

ENGLAND AND WALES / JUDGMENT

Demanya v The General
Medical Council [2025] EWHC
247 (Admin) (07 February 2025)
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Case No:	AC-2024-LON-000113 IN THE HIGH COURT OF JUSTICE KING'S BENCH DIVISION ADMINISTRATIVE COURT Royal Courts of Justice Strand, London, WC2A 2LL Date: 07/02/2025 Before : Mr Justice Dexter Dias -----
Between :	Dr Allen Axornam Ametowotor Demanya Appellant - and - The General Medical Council Respondent ----- ----- Giles Powell (instructed by Direct Access) for the Appellant Alexis Hearnden (instructed by GMC Legal) for the Respondent Hearing dates: 23 January 2025 -----

JUDGMENT

(circulated in draft: 31 January 2025) Mr Justice Dexter Dias : This is the judgment of the court. To assist the parties and the public follow the court's line of reasoning, the text is divided into 13 sections, as set out in the table below, together with an annex setting out the case materials.

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Introduction

On 6 December 2023, the Medical Practitioners Tribunal decided that the name Dr Allen Axornam Ametwotor Demanya should be erased from the medical register due to impairment of his fitness to practise arising out of misconduct, principally dishonesty. This is Dr Demanya's appeal brought under section 40 of the Medical Act 1983 (" the Act ") against the Tribunal's decision (" the Decision " and " the Tribunal ") reached in the requisite staged way on 27 April 2023 (determination of misconduct), 2 May 2023 (impairment) and 6 December 2023 (sanction). Summarising greatly, the Tribunal found that Dr Demanya failed to diagnose sepsis, a severe and potentially life-threatening infection, then acted dishonestly in falsifying medical records to suggest he had prescribed antibiotics in a timely way when he had not, and had included antibiotics and catheterisation in his original treatment plan when he had not. He then attempted to "cover up" his falsifications by crossing out the prescription entries on the medical records. He persisted in his falsehood by making false representations on oath to the coroner at the inquest held to investigate the circumstances of his patient's death, falsely maintaining that antibiotics and catheterisation had been part of his original treatment plan. The patient (" Patient A ") was a 75-year-old woman who was brought by ambulance to the Royal Glamorgan Hospital ("RGH") in Wales on 26 February 2019 and admitted to the Emergency Department, where Dr Demanya was working as a locum. She died on the day after her admission. Dr Demanya (" the appellant ") is represented by Mr Powell of counsel. The respondent is the General Medical Council ("GMC" or " respondent ") and is represented by Ms Hearnden of counsel. The court is grateful to both counsel for their helpful written and oral submissions. Dr Demanya is a very experienced medical professional. He qualified as a doctor in Ghana in 1992 and after having worked in various hospitals there, moved to the United Kingdom in 2003. He worked here as a locum, until in 2021 he completed his examinations for Fellowship of the Royal College of Emergency Medicine and was offered a locum consultant position at Hillingdon Hospital, London. At the time of events in 2019, he was working as a locum middle grade doctor in the Emergency

Department at RGH. Dr Demanya's case on appeal is that the findings of fact and determinations of the Tribunal were wrong and should be quashed, as should the sanction. In any event, erasure was neither appropriate nor necessary in the public interest and even if the other determinations stand, suspension would be the proportionate sanction rather than career-ending erasure. II Chronology A condensed chronology was presented in the respondent's skeleton argument, for which the court is grateful. It has been adapted and edited. Date/Time Event 26.02 01:51 hours Patient A, female aged 75, brought to RGH by ambulance, presenting with diarrhoea, pyrexia, tachycardia and low blood pressure. 02:11 hours Patient A triaged. Triage nurse writes "possible sepsis" in triage notes. Orange category patient (to be seen by doctor within 10 minutes). 03:00 hours Dr Demanya examines Patient A. 04:00 hours At or before 04:00 hours, Patient A fell out of bed. Found by Nurse Usifoh. 05:00 hours Dr Demanya examines Patient A again. 07:00 hours Dr Atkinson arrives, alerted by bleeper and telephone call. He expresses concern about condition of Patient A. Dr Conway (consultant in acute medicine) attends to undertake her ward round. 27.02.19 Patient A dies in A&E. 25-26.02 Inquest into the death of Patient A. Dr Demanya gives evidence before the coroner. 27.02 Senior Coroner of South Wales refers Dr Demanya to GMC 13.07 GMC Case Examiner refers allegations to the Medical Practitioners Tribunal ("MPT"). 11.04-02.05 MPT stage 1 27.04 MPT findings of fact. 02.05 MPT determination on impairment. 05-06.12 Resumed MPT. 06.12 07.12 MPT determination on sanction. Dr Demanya's name erased from medical register. Notice of outcome letter gives date for appeal as 8 January 2024. III Allegations Given the nature of the challenge on appeal, it will help to set out the complex structure of allegations made by the GMC, clarifying Dr Demanya's responses about what was denied, what was admitted as a matter of fact only and what remained to be determined. In bold at the end of each allegation is the Tribunal's determination. While on first inspection this appears difficult to follow, the key points will soon become clear. "1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you: 1. failed to: a(i) make a specific diagnosis of severe infection; **FOUND PROVED** a(ii) consider a differential diagnosis of intra-abdominal infection or acute abdomen; **NOT PROVED** a(iii) prescribe antibiotics to Patient A either: i. at all; **NOT PROVED** ii. within an adequate time period; **FOUND PROVED** a(iv) include as part of your treatment plan for Patient A: i. referral to the surgical team; **NOT PROVED** (Admitted as a matter of fact only) ii. catheterisation and/or urinary output monitoring; **FOUND PROVED** a(v) escalate the seriousness of Patient A's condition to either the: i. medical registrar on call; Admitted and **FOUND PROVED** ii. emergency medicine consultant; **FOUND PROVED** (Admitted as a matter of fact only) b retrospectively added:

- i. antibiotics to Patient A's prescription chart; **FOUND PROVED** ii. 'catheterise...intake/output monitoring' to your treatment plan in Patient A's medical record; **FOUND PROVED** c crossed out the antibiotic prescriptions in Patient A's prescription chart without a valid reason for doing so; **FOUND PROVED** d failed to record:
- i. why you had crossed out the antibiotic prescriptions in Patient A's prescription chart; **FOUND PROVED** ii. that 'catheterise...intake/output monitoring' had been retrospectively added to your treatment plan in Patient A's medical record. **FOUND PROVED** 2. On 25 February 2020 you made a false representation to the Coroner in that you stated: a you

prescribed antibiotics to Patient A as part of your treatment plan, or words to that effect; FOUND PROVED (initially admitted as a matter of fact only) b that catheterisation and/or urinary output monitoring was part of your treatment plan, or words to that effect. FOUND PROVED

3. You: a added the entries mentioned in paragraph 1b to give the false impression that they had been part of your treatment plan; FOUND PROVED b knew, at the time of your actions set out in paragraph 1b and paragraph 2, that: i. antibiotics had not been part of your treatment plan; FOUND PROVED ii. catheterisation and urinary output monitoring had not been part of your treatment plan. FOUND PROVED
4. Your action described at paragraph: a 1bi was dishonest by reason of paragraph 3a and 3bi; FOUND PROVED b 1bii was dishonest by reason of paragraph 3a and 3bii; FOUND PROVED c 2a was dishonest by reason of paragraph 3bi; FOUND PROVED d 2b was dishonest by reason of paragraph 3bii. FOUND PROVED And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. FOUND PROVED " IV Directions of law The Tribunal's legally qualified chair set out legal advice for the determination of the allegations against Dr Demanya. The Tribunal accepted the advice. These directions of law were used by the Tribunal having been agreed between the parties without objection. Counsel for Dr Demanya (Mr Mellor) was offered full opportunity to comment on the directions or suggest alternative directions. He did not. The directions before the Tribunal were: 1. In reaching its decision on facts, the Tribunal bears in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred. 2. In assessing a witness's credibility, the Tribunal reminds itself that it should not assess witness credibility exclusively on the demeanour of the witness when giving their evidence, but their veracity should be tested by reference to objective

facts

proved independently in their evidence, in particular by reference to the documents in the case. The Tribunal should make a rounded assessment of a witness's reliability, rather than approaching their reliability in respect of each charge in isolation from the others: R (on the application of Dutta) v GMC [2020] EWHC (Admin). 3. It is open to the Tribunal not to rule out the whole of a witness's evidence based on credibility; credibility could be divisible: Khan v The General Medical Council [2021] EWHC (Admin). 4. The Tribunal note that, when considering the evidence of any witness in this case, it should also bear in mind the extent to which the passage of time may have affected the memory of a witness. The Tribunal would be aware from its own experience that memories can fade with the passage of time, and that recollections may change, or may become confused, as to what did or did not happen at a particular time. The Tribunal should make due allowance for the way in which the passage of time may have affected the recollections of any of the witnesses. 5. In relation to witnesses generally, the Tribunal bear in

mind that an honest witness could be mistaken, and a mistaken witness was not necessarily wrong about every fact. 6. As to individual pieces of evidence, the Tribunal is entitled to draw proper inferences - to come to common sense conclusions based upon the evidence which it accepted as reliable; but it must not speculate. Similarly, the Tribunal should not speculate about what other evidence there might have been. The Tribunal should only draw an inference if it could safely exclude other possibilities: *Soni v GMC* (2015) EWAC Admin. 7. The Tribunal has regard to the Supreme Court

judgment

in the case of *Ivey v Genting Casinos (UK) Limited* [2017] UKSC 67, in which Lord Hughes set out the correct test for dishonesty, which is as follows: 'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to

facts

is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.' 8. [Expert evidence direction omitted as not challenged.] 9. Doctor Demanya is of good character which must be taken into account by the Tribunal when assessing his credibility and the likelihood of him having done what has been alleged. His good character is not a defence to the Allegation, it is simply one factor to take into account when considering all of the evidence in the round. The weight to assign Dr Demanya's good character is a matter for the Tribunal to determine. V Grounds of appeal The grounds of appeal in summary are: 1. In reaching its determination on the facts, the MPT failed to consider/apply the relevant legal principles in terms of: a. Witness evidence; b. The standard of proof and cogency of evidence required; 2. The MPT was not properly advised/did not properly direct itself as to the law at stage 1; 3. The MPT's assessment of the witness evidence was wrong, and overly reliant on credibility; 4. The MPT was wrong in a number of specific regards relating to Nurse Usifoh's evidence/the Appellant's evidence; 5. The MPT's reasons were inadequate; 6. The sanction was disproportionate. VI

Legal framework

The statutory framework for the GMC and the Tribunal is to be found in the Act, and the General Medical Council (Fitness to Practise) Rules 2004, made under the Act ("the Rules"). Section 1(1A) of the Act provides that "the over-arching objective of the General Council in exercising their functions is the protection of the public". Section 35C(2) of the Act provides that: "a person's fitness to practise shall be regarded as impaired for the purposes of this Act by reason only of –

(a) misconduct..." The burden of proof is on the regulatory body making the allegation. There is no burden whatsoever on the registrant. Rule 34(12) of the Rules provides that the standard of proof "is that applicable to civil proceedings." Section of the Act makes provision for appeals from Tribunal decisions to, inter alia, the High Court. "

(1) The following decisions are appealable decisions for the purposes of this section, that is to say—

(a) a decision of a Medical Practitioners Tribunal under section 35D above giving a direction for erasure, for suspension or for conditional registration or varying the conditions imposed by a direction for conditional registration;

(4) A person in respect of whom an appealable decision falling within subsection (1) has been taken may, before the end of the period of days beginning with the date on which notification of the decision was served under section 35E(1) above, or section 41(10) 9 below, appeal against the decision to the relevant court.

(7) On an appeal under this section from a Medical Practitioners Tribunal, the court may— a. dismiss the appeal; b. allow the appeal and quash the direction or variation appealed against; c. substitute for the direction or variation appealed against any other direction or variation which could have been given or made by a Medical Practitioners Tribunal; or d. remit the case to the MPTS for them to arrange for 15 a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court, and may make such order as to costs ... as it thinks fit. " The appeal test is set out at Part 52 of the Civil Procedure Rules 1998 ("CPR"): Hearing of appeals 52.21

(1) Every appeal will be limited to a review of the decision of the lower court unless—

(a) a practice direction makes different provision for a particular category of appeal; or

(b) the court considers that in the circumstances of an individual appeal it would be in the interests of justice to hold a re-hearing.

(2) Unless it orders otherwise, the appeal court will not receive—

(a) oral evidence; or

(b) evidence which was not before the lower court.

(3) The appeal court will allow an appeal where the decision of the lower court was—

(a) wrong; or

(b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court. (Emphasis provided) In *Sastry v GMC*

[2021] EWCA Civ 623 ("*Sastry*"), Nicola Davies LJ in delivering the judgment of the Court of Appeal set out the approach of the appeal court (here the High Court sitting in an appellate capacity) in section 40 appeals: "102. Derived from *Ghosh* are the following points as to the

nature and extent of the section 40 appeal and the approach of the appellate court: i) an unqualified statutory right of appeal by medical practitioners pursuant to section 40 of the 1983 Act; ii) the jurisdiction of the court is appellate, not supervisory; iii) the appeal is by way of a rehearing in which the court is fully entitled to substitute its own decision for that of the Tribunal; iv) the appellate court will not defer to the judgment of the Tribunal more than is warranted by the circumstances; v) the appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate; vi) in the latter event, the appellate court should substitute some other penalty or remit the case to the Tribunal for reconsideration.

103. The courts have accepted that some degree of deference will be accorded to the

judgment

of the Tribunal but, as was observed by Lord Millett at [34] in Ghosh , "the Board will not defer to the Committee's

judgment

more than is warranted by the circumstances". In Preiss , at [27], Lord Cooke stated that the appropriate degree of deference will depend on the circumstances of the case. Laws LJ in Raschid and Fatnani , in accepting that the learning of the Privy Council constituted the essential approach to be applied by the High Court on a section appeal, stated that on such an appeal material errors of fact and law will be corrected and the court will exercise

judgment

but it is a secondary

judgment

as to the application of the principles to the facts of the case ([20]). In Cheatle Cranston J accepted that the degree of deference to be accorded to the Tribunal would depend on the circumstances, one factor being the composition of the Tribunal. He accepted the appellant's submission that he could not be "completely blind" to a composition which comprised three lay members and two medical members.

104. In Khan at [36] Lord Wilson, having accepted that an appellate court must approach a challenge to the sanction imposed by a professional disciplinary committee with diffidence, approved the approach and test identified by Lord Millett at

[34] of Ghosh .

