Neutral Citation Number: [2024] EWHC 131 (Admin)

Case No: CO/3899/2022

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 07/02/2024

Before :

MR JUSTICE JULIAN KNOWLES

- -

Between :

DR SHERINE AMIN HENDAWY IBRAHIM	**Appellant**
- and -	
GENERAL MEDICAL COUNCIL	**Respondent**

- -
- -

Stephen Vullo KC (instructed by **Twelve Tabulae**) for the **Appellant**
Alexis Hearnden (instructed by **GMC Legal**) for the **Respondent**

Hearing dates: 20 April 2023

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 7 February 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Mr Justice Julian Knowles:

Introduction

1. This is an appeal by Dr Sherine Ibrahim, the Appellant, under s 40 of the Medical Act 1983 against decisions of the Medical Practitioners Tribunal (MPT) dated 12, 14 and 20 September 2022. In its decisions the MPT found that the Appellant had acted dishonestly in submitting inaccurate timesheets when working as a Locum Surgical Registrar for the Maidstone and Tunbridge Wells NHS Trust (the Trust), also that he had lied to the Trust during an investigation, and therefore had committed serious misconduct. It found his fitness to practice was impaired by his misconduct, and ordered his name be erased from the Register.

2. The appeal is brought against all three limbs of the MPT's decisions.

3. The General Medical Council (GMC), which is the Respondent, resists the appeal.

4. The Appellant was represented by Mr Vullo KC and the GMC by Ms Hearnden, neither of whom appeared below.

5. Mr Vullo relied on his full and comprehensive Perfected Grounds of Appeal (Grounds), and Ms Hearnden produced a Skeleton Argument for the appeal. I am grateful to both of them. As well as my notes, I have consulted recordings of the hearing in preparing this judgment.

6. In the Bundle is a single comprehensive Determination by the MPT on the facts; on misconduct; on impairment; and on sanction. There are also separate decisions on each of these matters dated 12 September 2022, 14 September 2022 and 20 September 2022 respectively. Save for some anonymisation they are identical to the comprehensive Determination. In this judgment I will refer to the single comprehensive Determination, and paragraph references are to that document unless otherwise stated.

Factual background

7. Dr Ibrahim qualified as a doctor in 1990 with a Licentiate in Medicine and Surgery of the Society of Apothecaries (LMSSA), London. At the time of the MPT hearing he was 71 years old. I accept, as Mr Vullo submitted, that before this matter arose he had had an unblemished and distinguished record of service in the NHS going back over many years. There were numerous testimonials before the MPT (Bundle, pp647-665) about his qualities as a doctor and a colleague which it took into account, in particular at the impairment stage and the sanction stage.

8. Dr Ibrahim started working for the Trust in around 2013 and apart from one short break, remained there until August 2019 when he was dismissed for gross misconduct, including some of the matters which formed part of the GMC's case against him before the MPT.

9. The Trust had two hospital sites, at Tunbridge Wells (where Dr Ibrahim predominantly worked) and at Maidstone. The allegations that led to the MPT hearing can be summarised as follows.

10. Dr Ibrahim worked as part of the Trust's internal staff bank on a zero hours contract. This meant he was not guaranteed hours and would be allocated shifts, whenever needed, in order to fill gaps in the Trust's rota (see [19]).

11. In order to get paid for the work he undertook, he was required to complete timesheets, setting out his 'start' and 'finish' times, his 'breaks taken' and 'total hours worked'. Breaks were not paid, whether they were taken by him or not. In the evidence they were sometimes referred to as 'lunch breaks'. He was paid by the hour, at a rate of £65 per hour.

12. It was said that between 2 March 2018 and 8 March 2019, whilst working for the Trust, Dr Ibrahim dishonestly submitted timesheets claiming for work undertaken when he knew he had not worked until the shift finish times claimed on the timesheets. In very simple terms, car park exit times obtained by the Trust during its investigation often showed Dr Ibrahim exiting the car park at a time before the shift 'finish time' as declared on his timesheets. Sometimes he left more than 120 minutes before his declared shift finish time. Counsel prepared a helpful schedule of particularly early departures by Dr Ibrahim. For example, on 2 April 2018 he left two hours and 33 minutes early; on 19 April 2018: one hour 37 minutes; and 14 June 2018, one hour and 44 minutes. As I will discuss later, Dr Ibrahim's explanation for these particularly early departures was that he had been asked to go over to the Maidstone site to assist.

13. Each time sheet covered a week, from Monday – Sunday. Each contained a declaration of truth, which Dr Ibrahim was required to sign, which included the following statement:

> "I confirm that the hours submitted are a true record of the hours worked and overtime I am entitled to claim. I understand that if I knowingly give false information this may result in disciplinary action and I may be liable for prosecutions and civil recovery proceedings…"

14. The timesheets then had to be countersigned by a manager, after which Dr Ibrahim would be paid.

15. In 2019, as a result of an unrelated incident, Dr Ibrahim was suspended by the Trust and an investigation commenced.

16. In the course of the investigation, the timesheets Dr Ibrahim had submitted between March 2018 and March 2019 were reviewed and compared to entry and exit data obtained from the car park at the Tunbridge Wells site. This revealed around 149 dates when he had exited the car park earlier than the 'finish' time stated on his timesheet for the relevant date. It also revealed some dates when he exited the car park later than the stated 'finish' time.

17. By way of example, on the timesheet for the week including Wednesday 28 March 2018 (Bundle, p406), on that day Dr Ibrahim put down an 8:00am start, a 17:30pm finish, a 30 min break, and he claimed payment for a total of nine hours. The car park data showed that on that day he exited at 16.28pm, 62 minutes before his declared shift 'finish' time.

18. The claims on days of early departures were suspected to be fraudulent by the Trust, and Dr Ibrahim was therefore made subject to internal Trust disciplinary proceedings. There were other allegations which I am not concerned with (and which have been redacted in the documents). He was summarily dismissed for gross misconduct in August 2019, and an internal appeal was rejected.

19. One of the GMC's allegations was that on 10 May 2019, during an interview with the Trust as part of its internal investigation, Dr Ibrahim was dishonest in relation to a statement he made about why he had adopted the practice of leaving early. There was also an issue about the length of time it took him to complete Part 5 Cremation forms, however that has now fallen away, as I shall explain.

20. Counsel for the GMC opened the case to the MPT as follows:

> "Mr Ibrahim was, however, referred to the GMC on 2 January of 2020 by Dr Sarah Mumford. She was the Deputy Medical Director for that Trust. Dr Mumford informed the GMC that during the period of March 2018 to March 2019, it had been alleged that the doctor, Mr Ibrahim, had consistently and systematically falsified claims on timesheets for work that he had not done. It was said in the referral that, although the times stated on the timesheets – and those are timesheets completed by the doctor – matched the times that his shifts had been booked for, car park barrier data showed that in fact he had regularly left work in advance of the times stated on the timesheets."

The allegations

21. The allegations before the MPT, and Dr Ibrahim's response at the outset of the hearing, were as follows:

> "That being registered under the Medical Act 1983 (as amended):
>
> 1. Between 2 March 2018 and 8 March 2019, whilst working for Maidstone and Tunbridge Wells NHS Trust ('the Trust'), you:
>
> a. submitted timesheets ('the Timesheets') claiming for work undertaken until the purported end times of your shifts as set out in Schedule 1;
>
> **Admitted and found proved**
>
> b. exited the Trust's car park at the times as set out in Schedule 1.
>
> **Admitted and found proved**

2. You knew you did not work until the shift end times claimed on the Timesheets.

Admitted and found proved

3. Your actions as described at paragraph 1.

a. was dishonest by reason of paragraphs:

a. 1. b.;

To be determined

b. 2.

To be determined

4. In an interview with the Trust on 10 May 2019 in respect of the:

a. inconsistencies on the Timesheets set out in Schedule 1, you stated that:

i. you had adopted a practice whereby you did not take a lunch break and instead deducted time from the end of your working day ('the Practice');

Admitted and found proved

ii. the Practice came about following a discussion with Dr A.

Admitted and found proved

b. completion of Part 5 Cremation forms, you stated that it takes approximately ten minutes ('the Time Estimate') to fully complete one form.

Admitted and found proved

5. You knew that:

a. you had not been told to adopt the Practice;

Admitted and found proved

b. the Time Estimate given was untrue.

To be determined

6. Your actions as described at paragraph(s):

a. 4. a. i. and 4. a. ii. were dishonest by reason of paragraph 5. a.;

To be determined

c. 4. b. was dishonest by reason of paragraph 5. b.

To be determined

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.

To be determined"

22. The first few lines of Schedule 1 illustrate how it was set out (Bundle, p57):

Date	**End time claimed via timesheet**	**Exit time from car park**
2 March 2018	17:00	16:53
9 March 2018	16:30	15:54
20 March 2018	17:15	16:22
26 March 2018	17:30	17:01
28 March 2018	17:30	16:28

23. In light of Dr Ibrahim's response to the allegations, the MPT was principally required to determine whether his actions in submitting the timesheets claiming for work undertaken until the purported finish times of his shifts, and his subsequent statement in interview, were dishonest. The allegations related to Cremation Forms were found not proved and I will largely pass over them.

Witnesses before the MPT

24. The Tribunal heard evidence on behalf of the GMC from the following witnesses:

a. Dr Mudhar (referred to in the composite Determination as Dr B), locum Senior House Officer at the Trust at the time of the events, provided a witness statement dated 25 March 2021 and also gave oral evidence on 5 September 2022 via video link;

b. Jelena Pochin (referred to as Ms C), General Manager for Surgery at the Trust at the time of the events, provided a witness statement dated 3 March 2021 and also gave oral evidence on 5 September 2022 via video link;

c. Dr Ali (referred as Dr D), Senior House Officer at the Trust Maidstone and Tunbridge Wells NHS Trust at the time of the events, provided a witness statement dated 7 March 2021 and also gave oral evidence on 6 September 2022 via video link;

d. Mr Hubbard (referred as Dr A), Deputy General Manager for Medicine/General Manager for Medicine at the Trust at the time of the events, provided a witness statement dated 16 November 2021 and also gave oral evidence on 6 September 2022 via video link;

e. Dr Chambers (referred to as Dr E), Consultant Histopathologist at the Trust, provided a witness statement dated 16 November 2021 and also gave oral evidence on 6 September 2022 via video link.

