states he was very uncomfortable with that and felt very violated*. *He has since stopped seeing the GP*". Patient A's police statement dated 11 July 2013 states that he booked a flight to Saudi Arabia due in part to "*what Dr Cruz had done to me*". This undermines Patient A's suggestion that he was unaware of the inappropriate nature of the examination prior to attending Queen's Hospital.

152. It is clear from the medical records that Patient A, specifically, having had concerns about the alleged treatment, after his trip to Saudi Arabia, repeatedly returned to the Appellant in relation to intimate matters and sought out an appointment on 28 December 2012 presenting with what the medical notes record as "*soreness of penis during sexual intercourse and masturbation*" and "*needs to ejaculate often to release discomfort/pressure in scrotum"*. On this occasion, Patient A declined a chaperone and an intimate examination was conducted. Furthermore, there was a discussion regarding a psychosexual referral but Patient A declined this. This also undermined Patient A's evidence that he did not want the Appellant to examine him again after what happened and only spoke to the Appellant about his rash after visiting Saudi Arabia and not about his erectile dysfunction or anything else.

153. We also noted that the Appellant's attempts to persuade Patient A to undergo investigation for his testicular symptoms by way of an ultrasound, which were supported by the medical records and not denied by Patient A. In our view, we agreed with the submission put forward on behalf of the Appellant, that these actions would be inconsistent with the actions of an abusive doctor. Any doctor who sexually abused his patient in the manner alleged would be reluctant, although we accept that this may not always be the case, to refer the patient to a third party and risk exposure.

154. We preferred the evidence of the Appellant and that of Professor Wall. This was corroborated by the contemporaneous medical notes which we accept were produced by the Appellant. We accept that the Appellant has had an opportunity to consider the medical record of Patient A before providing a

response. However, from what evidence we heard and read, it is clear that the medical records are consistent with what occurred with the exception of the sexual misconduct allegations. In relation to Patient A, it is clear that the issue of premature ejaculation and sexual performance were discussed on three occasions in late 2011 (14 October, 12 December and 29 December) when Patient A attended and the Appellant accepted these were not recorded. However, we accepted the Appellant's explanation that he was simply checking with Patient A as to how he was getting on in respect of an issue that was previously discussed with the Appellant. In our view, we did not find this particularly unusual as for, example, the Patient A was experiencing issues with his genitalia on 12 and 29 December 2011.

155. We were also provided with dates in the closing submissions as to the three occasions in 2011 when it is likely that the incidents of masturbation took place. These were 14 October, 12 December and 29 December 2011 when Patient A attended at the surgery and saw the Appellant in relation to his genitals. However, the submissions also state that "it may be that the first occasion was 20 May 2011". In our view, that is the Respondent's real difficulty. Patient A wasn't sure and could not say with any certainty as to when it happened. Patient A even suggested that it might be possible that one of those incidents occurred after he returned from pilgrimage in 2012

156. We also concluded that it was not possible to reconcile Patient A's account with the medical records. We accepted the unchallenged analysis from Professor Wall. It was not simply when events took place but the logical sequence of events that cannot be reconciled. There has been no suggestion in this case of any audit data throwing doubt on the reliability or contemporaneous nature of the medical records. Furthermore, in relation to all the various symptoms recorded, Patient A accepted that these were correctly recorded in his previous evidence.

157. We also concluded that the records were, in any event, internally consistent. They refer to the investigations being carried out and the results received (for example the urethral swab on 16 May 2011 with lab results). Five months elapsed before Patient A returned to see the Appellant after raising the issue of premature ejaculation. The next appointment on 3 October 2011 was for eye problems and there was independent confirmation of this from the unchallenged referral letter.

158. We had no reason to doubt Professor Wall's evidence that, on the Appellant's version, he acted in accordance with acceptable and recognised practice and that his history taking was of an acceptable standard. Furthermore, Professor Wall, having reviewed the medical notes has accepted that, based on the Appellant's evidence, the examination/treatment/advice provided was also in accordance with recognised practice.

159. We concluded that the Appellant may have touched Patient A's testicles and the area between his testicles and his anus. However, where this occurred it was in line with the symptoms presented and in accordance with

acceptable and recognised practise. For example, the entry 12 December 2011 indicates that Patient A was complaining of intermittent aching in his testicles. And the entry on 29 December 2011 records that Patient A was complaining of discomfort in his scrotum. This involved an examination by the Appellant. We have no reason to doubt Professor Wall's evidence that on the symptoms presented, the Appellant acted in accordance with acceptable and recognised practice. We considered that the actions of Appellant in this respect were clinically appropriate.

160. We were not persuaded that the EMIS system could be said to accurately reflect the length of the consultations which took place. It was clear from the evidence of the Respondents own witness Dr Spiteri and that of the Appellant that the system depended largely on when each doctor filed the patient record. In practical terms, it did not follow that just because the system recorded that the entry was open for 30 minutes that this was how long a patient was with the relevant doctor. For example, the longest appointment on the 28 December 2012, according to the audit, was not an occasion for which there was any complaint.

161. We concluded therefore that, based on the evidence before us, we were not persuaded that, on the balance of probabilities, that that during consultations with Patient A in 2011, that the Appellant did tell Patient A that he needed to see him masturbate, tell Patient A to masturbate in front of him, allow Patient A to masturbate and masturbate Patient A. We concluded that the Appellant did touch Patient A's testicles and the area between his testicles and anus but only insofar as it related to the symptoms presented and in accordance with acceptable and recognised practice.

162. There was no dispute between the parties' that if the Appellant acted as alleged, his behaviour was highly inappropriate and there was no clinical basis for acting as he did. It was also agreed that, on the other hand, if he did not act as alleged, there was no other basis on which his removal is alleged to be necessary. The Respondent also made it clear that this is an unsuitability case and that it does not seek removal or conditions on any other ground. As we have concluded, on the balance of probabilities, and on the evidence before us that we were not satisfied that the Appellant acted as alleged in the agreed Scott Schedule and set out above, in line with what was agreed, there is no other basis on which removal is necessary.

163. We, therefore, allow the Appellants appeal

Order

164. The Appellant's appeal against the decision of the National Health Service (NHS) Performers List Decision Panel dated 26 May 2017 is allowed.

Judge H Khan
Lead Judge Primary Health Lists/Care Standards
First-tier Tribunal (Health Education and Social Care)

Date Issued: 11 April 2018