105. It follows from the above that the Judicial Committee of the Privy Council in Ghosh , approved by the Supreme Court in Khan , had identified the test on section appeals as being whether the sanction was "wrong" and the approach at the hearing, which was appellate and not supervisory, as being whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate.
106. In Jagjivan the court considered the correct approach to appeals under section 40A. At [39] Sharp LJ accepted that the "well-settled principles" developed in relation to section appeals "as appropriately modified, can be applied to section 40A appeals." At [40], Sharp LJ acknowledged that the appellate court will approach Tribunals' determinations as to misconduct or impairment and what is necessary to maintain public confidence and proper standards in the profession and sanctions with diffidence. However, at [40(vi)], citing [36] of Khan and the observations of Lord Millett at [34] of Ghosh , she identified matters such as dishonesty or sexual misconduct as being matters where the court is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal.
107. The court in Bawa-Garba (a section 40A appeal) at [60] identified the task of the High Court on an appeal pursuant to section or section 40A as being whether the decision of the MPT is "wrong". At [67] the court identified the approach of the appellate court as being supervisory in nature, in particular in respect of an evaluative decision, whether it fell "outside the bounds of what the adjudicative body could properly and reasonably decide". It was this approach which was followed by the judge in the appeal of Dr Sastry and which led to the ground of appeal upon which Leggatt LJ granted permission. In so granting, Leggatt LJ stated that there was a real issue as to whether the judge deferred unduly to the Panel's view by approaching the appeal, in effect, as a challenge to the exercise of a discretion when arguably the judge was required to exercise her own

judgment

as to whether the sanction imposed was excessive and disproportionate. The words and reasoning of Leggatt LJ reflect the approach of the court to section appeals identified in Ghosh and approved in Khan .

108. We endorse the approach of the court in Bawa-Garba , as appropriate to the review jurisdiction applicable in section 40A appeals. We regard the approach of the court in section appeals, as identified in Ghosh and approved in Khan , as appropriate in section 40 appeals which are by way of a rehearing." On appeal, the question for the court is whether the Tribunal was wrong, or the decision unjust because of serious procedural or other irregularity (CPR Part 52.21(3)). Further, an appeal under section 40 is a full appeal by way of re-hearing (CPR 52.21(1)(a) and Practice Direction 52D, para 19). The appeal court will interfere with findings of primary fact in limited and defined circumstances, as helpfully summarised by Morris J in *Byrne v GMC*

- [2021] EWHC (Admin) 2237 ("Byrne") at para 15: "where "any advantage enjoyed by the trial judge by reason of having seen and heard the witnesses could not be sufficient to explain or justify the trial judge's conclusions": per Lord Thankerton in *Thomas v Thomas* approved in *Gupta* ;
- findings "sufficiently out of the tune with the evidence to indicate with reasonable certainty that the evidence had been misread" per Lord Hailsham in *Libman* ;
 - findings "plainly wrong or so out of tune with the evidence properly read as to be unreasonable": per in *Casey* at §6 and *Warby J* (as he then was) in *Dutta* at §21(7); where there is "no evidence to support a ... finding of fact or the trial judge's finding was one which no reasonable judge could have reached": per Lord Briggs in *Perry* after analysis of *McGraddie and Henderson* ." The approach to fact-finding was also summarised by *Cranston J* in *Yassin v the General Medical Council* [2015] EWHC (Admin) ("Yassin") at para 32: " iii) The Panel has the benefit of hearing and seeing the witnesses on both sides, which the Court of Appeal does not; iv) The questions of primary and secondary

facts

and the over-all value judgment made by the Panel, especially the last, are akin to jury questions to which there may reasonably be different answers: *Meadows v. General Medical Council* [197], per *Auld LJ*;

- v) The test for deciding whether a finding of fact is against the evidence is whether that finding exceeds the generous ambit within which reasonable disagreement about the conclusions to be drawn from the evidence is possible: *Assicurazioni Generali SpA v. Arab Insurance Group*

[2003] 1 WLR 577 , [197], per *Ward LJ*; vi) Findings of primary fact, particularly founded upon an assessment of the credibility of witnesses, will be virtually unassailable: *Southall*

v. General Medical Council

[2010] EWCA Civ 407 ["*Southall*"], [47] per *Leveson LJ* with whom *Waller* and *Dyson LJ* agreed." VII Ground 1 The ground was summarised by the appellant's counsel in this way: "The MPT failed to properly remind, advise or caution itself of the proper and full approach to the evidence, documentary and oral; to the evidence of the witnesses; and / or to the credibility of witnesses, in making its determination on the facts."

Submissions

Appellant . If the Tribunal is not directed in accordance with *Dutta et cetera*, the legal directions are insufficient and in breach of Article 6 of the European Convention on Human Rights (*R* (on the application of *Dutta*) v General Medical Council

[2020] EWHC 1974 (Admin) (" Dutta "). The principles of law were only "partially set out"; they were "brief and incomplete". Since there is so much argument about it, I set out the passage from Warby J's judgment in Dutta cited by the appellant: "39. There is now a considerable body of authority setting out the lessons of experience and of science in relation to the judicial

determination

of

facts.

Recent first instance authorities include Gestmin SGPS SA v Credit Suisse (UK) Ltd [2013] EWHC (Comm) (Leggatt J, as he then was) and two decisions of Mostyn J: Lachaux v Lachaux [2017] EWHC (Fam) [2017] WLR and Carmarthenshire County Council v Y [2017] EWFC

[2017] 4 WLR 136 . Key aspects of this learning were distilled by Stewart J in Kimathi v Foreign and Commonwealth Office [2018] EWHC (QB) [96]: "i) Gestmin : · We believe memories to be more faithful than they are. Two common errors are to suppose (1) that the stronger and more vivid the recollection, the more likely it is to be accurate; (2) the more confident another person is in their recollection, the more likely it is to be accurate. · Memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is even true of "flash bulb" memories (a misleading term), i.e. memories of experiencing or learning of a particularly shocking or traumatic event. · Events can come to be recalled as memories which did not happen at all or which happened to somebody else. · The process of civil litigation itself subjects the memories of witnesses to powerful biases. · Considerable interference with memory is introduced in civil litigation by the procedure of preparing for trial. Statements are often taken a long time after relevant events and drafted by a lawyer who is conscious of the significance for the

issues

in the case of what the witness does or does not say. · The best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable

facts.

"This does not mean that oral testimony serves no useful purpose... But its value lies largely... in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth". ii) Lachaux : · Mostyn J cited extensively from Gestmin and referred to two passages in earlier authorities. I extract from those citations, and from Mostyn J's judgment, the following: ·

"Witnesses, especially those who are emotional, who think they are morally in the right, tend very easily and unconsciously to conjure up a legal right that did not exist. It is a truism, often used in accident cases, that with every day that passes the memory becomes fainter and the imagination becomes more active. For that reason, a witness, however honest, rarely persuades a judge that his present recollection is preferable to that which was taken down in writing immediately after the incident occurred. Therefore, contemporary documents are always of the utmost importance..." "... I have found it essential in cases of fraud, when considering the credibility of witnesses, always to test their veracity by reference to the objective fact proved independently of their testimony, in particular by reference to the documents in the case, and also to pay particular regard to their motives and to the overall probabilities..." · Mostyn J said of the latter quotation, "these wise words are surely of general application and are not confined to fraud cases... it is certainly often difficult to tell whether a witness is telling the truth and I agree with the view of Bingham J that the demeanour of a witness is not a reliable pointer to his or her honesty." iii) Carmarthenshire County Council: · The general rule is that oral evidence given under cross-examination is the gold standard because it reflects the long-established common law consensus that the best way of assessing the reliability of evidence is by confronting the witness. · However, oral evidence under cross-examination is far from the be all and end all of forensic proof. Referring to paragraph of Gestmin, Mostyn J said: "... this approach applies equally to all fact-finding exercises, especially where the

facts

in issue are in the distant past. This approach does not dilute the importance that the law places on cross-examination as a vital component of due process, but it does place it in its correct context. The dissenting speech of Lord Pearce in *Onassis and Calogeropoulos v Vergottis* [1968] Lloyd's Rep 403, 431; Robert Goff LJ in *Armagas Ltd v Mundogas SA*

[1985] 1 Lloyd's Rep 1, 57." Respondent . Before the Tribunal were detailed written submissions on the law and facts. Dr Demanya was provided with an opportunity to comment on the legal directions and his counsel did not dissent from the proposed directions of law. Discussion First, the legal accuracy of directions of law seems to me to be a hard-edged question. I must most vitally consider whether the directions were in accordance with the law irrespective of whether there was objection below from the appellant's counsel. The directions are right or wrong. If his counsel erred below on the law, it would to my mind be unfair to hold that against Dr Demanya. Second, there is no Court of Appeal or superior authority for the proposition that the directions identified by the appellant are mandated self-directions. Therefore, the appellant relies on a series of first instance directions. That said, these are the observations of eminent and experienced jurists (Warby J in " Dutta "; Leggatt J (as he then was) in *Gestmin SGPS SA v Credit Suisse (UK) Ltd* [2013] EWHC (Comm); Mostyn J in *Lachaux v Lachaux* [2017] EWHC (Fam) and *Carmarthenshire County Council v Y*

[2017] EWFC 36 ; and Stewart J in *Kimathi v Foreign and Commonwealth Office*

- [2018] EWHC 2066 (QB) . While I am not convinced there is a mandatory requirement for the directions, I regard the guidance offered as persuasive. I must explain what that means: these are identified factors that may be relevant to have regard to depending on the specific facts of a case. Indeed, this is likely to be why the most senior courts have resisted mandating a prescribed set of directions or checklist of factors - which factors are relevant is highly fact-contingent. Third, the appellant invokes on the extrajudicial observations of Popplewell LJ in a Combar lecture dated 7 November 2023, which the appellant "relies upon in full in this appeal". However, while Popplewell LJ certainly refers to the research base on human memory, his informative and thought-provoking lecture tellingly ends: 97. "Third, some of the judicial pronouncements on this topic may require reconsideration, particularly in relation to the extent to which contemporaneous documents and inherent probabilities are treated as assuming almost exclusive primacy over recollections. 98. Leggatt J said in *Gestmin* that: "The best approach for a judge to adopt in the trial of a commercial case is, in my view, to place little if any reliance at all on witnesses' recollections of what was said in meetings and conversations, and to base factual findings on inferences drawn from the documentary evidence and known or probable facts." 99. That is a theme which has been repeated since by many judges. I would not myself wholly agree with it, based on the science." This culminates in a conclusion at para 100 that appears to run contrary to the core argument advanced by the appellant: "Conclusion 100. I would finish where I started, by emphasising that generally human memory is remarkably accurate and recollection is a very valuable tool in determining what happened and why it happened. A paper by Professor Brewin and another published in the *Criminal Law Review* argues convincingly that the pendulum may have swung too far in the direction of dismissing memory as a useful and reliable tool in court." Fourth, further support for the fact that no unequivocal consensus exists about these questions comes from *Morris J in Byrne* at para 18: "in assessing the reliability and credibility of witnesses, whilst there are different schools of thought, I consider that, if relevant, demeanour might in an appropriate case be a significant factor and the lower court is best placed to assess demeanour: Despite the doubts expressed in *Dutta* §42 and *Khan* §110, the balance of authority supports this view: *Gupta* §18 and *Southall* at §59." The notion that two schools of thought exist on the significance or probative force of demeanour is clear from the speech of Peter Jackson LJ in *Re B-M (Children: Findings of Fact)*
- [2021] EWCA Civ 1371 at para 25: "No judge would consider it proper to reach a conclusion about a witness's credibility based solely on the way that he or she gives evidence, at least in any normal circumstances. The ordinary process of reasoning will draw the judge to consider a number of other matters, such as the consistency of the account with known facts, with previous accounts given by the witness, with other evidence, and with the overall probabilities. However, in a case where the facts are not likely to be primarily found in contemporaneous documents the assessment of credibility can quite properly include the impression made upon the court by the witness, with due allowance being made for the pressures that may arise from the process of giving evidence." However, as *Morris J*

pointed out, other similar judicial observations exist. Conclusion: Ground 1 The key point is that there are different approaches to the significance of matters such as demeanour. The appellant places full reliance on the observations of Popplewell LJ, which conclude by cutting across the thrust of the appellant's argument. Without conclusive direction from the most senior courts that such self-directions are mandated for a "proper and full approach to the evidence" (as Ground 1 puts it), this ground fails. The argument that the Tribunal "must be directed on the Dutta factors" lacks support in authority. Indeed, in Dutta , Warby J said immediately following extracting elements from various judgments, "I have emphasised passages that have particular resonance in this case." This supports the analysis that the various precepts are not mandated in every case. What is crucial is to be alive the legal needs of case before the court and tailor the directions or self-directions accordingly. Therefore, the appellant's argument that the principles of law were only "partially set out" has no legal basis. There is no "fundamental failure" of legal direction here. I reject the submission that the findings are unsafe "and cannot stand" because of a lack of mandated legal directions. However, the question of whether important factors have not been considered by the Tribunal is a separate matter and analysed in the Ground 2 discussion. Ground 1 is misconceived in law. It is dismissed. VIII Ground 2 The essence of this ground is that the Tribunal did not "apply ... in full or properly" the principles in Dutta . The appellant puts it this way: "The MPT failed to apply the proper and full approach to the evidence, documentary and oral; to the evidence of the witnesses; and / or to the credibility of witnesses, in making its determination on the facts."