25. The MPT also received evidence on behalf of the GMC in the form of a witness statement, dated 26 April 2021, from Dr Su Ling Yeoh (referred to as Dr F), Foundation Level One Doctor at the Trust at the time of the events who was not called to give oral evidence.

26. Dr Ibrahim provided his own witness statements dated 24 March 2022 and 2 September 2022 (and exhibits) and gave oral evidence at the hearing. He also adduced a number of testimonials and other evidence, as I have said.

27. There are full transcripts and partially redacted witness statements in the Bundle, and I do not therefore propose to set out the evidence in huge detail, save as follows (taken from [12] onwards). As Mr Vullo said, much of the evidence was not really in dispute (although some matters were); it was the inferences to be drawn from it which was the central issue. (I also asked for, and was sent, a list of transcript references).

28. Dr Mudhar told the MPT that he had worked on the same wards as Dr Ibrahim in February and March of 2019. Dr Mudhar would usually see Dr Ibrahim during the morning handover periods and in passing. There were no formal handovers in the afternoon, and they were working on different teams, but Dr Mudhar was present on occasions when he heard Dr Ibrahim say he was leaving well before 5:30pm.

29. Dr Mudhar told the MPT that he recalled being contacted for help by junior staff members from Dr Ibrahim's team, who had tried contacting Dr Ibrahim, but he had already left, and his mobile phone was switched off. Dr Mudhar confirmed that these calls were not usually between 3:30pm and 4:00pm but certainly before 5:00pm, and he gave the Tribunal a breakdown of the dates he had worked alongside Dr Ibrahim. He also confirmed that these were predominantly weekdays and that out of seven days that he had been on call from mid-February to mid-March 2019, Dr Ibrahim had left early on at least three occasions and Dr Mudhar was contacted by staff members to deal with clinical issues.

30. Ms Pochin had administrative contact with Dr Ibrahim every few weeks to sign off his timesheets. Once the complaint in relation to Dr Ibrahim's timekeeping had been raised, she acted as the case investigator.

31. Ms Pochin stated that she had signed off all Dr Ibrahim's timesheets and that in doing so, she was confirming that the hours worked were accurate and that she approved payment. When challenged about checking the accuracy of the hours worked, Ms Pochin responded that her normal checks included that the doctor had been rostered for the shift claimed, and that the doctor had attended the hospital on that date.

32. She was asked about countersigning the timesheets:

> "Q In signing them, you are confirming that you have checked them to be accurate, aren't you?
>
> A Within the best of my knowledge, yes.
>
> Q There's no caveat there, is there,
> 'I'm signing' – it simply says: 'I am signing to confirm that the hours/overtime are accurate and I approve payment.' Yes?
>
> A Then the next sentence talks about 'knowingly authorising'. Now, I think it's relevant to note that the timesheets that are signed are often signed with hours that are outside of my own working hours and there is a responsibility of those completing the timesheets to ensure that they are accurate. There is a level of trust and responsibility from the doctors to record that information as accurate."

33. Ms Pochin clarified that no significance would be placed on the time that Dr Ibrahim entered the car park at Tunbridge Wells, and any reference to a start time would be the actual time the shift started. Likewise, unless a doctor stated a later end time on their timesheet due to staying for extended duties, the reference would be the shift end time.

34. Ms Pochin explained the nature of Dr Ibrahim's contract. There was no guarantee of any hours, but he would be allocated shifts that were gaps on the Trust's rota. If a bank doctor's routine work was completed before the shift end time, the doctor would be expected to stay the entirety of the shift to provide support for more junior doctors and nursing staff. As a middle grade doctor, the bank doctor would still be needed.

35. Part of Dr Ibrahim's defence was that on some of the days when he had left especially early, he had been called to cover for a clinic at Maidstone, which was about a 20 minute drive away. Ms Pochin told the Tribunal that on those days Dr Ibrahim's name would have been added to the electronic clinic list and be trackable through clinic letters. The only evidence Dr Ibrahim would have of being asked to work there would be an email or a text.

36. Ms Pochin said that she had been unable to find any evidence that corroborated his claims. She had checked the clinic lists, but a search of clinical correspondence had not been carried out as Dr Ibrahim had been unable to provide specific dates when he claimed he had attended a clinic there. A cross-check had been undertaken of significant early finishes at Tunbridge Wells, the electronic rota, and car park records at Maidstone.

37. Ms Pochin agreed that there were two car parks at Maidstone. She said that if Dr Ibrahim chose to park in the visitor car park due to the staff car park being full, there would be no record of entry or exit times as this was a ticketed system, and Dr Ibrahim could not use his swipe card.

38. Ms Pochin also explained to the MPT the outcome of the investigatory meeting held on 10 May 2019 in relation to Dr Ibrahim's filling in of the Part 5 Cremation form, and his understanding of his conversation with Mr Hubbard about the 30-minute lunch breaks. I will come back to the 10 May 2019 later.

39. Dr Ali gave evidence in relation to the filling in of the Part 5 Cremation forms by Dr Ibrahim. As I have said, the MPT found this part of the case not proved, and so I will pass over it.

40. Mr Hubbard told the MPT that he could not recall having a conversation with Dr Ibrahim in which he had advised him that he could take his break at the end of his shift (which as I shall explain was also part of Dr Ibrahim's case; he said he left early *in lieu* of taking his break during a shift). Mr Hubbard categorically stated that he would never advise a member of staff to leave the hospital early *in lieu* of taking the 30-minute break.

41. In his written statement Mr Hubbard stated:

> "The only sort of conversation I remember about anything similar to this was that Dr Ibrahim was challenging the fact that he was on call and on bleep so he couldn't take a break. He said something like, 'I'm unable to take a break so I should be paid for the whole shift' and I said, 'No. You have to take your breaks'. I was adamant that Dr Ibrahim took his breaks and for that short time, pass the bleep to a colleague. I told Dr Ibrahim to make arrangements for the bleep to be covered and that if he experienced any problems, to let me know. I remember Dr Ibrahim having a bee in his bonnet about his perception that he was expected to work a full day and then have money deducted for his break. My impression was that Dr Ibrahim was more concerned about losing the half hour of pay for his break."

42. Mr Hubbard told Ms Pochin in an investigation meeting on 6 June 2019 that he recalled speaking with Dr Ibrahim and telling him that the shifts needed to be covered and he should take his breaks, but he did not say he should add them at the end of the shift, and that there were issues at this time of him being uncontactable during shifts.

43. Mr Hubbard was clear that Dr Ibrahim's contract was not a 'flexi-time' contract but one with set times. The expectation was that a doctor would be on site for the duration of the shift (Bundle, p185):

> "… ; it's a shift pattern – yes, so against a rota, you're expected to be on site for the duration of your shift."

44. Mr Hubbard was asked (Bundle, p186):

> "Q. … what the tribunal wants to know is, does the rota stipulate – say if Dr Ibrahim was hired for a day, would he be hired from 8.00 to 5.00, 9.00 to 5.00, 8.00 to 4.00; can you explain that shift, please?
>
> A. Yes, absolutely. The shift would always be agreed in advance of the start time, so we'd say – if it was short notice, but the majority of Sherine's lift shifts were not short notice because he was rotaed into the workforce, so he would have known well in advance that we were expecting him to work from 8.00 'til 5.00 or 8.00 to 12.00 or 8.00 'til 8.00 in the morning. You know, he would know in advance. We would know where he's supposed to be because we know where the rota is and where he's rotaed and we had a sort of e-rostering system I think we implemented at the time, so you could have visibility of where everybody was. The shifts were set on that rota as the time – the start time and finish time were on that rota."

45. Dr Chambers also dealt with the Cremation Forms part of the case, which again I will pass over.

46. The MPT turned to Dr Ibrahim's evidence at [36] of its Determination.

47. Dr Ibrahim started his oral evidence by telling the MPT how his practice of leaving the Trust early had come about. He said he had adopted it following a conversation one day with Mr Hubbard, probably in 2017, when Mr Hubbard was Deputy General Manager for Surgery. Dr Ibrahim said (Bundle, pp202-3):

> "MR LODGE: Doctor, if I can understand your case, you adopted a practice of leaving the hospital premises before the end time of your shift, you say to make up for breaks you didn't take.
>
> A. Correct.
>
> Q Did you adopt that practice simply as a result of the discussion you had had with Mr Hubbard? A. Yes.
>
> Q. I would like to ask you about one of the pages, page 58. Would you turn to page 58 in the main bundle, please? That

> is the note of the interview you had with Jelena Pochin on 10 May. You were asked, 'Can you explain why you appear to be frequently leaving earlier. You and Mark' – was Mark your representative?
>
> A. Yes, he was my representative.
>
> Q. He said, 'Mr Ibrahim has adopted a practice where he does not take his lunch break and instead deducts it from the end of the working day, though this is not reflected in the timesheet…this came about following a discussion he had with Tim Hubbard years ago'. I think from elsewhere in the document, did that conversation take place in 2007? Was it as long ago as that?
>
> A. No, because I did not start working at Tunbridge Wells & Maidstone as a locum until, I believe, 2012. I may have had a short locum before that, but the bulk of the work I start doing there was from 2012. It must have been after that. At the time, Mr Hubbard was the assistant manager of the department, or acting manager – I can't remember – and I just noticed that he had started deducting half an hour being a break, so I crossed him in the corridor and I said, 'Tim, you are deducting this'. He said, "Yes". I said, but I am not taking this because the workload is too much and nobody would carry somebody's bleep and do his work. He said, "Whether you take it or not, it has to be deducted because that is the programme, the system we have in the hospital". I said, 'Can I take it at any time, whenever I can?" He said, "Yes, you can take it, but you must take it'."