Submissions

Appellant . The Tribunal erred in failing to account for or reaching wrong conclusions because of the following matters:

- (1) The evidence was "significantly dated" (passage of time);
- (2) The "recollections of witnesses were "incomplete";
- (3) there were "outside influences" on testimony through the internal inquiry, coronial proceedings and the professional disciplinary proceedings themselves;
- (4) it was wrong that Dr Demanya did not diagnose sepsis;
- (5) the findings were made "largely if not wholly by reference to credibility" without considering "other material ... and potential explanations";
- (6) the focus on Nurse Usifoh's dishonesty ignored other reasons why her evidence was wrong;
- (7) no proper account was taken of the fact that the time of the writing of the antibiotics prescription could not be established;
- (8) a failure to weigh the inherent improbability of Dr Demanya crossing out the antibiotics entry;

- (9) the disregard of the discussions about sepsis between Nurse Usifoh, Nurse Roberts and Dr Demanya;
- (10) no credit being given for Dr Demanya correcting his evidence before the coroner;
- (11) making insufficient allowance for Dr Demanya not having to address events until his statement to the coroner a year later, delays and passage of time and their influences on the evidence. Respondent . The respondent addressed Grounds 1 and 2 together as there was "a degree of overlap" between them. Even applying Dutta , which it did not accept was mandated, none of the findings of the Tribunal was so "out of tune with the evidence" to be "unreasonable". Discussion First, the court examines and recognises the approach of the Tribunal (para 22 of the Decision), which was to consider each allegation "separately" and evaluate "all the evidence in relation to each element to make its findings of fact". I have set out the constituent parts of the appellant's submission on this ground in detail to give a flavour of the nature of the submissions the appellant made to this court. I begin my analysis by returning to the cardinal principles before examining the submissions on the evidence. Principles The limits to this court's function on an appeal must be strictly followed. It is no part of the appeal court's task to substitute its view for the primary decision-maker's because the High Court takes a different view of this or that piece of evidence or might make a different inference out of those reasonably available. The sole function is to apply Part 52 and ask itself whether any of the statutory appeal tests are met. Appeal lies as of right. There is no permission requirement, which reflects the important issues at stake for registrants. But this court cannot simply second-guess the Tribunal. That runs contrary to the statutory scheme. The right of appeal has been granted by statute and must be conducted accordingly. The Part 52.21(3) test applies and only that: whether the decision of the lower court was either wrong or unjust due to serious irregularity. Nothing else. Not that this court's decision would be a different one from a range of decisions on the evidence reasonably open to the Tribunal. Something must have gone wrong or there must be serious procedural or other injustice. This restatement of core principle is necessary because much of this appeal has been by way of a rearguing of the case as if this court were the Tribunal, with what might be termed "jury point" after jury point. This is not a criticism of Mr Powell who, if I may say, conducted the case on behalf of Dr Demanya with boundless energy and an impressive command of the facts. However, many of the arguments amounted to a submission that the Tribunal should have believed this person rather than that or made that inference rather than this instead of offering a convincing explanation why decisions on credibility or inference made by the primary fact-finder were not reasonably open to it. The appeal court must always return to the question of whether it was reasonably open on the evidence for the Tribunal to reach the conclusion or finding it did. The great difficulty with the appellant's arguments is that this court simply did not hear any evidence. In the Tribunal, the hearing extended to ten days of what Ms Hearnden, in an understated way, described as a "hard-fought case". None of this is to say that this court cannot reach a conclusion that a finding or conclusion of the Tribunal was wrong in a statutory sense being unreasonable to the requisite sense or out of tune with the evidence. But it is vital to restate the proper and

principled approach as the unvarying starting-point. Evidential submissions First, the Tribunal evaluated the credibility of witnesses. It was obliged to do so. Indeed, it would have been remiss not to have reached a view on the principal actors who gave markedly differing evidence on the key disputes. As explained in the discussion on Ground 1, it is insupportable to approach the finding of fact by ignoring the credibility of witnesses. Equally, demeanour can play a legitimate and sometimes important role in reaching conclusions of fact. However, in this case the Tribunal did not mention the demeanour of witnesses and did not rely on demeanour as a material factor in pointing to the truth. Second, it is an inaccurate characterisation of the Tribunal's approach to say that it focused on credibility at the expense of a rounded consideration of evidence. It is absolutely plain that in considering the question of the writing and crossing out of the antibiotics prescriptions, for example, the Tribunal considered all the evidence before it from the various witnesses, what they said at the hearing and, where relevant, what they had said previously at the inquest or in witness statements (for example, Nurse Usifoh's written account of seeing Dr Demanya crossing out the entries). Documentary evidence was particularly important to the Tribunal ("had particular regard to"). At para 23 of its Decision, the Tribunal states: "The Tribunal had particular regard to Patient A's medical records and the entries made by Dr Demanya when he assessed Patient A at 03:00 on 26 February 2019. The medical record in relation to Patient A, the 'Cas Card', exhibit MA4, was central to the evidence as to what diagnosis was made by Doctor Demanya, what treatment was ordered and administered and when this occurred." The Tribunal compared the treatment card prepared by Dr Demanya with that written by Dr Conway, "The Tribunal had regard to the treatment plan later devised by Dr Conway for Patient A. In this the antibiotics prescribed by her were clearly stated." Therefore, the suggestion of an over-reliance on credibility and/or demeanour of witnesses is an unjustified criticism of the Tribunal's approach. The Tribunal as primary fact-finder was holistic in approach in accordance with the best practice of judging items of evidence in the context of all the other evidence. Sepsis diagnosis To take a prime example of fact-finding, one can examine the Tribunal's approach to the first allegation for determination (1(a)(i)), that of the failure to diagnose sepsis ("a specific diagnosis of severe infection"). The Tribunal states at para 22: "In respect of the outstanding paragraphs of the Allegation, the Tribunal considered them separately and evaluated all the evidence in relation to each element to make its findings on the facts." Further, at para 23 of the Decision, the Tribunal stated that it specifically had regard to: "Patient A's medical records and the entries made by Dr Demanya when he assessed Patient A at 03:00 on 26 February

2019. The medical record in relation to Patient A, the 'Cas Card', exhibit MA4, was central to the evidence as to what diagnosis was made by Doctor Demanya, what treatment was ordered and administered and when this occurred." The Tribunal then considered not only Dr Demanya's testimony before it, but his witness statement dated 16 February 2023 (Decision para 24) comparing it to his testimony (next references all *ibid*; here para 25). It considered next the report of the independent expert Dr Ameh (para 26), citing it relevantly and fully (two extracts). The Tribunal then referred to the contemporaneous record of Dr Conway's

treatment plan and "very carefully" considered the evidence of Dr Atkinson (para 30). It considered Dr Demanya's account of the information he imparted to Dr Atkinson, but regarded it "particularly unlikely" (para 31), a conclusion reasonably open to it and indicating a consideration of probabilities. The Tribunal referred to the content of the evidence Dr Atkinson provided, and accepted Dr Atkinson's account, as it was open to do, the substance not being inherently improbable or contrary to proven evidence, as Dr Atkinson "was insistent in his evidence that he was never made aware of the gravity of Patient A's condition and would have had no cause to decline to assist if he was. He also stated that if he was aware, he would have alerted his seniors as per local protocol" (para 32). In terms of sufficiency of evidence before the Tribunal about the sepsis question, it should be remembered it had the evidence Dr Conway gave before the coroner (see immediately below). It was entitled to have regard to the evidence from Dr Conway when she related the reaction of Dr Demanya to their discussion. The Tribunal was entitled to prefer her evidence. There is no convincing reason provided by the appellant why the Tribunal could not reasonably rely on Dr Conway. The fact that there was discussion between Dr Demanya and nurses about sepsis, does not mean that Dr Demanya had diagnosed sepsis himself. The fact that sepsis was written on triage notes by the triaging nurse as an early possible descriptor of the patient's condition, does not mean that Dr Demanya did diagnose it. Indeed, if he had made a diagnosis of sepsis, it makes little sense that he reacted in the way he did with Dr Conway. This was the evidence of Dr Conway to the coroner: "Q What was the gist of that discussion with him? A So, I explained to him I've just seen this lady and I've got some concerns about the way she's being managed and he sort of said, "What do you mean?" and I said, "Well, this lady is really unwell and she's got sepsis", and he said, "Oh, really?" like that. Q Was that, in your impression, that he was surprised --- A Yes. Q --- that you'd made a diagnosis of sepsis? A Yes, absolutely. Q What did he volunteer after that? A He was quite hesitant. I could tell he was a little bit nervous." It can be seen how the Tribunal's analysis was multifaceted and thorough. The Tribunal was entitled to weigh the Conway evidence. It is not evidence about demeanour of a testifying witness but Dr Conway's strong impression of the appellant's reaction to her questions about the condition of the patient. It is a striking piece of evidence for a doctor who has previously diagnosed sepsis to respond to a consultant's comment that the patient has sepsis, "Oh, really?". It was inevitable that this evidence was weighed in the finding of fact and reasonable that it was taken into account. The Tribunal concluded at para 33: "On the basis of all the evidence before it, and in the absence of any clear or objective evidence that Dr Demanya had indeed diagnosed sepsis or severe infection, the Tribunal concluded that on 26 February 2019, Dr Demanya failed to make a specific diagnosis of severe infection. It therefore found paragraph 1a(i) of the Allegation proved." On the sepsis question, it has not been explained in any satisfactory way to this court how or why it was not open to the Tribunal to conclude that Dr Demanya had failed to diagnose sepsis. There was plainly a sufficiency of evidence to reach the civil standard. The closest the appellant comes is by submitting that "arguably" the Tribunal had reached an inconsistent conclusion when deciding that Dr Demanya had considered a differential diagnosis. This fails to recognise

that the Tribunal was clear: the appellant failed to diagnose sepsis. The suspected intra-abdominal infection was distinct. Further, the surprise and nervousness the appellant exhibited when Dr Conway spoke to him about sepsis clearly cuts across this blurring of the lines. The appellant complains that the Tribunal "disregarded or did not address" that sepsis had been written on the triage notes by the triaging nurse. The entry was mentioned in the evidence the Tribunal surveyed and in the text of the Decision. It has the capacity of demonstrating the lack of attention to detail by Dr Demanya. Further, the fact that sepsis was discussed between Nurse Usifoh, Nurse Roberts and Dr Demanya, rather than assisting him on another valid interpretation makes it more puzzling that he failed to reach a diagnosis of sepsis. But these are paradigmatic jury points as simply arguing them out unmistakably reveals. They do nothing to undermine the Tribunal's conclusion on sepsis. Indeed, the great weight of evidence points strongly to the correctness of its conclusion about the appellant's diagnostic failure. The sepsis analysis is but one example. This court's analysis can be repeated for the other criticisms of the Tribunal's fact-finding as the Tribunal adopted the same approach broadly for each allegation, surveying the relevant evidence holistically, side-by-side, drawing inferences, and making findings of fact. To argue as the appellant does that the Tribunal's determinations were made "if not wholly" on credibility does great injustice to the painstaking composite piecing together of the oral and documentary evidence that the Tribunal undertook. I have performed that exercise, examining each allegation, the Tribunal's method and have reviewed the sources of evidence it relied on. It is plain that a global approach to evidence was taken (on "all the evidence", as the Tribunal said), thinking through not just what was said but how it fitted with other evidence - or did not. It seems to me that this is an unimpeachable approach. Indeed, it is to be commended. I cannot accept that it is wrong in approach or outcome (determination). The findings of fact were a logical and reasonable (and reasonably available) outworking from the evidence. There is clearly a sufficiency of evidence to reach the civil standard and the conclusions are not out of tune with the evidence base. I have concluded that for each of the particularised complaints under this ground that the findings were reasonably open to the Tribunal and the complaint is fundamentally misplaced. For much of the hearing, submissions were made to the court on behalf of the appellant prefaced with the word "why". These were rhetorical assertions that may be persuasive to a jury in a criminal trial, but they failed to identify how the findings were not reasonably open to the Tribunal on the evidence or out of tune with it. It amounted to a rearguing of the first instance case rather than a consistently rigorous application of the statutory appeal test. Therefore, the appellant's approach on appeal on Grounds 1 and 2 was wrong in law and unpersuasive on the evidence. Rather than stop there despite the complaint being of the same nature on each of the sub-headings, I set out my analysis on some further important issues. Prescription of antibiotics In respect of the allegations about prescription of antibiotics (1(a)(iii)), the Tribunal considered Dr Demanya's evidence under oath to the coroner. It noted that the appellant told the coroner that he prescribed the antibiotics at 03:00 hours; it noted that he changed his account. In deciding whether Dr Demanya prescribed antibiotics at all, the Tribunal considered all his accounts, and the

accounts of Nurse Roberts and Nurse Usifoh (Decision, paras 40 and 45). Both the testimony of Nurse Roberts before the coroner and the Tribunal were considered. It then compared the emergent details with the contemporaneous records such as the charts (Cas Card). The Tribunal carefully considered the evidence of Dr Atkinson who refuted Dr Demanya's claims of having his memory "jogged" by the inquest and recollecting a conversation with Dr Atkinson about antibiotics. In considering who was providing truthful and accurate evidence about this, the Tribunal reasonably considered the implications of "blood results" and how if sepsis was suspected it was not "prudent" to await the results before prescribing antibiotics. The Tribunal concluded that the change in account by Dr Demanya following the inquest evidence from Nurse Roberts that there was no antibiotics prescription at 03:37 hours was "convenient" and an attempt to explain away the unsustainable position that he had written the prescription earlier (03:00 hours). In determining what actually happened, the Tribunal considered Dr Demanya's later statement at paras 38-39: "In any event, having reviewed the FBC results and printed them off at 03.42, I then subsequently returned to the cubicle and added prescriptions for two IV antibiotics (being 1g of Amoxicillin and 500mg of Metronidazole) to treat the sepsis, as fourth and fifth entries on the drug chart. " (emphasis added by Tribunal) It will be seen how the Tribunal drew out the significant passages of the statement by adding its own emphasis. This shows the attention to detail it devoted to the analysis. It did not simply reject Dr Demanya's revised account outright, but sought other evidence that cast light on its reliability. It turned to the witness statement of Nurse Usifoh dated 18 January 2022 at paras 15 and 19: "15. Between 3.30am and 4.00am , I went on my break. At approximately 4.00am on return from my break, I spoke to Nurse Roberts who told me she had connected the IV paracetamol to Patient A. (emphasis added by the Tribunal) 19. The IV paracetamol had finished before Patient A went for her x-ray. At approximately 5.50am I mentioned to Dr Demanya that Patient A's blood pressure was still very low. I said to Dr Demanya, the previous IV saline bag is finished I asked can you prescribe another bag of Iv saline I signed the prescription chart and Nurse Roberts co-signed. There was no IV antibiotics on the prescription chart at this stage. I then connected a new IV saline to Patient A." (emphasis added by the Tribunal) Once more, the Tribunal identified and emphasised significant detail. The evidence of Nurse Usifoh, therefore, contradicted Dr Demanya's change of narrative. The Tribunal continued to seek further evidence pointing to the truth of what happened. It considered Nurse Roberts's statement dated 27 October 2021 at para 27 (quoted at Decision para 46): "Dr Demanya was at the nursing station writing notes on the pages in the middle of the triage note. He stopped writing so I could sign the medication page to say I had given the patient paracetamol. The medication page is the back page of the triage note. On the medication page I saw 'paracetamol' and 'saline'. I definitely didn't see 'antibiotics' written on the form at this time as I would have offered to get them because Nurse Usifoh wouldn't have been able to get them out of the cupboards." (emphasis added by the Tribunal) The Tribunal then moved to the expert evidence. It examined what the expert Dr Ameh said in his report: "I would have expected Dr Demanya to have prescribed the antibiotics at the same time as the Paracetamol and saline at approx. 3:30am. It is