48. Dr Ibrahim said that as the Tunbridge Wells site was mainly an emergency hospital, there would always be patients that needed to be looked after. Dr Ibrahim said that sometimes he would be asked to look after other teams, and it was impossible for him to get his break. He disagreed with Mr Hubbard's statement that 'most people find time within a 12 hour shift to sit down and have a cup of tea and a sandwich, and if they were called away whilst taking their break, they could have another short break later in the shift to ensure they had taken their full break entitlement.'

49. Dr Ibrahim stated that a cup of tea was not a short break and that his understanding was that he was entitled to a full half hour break per every six hours worked.

50. Dr Ibrahim explained the structure of his average working day. The day would start after the morning handover and involve assessing patients who had been transferred from the acute ward and those who were likely to go to the acute ward; ward rounds being conducted with junior doctors during which patients would be examined; and putting discharge plans in place. Around midday some test results would have come back, and patients would be booked in for other procedures and tests such as an MRI, CT scan, or endoscopy. Dr Ibrahim would also sometimes be asked by consultants to go to the SAU

(Surgical Assessment Unit) or the outpatient clinic. He said that getting away from work was difficult, and he had 'paid heavily'.

51. Dr Ibrahim said that the only space to be able to take a break was the doctors' office. There were usually people there preparing things and he felt it inappropriate to take a break in there as it was not away from a work-related environment. He added that he was not saying that in all the years he had worked at the Trust that he had been unable to take a break. It was just that since being on bank staff there was more work, and he could not find the time. If his bleep went off or his phone rang, he could not ignore it or say that he was on a break. Dr Ibrahim said, 'I decided to not split my breaks to comply, I would rather take it at end of shift.'

52. Dr Ibrahim understood that he was required to be on site for the entirety of his shift if it was busy. However, he said that if he was satisfied that everything was in order, he was not on call and he had completed his work, he would leave early ([40]):

> "I was looking after 15,20,30 patients and I was satisfied my work was complete and I was entitled to leave early. My mistake was to not take this in writing from management. Not a conventional approach but I stayed contactable and how else would I recoup the breaks otherwise? Not a very helpful approach but that was the only way I could get my hours back. I took the conversation with Dr A and my right to take the breaks into account."

> "I accept however that I should have discussed my working arrangements and claims in respect of lost break times with the Trust's management more formally and obtained their specific agreement to allow me to claim a period of compensatory equivalent rest which is what I did and what was provided for in my staff bank contract. I did not do this because I had worked at the Trust for a number of years and trusted the advice, I had received from Dr A without thinking I needed to receive it in writing."

53. In response to questions arising from Dr Mudhar's evidence, Dr Ibrahim told the MPT that while they were both in the same department, they had never worked together. He stated that Dr Mudhar's assertion that he had left early on at least three out of seven times they had worked together was untrue, and suggested this had been fabricated as a response to an incident in the doctors' room in which Dr Ibrahim had told Dr Mudhar and his colleagues to be quiet when they were being quite loud, which produced an angry response from Dr Mudhar.

54. In total there had been nine occasions when Dr Ibrahim had left the Tunbridge Wells car park more than 90 minutes prior to the end of his shift, four of these being greater than 120 minutes. Dr Ibrahim told the Tribunal that the most likely reason for this was that he had been asked to cover at the Maidstone site on those days ([42]).

55. When asked about these occasions, Dr Ibrahim stated that there was no written evidence that he had been called to Maidstone, as he would get a phone call requesting his

assistance. He was receiving neither emails nor texts and his name was not on the rota as the nature of these requests was short notice. He would inform the team at Tunbridge Wells that he was leaving, then make his way to Maidstone. Dr Ibrahim added that the Trust had been unable to provide any evidence of any occasion that he had been called to cover at Maidstone. He could not see himself leaving so early then claiming for those hours had he not been at Maidstone. ([43]).

56. Dr Ibrahim told the MPT that there were two car parks at Maidstone; one for visitors and one for staff. Around this time, he was having to carry his bags, so chose to park in the nearer visitors' car park, which did not have any system of recording entry and exit times.

57. In relation to the timesheets, Dr Ibrahim stated that he did not fill them in on a daily basis but at the end of the week, sometimes the week after, and by memory. He did not round up any times to the exact minutes worked, inputting just the standard shift times. He highlighted the times that he had arrived at the car park before the start of his shifts, stating that this time should be taken into account and offset against the times he had left early. He said he came in early to prepare for the morning handover. There was only one occasion when he had come in over an hour early, Dr Ibrahim said he had been asked to do so by Mr Hubbard, to cover a colleague's shift. Dr Ibrahim told the Tribunal that it took about five minutes to get from the car park to the office ([45]).

58. He then dealt with the Cremation Forms, which again I will pass over.

The MPT's findings

59. The MPT's findings begin at [49].

60. It directed itself correctly that the burden of proof lay on the GMC to the civil standard. It also directed itself correctly that whilst there is one standard of proof, 'the more serious the allegation, the more cogent the evidence may need to be to find it proved to the civil standard' ([50]).

61. At [52] it directed itself on the issue of dishonesty by reference to *Ivey v Genting Casinos (UK) Ltd* [2018] AC 391, [74]. I will come back to this decision later. At [53], the MPT referred to *R (Dutta) v General Medical Council* [2020] EWHC 1974 (Admin), which again I will come back to.

62. At [54] under the hearing 'The Tribunal's Analysis of the Evidence and Findings' the MPT said that it had considered each outstanding paragraph of the allegations separately and had evaluated the evidence in order to make its findings on the facts.

63. At [55] – [67] the MPT found [3(a)] and [3(b)] in the allegations proved in their entirety. Its reasoning, in summary, was as follows.

64. The MPT took into account the evidence of Mr Hubbard and Dr Ibrahim relating to the conversation held between them in 2017, relating to the 30-minute breaks. Mr Hubbard had explicitly told Dr Ibrahim that as the unpaid break time would be deducted from his total hours, he would need to take the break. Dr Ibrahim had agreed that at no point had Mr Hubbard advised him to take this break at the end of the day, and that he had not

understood Mr Hubbard to be saying that he should take his break at the end of his shift ([55]).

65. The MPT said it was clear from Dr Ibrahim's evidence (and that of Mr Hubbard), that Dr Ibrahim was unhappy that the break was no longer a paid one (as it had been when he had been an agency doctor) and that he felt that he was unable to take his 30 minutes on his terms. He stated that he 'decided' that he would take it at the end of the day, a practice that he then implemented as routine. He knew he was entitled to a break but at no point sought to clarify if he could leave early in the manner he adopted. Indeed, the timesheet required a specific start and finish time. The MPT considered that by filling in the timesheets in the way he did, he was not accurately recording the practice he had adopted ([56]).

66. The MPT noted Dr Ibrahim's evidence that, in his view, he could leave the hospital when his work was complete, and then considered the evidence of Dr Mudhar. The MPT accepted Dr Mudhar's evidence that because Dr Ibrahim left work early and could not be contacted, Dr Mudhar sometimes had been contacted by junior doctors from Dr Ibrahim's team asking for support. It found Dr Mudhar to be credible and his evidence was supported by the documentary evidence ([57]).

67. A check of the dates Dr Mudhar had given revealed that on 18/19/20/21/22/26/27 February 2019 they were both at work. The Tribunal noted that on 19 February, Dr Ibrahim left the car park at 4:06pm; on 20 February he left at 4:03pm; on the 21 February he left at 3:32pm; and on the 22 February he left at 4:28pm.

68. The MPT said that Dr Ibrahim's early exits from the hospital had had an impact on other doctors, as well as a potential impact on patients. It noted that as Dr Ibrahim stated in his own evidence, of his conversation with Mr Hubbard, 'there would always be patients to be looked after'. The MPT considered that Dr Ibrahim could not properly regard his work as complete when he elected to leave the hospital.

69. Based on the evidence Dr Ibrahim had given, the MPT concluded that he had been seeking to recoup pay he was not entitled to because of his dissatisfaction over his contractual terms and, as a consequence, he decided to leave work before his shift was complete ([58]).

70. It noted that Dr Ibrahim's justification that the times he had arrived early for his shift should be taken into account, in other words, offset in some way against his early departure times. It quoted his evidence (at [59]):

> "When Trust has now accused me of taking more money than I deserve what about my good work for turning up early for a meeting that concerned all in the department and ensuring things ran in a smooth way. I would turn up early and that's why I asked for entry times too at beginning of the day."

71. The MPT accepted that while on most occasions Dr Ibrahim had arrived early for his shift, this was not unusually early for an 8:00am start time. The car park entry times, mainly between 7:40am-7:50am, were consistent with what would be expected for

someone who had to park their car, walk to the office, and be on time for the morning handover. The MPT said that this could not be offset against the exit times for the car park. In fact, it said the true leaving time from the ward would be even earlier than that reported in the available statistics, taking into account walking to the car park, getting into his car and driving up to the barrier ([59]).

72. The MPT noted that whilst there were times that Dr Ibrahim had left the Trust car park around 30 minutes earlier than the end of his shift, there were other times when he left earlier than this, and a number of occasions on which he left far earlier. Fourteen examples in the data that showed Dr Ibrahim left the car park more than 90 minutes prior to the end of his shift, and four of these were greater than 120 minutes ([60]).

73. Dr Ibrahim stated that if he left earlier than half an hour before his shift time, this was due to his being called over to help out at the afternoon clinic in Maidstone.

74. The MPT considered this was credible if he had left prior to 3:00pm but not if he had left later than that time. It noted that Ms Pochin had not been able to find any evidence of Dr Ibrahim's attendance at Maidstone at these times, but considered that the Trust had not established that Dr Ibrahim had not travelled to Maidstone to the Tribunal's satisfaction. However, the MPT did not find it credible that if Dr Ibrahim was leaving the hospital at 3:30pm or later, that he would be leaving to assist on the other site, some 20 minutes' drive away. Dr Ibrahim himself could offer no explanation for why he would be leaving at these times. The MPT did not accept Dr Ibrahim's evidence that he 'forgot' the times he left the hospital when completing the forms. Dr Ibrahim would have known that he should have remained on the hospital site to provide support for his juniors in any event ([61]-[62]).

75. The MPT said it had deliberated over whether Dr Ibrahim was able to take a break during his shifts. He had stated that he 'never' had time for a break. The MPT took into account Dr Ibrahim's explanation of what his average working day looked like. He had stated in his evidence that there were no elective clinics to attend, and he was not requested to work in the operating theatre. The MPT said it did not seem likely that he would be too busy on every shift and unable to take a break. It did not accept Dr Ibrahim's evidence that even in a 12-hour shift he would not take a break. The MPT was of the view that while Dr Ibrahim could get a break on many occasions, either he chose not to take a break as he was not getting the break on his terms, or he did take a break but did not disclose it ([63]).

76. The MPT did not accept that Dr Ibrahim thought he was entitled to behave in this way or that he believed that the Trust would have accepted his choosing to work in this way. This was evidenced by the manner in which he completed his timesheets, which would have misled the Trust into thinking he had been present in the hospital at the end of his shift.

77. The MPT's key conclusions on this part of the case are at [56], [64]-[67]. I will set these out later. In summary, it said at [66] that a doctor deciding to routinely leave work early and submitting timesheets with incorrect shift end times which resulted in him being paid money to which he was not entitled, would be seen as dishonest and that it found [3] to be proved in its entirety.

78. The MPT then turned to [5(b)] of the allegations, which it found not proved, and so I will pass over it.

79. The MPT then turned to [6(a)] of the allegations.

80. The MPT said that on the first day of the hearing, Dr Ibrahim made admissions to [4] of the allegation in its entirety, ie, that he had told the Trust he implemented the Practice and this had been as a direct result of his discussion with Mr Hubbard. Dr Ibrahim also made an admission to [5(a)] of the allegations, that he knew he had not been told to adopt the Practice. This was further corroborated in his oral evidence ([72]).

81. The MPT said at [73] that by his actions in completing his timesheets in a manner which implied that he had been present at the end of the shift, the MPT considered that Dr Ibrahim was fully aware that the Trust would not have condoned this practice. The MPT did not accept Dr Ibrahim's evidence that he could not find time for a break and that in any event, this would not have provided an excuse for his leaving before the end of the shift when he was still required to supervise the juniors on his team.

82. Dr Ibrahim had stated in his evidence that it did not occur to him that the additional time spent in the morning should be added to his shift time until after the Trust began its investigation. The MPT accepted that he did not believe he was so entitled when he was completing his timesheets. The MPT did not accept that Dr Ibrahim believed that when he had arrived early, he could leave early ([74]).

83. At [75]-[76] the MPT concluded:

> "75. The Tribunal, having taken all of the above into consideration, deliberated over what an ordinary decent person would think if they had the facts before them. It concluded that a doctor deciding to routinely adopt a practice whereby he deducted his lunch break from the end of his working day so that he could leave work early when he knew that he had no authority to do this, would be seen as dishonest.
>
> 76. Accordingly, the Tribunal found paragraph 6a to be proved."

84. The MPT found [6(b)] of the allegations not proved.

85. Hence, overall, of the matters it had had to decide on the facts, the MPT said that it had found:

    a. [3(a)], [3(b)] and [6(a)] of the allegations proved upon determination; and

    b. [5(b)] and [6(b)] not proved.

86. The MPT then turned to the question of misconduct and impairment at [79] onwards. It delivered its Determination on these on 14 September 2022. At [96] it said that in approaching the decision, it was mindful of the two-stage process to be adopted: (a) first,

whether the facts as found proved amounted to misconduct and whether the misconduct was serious; and then (b) whether the finding of that misconduct which was serious could lead to a finding of impairment.

87. In relation to dishonesty, the Legally Qualified Chair referred the MPT to *General Medical Council v Nwachuku* [2017] EWHC 2085 (Admin), [45]-[50]:

> "45. Dishonesty encompasses a very wide range of different facts and circumstances. Any instance of it is likely to impair a professional person's fitness to practise: *R (Hassan) v General Optical Council* [2013] EWHC 1887 per Leggatt J at paragraph [39].
>
> 46. Dishonesty constitutes a breach of a fundamental tenet of the profession of medicine: *PSA v GMC and Igwilo* [2016] EWHC 524. A finding of dishonesty lies at the top end in the spectrum of gravity of misconduct: *Patel v GMC* Privy Council Appeal No.48 of 2002.
>
> 47. A finding of impairment does not necessarily follow upon a finding of dishonesty. If misconduct is established, the tribunal must consider as a separate and discrete exercise whether the practitioner's fitness to practise has been impaired: *PSA v GMC and Uppal* [2015] EWHC 1304 at paragraph [27].
>
> 48. However, it will be an unusual case where dishonesty is not found to impair fitness to practise: *PSA v Health and Care Professions Council and Ghaffar* [2014] EWHC 2723 per Carr J at paragraphs [45] and [46]. 49. The attitude of a practitioner to the allegations made and any admissions of responsibility for the misconduct will be taken into account as relevant factors in determining whether or not fitness to practise has been impaired: *Nicholas-Pillai v GMC* [2009] EWHC 1048 per Mitting J at paragraph [18].
>
> ..
>
> 50. The overarching concern is the public interest in protecting the public and maintaining confidence in the practitioner and medical profession when considering whether the misconduct in question impairs fitness to practise: *Yeong v GMC* [2009] EWHC 1923 per Sales J at paragraphs [50] and [51]; *Nicholas-Pillai* (above) at paragraph [27]:
>
> > 'In cases of actual proven dishonesty, the balance ordinarily can be expected to fall down on the side of maintaining public confidence in the profession by a severe sanction against the practitioner concerned.

> Indeed, that sanction will often and perfectly properly be the sanction of erasure, even in the case of a one-off instances of dishonesty.'"

88. At [99]-[104] the MPT found that Dr Ibrahim's actions amounted to misconduct which was serious.

89. In making its decision on impairment, the MPT considered that [65], [71] and [77] of the GMC's *Good Medical Practice* were engaged in this case. Paragraph 77 states: 'You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals.'

90. At [110]-[116] the MPT said:

> "110. The Tribunal concluded that public confidence in the medical profession would be undermined and that there would be a failure to uphold professional standards if a finding of impairment was not made.
>
> 111. The Tribunal accepted that there had been no incidents relating to patient safety during that time. However, on taking into account Dr B's evidence that he had been called by staff members for assistance as Dr Ibrahim could not be located, the Tribunal considered that there had been the potential for a risk to patient safety and the third limb of the overarching objective was engaged.
>
> 112. The Tribunal had regard to Dr Ibrahim's reflective statement. It took into account that dishonesty is not easily remediable and appreciated that Dr Ibrahim had taken an initial step by producing his statement and finding appropriate courses to attend. The Tribunal also noted Dr Ibrahim's remorse and that he was now filling in timesheets daily and inputting the exact start and end times of his shifts, as a remediation step. However, in his reflective statement Dr Ibrahim had demonstrated little, if any, insight as to the impact of his conduct on others and was silent on what other actions he could take to address his conduct and prevent a recurrence in future.
>
> 113. This highlighted to the Tribunal that this reflection was the first step of a journey, and a true reflection of the seriousness of the issues involved did not hinge only on the correct filling in of timesheets.
>
> 114. The Tribunal concluded that while it had been presented with some evidence of the beginning of remediation and insight, this was a process and not something that would happen overnight, and Dr Ibrahim did not yet fully appreciate the reason for this hearing. The

> Tribunal considered that, given Dr Ibrahim's limited insight, there remained a significant risk of recurrence.
>
> 115. The Tribunal therefore considered that the overarching objective required a finding of impairment in order to promote and maintain public confidence in the profession, promote and maintain proper professional standards and conduct for the members of the profession, and also to protect the health, safety, and wellbeing of the public.
>
> 116. Accordingly, the Tribunal determined that Dr Ibrahim's fitness to practise is currently impaired by reason of his misconduct."

91. The MPT gave its decision on sanction on 20 September 2022. Its decision starts at [117]. It was referred by counsel for the GMC to the *Sanctions Guidance* (November 2020 edition) and the following paragraphs in particular in relation to dishonesty: [120], [121], [125] and [128]. I will set these out later.

92. At [148] the MPT said:

> "148. The Tribunal bore in mind that the main reason for imposing sanctions was to protect the public and that sanctions are not imposed to punish or discipline doctors, though they may have a punitive effect. The Tribunal took a proportionate approach, by balancing Dr Ibrahim's interests with the public interest, but bore in mind that the reputation of the profession as a whole was more important than the interests of any individual doctor."

93. At [152] and [153] the MPT had regard to aggravating and mitigating factors. As to the former, it said that dishonesty is always a serious matter, and that in this case it had persisted for over a year until it was discovered. It also said Dr Ibrahim's insight had been limited. As to mitigation, it noted *inter alia* he was a good doctor and that he had expressed remorse and offered an apology.

94. The MPT then worked up the list of possible sanctions, starting with the least serious. It concluded that only erasure was appropriate ([168]-[170]):

> "168. Taking into account its conclusions from paragraphs 44 – 47 above, the Tribunal took the view that there were no factors in Dr Ibrahim's case to justify departing from the guidance as set out above and determined that Dr Ibrahim's misconduct was fundamentally incompatible with continued registration.
>
> 169. The Tribunal concluded that the only appropriate and proportionate sanction that would adequately reflect the seriousness of this misconduct and be sufficient to uphold the overarching objective to maintain public confidence in

> the profession and uphold proper professional standards, was one of erasure.
>
> 170. The Tribunal therefore directed that Dr Ibrahim's name be erased from the medical register."