certainly desirable to prescribe the antibiotics within one hour of assessment which would be by 04:00am." The Tribunal next stood back to assess the implications of this body of evidence from disparate sources. It reasonably identified the contrast between the prompt administration of saline and paracetamol and the delay in the antibiotics entries. The Tribunal could "identify no reason" why if Dr Demanya had promptly prescribed antibiotics they would not be administered in a timely way as the saline and paracetamol had been. It reviewed Dr Demanya's oral testimony: "I am unable to explain why further i.v. fluids were administered at this point, but not antibiotics. I seem to recall that the i.v. fluids were stored separately to the antibiotics, and I therefore wonder if it was because access to the antibiotics was more restricted." Before reaching any conclusion, the Tribunal considered Dr Demanya's presented case on the topic that included the alternative explanation that the fault was Nurse Usifoh's. Therefore, it cannot be criticised for not engaging with possible alternative explanations. It did. The Tribunal then reminded itself of weaknesses in Nurse Usifoh's evidence, including "the concerns expressed by the Doctor's counsel regarding Nurse Usifoh's evidence, her record keeping and the accuracy of some statements she makes. The Tribunal noted this and shared some of the concerns." It emphasised that it "bore all this in mind when considering her evidence and sought corroboration where possible". It considered probabilities, including Nurse Usifoh's agency nurse status and access to drugs and that Nurse Roberts was nearby. It considered all the relevant evidence. The Tribunal made nuanced findings, distinguishing between concerns about Nurse Usifoh's reliability of account and her "material inaccuracies". In reaching the decision on Nurse Usifoh's dishonesty, the Tribunal was entitled to weigh the fact that she did not dispose of the notes entirely "covertly" but chose to inform Dr Conway about it. The conclusion about lack of dishonesty was an entirely logical inference from the facts and cannot be said not to be reasonably available. It was. Once more, the true criticism made by the appellant is that he disagreed with the conclusion that he was the person who was dishonest and not Nurse Usifoh. The criticism fails to engage with the undoubted fact that it was open on all the evidence before the Tribunal to conclude that Nurse Usifoh was not dishonest. He may disagree. That is not the same as the finding being "wrong" in a statutory sense or so unreasonable that it amounted to a legal error. The Tribunal concluded at para 53 of the Decision: "On consideration of all the evidence the Tribunal determined it was more likely that Dr Demanya had not prescribed the antibiotics by 05:50, almost three hours after his initial assessment of Patient A. It therefore found paragraph 1(a)(iii)(2) of the Allegation proved." The Tribunal did not consider the evidence of Dr Demanya and Nurse Usifoh in an artificial vacuum, but considered the evidence of Nurse Roberts, the contemporaneous records and reasonable inferences from the totality of evidence. It was entirely reasonable to draw inferences, for example, from the fact that both saline and paracetamol were administered "in a very timely manner" (Decision, para 48) and the absence of prescription for antibiotics on the "medication page" on the back of the triage notes was commented upon by both nurses in their separate witness statements written on materially different dates (Nurse Usifoh, 18 January 2022, paras 15 and 19; Nurse Roberts, 27 October 2021, para 27). Nurse Roberts provided vital additional detail that she would

have "offered to get [the antibiotics] out of the cupboard" as Nurse Usifoh as an agency nurse did not have that authority. The Tribunal was entitled to rely on Nurse Roberts's evidence that she "definitely" did not see the word antibiotics on the triage notes. In forming a view of the true facts, the Tribunal was entitled to rely on the fact that "Nurse Roberts was nearby and had herself administered the paracetamol". That makes sense and is consistent with Nurse Roberts's account. I have no doubt that this is a proper way to conduct an evidential analysis. It cannot be properly criticised. The real criticism that the appellant makes is that he does not agree with the Tribunal's conclusions. But that is not a statutory ground of appeal. Tellingly, the Tribunal found Allegation 1(a)(iii)1 - that Dr Demanya did not prescribe antibiotics at all - not proved. The nuance of the decision-making reveals a careful and measured approach, being fair towards the appellant, and finding in his favour where the evidence indicated it. It was entirely open to the Tribunal reasonably and in tune with the evidence to determine that Dr Demanya did not prescribe antibiotics in a timely way (Allegation 1(a)(iii)2). Further support for the balance and fairness of the decision-making comes from the Tribunal finding that Allegation 1(a)(iv)1 - failure to refer to the surgical team - was "not a failure of care" and not proved. When a fundamental evidential contest exists between two diametrically opposed witnesses such as Nurse Usifoh and Dr Demanya, it is a perfectly legitimate course for the Tribunal to state which evidence it preferred (see *English v Emery Reimbold & Strick*

[2002] 1 WLR 2409 ("*English v Emery*"), per Lord Phillips). But it is inaccurate to deem this as simply a credibility contest between the two witnesses in a vacuum. The Tribunal made it absolutely clear that it considered the whole of the evidential record, including the contemporaneous documents and the evidence of other witnesses to establish a likely timeline. That timeline materially supports Nurse Usifoh's evidence. Therefore, at para 53 of the Decision the Tribunal found: "53. On consideration of all the evidence the Tribunal determined it was more likely that Dr Demanya had not prescribed the antibiotics by 05:50, almost three hours after his initial assessment of Patient A. It therefore found paragraph 1(a)(iii)(2) of the Allegation proved." It is noteworthy that the Tribunal goes out of its way to state in terms that the determination was made "on all the evidence". It continued: "54. It was clear that at some point after 05:50, and before it was crossed out, Dr Demanya wrote a prescription for antibiotics. The Tribunal could find no evidence to determine when this happened or for how long the prescription stood. In the absence of such evidence, the Tribunal determined that the GMC had not discharged its burden of proof in relation to paragraph 1(a)(iii)(1). It therefore found paragraph 1(a)(iii)(1) of the Allegation not proved." This paragraph is significant: nuanced determinations; some allegations proved; others not. It considered the whole of the evidence and certainly did not find uniformly against Dr Demanya. This is a signpost to the fairness of the Tribunal's approach and its meticulousness. The composite way in which the Tribunal reached its findings can be seen from the depth of analysis of the sepsis diagnosis. The starting-point is the discussion between Dr Demanya and Dr Atkinson and considered in the Decision from para 39: "39. In his statement for the coroner and in evidence under oath at the

inquest Dr Demanya maintained explicitly that he prescribed antibiotics after his initial assessment of Patient A at 03:00. This was at the same time that he prescribed intravenous fluids and paracetamol.

40. At the inquest, and before this Tribunal, Nurse Roberts stated that when she administered the paracetamol there was no prescription for antibiotics written up and outstanding. She was clear that had there been, she would have administered it. She signed the prescription on the Cas Card to show she administered the paracetamol at 03:37, this is witnessed by a colleague.
41. In his statement prepared for these proceedings, and in his evidence to the Tribunal, Dr Demanya stated that following his evidence at the Inquest he remembered that it was in fact after Nurse Roberts administered the paracetamol that he first wrote up the prescription for antibiotics. This was done after he saw the blood results at around 03:40.
42. The Tribunal heard from Dr Demanya that it was on later reflection as he recalled his conversation with Dr Atkinson, and in particular the discussion he claims they had regarding antibiotics, that his memory was 'jogged'. In defending his prescription of antibiotics to Dr Atkinson he invoked the blood results and realises now they would not have been available at the time he first stated he prescribed, so it must have been later. He now remembers it was in fact when he saw those results that he did add the antibiotic prescription to the Cas Card.
43. The Tribunal noted: · Dr Atkinson does not accept that this discussion took place as stated, and claims that it is inherently illogical that he would challenge or question a prescription for antibiotics if given the information Dr Demanya claims; · The medical evidence is consistent that whilst the blood results supported or 'bolstered' a decision to prescribe antibiotics, it was not necessary or clinically prudent to await those results if sepsis was suspected; · It is convenient for Dr Demanya to be able to explain away the fact that Nurse Roberts stated at the inquest there was no prescription for antibiotics at 03:37; · It would be surprising in the extreme if Dr Demanya was so mistaken about something so central to a matter under serious investigation by the Trust and the Coroner. The Tribunal noted he stated that he had only limited access to the notes, however he travelled from London to Glamorgan specifically to write the statement, has provided no evidence he was not granted access to any documents which he requested or was under undue or unfair time pressures, and he was clearly aware of the importance of what he was stating." It is evident from the end of the extract that the Tribunal considered the circumstances in which the appellant provided his earlier account. It is clear how a holistic approach was adopted, assembling the evidence of Dr Atkinson and the objective scientific evidence from the "blood results". The Tribunal then put together evidence it received about the question of prescription with evidence about whether or not Dr Demanya diagnosed sepsis. It considered this question from para 73: 73. "The Tribunal has already found Dr Atkinson's evidence the more credible version. The Tribunal has determined that the evidence as a whole shows that Dr Demanya did not diagnose and was not treating sepsis, and this is consistent with Dr Atkinson's

account of what was told to him. The Tribunal was aware that it must avoid 'recycling' evidence, in that having used Dr Atkinson's account to help determine sepsis was not diagnosed, it should not then simply use that

determination

to establish the credibility of Dr Atkinson's statement. It is, however, a logical consistency that having determined Dr Demanya did not appreciate the seriousness of Patient A's condition, he did not adequately escalate it. It does not add to the gravity of the failings established. 74. The Tribunal notes paragraph 1(a)(v)(i) is admitted and found proved and it found paragraph 1(a)(v)(ii) proved." It is clear how the Tribunal was careful to direct itself to be cautious about the reach of the evidence and not to make assumptions on the basis of earlier findings, but to continue to examine subsequent issues with care. It considered the evidence "as a whole". Having earlier analysed carefully the evidence of Dr Atkinson in comparison with Dr Demanya's and the balance of the evidence, the Tribunal was entitled to prefer Dr Atkinson's account to the appellant's. The appellant has not provided this court with any plausible basis for why that conclusion was not reasonably open to the Tribunal. This is again a disagreement with the conclusion. Retrospective entries A similarly careful and cautious approach was taken to the important issue of retrospective entries about antibiotics and catheterisation. The decision proceeded from para 75, building on the 1(a)(v)(i) admission and the 1(a)(v)(ii) finding. "Paragraph 1(b)(i) On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you: a. retrospectively added: i. antibiotics to Patient A's prescription chart; 75. The Tribunal has already found in respect of paragraph 1(a)(iii)(2) that Dr Demanya failed to prescribe antibiotics to Patient A within an adequate time period, and certainly not before 05:50, as set out in detail above. Dr Demanya has accepted that the handwriting is his, that he wrote the prescription for antibiotics. The only account he has offered to the Tribunal is that the antibiotics were written up at or around 03:40, which the Tribunal did not accept. It therefore follows that the Tribunal is satisfied that the prescription was written 'retrospectively'. 76. The Tribunal therefore found paragraph 1(b)(i) of the Allegation proved." It can be seen how the Tribunal considered the appellant's evidence and placed it in the context of other findings it had made. It was open to the Tribunal to reject Dr Demanya's account about the time he wrote the prescription, bearing in mind in particular as it had earlier done that the totality of the other evidence for logical and rational reasons pointed to the entries being "not before 05:50". The key point is that evidence is placed in context of other evidence and the inconsistent accounts about timing of the entries that the appellant gave weighed appropriately. Catheterisation The Tribunal then moved on to consider the allegation about the catheterisation entry. This must be viewed in the context of whether the catheterisation was in the appellant's original formulation of the treatment plan. The Tribunal repeated its comprehensively detailed analytical approach from para 60 of the Decision: 60. In his statement, dated 16 February 2023, Dr Demanya stated at paragraph 88: '88. I included catheterisation and urinary output monitoring in my treatment plan. This was recorded at my 03:00 assessment of Patient A; and I chased the nurses several times when I realised Patient A had not been catheterised.' 61. During his oral evidence to the Tribunal, Dr Demanya maintained

this account. He told the Tribunal that he wrote the treatment plan for Patient A at around 03:15 after he assessed her at 03:00, and that he included in it that she should be catheterised. Dr Demanya added that he asked the nursing staff on several occasions throughout the shift to catheterise Patient A. 62. The Tribunal had regard to Dr Atkinson's statement, dated 17 December 2021, in relation to his second conversation with Dr Demanya at 06:30. At paragraphs 17 and 18 he stated that he asked whether the patient was passing urine and 'Dr Demanya was unsure'. He said that he then suggested a catheter and that Dr Demanya replied 'OK, we can arrange that'. 63. Dr Atkinson was cross examined as regards this conversation, and in particular any assumption he may have formed as a result. He accepted that Dr Demanya may have said 'it will be done', but maintained under challenge that he formed a clear impression from the exchange that it was a new plan. The Tribunal then had regard to the witness statement of Nurse Usifoh in which she said at para 23: "Around this time perhaps at 7.00am, while Dr Michael Atkinson (whom I recall from the Inquest) came and reviewed the patient and asked me had the patient passed urine or had a bladder scan. I said no she had not passed urine, but had watery stool twice to my knowledge. Dr Atkinson then told me she needs to be catheterised. I asked one of the night staff to please get me a catheterisation kit while I was still trying to cannulate. The nurse said I shouldn't worry, the morning team are here. The only person that asked me to catheterise Patient A was Dr Atkinson." Next the Tribunal turned to Dr Demanya's testimony to it. It sought to assess how his account tallied with other evidence and probabilities. At para 65 of the Decision: "In his evidence to the Tribunal, Dr Demanya said that he performed a 'top to toe' examination of Patient A at 05:00, following her fall. However, either he did not notice that a catheter had not been fitted as he had requested or took no effective action as a result. This would have been nearly two hours after he had first requested it be done. The Tribunal considered it would have been obvious to Dr Demanya that a catheter had not been fitted. It appeared to the Tribunal highly unlikely that if catheterisation was an integral part of Dr Demanya's initial treatment plan he would have taken no decisive action at this time. There is also no evidence that, having ordered monitoring as he claims, he ever inquired as to Patient A's intake/output monitoring data. It is clear that a catheter was only fitted after 06:30 after Dr Atkinson had inquired whether Patient A had passed urine." Therefore, having considered evidence from a variety of different sources and kinds and having regard to the canons of probability, the Tribunal concluded at para 66: "In the circumstances, the Tribunal determined, on the balance of probabilities, that Dr Demanya did not include catheterisation as part of his treatment plan for Patient A and therefore found paragraph 1(a)(iv)(2) of the Allegation proved." It is difficult to conceive how such conclusion can be properly assailed as out of tune with the evidence or insensitive to probabilities and improbabilities. It was significant evidence that Dr Atkinson related how the appellant was "unsure" if Patient A had passed urine. It was relevant that it was Dr Atkinson's evidence that he, not Dr Demanya, suggested a catheter. The Tribunal was entitled to accept Dr Atkinson's evidence that it appeared to be "a new plan". This was materially supported by Nurse Usifoh's evidence about which she was "adamant" that Dr Demanya never asked her to catheterise the patient. Indeed, her evidence was that it was Dr Atkinson who asked her to catheterise the patient and he was "the only person" to do so. All this was relevant to the Tribunal's conclusion which was not wrong in statutory terms. It had a sufficient evidential underpinning and was

reasonably open to the Tribunal. It reminded itself of the applicable standard of proof (para 66). The Tribunal also considered the further aspect of catheterisation, the allegation of retrospective entry. "Paragraph 1(b)(ii) 1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you: b. retrospectively added: ii. 'catheterise...intake/output monitoring' to your treatment plan in Patient A's medical record; 77. The Tribunal has already found in respect of paragraph 1(a)(iv)(2) that Dr Demanya failed to include catheterisation as part of his treatment plan for Patient A. Dr Demanya has accepted that the handwriting is his, that he wrote the instruction to catheterise. The only account he has offered to the Tribunal is that this was written immediately after the examination at 03:00 was concluded, which the Tribunal did not accept. It therefore follows that the Tribunal is satisfied that this instruction was written retrospectively. 78. Therefore, for the reasons set out in relation to paragraph 1(a)(iv)(2), the Tribunal determined that Dr Demanya had not included catheterisation in his initial treatment plan for Patient A and that he added this retrospectively. 79. The Tribunal therefore found paragraph 1(b)(ii) of the Allegation proved." It can be seen that the Tribunal considered the appellant's explanation and placed its rejection of it in the context of its previous rejection ("already found") of his account of including catheterisation in the treatment plan. It was a logical consequence that if the Tribunal concluded that Dr Demanya did not include catheterisation originally, the entry was written retrospectively. It should be noted that the analysis of retrospectivity is more compressed, but that is justifiable given the depth of the earlier analysis on the foundational question of the treatment plan. The Tribunal appropriately tailored its approach according to the complexity of issue. It proceeded proportionately, while reviewing the additional relevant evidence. Outside influences It is submitted that the witnesses "had been subjected to outside influences". If this means there were previous proceedings, this is a common feature of such disciplinary cases which often follow earlier investigations or proceedings which occur before a disciplinary tribunal is held several years after the events. The critical question is not addressed by the appellant: the demonstrable effect of other proceedings or processes. Here, there is no evidence about any such effect. The suggestion that there was any material influence is purely speculative on the appellant's part. What is essential is that the primary fact-finder views all the evidence in the round. There is no evidence identified by the appellant that demonstrates that witnesses have modified accounts due to the influence of other proceedings or in light of other accounts. One clear exception to this exists: how Dr Demanya himself, as indicated, changed his account of when he claims to have written the prescription for antibiotics. The Tribunal specifically dealt with this material alteration. It concluded that the appellant changed his evidence to "explain away the fact that Nurse Roberts stated at the inquest that there was no prescription for antibiotics at 03:37." This was a conclusion the Tribunal was entitled to reach. It was entitled to further conclude that the change of account raised concerns about Dr Demanya's evidence. The appellant's criticism is a disagreement about what the Tribunal decided. It does not begin to support a challenge on the basis that the Tribunal was "wrong" in statutory terms. Crossing out The Tribunal considered the question of the crossing out of the antibiotics prescription entries later in the Decision from para 80. The Tribunal said: "Paragraph 1(c) 1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you: c. crossed out the antibiotic prescriptions in Patient A's prescription chart

without a valid reason for doing so; 80. In his statement, dated 16 February 2023, at paragraphs 101 and 102 stated: '101. I did not cross out my antibiotic prescriptions and I particularly reiterate the matters set out at paragraphs to above. As explained above, if I was going to cancel a prescription, I would put a line through it, initial or sign this, date and time it, and then explain my reason for doing so in the records.