Legal principles

95. I do not think these are materially in dispute between the parties.

96. Section 40 of the MA 1983 Act provides a right of appeal to the High Court against determinations made by the MPT. The relevant part of s 40 provides:

> "(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;
>
> ...
>
> (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 PractitionersTribunal; or
>
> (d) remit the case to the MPTS for them to arrange for 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 (or, in Scotland, expenses) as it thinks fit."

97. Civil Procedure Rules, r 52.21 provides:

> "(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.
> ...
>
> (3) The appeal court will allow an appeal where the decision of the lower court was -
>
> (a) wrong; or
>
> (b) because of a serious procedural or other irregularity in the proceedings in the lower court."

98. Appeals under s 40 are by way of re-hearing by virtue of [19] of CPR PD 52D.

99. The approach the High Court should take to appeals under s 40 was explained in *Fish v General Medical Council* [2012] EWHC 1269 (Admin), [28]-[32]:

> "28. Whilst the appeal constitutes a 're-hearing', it is a re-hearing without hearing again the evidence.
>
> 29. I venture to repeat certain quotations from earlier cases that I made in the case of *Chyc v General Medical Council* [2008] EWHC 1025 (Admin) concerning the approach of this court to challenges to findings of fact. I *referred in Chyc* to what was said by the Judicial Committee of the *Privy Council in Gupta v General Medical Council* [2002] 1 WLR 1691 where the following appears at paragraph 10:
>
> > '[T]he obvious fact [is] that the appeals are conducted on the basis of the transcript of the hearing and that, unless exceptionally, witnesses are not recalled. In this respect, these appeals are similar to many other appeals in both civil and criminal cases from a judge, jury or other body who has seen and heard the witnesses. In all such cases the appeal court readily acknowledges that the first instance body enjoys an advantage which the appeal court does not have, precisely because that body is in a better position to judge the credibility and reliability or the evidence given by the witnesses. In some appeals that advantage may not be significant since the witnesses' credibility and reliability are not in issue. But in many cases the advantage is very significant and the appeal court recognises that it should accordingly be slow to interfere with the decisions on matters of fact taken by the first instance body. This reluctance to interfere is not due to any lack of jurisdiction to do so. Rather, in exercising its full jurisdiction, the appeal court acknowledges that,

> if the first instance body has observed the witnesses and weighed their evidence, its decision on such matters is more likely to be correct than any decision of a court which cannot deploy those factors when assessing the position. In considering appeals on matters of fact from the various professional conduct committees, the Board must inevitably follow the same general approach. Which means that, where acute issues arise as to the credibility or reliability of the evidence given before such a committee, the Board, duly exercising its appellate function, will tend to be unable properly to differ from the decisions as to fact reached by the committee except in the kinds of situation described by Lord Thankerton in the well known passage in *Watt or Thomas v Thomas* [1947] AC 484 , 484–488."

30. The passage from Lord Thankerton's opinion was as follows:

> "I do not find it necessary to review the many decisions of this House, for it seems to me that the principle embodied therein is a simple one, and may be stated thus: I. Where a question of fact has been tried by a judge without a jury, and there is no question of misdirection of himself by the judge, an appellate court which is disposed to come to a different conclusion on the printed evidence, should not do so unless it is satisfied that 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 conclusion; II. The appellate court may take the view that, without having seen or heard the witnesses, it is not in a position to come to any satisfactory conclusion on the printed evidence; III. The appellate court, either because the reasons given by the trial judge are not satisfactory, or because it unmistakably so appears from the evidence, may be satisfied that he has not taken proper advantage of his having seen and heard the witnesses, and the matter will then become at large for the appellate court. It is obvious that the value and importance of having seen and heard the witnesses will vary according to the class of case, and, it may be, the individual case in question."

31. I referred also to *Threlfall v General Optical Council* [2004] EWHC 2683 (Admin), at paragraph 21, where Stanley Burnton J, as he then was, said this:

> ‘Because it does not itself hear the witnesses give evidence, the court must take into account that the Disciplinary Committee was in a far better position to assess the reliability of the evidence of live witnesses where it was in issue. In that respect, this court is in a similar position to the Court of Appeal hearing an appeal from a decision made by a High Court Judge following a trial ...’
>
> 32. So those are the parameters for considering the issues raised in this appeal in relation to the findings. It is plain that where the conclusion of the FTP is largely based on the assessment of witnesses who have been “seen and heard”, this court will be very slow to interfere with that conclusion. Nonetheless, the court has a duty to consider all the material put before it on an appeal in order to discharge its own responsibility, appropriate deference being shown to conclusions of fact reached on the basis of the advantage of having seen and heard the witnesses. Where this court does not feel disadvantaged by not having heard the witnesses, and the issues can be addressed with little emphasis on the direct assessment of the evidence by the Panel, it is in a position to take a different view in an appropriate case.”

100. In *Yassin v General Medical Council* [2015] EWHC 2955 (Admin), Cranston J said at [32]:

> “32. Appeals under section 40 of the Medical Act 1983 Act are by way of re-hearing (CPR PD52D, [19]) so that the court can only allow an appeal where the Panel's decision was wrong or unjust because of a serious procedural or other irregularity in its proceedings: CPR 52.11. The authorities establish the following propositions:
> i) The Panel's decision is correct unless and until the contrary is shown: *Siddiqui* v. *General Medical Council* [2015] EWHC 1996 (Admin), per Hickinbottom J, citing Laws LJ in *Subesh* v. *Secretary of State for the Home Department* [2004] EWCA Civ 56 at [44];
>
> ii) The court must have in mind and must give such weight as appropriate in that the Panel is a specialist tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserves respect: *Gosalakkal* v. *General Medical Council* [2015] EWHC 2445 (Admin);
>
> iii) The Panel has the benefit of hearing and seeing the witnesses on both sides, which the Court of Appeal does not;

> iv) The questions of primary and secondary facts and the over-all value judgment made by the Panel, especially the last, are akin to jury questions to which there may reasonably be different answers: *Meadows* v. *General Medical Council* [197], per Auld LJ;
>
> v) The test for deciding whether a finding of fact is against the evidence is whether that finding exceeds the generous ambit within which reasonable disagreement about the conclusions to be drawn from the evidence is possible: *Assucurazioni 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, [47] per Leveson LJ with whom Waller and Dyson LJJ agreed;
>
> vii) If the court is asked to draw an inference, or question any secondary finding of fact, it will give significant deference to the decision of the Panel, and will only find it to be wrong if there are objective grounds for that conclusion: *Siddiqui*, paragraph [30](iii).
>
> viii) Reasons in straightforward cases will generally be sufficient in setting out the facts to be proved and finding them proved or not; with exceptional cases, while a lengthy judgment is not required, the reasons will need to contain a few sentences dealing with the salient issues: *Southall* v. *General Medical Council* [2010] EWCA Civ 407, [55]-[56].
>
> ix) A principal purpose of the Panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the medical profession so particular force is given to the need to accord special respect to its judgment: *Fatnani and Raschid* v. *General Medical Council* [2007] EWCA Civ 46, [19], per Laws LJ."

101. In *R (Dutta) v General Medical Council* [2020] EWHC 1974 (Admin), Warby J (as he then was) said at [21]:

> "(1) The appeal is not a re-hearing in the sense that the appeal court starts afresh, without regard to what has gone before, or (save in exceptional circumstances) that it re-hears the evidence that was before the Tribunal. 'Re-hearing' is an elastic notion, but generally indicates a more intensive process than a review: *E I Dupont de Nemours &*

Co v S T Dupont (Note) [2006] 1 WLR 2793 [92-98]. The test is not the 'Wednesbury' test.

(2) That said, the appellant has the burden of showing that the Tribunal's decision is wrong or unjust: *Yassin* [32(i)]. The Court will have regard to the decision of the lower court and give it 'the weight that it deserves': *Meadow* [128] (Auld LJ, citing *Dupont* [96] (May LJ)).

(3) A court asked to interfere with findings of fact made by a lower court or Tribunal may only do so in limited circumstances. Although this Court has the same documents as the Tribunal, the oral evidence is before this Court in the form of transcripts, rather than live evidence. The appeal Court must bear in mind the advantages which the Tribunal has of hearing and seeing the witnesses, and should be slow to interfere. See *Gupta* [10], *Casey* [6(a)], *Yassin* [32(iii)].

(4) Where there is no question of a misdirection, an appellate court should not come to a different conclusion from the tribunal of fact unless it is satisfied that any advantage enjoyed by the lower court or tribunal by reason of seeing and hearing the witnesses could not be sufficient to explain or justify its conclusions: *Casey* [6(a)].

(5) In this context, the test for deciding whether a finding of fact is against the evidence is whether that finding exceeds the generous ambit within which reasonable disagreement about the conclusions to be drawn from the evidence is possible: *Yassin* [32(v)].

(6) The appeal Court should only draw an inference which differs from that of the Tribunal, or interfere with a finding of secondary fact, if there are objective grounds to justify this: *Yassin* [32(vii)].

(7) But the appeal Court will not defer to the judgment of the tribunal of fact more than is warranted by the circumstances; it may be satisfied that the tribunal has not taken proper advantage of the benefits it has, either because reasons given are not satisfactory, or because it unmistakably so appears from the evidence: *Casey* [6(a)] and cases there cited, which include *Raschid* and *Gupta* (above) and *Meadow* [125-126], [197] (Auld LJ). Another way of putting the matter is that the appeal Court may interfere if the finding of fact is 'so out of tune with the evidence properly read as to be unreasonable': *Casey* [6(c)], citing *Southall* [47] (Leveson LJ)."

102. The approach which the High Court should take to challenges to findings of fact was also considered in *Byrne v General Medical Council* [2021] EWHC 2237 (Admin), [11]-[16]:

> 11. The issue is as to the circumstances in which an appeal court will interfere with findings of fact made by the court or decision maker below. This is an issue which has been the subject of detailed judicial analysis in a substantial number of authorities and where the formulation of the test to be applied has not been uniform; the differences between formulations are fine. I do not propose to go over this ground again in detail, but rather seek to synthesise the principles and to draw together from these authorities a number of propositions.
>
> 12. First, the degree of deference shown to the court below will differ depending on the nature of the issue below; namely whether the issue is one of primary fact, of secondary fact, or rather an evaluative judgment of many factors: *Assicurazioni Generali* at §§16 to 20. The present case concerns findings of primary fact: did the events described by the Patient A happen?
>
> 13. Secondly, the governing principle remains that set out in *Gupta* §10 referring to *Thomas v Thomas*. The starting point is that the appeal court will be very slow to interfere with findings of primary fact of the court below. The reasons for this are that the court below has had the advantage of having seen and heard the witnesses, and more generally has total familiarity with the evidence in the case. A further reason for this approach is the trial judge's more general expertise in making determinations of fact: see *Gupta*, and *McGraddie v McGraddie* at §§3 to 4. I accept that the most recent Supreme Court cases interpreting *Thomas v Thomas* (namely *McGraddie* and *Henderson v Foxworth*) are relevant. Even though they were cases of "review" rather than "rehearing", there is little distinction between the two types of cases for present purposes (see paragraph 16 below).
>
> 14. Thirdly, in exceptional circumstances, the appeal court will interfere with findings of primary fact below. (However the reference to 'virtually unassailable' in *Southall* at §47 is not to be read as meaning 'practically impossible', for the reasons given in *Dutta* at §22.)
>
> 15. Fourthly, the circumstances in which the appeal court will interfere with primary findings of fact have been formulated in a number of different ways, as follows:

- 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.*

In my judgment, the distinction between these last two formulations is a fine one. To the extent that there is a difference, I will adopt, in the Appellant's favour, the former. In fact, as will appears from my analysis below, I have concluded that, even on that approach, I should not interfere with most of the Tribunal's primary findings of fact.

16. Fifthly, I consider that, whilst noting the observations of Warby J in *Dutta* at §21(1), on the balance of authority there is little or no relevant distinction to be drawn between 'review' and 'rehearing', when considering the degree of deference to be shown to findings of primary fact: *Assicurazioni* §§13, 15 and 23. *Du Pont* at §§94 and 98 is not clear authority to the contrary. Rather it supports the proposition that there may be a relevant difference when the court is considering findings of evaluative judgment or secondary or inferential findings of fact, where the court will show less deference on a rehearing that on a review. Nevertheless if less deference is to be shown in a case of rehearing (such as the present case), then, again I will assume this in the Appellant's favour."

103. The relevant test for dishonesty is that set out in *Ivey*, [74]:

"74. … 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.

104. Where dishonesty is alleged in professional fitness to practise proceedings, it must be clearly particularised. In *Fish* the appellant was a consultant anaesthetist who was regularly employed by an agency and worked as a locum. It was alleged that he had been dishonest in relation to declarations made when submitting timesheets. In relation to the allegation of dishonesty, Foskett J said (at [67] – [70]):

> "67. What, however, seems to be a proposition of common sense and common fairness is this: an allegation of dishonesty should not be found to be established against anyone, particularly someone who has not been shown to have acted dishonestly previously, except on solid grounds. Given the consequences of such a finding for an otherwise responsible and competent medical practitioner, any Panel will almost certainly (without express reminder) approach such an allegation in that way.
>
> 68. An allegation of dishonesty against a professional person is one of the allegations that he or she fears most. It is often easily made, sometimes not easily defended and, if it sticks, can be career-threatening or even career-ending. Who would want to employ or otherwise deal with someone against whom a finding of dishonesty in a professional context has been made? I am, of course, dealing with the issue of dishonesty in a professional person simply because that is the issue before me. It is, however, a finding that no-one, whatever their walk in life, wishes to have recorded against his or her name.
>
> 69. I do not think that I state anything novel or controversial by saying that it is an allegation (a) that should not be made without good reason, (b) when it is made it should be clearly particularised so that the person against whom it is made knows how the allegation is put and (c) that when a hearing takes place at which the allegation is tested, the person against whom it is made should have the allegation fairly and squarely put to him so that he can seek to answer it. It is often uncomfortable for an advocate to suggest that someone has been deliberately dishonest, but it is not fair to shy away from it if the same advocate will be inviting the tribunal at the conclusion of the hearing to conclude that the person being cross-examined was dishonest. (I should say that Counsel presenting the case to the FTP did

> put the case advanced against him fairly to the Appellant. The problem, as I see it, for the reasons I will give below, is that what she put to him and what the Panel in due course concluded were arguably different or, at all events, the conclusion for which she contended did not have the compelling logic behind it that made its acceptance by the Panel valid.)
>
> 70. At the end of the day, no-one should be found to have been dishonest on a side wind or by some kind of default setting in the mechanism of the inquiry. It is an issue that must be articulated, addressed and adjudged head-on."

105. The approach to appeals against sanction which the High Court must take on an appeal by a doctor under s 40 of the Medical Act 1983 was set out by the Court of Appeal in *Sastry and Okpara v General Medical Council* [2021] 1 WLR 5029, [100]-[110]:

> "100. Drawing from the principles to be derived from the authorities we cite in [19] to [39] above, the following is of note.
>
> 101. The breadth of the section 40 appeal and the appellate nature of the court's jurisdiction was recognised by the Judicial Committee of the Privy Council in *Ghosh* [2001] 1 WLR 1915], and set out at [33] and [34] of the judgment of the Board given by Lord Millett. At [33] Lord Millett noted that the statutory right of appeal of medical practitioners under section 40 of the 1983 Act "does not limit or qualify the right of the appeal or the jurisdiction of the Board in any respect. The Board's jurisdiction is appellate, not supervisory. The appeal is by way of a rehearing in which the Board is fully entitled to substitute its own decision for that of the committee."
>
> 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* [*v General Medical Council* [2007] 1 WLR 1460], in accepting that the learning of the Privy Council constituted the essential approach to be applied by the High Court on a section 40 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* [*v General Medical Council* [2009] EWHC 645 (Admin)] 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* [*v General Pharmaceutical Council* [2017] 1 WLR 169] 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 40 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 [*General Medical Council v Jagjivan and Another* [2017] 1 WLR 4438] 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 40 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 40 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 40 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 40 appeals, as identified in *Ghosh* and approved in *Khan*, as appropriate in section 40 appeals which are by way of a rehearing.

109. We agree with the observations of Cranston J in *Cheatle* that, given the gravity of the issues, it is not sufficient for intervention to turn on the more confined grounds of public law review such as irrationality. The distinction between a rehearing and a review may vary depending upon the nature and facts of the particular case but the distinction remains and it is there for a good reason.

> To limit a section 40 appeal to what is no more than a review would, in our judgment, undermine the breadth of the right conferred upon a medical practitioner by section 40 and impose inappropriate limits on the approach hitherto identified by the Judicial Committee of the Privy Council in *Ghosh* and approved by the Supreme Court in *Khan*.
>
> 110. Accordingly, we agree with the view expressed by Leggatt LJ that the judge, in the section 40 appeal of Dr Sastry was required to exercise her own judgment as to whether the sanction imposed was excessive and disproportionate …
>
> …
>
> 112. Appropriate deference is to be paid to the determinations of the MPT in section 40 appeals but the court must not abrogate its own duty in deciding whether the sanction imposed was wrong; that is, was it appropriate and necessary in the public interest. In this case the judge failed to conduct any analysis of whether the sanction imposed was appropriate and necessary in the public interest or whether the sanction was excessive and disproportionate, and therefore impermissibly deferred to the MPT.
>
> 113. … We agree that in matters such as dishonesty or sexual misconduct, the court is well placed to assess what is needed to protect the public or maintain the reputation of the profession and is less dependent upon the expertise of the Tribunal …"

Submissions

Dr Ibrahim's submissions

106. On behalf of the Appellant, Mr Vullo advanced in writing the following grounds of appeal in the following order. (Orally, he took Ground 2 first, and focused on that and Ground 1 and Ground 3). He made clear at the outset that in relation to Grounds 4 and 5 he was content to rest on his written submissions.

107. Ground 1: the MPT's findings of dishonesty at [3(a) and [3(b)] of the allegations were wrong and/or unfair because it:

    a. did not make findings on key parts of Dr Ibrahim's 'break at the end of shift' defence (ie, that when he left early he was often just taking his break at the end of the shift, he not having been able to take it during the shift);

    b. erred in its approach to the 'Maidstone' defence (ie, some particularly early departures were because he had been called over to the Maidstone site to assist);

c. erred in its approach to the 'offset' defence (ie, that he left early on occasion because he had arrived early, before the start time of his shift);

d. found that Dr Ibrahim's conduct had been financially motivated, which had not been pleaded.

108. Ground 2: the finding of dishonesty in [6(a)] was wrong/unfair because the MPT misunderstood the meaning of the charge.

109. Ground 3: the finding of misconduct was wrong because it was unfair to find that Dr Ibrahim had gained financial advantage by his misconduct, when this had not been pleaded at the facts stage.

110. Ground 4: the finding of current impairment was based on possible risk to patients, which was tenuous and was not pleaded.

111. Ground 5: the direction of erasure was wrong in that it was based upon a finding of financial gain and/or gave undue weight to immaterial matters.

112. In relation to Ground 1, Mr Vullo clarified that when, at the outset, Dr Ibrahim had admitted [2] of the allegations (which alleged 'You knew you did not work until the shift end times claimed on the Timesheets'), Dr Ibrahim's case made it clear that all that he was admitting in respect of the dates to which the 'break at the end of shift' and the 'Maidstone defence' applied, was that he knew he had not remained at the Tunbridge Well site until the shift end times claimed on the time sheets. He was *not* admitting he had not worked until the end of the shift times claimed. That was because: in respect of the 'break at the end of shift' dates, his case was that he had worked a full shift, taking a 30-minute break as required (which he declared on the timesheets), which he chose to have during the last 30 minutes of his shift. Accordingly, the hours 'worked' had been as declared on his timesheet, and in respect of the 'Maidstone defence' dates, his case was that he had continued working – albeit at Maidstone – after leaving the Tunbridge Wells site. Mr Vullo accepted the MPT had correctly understood the nature of Dr Ibrahim's defence.