102. In the event, I had no reason for cancelling the antibiotics I had prescribed given my diagnosis of sepsis and my view that immediate antibiotic treatment was required.' 81. During his evidence to the Tribunal Dr Demanya maintained that he had included antibiotics as part of his treatment plan for Patient A. He said that he had repeatedly chased up with the nursing staff as to why the antibiotics had not been administered. 82. The Tribunal reminded itself that Dr Demanya originally stated he had written the prescription directly after the 03:00 examination. His evidence in his statement and before the Tribunal was that it was written at 03:40. He accepts that at the time when Dr Atkinson arrived antibiotics had not been administered." One sees here immediately the variety of evidential sources that the Tribunal weighed: statements, testimony, documents. This cannot be said to be determinations based solely on a crude credibility contest. Indeed, at para 83, the Tribunal referenced Nurse Usifoh's statement to the coroner: "83. In paragraph 24 of her statement, Nurse Usifoh stated: '24. Dr Demanya came into Patient A's room with prescription chart while I was attempting to cannulate, he showed me the prescription chart between 07:15am and 07:20am with IV antibiotic written on the chart. On the prescription chart the antibiotics amoxicillin and metronidazole had been added to the chart. I didn't see Dr Demanya writing those antibiotics down. Dr Demanya then said 'the morning team are here, and they are arranging to take Patient A to resuscitation unit. They can cannulate', I then saw him cross out the antibiotics on the prescription chart. When he was crossing it out I said 'No, don't. I am trying to cannulate her and I can give the antibiotics when I insert the cannula' but he crossed out the medications. Please find that prescription chart attached as Exhibit LU4.'" The Tribunal then actively considered the case on the crossing out put before it. It continued: 83 The inference put before the Tribunal is that Nurse Usifoh was not telling the truth, and that she crossed out the prescription to cover for her failure to administer the prescription. The Tribunal has already noted its concern as to the reliability of some details of Nurse Usifoh's account, and the manner of her record keeping. However, it found no evidence to question her integrity and honesty. On the contrary the Tribunal bore in mind the significant changes in Dr Demanya's account of the writing of the prescription. It had found that he did not include catheterisation as part of his initial treatment plan as he has claimed. The Tribunal noted that at the time Nurse Usifoh states she saw Dr Demanya cross out the prescription for antibiotics, he would have been aware that his care and treatment of Patient A was likely to be questioned. 84 On the other hand, the Tribunal gives proper regard to Dr Demanya's good character and recognises the force in the argument put forward by his counsel that it would make little sense for him to cross out the prescription if he had just written it. The Tribunal has avoided speculating as to the actors' intent and motive, but was aware that at this point Dr Demanya had recently had a

conversation with Dr Atkinson at 06:30 and that Dr Atkinson had raised concerns about the care and treatment of Patient A. It was the Tribunal's view that as Nurse Usifoh stated she witnessed Dr Demanya cross out the prescription there was a binary choice: she gave a false account to cover her own actions, or he did. Taking into account all the circumstances of the morning as the evidence had established them to have happened, the Tribunal was of the view that on the balance of probabilities it was more likely that Nurse Usifoh was telling the truth and that Dr Demanya did cross out the prescriptions for the antibiotics. The Tribunal found paragraph 1(c) of the Allegation proved." Working through these passages, it is clear that the criticisms of the Tribunal's determinations are misplaced. The determinations were not based "largely if not wholly" on credibility without reference to contemporaneous documentation ("other material"). The Tribunal specifically made a finding that it could not establish the time that the antibiotics prescription was written. Note: I deal with the issue of inherent improbability of the crossing out below in more detail at Grounds 3 and 4, it having been specifically pleaded there. One of the difficulties in examining the grounds of appeal here is their substantial overlap and repetition. It will not assist for the court to repeat the analysis laboriously. Equally, the itemised complaints within Grounds 2 and 4 make very similar arguments about the alleged failures of evidential analysis. I have identified for the vital issues above that such challenges are misplaced and unjustified. It is not proportionate to go through the same exercise for each complaint as that would inevitably result in an unnecessarily and unjustifiably long judgment where the court is compelled to painstakingly perform precisely the same exercise for each complaint and demonstrate why it is misconceived in the same way. In fairness to Dr Demanya, I have already set out in perhaps fuller detail than many would my analysis of the more central issues in the case, the sepsis question, the antibiotics and catheterisation entries, the crossing out. I have touched on Nurse Usifoh, but return to the challenges to her evidence in further detail in Ground 4.

Delay As to delay, the Tribunal directed itself about delay in the agreed legal directions. The court is entitled to conclude that the Tribunal had such matters firmly in mind. But a measure of realism must be introduced. To suggest, as the appellant does, that these events lie in the "distant past" defies common sense. There is nothing unique about the delays or timelines in this case. Our courts have great experience of receiving evidence with far greater intervals between event and hearing. There is nothing unusual in this. The appellant makes the general submission that all the evidence should be "viewed through the prism of delay, what witnesses could remember and outside influence". However, the appellant fails to recognise sufficiently how the Tribunal compared the oral evidence with the contemporaneous records and scientific evidence. While some witnesses said in terms that they could not recollect this or that detail, this is precisely what one would expect of honest witnesses trying to assist the court when testifying about historical events. It would be of more concern if a witness purported to have a photographically perfect recollection of every minute detail after several years. As noted, there is no trace of the altering of accounts because of other proceedings save for Dr Demanya himself changing his evidence. The Tribunal was entitled to have concerns about this as opportunistically tailoring his evidence. As to the various criticisms about "insufficient allowance" (weight) placed on various factors,

or affording "no proper consideration or weight" (weight there stated explicitly) these are, as Ms Hearnden correctly submits, "paradigm examples" of precisely "the exercise that a fact-finding tribunal must undertake." This court did not hear the evidence. It agrees with Ms Hearnden's submission that some deference should be accorded to the determinations of the primary fact-finders. That said, there are limits. Findings of fact in the Tribunal are not unassailable. In appropriate cases they can be upset. But I find that in the instant case, they are not "wrong" in a statutory sense. They are amply evidentially supported, reasonably open to the Tribunal and indeed obviously reasonable. Conclusion: Ground 2 This ground is about application of legal principles to the evidence. However, it is based on a fundamentally false premise: there is no need "fully" to apply all the factors mentioned in Dutta . It is interesting to note the reasons that the decision of the Tribunal was overturned by Warby J in Dutta : "38. In any event, I regret to say, in my

judgment

the Tribunal's reasoning process is vitiated by at least three fundamental errors of approach. First, the Tribunal approached the resolution of the central factual dispute by starting with an assessment of the credibility of a witness's uncorroborated evidence about events ten years earlier, only then going on to consider the significance of unchallenged contemporary documents. Secondly, the Tribunal's assessment of the witness's credibility was based largely if not exclusively on her demeanour when giving evidence. Thirdly, the way the Tribunal tested the witness evidence against the documents involved a mistaken approach to the burden of proof and the standard of proof." These are entirely conventional grounds of legal concern and error. First, a fragmented approach to evidential analysis without considering the totality of evidence holistically. This is the opposite of the Tribunal's approach in Dr Demanya's case where a globally holistic analysis was undertaken. Second, the focus on demeanour. In this case, the Tribunal did not mention demeanour. Third, the criticism of the burden of proof, which is not in issue here. Warby J plainly took the burden and standard of proof together as a compounded error of approach in the appeal he was considering: "43. ... When deciding what to make of the apparent mismatch between its impressionistic assessment of Patient A and the contemporaneous documents, the Tribunal's approach was to ask itself whether the documentation was "determinative", and such as to "preclude" the novel case theory which the Tribunal came to adopt. This was, in effect, to require Dr Dutta to establish to the criminal standard a defence to the Charge (and to an amended version of the Charge, which had not been put to him). The Tribunal's task was, however, to assess the evidence in the round and decide whether the GMC had discharged the burden of showing that it was more likely than not that pressure was applied by means of a discount offer, for financial motives, as alleged in Charges 1(a) and ." Therefore, the Tribunal in Dutta obviously adopted an impermissible approach. This is a world away from the instant case. It does not appear that the Tribunal's failures in Dutta chiefly arose from the failure to apply the precepts helpfully identified by Warby J. Moving on to the evidential evaluation in the instant case, it is vital to recognise that this court does not arrogate the finding of primary fact to itself. It exercises at all times an appellate function (on which, see Dutta at para 62: "I

remind myself that the assessment of the evidence is primarily for the Tribunal, and the appellate role is subject to the constraints I have mentioned.") In this court's appellate capacity, I judge that Dr Demanya's criticisms of the Decision do not come close to establishing that the Tribunal's findings are "so out of tune" with the evidence to be "unreasonable". The Tribunal was entitled to reach its conclusions on the respective credibility of the witnesses. Indeed, it was duty-bound to. It performed this important task not based on impressionistic superficialities such as demeanour, or a crude credibility contest, but through a painstaking analysis of the oral evidence of all relevant witnesses on the topic in combination with the contemporaneous records holistically, drawing inferences and having regard to probabilities. This is precisely how such findings should be made. The bulk of the submissions made under the heading to the court were jury points and in effect argued for a different weight to be placed on certain evidence and for the appellant's account to be believed rather than doubted and disbelieved. It cannot be said that the conclusions challenged were wrong. Ground 2 is dismissed. IX Ground 3 The appellant frames Ground 3 in this way: "Standard of Proof The MPT failed to properly remind, advise or caution itself of the proper approach to the Standard of Proof and the flexible requirements for cogent evidence and / or it did not apply the proper approach to the Standard of Proof, in making its

determination

on the

facts

."

Submissions

Appellant . At no point did the Tribunal direct itself about the "flexible" standard of proof, nor mention the need for "cogent" evidence. Respondent . The respondent submits that "further gloss" to the orthodox direction about the civil standard is "not required". There is no evidence that the Tribunal misapplied the burden of proof or otherwise erred (which I take to mean misapplied the standard of proof). Discussion No challenge is made to the approach to the burden of proof. The Tribunal correctly placed the burden of proof at all times on the respondent. However, the appellant challenged the approach to the standard of proof. The misapplication of the "relevant principles" is submitted to amount to "an error of law and a serious procedural or other irregularity in the proceedings, such that the findings of fact are not safe and cannot stand or be upheld." Three sources were cited in support. First, extracts from Phipson on Evidence (20 th Ed, 2021). Second, the judgment of Lord Nicholls in In re H (Minors) (Sexual Abuse: Standard of Proof)

[1996] AC 563 (" re H "). Third, the judgment of Richards LJ in R(N) v Mental Health Review Tribunal (Northern Region)

[2006] QB 468 (" R(N) "), as approved by Lord Carswell in In re D

[2008] UKHL 33 at para 27. Phipson paints the wide backdrop from paras 57-59: "57. Where a serious allegation is made in a civil case, such as an allegation of criminal conduct, the standard of proof remains the civil standard. ... however, the civil standard is flexible in its application. Thus if a serious allegation is made then more cogent evidence- may be required to overcome the unlikelihood of what is alleged, in order to prove the allegation. It has also been held that the more serious the consequences for an individual if allegations are proved, the stronger the evidence must be before a court will find the allegation proved. Courts have for some time sought to grapple with the logical difficulty of requiring more cogent evidence, but still holding that the allegation must be proved on a balance of probabilities ". " 58 ... " as H made clear, more cogent evidence is generally required to satisfy a civil tribunal that a person has been fraudulent or behaved in some reprehensible manner on the basis that such allegations are in most cases inherently improbable. In such cases, "careful and critical consideration must be given to the evidence relied on ". "59. Where the civil standard applies, a tribunal may nevertheless need to look critically or anxiously at evidence of serious allegations, in light of H (as subsequently interpreted). The applicable standard must now be viewed in light of B, considered above" . In re H , Lord Nicholls said at 586 F-G: "... Built into the preponderance of probability standard is a generous degree of flexibility in respect of the seriousness of the allegation. Although the result is much the same, this does not mean that where a serious allegation is in issue, the standard of proof required is higher. It means only that the inherent probability or improbability of an event is itself a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred. The more improbable the event, the stronger must be the evidence that it did occur before, on the balance of probability, its occurrence will be established." In R(N) , Richards LJ said at paras 62-63: "62. Although there is a single civil standard of proof on the balance of probabilities, it is flexible in its application. In particular, the more serious the allegation or the more serious the consequences if the allegation is proved, the stronger must be the evidence before a court will find the allegation proved on the balance of probabilities. Thus the flexibility of the standard lies not in any adjustment to the degree of probability required for an allegation to be proved (such that a more serious allegation has to be proved to a higher degree of probability), but in the strength or quality of the evidence that will in practice be required for an allegation to be proved on the balance of probabilities. 63. The flexibility that exists in the application of the standard is clear from In re H (Minors) (Sexual Abuse: Standard of Proof) [1996] AC itself, where Lord Nicholls, whilst affirming the existence of a single civil standard, stressed, at p f , that it had "a generous degree of flexibility" in respect of the seriousness of the allegation (see also his reference, at p e , to "the in-built flexibility already mentioned")." First, there remains at all times one and only one standard of proof in proceedings such as these: the civil standard of a balance of probabilities. It is unalterable. Second, the "flexibility" is not in the standard of proof but in its application in certain circumstances. Thus, the flexibility touched on in authority is in truth flexibility in a distinct sense, not in the level of proof that must be achieved - that would alter the

unalterable. Instead, it is a different understanding of flexible approach that is circumstance-specific. Third, those circumstances that may - I emphasise may - require a flexible application of the standard of proof could arise where serious allegations are made. But it is not the mere fact of the seriousness that may call for a flexible approach. The flexibility arises from the inherent improbability of the event or fact. In many professional disciplinary cases, the two go hand-in-hand. A doctor with a previously unblemished professional track record is accused of very serious misconduct. That appears on its face to be inherently improbable. Therefore, it is that fact-specific improbability, not the mere fact of a serious allegation, that calls for a flexible approach. Fourth, the key is the genesis of that mentioned flexibility. It arises in cases of inherent improbability or unlikelihood. Take two very different factual situations. The first situation: if the factual issue for a tribunal's determination is what a person did when coming out of a building, whether turning left or right, which may be on balance equally likely on the facts, the usual approach should suffice. However, what if the suggestion were that on coming out of the building the person began scaling the outside walls without ropes (what is sometimes known as urban climbing or edificeering)? That seems a relatively improbable event. It is the improbability that would call for strong or cogent evidence. The improbability of the activity or event moves the scale of probability from something that may or may not commonly occur (turning left or right) to something inherently improbable but not impossible. The clues to the strength, quality or cogency of evidence required to prove an inherently improbable event are evident in a close reading of the sources. As Lord Nicholls says: "The more improbable the event, the stronger must be the evidence that it did occur before, on the balance of probability, its occurrence will be established." Another way to view this is Phipson's comment that "if a serious allegation is made then more cogent evidence may be required to overcome the unlikelihood of what is alleged." The key words are "overcome" and "unlikelihood" - a shifting of probability. The second situation: take a professional misconduct situation. Serious allegations often allege matters so out of the norm for a professional that they are improbable. But if a registrant had a history of previous misconduct and has been permitted to continue practising under supervision, the repeat of the misconduct may not in itself be inherently improbable in that case. This illustrates that the question is not seriousness of allegation per se, but inherent improbability. The improbability shifts the position to which evidence must be applied in the process of proof, from a neutral or even starting-point, down the sliding scale of likelihood to a position of inherent improbability. This may well require cogent or strong evidence to "overcome" that fact-specific improbability. In this, I respectfully adopt what Morris J said in *O v Secretary of State Education*

[2014] EWHC 22 (Admin) at para 66 at proposition (4) (repeated by Morris J in *Byrne* at para 22) that: "... it does not follow, as a rule of law, that the more serious the allegation, the less likely it is to have occurred. So whilst the court may take account of inherent probabilities, there is no logical or necessary connection between seriousness and probability. Thus, it

is not the case that "the more serious the allegation the more cogent the evidence need to prove it". I strongly agree. This issue is best understood in its legal historical context. For a period, there was confusion about what standard of proof applied in disciplinary proceedings and certain non-criminal proceedings where very serious allegations are made. The courts were not speaking with one voice on the question. In Part IV Children Act 1989 care order cases where allegations tantamount to criminal or grievous conduct were made, arguments were advanced that the distinction between civil and criminal standards were "largely illusory". This approach was resolutely ended by *Re B (Children)*

[2008] UKHL 35 (" *Re B* "). Lord Hoffmann said at 13: "I think that the time has come to say, once and for all, that there is only one civil standard of proof and that is proof that the fact in issue more probably occurred than not." In *Re B* , the court also considered the question of inherent probability. In a much-cited passage, Lord Hoffmann at para 14 comments upon what Lord Nicholls said in *re H* : "Finally, I should say something about the notion of inherent probabilities. Lord Nicholls said, in the passage I have already quoted, that: "... the court will have in mind as a factor, to whatever extent is appropriate in the particular case , that the more serious the allegation the less likely it is that the event occurred and, hence, the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability." I wish to lay some stress upon the words I have italicised. Lord Nicholls was not laying down any rule of law. There is only one rule of law, namely that the occurrence of the fact in issue must be proved to have been more probable than not. Common sense, not law, requires that in deciding this question, regard should be had, to whatever extent appropriate, to inherent probabilities." The critical words are "to whatever extent appropriate". My approach to improbability outlined above aligns with Lord Hoffmann's observation. The question of inherent probability is not a rule of law. It is fact- and context-specific. I can find no authority for the proposition that a tribunal must direct itself on the flexible nature of the standard of proof when allegations of serious misconduct are made. Nor does authority exist that without such a self-direction a tribunal's approach is defective or unlawful. It seems to me that such arguments are a misreading of the judicial pronouncements on this question. I reject the submission that the Tribunal's self-direction on the standard of proof was defective or insufficient. There was nothing in the direction that was wrong. There was nothing further that the Tribunal was mandated to direct itself about; no error of law; no serious procedural or other irregularity; no breach of the appellant's Convention rights. To assess the adequacy of the Tribunal's legal directions, one must examine the directions as a whole and fairly. Micro-textual analysis will not do. It is insufficient to say that the Tribunal failed to mention the word "cogent" or "flexible". The court assesses substance not form. Questions about the improbability of a fact do not arise as a question of law, but may (or may not) be a context-specific feature of the evidence. To the extent that the basis of Ground 3 is a failure to be directed about a flexible standard, it is rejected. There is no such mandated approach which must then be applied and no "error of law" as submitted. The crucial question is how the Tribunal analysed the evidence before it and whether

there was a sufficiency of evidence to reach the balance of probabilities on the facts it found. That assessment may indeed include questions of inherency. It is to the evidential evaluation that I turn, the essence of Ground 4. In particular, the argued "inherent" improbability, irrationality and illogicality of Dr Demanya's acts are analysed in Ground 4 in respect of the principal allegations of dishonesty and the "cover up" through the crossing out of the antibiotics prescription. Conclusion: Ground 3 Ground 3 is misconceived as a matter of law and is dismissed. X Ground 4 The appellant styles Ground 4 in this way: "The MPT failed to properly address or take account of specific aspects of the evidence and / or did not properly address the submissions made to it in respect of these matters." The Ground lists eight failures. They are: (1) The conflicts between Nurse Usifoh and other witnesses; (2) The unreliability and lack of credibility of Nurse Usifoh's evidence; (3) Nurse Usifoh's destruction of original notes; (4) The inherent improbability (et cetera) of Dr Demanya crossing out the antibiotics entry; (5) The evidence that supported Dr Demanya's case that he had made a diagnosis of sepsis; (6) The effect of the passage of time; (7) The memories or "lack of memories" of witnesses; (8) Dr Demanya's concessions of being mistaken in his evidence to the coroner.

Submissions

Appellant . Either individually or cumulatively the failures amount to errors of law or serious procedural or other irregularity that mean that the Tribunal's findings are not safe. It is submitted that "all the flaws have to be analysed" by the Tribunal. Respondent . Each alleged failure is a paradigm example of the exercise which a fact-finding tribunal must undertake, and deference should apply to that

conclusion

in circumstances where it cannot be said that the determination was out of tune with the evidence. Discussion First, I accept that the main features of the evidence must be engaged with by the Tribunal, analysed and decided. However, I cannot accept that every contest between the parties on the evidence - and in this case there were numerous - must be specifically addressed in the Tribunal's decision. That would not be proportionate and would lead to interminably long decisions. The important matters must be addressed and reasons given, but I am not convinced that every secondary or tertiary point must be dealt with. The differences between Nurse Usifoh and other witnesses (Dr Demanya aside), such as they exist, are routine matters of evidence and the complaint simply is a dispute about weight attached to evidence. It amounts to nothing of substance. The Tribunal took fully into account its concerns about Nurse Usifoh's unreliability and "inaccuracies". Second, I agree with Ms Hearnden that there is a significant overlap between the complaint in Ground 2 and Ground 4 about directions on the effect of time and the nature of human memory. These are not mandated directions and when a tribunal assesses the evidence in the round and holistically with each piece of evidence in the context of all the other evidence, I cannot think it is necessary to explicitly make findings about the effect or otherwise of the passage of time or the peculiarities of human memory as relevant to the witnesses in this case.

What is essential is for the Tribunal to examine the evidence of all the witnesses and compare it to the documentary and other evidence and decide whether it is or is sufficiently truthful, accurate and reliable. Third, the submissions on this ground largely amount to a rearguing of the case before the Tribunal. This court heard no oral evidence whatsoever. In this, the Tribunal retains a great advantage over the High Court. On matters of credibility, there must be a recognised and meaningful measure of deference accorded to the assessments of the Tribunal. Put another way: this court must be cautious before it can safely say that the Tribunal's assessment of the credibility of a witness it saw testifying and being cross-examined is wrong or that inconsistencies between, say, Nurse Usifoh and other witnesses were of such weight to render a finding indefensible, that is, not reasonably available to the Tribunal. Fourth, when the Ground states that the Tribunal failed to address properly the issues listed in it, what is in fact being submitted is that the Tribunal should have reached different conclusions about the issue or given different weight to the evidence of the relevant witnesses or documents rather than these findings were not reasonably open to the primary fact-finder. These are all paradigmatically matters of factual determination and this court must be cautious about trespassing unless the conclusion is evidently insupportable (unreasonable) or wrong. To exemplify this point, I take the first area of complaint, Nurse Usifoh (first three listed items in Ground 4). Nurse Usifoh The difficulty for making good these complaints is that the Tribunal carefully analysed this nurse's evidence. The conclusions it reached about her were expressed clearly with meticulous justification for the measured conclusions. At para 51 of the Decision: " the Tribunal bore in mind the concerns expressed by the Doctor's counsel regarding Nurse Usifoh's evidence, her record keeping and the accuracy of some statements she makes. The Tribunal noted this and shared some of the concerns. However, it was of the view that whilst her system of recording was far from ideal, it should be noted she was not aware she was compiling them for legal proceedings. Her actions in creating a new note from the old and disposing of the first, ill-advised as they may have been, were not covert in that she told Dr Conway what she was doing. The material inaccuracies were seen by the Tribunal as markers as to the level of reliance that could be placed on her regarding detail, but not of themselves indicators of dishonesty. The Tribunal therefore bore all this in mind when considering her evidence and sought corroboration where possible. " This was a balanced and nuanced determination. It considered the actions of the Nurse Usifoh and found them to be unsatisfactory ("ill-advised"). The Decision continues at para 84: "84. The inference put before the Tribunal is that Nurse Usifoh was not telling the truth, and that she crossed out the prescription to cover for her failure to administer the prescription. The Tribunal has already noted its concern as to the reliability of some details of Nurse Usifoh's account, and the manner of her record keeping. However, it found no evidence to question her integrity and honesty." Therefore, the Tribunal engaged with the case advanced by Dr Demanya and repeated its concerns about the reliability of Nurse Usifoh. It is difficult to see how the Ground 4 complaint about the failure to address "the inherent unreliability" of the nurse's account can be maintained. The Tribunal reached the clear conclusion that it has "concern as to the reliability of some details" in her account. It was open to the Tribunal to do so. It was also justified in being concerned about her "record keeping". The question then moves on to her honesty and integrity. The starting-point on this issue is that the two rival cases put before the Tribunal were starkly and

irreconcilably opposed. It was maintained by the appellant that Nurse Usifoh was lying and dishonest. Indeed, quite properly this was put to her in cross-examination. She refuted it. The Tribunal, as was open to it, rejected the submission that she was dishonest. It resolved the contest between the two cases in this way, continuing at para 84 onwards: "84. ... On the contrary the Tribunal bore in mind the significant changes in Dr Demanya's account of the writing of the prescription. It had found that he did not include catheterisation as part of his initial treatment plan as he has claimed. The Tribunal noted that at the time Nurse Usifoh states she saw Dr Demanya cross out the prescription for antibiotics, he would have been aware that his care and treatment of Patient A was likely to be questioned. 85. On the other hand, the Tribunal gives proper regard to Dr Demanya's good character and recognises the force in the argument put forward by his counsel that it would make little sense for him to cross out the prescription if he had just written it. The Tribunal has avoided speculating as to the actors' intent and motive, but was aware that at this point Dr Demanya had recently had a conversation with Dr Atkinson at 06:30 and that Dr Atkinson had raised concerns about the care and treatment of Patient A. It was the Tribunal's view that as Nurse Usifoh stated she witnessed Dr Demanya cross out the prescription there was a binary choice: she gave a false account to cover her own actions, or he did. Taking into account all the circumstances of the morning as the evidence had established them to have happened, the Tribunal was of the view that on the balance of probabilities it was more likely that Nurse Usifoh was telling the truth and that Dr Demanya did cross out the prescriptions for the antibiotics." The Tribunal pointed out that Nurse Usifoh's rewriting of notes was not "covert" but in front of Dr Conway. It was a justifiable and reasonable inference made by the Tribunal that this ran contrary to dishonest conduct by Nurse Usifoh as alleged. These were findings of fact open to the Tribunal to make. It heard the evidence; this court has not. The complaint is really that the appellant does not like or agree with the conclusions. That is his right. It is not a proper basis to overturn them on appeal strictly applying the statutory test. There is no proper basis for this court to conclude or even begin to approach to conclude that the Tribunal's findings about Nurse Usifoh were wrong. They are simply findings the appellant still disputes. It was submitted on behalf of the appellant in reply that it was the absence of Nurse Usifoh's contemporaneous notes that substantially undermines the Tribunal's findings because these notes could have contained contemporaneous evidence that Dr Demanya in fact mentioned sepsis. That is purely speculative. There is no evidence whatsoever to suggest that was the case. Putting Dr Demanya's account about sepsis aside, there is no evidence from any witness or documentary source to support such speculation. Not infrequently in cases there is missing evidence. A finder of fact has to do the best it can and make allowances for it. Depending on the case, that absence of itself may preclude a safe finding of fact. That is certainly not the case here where there is a wealth of evidence from different and interlocking sources that point to and mutually combine to support the Tribunal's conclusion. The crossing out Next, one then turns from Nurse Usifoh to Dr Demanya. One must read the entirety of the Tribunal's determination and its reasons for it to understand what was concluded. The starting-point is that the Tribunal found that Dr Demanya did not diagnose sepsis. It was because of that initial failure that he took his subsequent dishonest actions. He dishonestly later added the antibiotics entries when he had not prescribed antibiotics. He dishonestly added the entry about catheterising. He later sought to