113. In relation to the 'break' defence, Mr Vullo said that it was clear from [56], [63] and [64] of the Determination that the MPT did not reject Dr Ibrahim's evidence that he had sometimes taken his break during the last 30 minutes of his shift; ie, the MPT did *not* find as a matter of fact that he had *not* taken his break during that period of time.

114. He said that the Tribunal had not made findings on two crucial issues: (a) whether there were any rules about exactly when during a shift a doctor was permitted to take their break (ie, whether there were any rules prohibiting a doctor from taking their break during the final 30 minutes of their shift); and (b) whether there were any rules about whether a doctor had to remain on the hospital site during their break (ie, whether they were prohibited from leaving the building to go for a walk or to the shops/bank etc.).

115. Accordingly, Mr Vullo submitted that there was insufficient evidence upon which the MPT could properly have concluded that it was impermissible (a) for Dr Ibrahim to take the break during the last 30 minutes of the shift; and (b) to leave the hospital site during the break. If these matters were not impermissible, it could not have been

said that Dr Ibrahim's conduct on the dates to which the 'break' defence applied was dishonest. He referred to *Williams v General Dental Council* [2022] EWHC 1380 (Admin).

116. Mr Vullo therefore submitted that the MPT had been wrong to find dishonesty proved in relation to the dates to which the 'break at the end of shift' defence applied. Its findings could not support such a conclusion.

117. In terms of the MPT's findings on the Maidstone defence, Mr Vullo emphasised that the MPT had not rejected it entirely (which is correct). It accepted that he may on occasion have left early to go to Maidstone.

118. However, Mr Vullo criticised the MPT's reasoning at [61]-[62], and its selection of 3pm/3.30pm as the 'cut off' times which, when Dr Ibrahim had left later than that, it could not have been because he was needed at Maidstone (because the period before the finish time, allowing for drive time to Maidstone would not have allowed him to do anything useful). Mr Vullo said in effect these were arbitrary times selected by the MPT. He pointed to the fact different 'cut-off' times were specified as evidence of that. He said it was perfectly possible that Dr Ibrahim had only gone to Maidstone for a short time, eg, to review one specific patient, or that despite the finish time as shown on the timesheet, he might actually have stayed at Maidstone and carried on working beyond that time.

119. On the offset defence, Mr Vullo's essential point was that it was unfair for the GMC to be able rely upon early departure times as evidence of dishonesty (even when it was only 10 or 20 minutes earlier) but for the MPT not to give Dr Ibrahim 'credit' for the times when he had arrived early, in order to 'balance out' the times overall. When that was done and the times looked at overall, he had not overclaimed and had not been dishonest.

120. Finally under this ground of appeal, Mr Vullo said that the MPT's rationale for the findings of dishonesty at [3] was also unfair in that it found dishonesty proved on a basis not in fact pleaded in the charges, namely that Dr Ibrahim had, by making the relevant entries on his timesheets, been seeking a dishonest financial benefit.

121. In relation to Ground 2, Mr Vullo said that in the paragraphs of the Determination dealing with the alleged dishonest lie in interview on 10 May 2019 ([72)-[76]), the MPT had misunderstood the issue and had instead merely considered again the issue they had already purported to resolve at [3], ie, whether the underlying conduct relating to the timesheets was dishonest. In any event, Mr Vullo submitted that the evidence in relation to what was said in the Trust interview had been insufficient to allow this part of the allegations to be found proved.

122. In relation to Ground 3, Mr Vullo submitted that as a result of what he said had been the errors particularised under Grounds 1 and 2, the finding of misconduct was also wrong. He also said it had been unfair to found a finding of misconduct on financial gain when this had been not pleaded, and also because the MPT had not considered the position overall on the offset defence.

123. In relation to Ground 4, Mr Vullo submitted that as a result of the wrongful findings on the facts and misconduct, particularised at Grounds 1, 2 and 3, the finding of impairment was also wrong. Additionally, he said the MPT's conclusion that Dr Ibrahim's actions

had caused 'the potential for a risk to patient safety' (when he had left early and not been contactable) too tenuous a basis upon which to find that the public protection limb of the overarching objective in s 1 of the Medical Act 1983. Furthermore, this had not been pleaded and had it been, it would have been addressed 'head on' by Dr Ibrahim and by his counsel, and hence there had been unfairness.

124. Finally, on Ground 5, Mr Vullo submitted that as a result of the wrongful findings on the facts, misconduct and impairment particularised in Grounds 1-4, the sanction of erasure was also wrong. He said that financial gain and the Trust having been defrauded should not have been taken into account, not having been pleaded. Also, viewed globally, taking into account 'early' times he had not been overpaid. The Maidstone defence had been partially accepted by the MPT. Further, the MPT had not given sufficient weight to the mitigation.

Submissions on behalf of the GMC

125. On behalf of the GMC, Ms Hearnden submitted as follows.

126. In relation to Ground 1, the MPT did not accept that Dr Ibrahim genuinely thought he was entitled to leave early in *lieu* of a break or that the Trust would accept it ([64]). There was no reason he could not have accurately completed his timesheets with start and finish times and put no break in the break column.

127. In relation to *Williams,* where Ritchie J held that if a regulator is going to hold a registrant to a rule, that rule must (a) be established in the first place; and (b) known to the registrant (if there is a dishonesty element to the charge), there was ample evidence on each matter. As to leaving early not being acceptable, evidence on this came from Mr Hubbard and from Dr Mudhar, who highlighted the problems which occurred on some days when Dr Ibrahim had left early. Dr Ibrahim knew he was not so entitled, which is why he had falsified his timesheets, which had been intended to give the impression that Dr Ibrahim had been at the Hospital until that time, when he had not.

128. The timesheets were misleading because they misled the reader into thinking that Dr Ibrahim had been present on site until the finish time, when he had not been. They were misleading even when a break was declared and he had worked right through his shift before leaving early. The MPT accepted the proposition emphatically agreed to by Mr Hubbard and agreed to by Dr Ibrahim: that a doctor on shift was expected to be on hospital grounds. Ultimately the MPT found that Dr Ibrahim knew what he was doing was wrong (Determination, [64]).

129. As to the Maidstone defence, whilst the MPT did not reject it outright, there was nothing by way of emails or texts to corroborate Dr Ibrahim's claim that he had been required at Maidstone, and none had been found during the Trust's own investigation. Ms Pochin's evidence was that doctors were not sent to a different site apart from 'very, very occasionally.' Dr Ibrahim had not added anything to the timesheets to suggest that part of the shift was completed at the other hospital on days he said that had happened. The MPT gave a clear rationale for its conclusions at [62], which were conclusions based on the evidence which fell within the generous margin to be afforded to it: *Dutta*, [21(5)].

130. As to the off-set defence, the MPT rightly concluded that early arrivals could not be offset against early departures. Dr Ibrahim was not on a flexi-time contract. Most of the time his arrival times were consistent with an 8am start allowing for arriving on the ward and handover. The fallacy in the argument is that Dr Ibrahim was booked for a particular shift, and that is what he was paid for, and by leaving early and putting his rostered finish time on the timesheet he was claiming for hours he had not worked.

131. Finally, although *financial* dishonesty had not been expressly pleaded, it had always been understood by everyone that the GMC's case was that Dr Ibrahim had defrauded the Trust by claiming for hours not worked, and so made a dishonest financial gain, and this had been put by his counsel in cross-examination to Ms Pochin in particular.

132. In relation to Ground 2, Dr Ibrahim's case was that the Practice (as referred to in the allegations) had come about as the result of a discussion with Mr Hubbard from which he had genuinely inferred that he could leave early in *lieu* of a break. In his evidence, he said he 'took it' as a result of that conversation that he could do as he did. The MPT was therefore required to judge whether Dr Ibrahim genuinely had the belief he said he had had. The MPT, having had the benefit of seeing Dr Ibrahim's live evidence, relied primarily upon the way in which he had completed the timesheets (ie, inaccurately) to reject the suggestion that he really had believed his conduct would nevertheless be condoned by the Trust ([73]). As such it was entitled to conclude that he had been dishonest in the interview. The MPT had not misunderstood the charge.

133. In relation to Ground 3, as with the related complaint under Ground 1, dishonest financial advantage had always been part of the GMC's case and that was understood.

134. In relation to Ground 4, the MPT had been entitled to find, on the basis of the evidence of Dr Mudhar in particular, that Dr Ibrahim's absence from the hospital before the end of the shift had potentially put patients at risk. The MPT's findings were sufficient to engage the third limb of the overarching objective so as to justify a finding of current impairment. In any event, the finding of current impairment was also made on the basis of public confidence and upholding professional standards.

135. Finally, on Ground 5, the MPT had found persistent and repeated dishonesty over a period of time; Dr Ibrahim had been found to have defrauded his employer; and so according to the *Sanctions Guidance*, erasure had not been a wrong sanction. The MPT had explicitly referred to the mitigation in the sanctions part of its Determination.

136. Ms Hernden submitted that even if there was a problem with the wording of the charge (per Ground 2) so that that part of the GMC's case went, that did not 'infect' the other parts of the MPT's Determination and in particular its findings on misconduct, impairment and sanction, which were still justified based on the false timesheets part of the case. In other words, if the MPT had erred on [6(a)], it was a harmless error so far as the other findings and conclusions in the Determination were concerned.