"cover up" his dishonesty by crossing out the false antibiotics entry. This was late in the shift and approaching the hand over to the day shift. He knew he had not prescribed antibiotics in a timely way and they had not been administered. Therefore, he crossed out the entries. He was seen by Nurse Usifoh doing this. The Tribunal concluded it was Dr Demanya who crossed out his own false entries rather than Nurse Usifoh or anyone else. The Tribunal found that this is what happened to the civil standard. These were all findings open to it. It applied the correct burden and standard of proof. There was a sufficiency of evidence to make those findings. Once more, the appellant's true complaint is that he disagrees with the findings. That is not a proper basis for this court to intervene where findings were open on the evidence to a fact-finding tribunal. The issue was squarely before the Tribunal for its adjudication from the very outset. The GMC case was opened before the Tribunal in this way: "The GMC's case is that not only were [the antibiotics] not prescribed at the time, or any effective way later, but that they were seen by a witness being crossed out by Dr Demanya at the time when the patient was being handed over to the incoming dayshift and when Dr Demanya was going to relinquish control of her care. He, knowing that she had not had the antibiotics, say the GMC, crossed out the mention of them on the "Drugs Administered in Department" chart. That must have been done, in my submission, after the second lot of saline was prescribed, because of the order in the list when they were written, which means that was afterwards, and they must have been crossed out after they were written. The Tribunal will be better able than I to puzzle out exactly what those antibiotics are, but it doesn't make any difference. Nobody's suggesting that if they had been prescribed, they wouldn't have been the right thing, what is suggested is that they were never prescribed, and this is all part of a cover-up, because by the time those entries were written, and by the time they were crossed out, Dr Demanya had become conscious of the fact that his care of Patient A had been, to say the least, suboptimal. In fact, the GMC's case is that Dr Demanya did really nothing effective to treat Patient A in her condition." The Tribunal's conclusion was clearly based on a holistic analysis of the evidence, including the documents, the witness statements, the evidence before the coroner and at the disciplinary hearing. In fact, a profusion of evidence was before the Tribunal to reach the conclusions it did. I have earlier detailed Dr Conway's evidence about her discussion with the appellant. As Ms Hearnden accurately submits, that evidence was "echoed" in evidence given to the Tribunal. Then there was the evidence of Nurse Roberts before the coroner: "Q If Dr Demanya had said to you at that time, when you were administering the paracetamol, when he asked you to do so, "I think it is possible sepsis" or he mentioned sepsis, what would you have done? A I would have made sure that the antibiotics and things were written up. I would have started the bundle 6 or I would have had Lilian to start the bundle 6 for that. Q The fact that that didn't start, does that suggest to you that Dr Demanya didn't raise with you a suspicion of sepsis? A Yes, he didn't." This runs contrary to Dr Demanya's evidence and supports the Tribunal's conclusion about the genesis of Dr Demanya's later act of "cover up" by crossing out. The Tribunal had the chart with the disputed crossed out entries. The entries did not sit in isolation and the Tribunal had before it the documented sequence of the entries on the chart which assisted in broadly fixing the time for the antibiotics entries as towards the end of the shift. This was combined with the evidence of the witnesses about what they saw and did not see. The Tribunal considered all this, as they were entitled to do and right to. This is how the Tribunal concluded

that the entries were made after 5:50 hours and before the morning shift came on. This was not a simple reliance on demeanour or credibility. Indeed, as noted, the Tribunal does not refer to demeanour in its analysis, but reaches this conclusion based on inferences from documentary and witness testimony. As to the allegation that it was Dr Demanya who crossed out chart entries, the Tribunal had the evidence of Nurse Usifoh. She provided a statement to the coroner in these terms: "24. Dr Demanya came into Patient A's room with prescription chart while I was attempting to cannulate, he showed me the prescription chart between 07:15am and 07:20am with IV antibiotic written on the chart. On the prescription chart the antibiotics amoxicillin and metronidazole had been added to the chart. I didn't see Dr Demanya writing those antibiotics down. Dr Demanya then said 'the morning team are here, and they are arranging to take Patient A to resuscitation unit. They can cannulate', I then saw him cross out the antibiotics on the prescription chart. When he was crossing it out I said 'No, don't. I am trying to cannulate her and I can give the antibiotics when I insert the cannula' but he crossed out the medications. Please find that prescription chart attached as Exhibit LU4." She testified to the coroner and was challenged about her account on behalf of the appellant: "THE WITNESS: Correct. I don't know who signed; I can't remember who signed the other one; that signature, I am not sure what it looks like. THE CORONER: Mr Morse, any more questions. MR MORSE: Sir, you are aware of where the conflict in the evidence is and without putting it bluntly between the two, it is a matter for you sir. THE CORONER: I think you need to put that to the witness. MR MORSE: Yes. Nurse, what I suggest is that the entries that we see at page 11 in terms of the prescriptions were there at three o'clock in the morning. A The IV paracetamol - sorry, the IV antibiotics? Q Yes. A No, it wasn't there. I didn't see it and if it was there when Claire, as the nurse-in-charge, knowing the state of the patient and she has seen that IV paracetamol is being prescribed, that should be the question; because I know when a patient comes in with sepsis, even before they transfer a patient to the unit they start IV fluid, IV antibiotics. All hands would be on deck before the patient is being moved. She was aware that the patient came in with sepsis and seeing that - let us assume if IV paracetamol was there, when she brought out the IV paracetamol she would have given that IV antibiotics, but she didn't give it because it was not there." It is puzzling indeed that counsel at the inquest did not seek to challenge Nurse Usifoh and only did so at the prompting of the coroner. The evidence from Nurse Usifoh in response is a vital fleshing out of her account and the Tribunal was entitled to take it into account. It was a matter for the Tribunal's evaluation whether it accepted this nurse's evidence and how much of it and with what weight. Plainly, as indicated, the Tribunal had concerns about aspects of Nurse Usifoh's evidence due to the discarding of her original notes. The Tribunal made it clear that it took those reservations into account. The appellant submitted on appeal that the "burden is on the GMC" and there is no explanation for why Nurse Usifoh "destroyed her notes". It is not necessary for the regulatory body to prove every facet of events and provide psychological explanations for the actions of participants. Equally, it is not necessary for the tribunal as primary fact-finder to do so. What is important is to make such findings as necessary to support a proved allegation if they exist. If that is not possible, the allegation is not proved. The Tribunal found certain allegations against Dr Demanya not proved for precisely this reason. In any event, Nurse Usifoh provided an explanation for discarding her original notes, saying that they were "messy". The Tribunal found

her actions "ill-advised" but not dishonest. The appellant has not clearly explained on appeal why that was not a finding open to the Tribunal, nor why it is out of tune with the evidence.

Submissions that the first account of the crossing out from Nurse Usifoh was "a year later" are obvious from the fact that the Tribunal specifically quotes her coronial statement and it is something the Tribunal obviously had well in mind when citing the coronial evidence. It knew precisely when the coronial proceedings took place. The appellant asked rhetorically on appeal "why prefer one witness (Nurse Usifoh) over another (Dr Demanya)?" The complaint is that the Tribunal approached this as a direct credibility contest based on the quality of their two accounts. It should be noted on this topic that in *English v Emery*, Lord Phillips stated that: "it may be enough to say that one witness was preferred to another, because the one manifestly had a clearer recollection of the material

facts

or the other give answers which demonstrated that his recollection could not be relied upon". As pointed out by Morris J in *Southall v GMC*

[2010] EWHC 407 at para 55 and *Gupta v GMC*

[2001] UKPC 61 at paras 13 and even such limited reasons are not necessarily required in every case. However, a narrow credibility contest is not how the Tribunal decided the issue. The lower court said: "Taking into account all the circumstances of the morning as the evidence had established them to have happened, the Tribunal was of the view that on the balance of probabilities it was more likely that Nurse Usifoh was telling the truth and that Dr Demanya did cross out the prescriptions for the antibiotics." This is clearly a holistic analysis ("all the circumstances"). It is a consideration of the totality of circumstances as established by the evidence that persuaded the Tribunal that to the civil standard it was Nurse Usifoh who was telling the truth about the crossing out, not the appellant. It remains unclear why this is not a finding open to the Tribunal. The answer to the appellant's rhetorical question is that the Tribunal heard all the evidence, considered it, decided what it established about all the relevant circumstances that morning, weighed the evidence of both Nurse Usifoh and Dr Demanya against all the other evidence and decided to the civil standard that Nurse Usifoh was telling the truth about the crossing out by Dr Demanya. This finding is not wrong in statutory test terms. A central submission on this topic made by the appellant is that for Dr Demanya to have crossed out the antibiotics entries would be improbable, irrational and illogical. It must be pointed out that the Tribunal "avoided speculating as to the actors' intent and motive". It was cautious about psychologising. It was right to take this prudent course. But that is not the same as concluding that its decision that Dr Demanya was the person responsible for the crossing out was wrong. The act of crossing out cannot be viewed alone. On the Tribunal's analysis, and indeed the case opened and presented by the GMC before it, the crossing out came at the end of a chain of actions by Dr Demanya that made cumulative sense. It is significant that the GMC did not allege that the crossing out was an act of dishonesty. However, the

case was that it was to cover up an act of dishonesty: the false entries about the antibiotics. Once the finding is legitimately made, as here, that Dr Demanya was dishonest in making the entries about antibiotics to falsely suggest that he had diagnosed sepsis when he had not, then the crossing out gains a rational and logical basis. The situation that confronted Dr Demanya, who had already committed an act of serious dishonesty by tampering with the contemporaneous record, was that he knew (1) he had not diagnosed sepsis; (2) he had not prescribed antibiotics; (3) the morning shift was about to take over. If the antibiotics entries remained and none had been administered, questions were bound to be asked. It is entirely explicable in such circumstances why Dr Demanya crossed out the entries. It would be speculation whether the animating forces driving him to the act of concealment were panic or because he thought that was his best way of defending his lack of action should it come up or some other motivation. It is of course important to remind oneself about an entirely different context that almost always when an allegation of serious criminal misconduct is made, the prosecution does not have to prove motive. It is the act and the intention when the act was done (whether deliberate or reckless) that must usually be proved (putting strict liability aside), depending on the elements of the offence. These are avowedly disciplinary not criminal proceedings. But the allegation of crossing out is an act of professional misconduct. It is necessary for the alleging party to prove to the requisite civil standard whether the impugned person did the act. It may never be possible to get to the bottom of the psychological motivation - the why it was done. Sometimes the person responsible, as is occasionally said in mitigation, does not know herself or himself why they suddenly acted so out of character. But thinking about the sequence of events, there is a clear logic to what the Tribunal found Dr Demanya to have done. It is not robbed of rationality because it may have been a deeply unwise course for the appellant to have taken. As to improbability, it must be remembered that the Tribunal has found that Dr Demanya committed two acts of serious dishonesty in falsifying the records about the antibiotics and the catheter, acts that are inherently improbable for a doctor of previously good character. The Tribunal had been directed accurately on the law about the significance of good character on both credibility and propensity limbs. The Tribunal reminded itself of the appellant's good character and took it into account. Nevertheless, it found that he tampered with the records (falsified them) and tried to cover his tracks. It then concluded that he maintained a false account and sought to mislead the coroner, a distinct but connected act of dishonesty. These were all findings open to the Tribunal to make. The key point is one cannot view the allegations of the allegation of crossing out to conceal the previous dishonesty in isolation. It is artificial to ask the isolated question whether it is improbable that Dr Demanya would dishonestly add false treatment plan entries and then would attempt to cover up his dishonesty. The crossing out must be seen in the context of record falsification and that in turn must be viewed in context of initial clinical error - a vivid example of the importance of contextual evidence analysis. The Tribunal found that the appellant did fail to diagnose sepsis. Once there is that factual backdrop of professional error, the act of dishonesty becomes less improbable as does the crossing out to conceal it. One is not operating then from a standing start or

completely neutral position. The registrant has made a serious clinical error. His actions in response must view in light of that serious medical oversight. Therefore, it is simply artificial to say it is inherently improbable that he would act dishonestly following such error and improbable that he would try to cover it up. The Tribunal took into consideration his good character. It reminded itself of the legal effect of both limbs of good character, including the probabilistic implications of it, a person of good character being less likely to act in a wrong or dishonest way. Once there is finding of such a significant medical error as Dr Demanya's failure to diagnose sepsis, the situation changes. More precisely: the probabilities shift. I can see that it would be a different scenario probabilistically if the allegation were simply of dishonesty in isolation. But it is not. The respondent's case at the disciplinary hearing, and on appeal, is markedly different: it is that the dishonesty and subsequent concealment come in the context of - and crucially following - an important clinical error about a very serious illness. Therefore, it is unnecessary for the Tribunal to specifically direct itself that it is inherently improbable that Dr Demanya would act dishonestly by falsifying the medical records and cover it up. Instead, the Tribunal had to consider whether, if it is proved (as it found it was in the sepsis finding) that the appellant made a significant clinical error, that the totality of evidence viewed holistically proved that he acted dishonestly by making false entries about his treatment plan (including antibiotics and catheterisation). It is clear that this was precisely the approach the Tribunal took. It is unarguably the correct approach. Passage of time and memory This complaint substantially repeats that in Ground 2. The analysis is the same. In reply on this submission, Mr Powell further submitted that the Tribunal had to "account for the other Dutta factors". I cannot agree. I do not read Dutta, a first instance decision, as laying down a rule of law that a tribunal must specifically have regard to and make findings about each of the factors identified in the judgment. It is an extremely helpful decision by an eminent jurist. But it does not mandate a checklist of factors that a tribunal of fact must have regard to, failing which its conclusions are fundamentally flawed or unlawful. Dr Demanya's change of account Dr Demanya changed his account when he gave evidence to the coroner. He explained that he had altered his position about timings having heard the evidence of Nurse Roberts. The Tribunal found that this inconsistency of narrative caused it to have concerns about the reliability of his account. The appellant's complaint is based on Dr Demanya's explanation that he did not have access to the original documents when he gave his initial account. This evidence and explanation were put before the Tribunal. It was open to the Tribunal to find nevertheless that the change of account caused concern. There is nothing of substance in this submission. This was an obviously reasonable finding. Conclusion: Ground 4 A fundamental failure in the appellant's argument on this ground is a failure to distinguish between a submission about different weight being attached to certain evidence and the identification of why the conclusion of the Tribunal was not reasonably open to it. It has not been helpful to have streams of what are jury points listed in the Grounds and oral argument without proper justification of how the statutory appeal test is met. For example, the claim that it was "far more likely" that Nurse Usifoh crossed out the

antibiotics entries than Dr Demanya is a straightforward claim about the evidence. It is not explained why it was not open to the Tribunal to reach a different conclusion - especially given the meticulous evidential analysis it performed. Where there are irreconcilably competing accounts from witnesses, it is essential that the primary fact-finder assesses and compares the credibility of the narrators (*English v Emery*). It was open to the Tribunal to prefer Nurse Usifoh's account about the crossing out to Dr Demanya's. There is nothing illogical, unreasonable or outrageous about such a conclusion. It is based on a global and holistic analysis and fairly allowed for the limitations in the reliability of Nurse Usifoh because of her discarding of the original notes. Overall, it is clear how the Tribunal carefully considered the intertwining strands of evidence. They lock together convincingly. The conclusions were reasonably open to the Tribunal and not wrong. Where there were gaps in or doubts about the evidence, the Tribunal had no hesitation in rejecting the GMC's case (see Allegation 1(a)(ii) on differential diagnosis; Allegation 1(a)(iv) on surgical team referral). The fairness, accuracy and nuance of the decision-making of the Tribunal is evident. The suggestion that the findings of fact "are not safe and cannot stand" is entirely without merit or substance; asserted, not demonstrated. Ground 4 is misconceived and is dismissed. XI Ground 5 The ground is set out in this way: "The MPT's reasons are inadequate and / or procedurally unfair." The appellant submits that the Tribunal's reasons were inadequate "for the reasons in Grounds 1 to 4". I accept Mr Powell's submission that it is not necessary for all of the grounds to succeed to assail the reasons for the purposes of Ground 5. However, all the previous grounds have been rejected. There is nothing therefore to undermine the Tribunal's reasoning as a result of them. For the sake of completeness, I have independently examined the Tribunal's reasoning as a whole to consider if looked at in the round there is any viable basis to challenge the reasoning. I apply the principles on adequacy of reasoning in *Southall* (which in turn cited the run of cases back to *English v Emery*). This was a comprehensive and meticulously justified decision. The determinations are clear. The reasons for them equally so. The evidential analysis was thorough and rigorous and for the main conclusions clear and full reasons were given. There is no procedural or substantive unfairness in the provision of reasons. Conclusion: Ground 5 Ground 5 is dismissed. XII Ground 6 Ground 6 is put in this way: "The Sanction imposed by the MPT was wrong and/ or procedurally unfair." The appellant submits that even if the previous grounds fail, the sanction was neither appropriate nor necessary, to apply the formulation in *Sastry and Yassin* . The sanction should at most be one of suspension of registration. It is clear that in imposing a sanction the Tribunal must have regard to the over-arching objective. This is not just about protecting the public from risk of harm, central though that is. It is also crucially directed at maintaining public confidence in the profession and maintaining professional standards. In Dr Demanya's case, the Tribunal reached unimpeachable findings that he failed to diagnose a serious condition, was dishonest in falsifying medical records retrospectively to conceal the fact that he had failed to diagnose the patient's sepsis, crossed out the dishonest entries he made about antibiotics prescription to "cover up" his failings, and gave a false account on oath to the coroner. The Tribunal found a

pattern of persistent dishonesty. It was correct to on the evidence and this was certainly within the range of reasonable conclusions. The Tribunal approached "appropriate" sanction in a systematic way in accordance with rule 17(2)(n) of the Rules. It took into account the "testimonials in support" filed on behalf of Dr Demanya. The four doctors who provided statements (all dated November 2023) spoke very positively about the appellant as a "valued colleague", being "highly reliable and trustworthy", "a great asset", "a great team player" and "a huge asset". The GMC submitted and the lower court acknowledged that the Tribunal had not found impairment of fitness to practise by reason of clinical failings. However, clinical error was the impetus for the series of dishonest actions of the appellant. The crossing out was to "cover up" the clinical error and the dishonest falsifications of medical records associated with that clinical error. The Tribunal carefully considered whether suspension was the appropriate sanction. It considered whether the misconduct was "fundamentally incompatible with continued registration". The GMC's case was the misconduct was "at the top end" of the scale of seriousness. The GMC's Sanctions Guidance (2020) provides: "108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor." Factors that may indicate that erasure is appropriate are found in para 109: "109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive). A A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor. B A deliberate or reckless disregard for the principles set out in Good Medical practice and/or patient safety. D Abuse of position/trust (see Good medical practice, paragraph 65: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession'). ... H Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 120–128). I Putting their own interests before those of their patients (see Good medical practice paragraph 1: – 'Make the care of [your] patients [your] first concern' and paragraphs 77–80 regarding conflicts of interest)." As to dishonesty, the following paragraphs are relevant: "124 Although it may not result in direct harm to patients, dishonesty related to matters outside the doctor's clinical responsibility (e.g. providing false statements or fraudulent claims for monies) is particularly serious. This is because it can undermine the trust the public place in the medical profession. Health authorities should be able to trust the integrity of doctors, and where a doctor undermines that trust there is a risk to public confidence in the profession. Evidence of clinical competence cannot mitigate serious and/or persistent dishonesty. Examples of dishonesty in professional practice could include: ... b falsifying or improperly amending patient records ... Dishonesty, if persistent and/or covered up, is likely to result in erasure." The Tribunal had evidence before it of substantial attempts by Dr Demanya to remediate. This included completing courses directed at, for example, better understanding of sepsis. The Tribunal outlined its approach at para 177: "The Tribunal is the final arbiter of sanction

but should bear in mind the guidance of Sir Thomas Bingham MR in *Bolton v Law Society*

[1994] 1 WLR 512 at 598) [51] that 'in cases of significant professional dishonesty, mitigation has a necessarily limited role.' The Tribunal was also directed to the case of *Nkomo v GMC* EWHC (Admin) , which states that whilst dishonesty is generally difficult to remediate and serious, particularly where sustained and covered up, each case should be considered on its own individual

facts

and a finding of dishonesty does not automatically mean that a doctor's fitness to practise must be impaired or that erasure must follow." The lower court then identified the relevant aggravating and mitigation factors: · Dr Demanya's repeated and sustained dishonesty as regards Patient A's care, which actions continued over the course of a year; · The inherent and clear gravity of creating false patient records; · The seriousness of lying to the coroner's court in a premeditated manner when giving evidence as to his professional conduct; · The nature of Dr Demanya's misconduct was such that it inevitably deflected blame onto other junior colleagues; · Multiple, serious breaches of GMP as already established. The Tribunal considered the following to be mitigating factors in this case: · Dr Demanya's previous good character; · His clinical skills and career to date; · The impressive nature of the accumulative testimonial evidence. The Tribunal concluded: "188. For these reasons, the Tribunal was of the view that Dr Demanya's misconduct of itself was of such a serious nature that it was 'fundamentally incompatible with [his] continued registration' (SG 97(a)) and that, accordingly, suspension was not an appropriate sanction. However, it then went on to consider Mr Mellor's submission that there was sufficient mitigation to justify suspension instead of erasure." While it considered that the testimonial evidence "went a long way" to addressing concerns about repetition, it considered that risk to patient safety and well-being was "still present". At para 190, the Tribunal said: "Rather than admit a potential error, Dr Demanya embarked on a sustained 'cover up', which was fundamentally at odds with the professional standards he was required to display, and that inevitably diverted blame to his colleagues. The Tribunal was of the view that for this reason there remained a risk, albeit low, that such behaviour could be repeated if similar circumstances presented." The Tribunal observed that remediation "was of less assistance in relation to promotion of public confidence and maintenance of professional standards" and crucially that: "the inherent seriousness of Dr Demanya's misconduct in falsifying Patient A's notes and giving false testimony under oath fundamentally undermined public trust in the profession, and that any sanction other than erasure would not appropriately promote and maintain professional standards." The Tribunal reminded itself of the fundamental tenet expressed in the Sanctions Guidance (para 17) that "the reputation of the profession as a whole is more important than any individual doctor". It therefore concluded: " 193. The Tribunal determined that Dr Demanya had seriously undermined public confidence in the profession and had brought the profession into disrepute. It was also of the view that there remained a risk to public safety ... the Tribunal found that all three elements of the overarching objective were engaged in their decision as to the appropriate sanction. The Tribunal therefore determined for these reasons that it was necessary to erase Dr Demanya's

name from the register to protect the wellbeing of the public, promote and maintain public confidence in the profession and to maintain proper professional standards." Discussion It is important to provide this compressed account of the reasoning of the Tribunal on sanction to show how thorough and carefully thought through it is. The starting-point is over-arching objective under the Medical Act 1983: "(1B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—

- (a) to protect, promote and maintain the health, safety and well-being of the public,
- (b) to promote and maintain public confidence in the medical profession, and
- (c) to promote and maintain proper professional standards and conduct for members of that profession." The appellant's criticism is that "undue weight" was placed on maintaining public confidence in the professional and proper professional standards. As seen, these are core elements of the over-arching objective. They perform vital public interest functions. The next criticism that the imposition of the sanction was "procedurally unfair". The nature of the procedural unfairness is not clearly explained. In any event, the argument is unsustainable. Further criticism is that para 128 of the Sanctions Guidance on dishonesty was inapplicable. It is not adequately explained how or why this part of the Guidance is irrelevant. It plainly applies to the proven misconduct. The integrity of medical records is crucial to the effective patient care and safety. Dr Demanya dishonestly tampered with medical records to cover up his clinical error. He then persisted in maintaining an account he knew was false on oath to the coroner's court that was investigating the cause of his patient's death. Through his advocate at the inquest, he sought to blame Nurse Usifoh for his error. However, he is entitled to a full and robust defence at the disciplinary hearing. As Mostyn J said in *General Medical Council v Awan*

[2020] EWHC at paras 37-38: "It seems to me that an accused professional has the right to advance any defence he or she wishes and is entitled to a fair trial of that defence without facing the jeopardy, if the defence is disbelieved, of further charges or enhanced sanctions." However, this cannot apply to giving false evidence on oath to a coroner. Those are inquisitorial proceedings convened to establish the facts about a person's death. By making false representations to the coroner, Dr Demanya obstructed the determination of the truth about the death of deeply ill elderly woman. The significance of dishonesty by a medical professional has been variously considered by this court. Julian Knowles J said in *Nkomo v General Medical Council* [2019] EWHC (Admin) at para 35: "The starting point is that dishonesty by a doctor is almost always extremely serious. There are numerous cases which emphasise the importance of honesty and integrity in the medical profession and they establish a number of general principles. Findings of dishonesty lie at the top end of the spectrum of gravity of misconduct [the Judge cited from *Theodoropolous*]...misconduct involving personal integrity that impacts on the reputation of the profession is harder to remediate than poor clinical performance: *Yeong v General Medical Council* [2009] EWHC and *GMC v Patel* [2018] EWHC (Admin) at [64] ...". In similar vein, Carr J (as she then was) said in *PSA v HCPC, Ghaffar*

- [2014] EWHC 2723 (Admin) at para 44: "There are, of course, numerous authorities emphasising the public interest in maintaining the standards and reputations in the professions. The importance of honesty to the health and care professions is underlined by the fact that striking off may be an appropriate sanction under the indicative sanctions guidance. It will often be proper, even in cases of one-off dishonesty (see *Nicholas-Pillai v GMC* [2009] EWHC (Admin) at paragraph 27). It has been said that where dishonest conduct is combined with a lack of insight, is persistent, or is covered up, nothing short of striking off is likely to be appropriate (see *Naheed v GMC*
- [2011] EWHC 702 (Admin))." It is the persistence of the appellant's dishonesty that was of grave concern to the Tribunal, initially when treating Patient A, then a year later at the inquest into her death. It was right to be deeply troubled by Dr Demanya's misconduct. The proper assessment of Dr Demanya's dishonesty is that it was of a scale and protracted duration that amply justify erasure. His mediation was of less significance when the concern was about fundamental professional integrity and honesty. The Divisional Court stated in *General Medical Council v Jagjivan & Anor*
- [2017] EWHC 1247 (Admin) at para 40: "(v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standards in the profession and sanctions, with diffidence: see *Fatnani* at paragraph 16; and *Khan v General Pharmaceutical Council*
- [2016] UKSC 64 ; [2017] 1 WLR 169, at paragraph 36. (vi) However there may be matters, such as dishonesty or sexual misconduct, where the court "is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal ...": see *Council for the Regulation of Healthcare Professionals v GMC and Southall* [2005] EWHC (Admin); [2005] Lloyd's Rep. Med at paragraph 11, and *Khan* at paragraph 36(c). As Lord Millett observed in *Ghosh v GMC* [2001] UKPC 29; [2001] WLR and 1923G, the appellate court "will afford an appropriate measure of respect of the

judgment

in the committee ... but the [appellate court] will not defer to the committee's

judgment

more than is warranted by the circumstances". (vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice, because the overarching concern of the professional regulator is the protection of the public." In accordance with these principles, I accord a measured but not excessive or undue degree of deference to the Tribunal's assessment of what is needed for the proper maintenance

of professional standards and public confidence in the profession. While the testimonials are positive in Dr Demanya's favour, I concur with the assessment of the lower court about their limited impact in meeting the concerns about his fundamental dishonesty. It is his indisputable dishonesty that allows this court to "more easily" evaluate the need to protect the public and maintain public confidence. Once more, the assessment of the Tribunal on sanction was reasonably open to it; it was rational, principle-based, unimpeachable to the appellate standard, and to the extent that gravity of dishonesty affects the decision-making, I endorse it. Conclusion: Ground 6 The erasure of Dr Demanya's name from the register was not only appropriate but, this court is entirely satisfied, necessary in the public interest. It is neither wrong nor unjust. To suggest that the Tribunal placed "undue weight" on the need for "public trust" in the medical profession, fails to recognise the vital importance of trust in a sensitive patient-facing activity like the practise of medicine. Ground 6 is dismissed. XIII Disposal Due to the necessarily wide-ranging analysis entailed by the pleaded grounds, I end by drawing together my prime conclusions: (1) The appellant's grounds based on mandated legal directions or errors of law mischaracterise and misunderstand the law (Grounds 1 and 3); (2) The challenges to the findings of fact made by the Tribunal fail to recognise the thorough and holistic evidential analysis the lower court undertook. Instead, they largely amount to claims that Dr Demanya was telling the truth and was accurate and the other witnesses were not. It is open, reasonable and rational for the Tribunal to reject his account (Grounds 2 and 4). While courts have offered various authoritative formulations of the threshold for upsetting findings of fact at first instance - "virtually unassailable", "out of tune with the evidence", "one no reasonable judge could have reached" - I find that the factual determinations of the Tribunal are fully and firmly supported. They are entirely harmonious with the evidence, not out of tune with it. They are justified not just by a sufficiency of evidence but a very powerful and convincing weight. Careful analysis of the materials before this court strongly points to Dr Demanya's evidence being manifestly unreliable, internally inconsistent, inconsistent with contemporaneous documentation, at odds with all the other witnesses and contrary to the canons of probability in vital respects. (3) Ground 5 falls away because the other grounds fail; but the content of the Tribunal's reasoning was in any event appropriate and rational; (4) On Ground 6 , the sanction is not inappropriate, disproportionate or excessive given the seriousness of the appellant's persistent dishonesty. The public duty of the Tribunal is succinctly summarised by Rice Collins J in PSA and GOC v Rose

[2021] EWHC 2888 (Admin) at para 82: " the duties that expert tribunals have to the public [are] to ensure that the public can understand why certain decisions have been reached in its name; can be reassured that healthcare professionals on whom they must depend are well and fairly regulated; and can know that the overarching obligation professionals have to deserve the trust the public places in them, and to discharge their professional duties with the interests and safety of patients uppermost, has a secure foundation." The high ambitions set down in the over-arching objective achieve nothing if they merely remain fine words. They must be respected, taken seriously and given full effect as living breathing guarantors to members of the public vulnerable through illness that the medical professionals who treat them can be trusted without a second thought. That cannot be said

of Dr Demanya: he falsified vital medical records about a deeply ill elderly patient to conceal his medical error about her potentially life-threatening condition, sought to cover up his dishonesty and then gave false evidence on oath at the inquest into his patient's death. I judge that the Tribunal was correct: anything less than the erasure of Dr Demanya's name from the medical register would be inimical to the maintenance of proper professional standards and damage public confidence in the good and safe regulation of the medical profession. The appeal is dismissed. Annex Materials Item Pages Hearing bundle Authorities bundle Appellant's skeleton Respondent's skeleton BAILII: Copyright Policy | Disclaimers | Privacy Policy | Feedback | Donate to BAILII

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