Discussion

137. I will discuss the grounds of appeal in the order which Mr Vullo took them orally, beginning with Ground 2.

Ground 2 – finding of dishonesty (allegation [6(a)]) wrongly made or otherwise unfair

138. For convenience I will set out the relevant parts of the allegations again:

> "4. In an interview with the Trust on 10 May 2019 in respect of the:
>
> a. inconsistencies on the Timesheets set out in Schedule 1, you stated that:
>
> i. you had adopted a practice whereby you did not take a lunch break and instead deducted time from the end of your working day ('the Practice');
>
> **Admitted and found proved**
>
> ii. the Practice came about following a discussion with mr Hubbard
>
> **Admitted and found proved**
>
> …
>
> 5. You knew that:
>
> a. you had not been told to adopt the Practice;
>
> **Admitted and found proved**
>
> …
>
> 6. Your actions as described at paragraph(s):
>
> a. 4. a. i. and 4. a. ii. were dishonest by reason of paragraph 5. a.;
>
> **To be determined"**

139. Paragraph 6(a), therefore, was an allegation of dishonesty through lying in the 10 May 2019 interview. It was alleged that Dr Ibrahim had been dishonest in the interview because he knew he had not been 'told' by Mr Hubbard to take his break at the end of the day.

140. Counsel for the GMC opened the matter this way (Bundle, p118):

> "During the course of that investigation, the doctor was asked to explain these discrepancies, why it was that his shift was said to end at, for example, 5.30, yet his car may be seen to have departed significantly earlier, whether it be four o'clock, 4.30, whatever time the document shows. In

> short he said this. He said that the times that he had left the Trust, left the hospital prior to the end of his shift was because he had not taken a lunch break during the working day. He did say that he never left before he was sure that all his tasks were fully completed, but he also said that he adopted this practice effectively as a result of a conversation he'd had with a gentleman, a witness called Tim Hubbard. He's the Deputy Divisional Director of Operations for Medicine and Emergency Care at the Trust. He said that Mr Hubbard had told him, in response to the doctor's question of whether your break could be taken at any time during the day, that Mr Hubbard had said that whilst he must take a break, he said that it could in fact be at any time of day. The doctor said that his interpretation of that conversation was this, that there was no reason why he couldn't take his break right at the end of the working day. The logical conclusion from that, he says, is that there would be nothing wrong in those circumstances with leaving the hospital, leaving the ward and leaving the car park early."

141. The summary note of the meeting on 10 May 2019 said this (Bundle, p374) (it would appear that Dr Ibrahim had the opportunity to correct Ms Pochin's original note – there are some annotations in blue):

> "Mr Ibrahim and Mark [his representative] explained that Mr Ibrahim had adopted a practice where he does not take his lunch break and instead deducts this from the end of his working day, though this is not reflected on the timesheet.
>
> Mr Ibrahim said this came about following a discussion he held with Tim Hubbard (assistant general manager for Surgery at the time before Ms Pochin) years ago. Mr Ibrahim explained that Tim had informed that he must take his breaks at any time, as they will be deducted anyway if he does not take them."

142. At the end of the Note, Bundle p376, it states:

> "Mr Ibrahim stated he was not defrauding the Trust, and that he firmly believed he was entitled to the time through his prior discussion with Tim Hubbard."

143. The Management's Statement of Case for the disciplinary process said at Bundle, p362:

> "Mr Ibrahim was interviewed on 10 May 2019 (Appendix 14) and acknowledged that the car park exit information was different to the times noted on his timesheets. He confirmed that the reason for this was because he had previously been advised by Tim Hubbard when he was Assistant General Manager for Surgery, that because he

> frequently could not take a lunch break, he should just add this onto the end of his working day."

144. The same document recorded Mr Hubbard's evidence during the investigation about this, at Bundle, p363:

> "Mr Hubbard does recall having a conversation with Mr Ibrahim confirming that he should take his breaks, that these would be need to be noted on the timesheets and that shifts would not be authorised unless they were present. Mr Hubbard denies telling Mr Ibrahim to add his breaks to the end of his shift and confirms he would never authorise such an action."

145. As Mr Vullo submitted, I accept that these two passages were not necessarily an accurate reflection of what the note of the 10 May 2019 meeting said Dr Ibrahim had said in that meeting.

146. In the Trust's disciplinary process in August 2019, one of the documents said under 'Your case' (my emphasis) (Bundle, p346):

> "You stated that that the times you have left the Trust prior to the end of your shift as per your signed timesheet was because you had not taken a break during your working day, but that you have always made sure that all of your tasks were fully completed before doing so. You clarified that Tim Hubbard had told you, in relation to your question of whether your break could be taken at any time, that it could be and that you must take it. *You said that taking the break at the end of the working day was your interpretation of Tim's response to you and that you believed there was no reason that you could not take your break at the end of the working day*."

147. It was also stated that Dr Ibrahim had (Bundle, p348):

> "… repeated that Tim had told [him] that [he] should take [his] break and [he] had interpreted that statement".

148. Before the MPT, Mr Hubbard was clear that he would not have advised anyone to take their break at the end of a shift and leave early. He said the following would be an accurate note of what he had told Dr Ibrahim (Bundle, p183):

> "Mr Ibrahim explained that Tim had informed that he must take his breaks, as they will be deducted anyway if he does not take them."

149. It was suggested that he had also said the words, 'at any time' after 'breaks' and he responded (Bundle, pp182-3):

> "I don't recall saying 'at any time'. I recall saying to him that he needed to take opportunities to take breaks, but if he needed to hand his bleep to a colleague to look after, if that was his concern, he should then, you know, arrange cover for himself. I don't recall specifically saying 'you need to take your breaks at any time', I was saying 'you should take your breaks during the course of your shift'.

150. In re-examination Mr Hubbard was asked by the GMC's counsel (Bundle, p183):

> "MR LODGE: Mr Hubbard, can you conceive of a circumstance where you could have said to somebody 'you can take your breaks at the end of the day and leave early'?
>
> A No."

151. Dr Ibrahim's witness statement for the MPT hearing said this:

> "13. My conversation with Mr Hubbard centred around whether I should be paid for the entire time I worked during a shift as I did not consider that time for a break should be deducted when I had not taken one. Mr Hubbard's response was that I could not be paid for the entire shift and that I was required to take a break. I did also ask Mr Hubbard whether there was any specific time when I had to take a break and he confirmed that there was not and that it depended on working conditions.
>
> 14. Following my conversation with Mr Hubbard I adopted the practice of taking my break at the end of the day which resulted in me completing time sheets with end times later than when I actually left the car park."

152. In his evidence, Dr Ibrahim accepted that he had not discussed the Practice *explicitly* with anybody, but had inferred – or 'took it' - from a conversation with Mr Hubbard that leaving early would be acceptable (Bundle, p206) (my emphasis):

> "Q. But emergencies can occur. Junior doctors need assistance. If you are not there to provide that assistance, it creates a patient safety issue, doesn't it?
>
> A. You are not working for eight hours. You are working certain hours and eight, yes, by five o'clock you should finish your work. So I, looking after maybe 15, 20, 30 patients at any time before close that day, if I am happy that everything is in order and I am entitled to take half an hour's break. That was my understanding, that I should take a half hour break. It was perhaps misguided that I did not really get this in writing from the management and I am sorry for that.

> Q. Do you accept that it is not a conventional approach to taking breaks, to take them at the end of the day and to leave the premises?
>
> A. I could still be contactable by my mobile. It is not conventional, but how would you recoup this half hour. A half hour in five days is two and a half hours. How do you get this two-and-a-half hours back?
>
> Q. What would happen if other doctors were to adopt the same practice as you and leave early before their shift has ended? It would be chaos, wouldn't it, in the hospital? Nobody would know where people were; patients going untreated. Do you accept it is not a helpful or particularly sensible approach to take?
>
> A. It is not very helpful, but that was the only way that I could actually get my hours protected. It should have been something that the hospital had acknowledged and looked into.
>
> *Q. Who did you discuss it with at the hospital when you decided to adopt this practice, which you have accepted was unhelpful.*
>
> *A. I did not say it was unhelpful. I did not discuss it with anybody. I took it from the conversation that I had with Mr Hubbard, that you should take the time off as it is my right to take it, and I did not, you know, think that it would be a problem.*"

153. Consistently with what he said on 10 May 2019, therefore, Dr Ibrahim's case was that he did what he did because that is what he *interpreted* Mr Hubbard as having authorised him to do, but *not* that Mr Hubbard had explicitly told him so.

154. His counsel, in closing submissions, clearly explained that Dr Ibrahim's case was that he had inferred his belief from his conversation with Mr Hubbard. At Bundle, p250, counsel said:

> "Mr Ibrahim's actual state of mind was that Mr Hubbard had advised him, as indeed you know was the case from Mr Hubbard, that he must take his breaks because the 30 minutes would be deducted in any event. Mr Ibrahim, consequential on that advice, adopted a practice of essentially taking his break at the end of the day. As I have said, that may have been a mistaken practice, but that was the genuine state of his mind. A mistake doesn't equate to dishonesty. He genuinely thought at the time he was allowed to do that."

155. Counsel then referred to it again at pp252-3.

156. Ms Hearnden fairly (and correctly) accepted in her oral submissions that Dr Ibrahim had never claimed - and particularly not on 10 May 2019 - that he had had an 'express sign-off' for the Practice from Mr Hubbard.

157. I turn to my conclusions.

158. I am satisfied that Ground 2 is made out and that the MPT's finding of dishonesty on [6(a)] was wrong and cannot be supported. I therefore quash that specific finding of dishonesty. My reasons are as follows.

159. The difficulty for the GMC on this part of the allegations is how [5(a)] was drafted and the use of the word 'told', which has a clear meaning. As I have explained, the allegation of dishonesty in [6(a)] rested on the allegation that Dr Ibrahim knew that he had not been 'told' to adopt the Practice. In other words, the GMC's case effectively was: 'You said in interview on 10 May 2019 you had been told to adopt the Practice. You knew you had not been told that. Therefore, you lied and so were dishonest'.

160. However, Dr Ibrahim never said that he had been 'told' to adopt the Practice. The note of the meeting did not record him having said that. His evidence to the MPT was that it came about as the result of what he inferred from – or how he interpreted - his conversation with Mr Hubbard.

161. Thus, the short answer to the allegation of dishonesty in [6(a)] by reason of [5(a)] is this: 'I knew that I had not been told to adopt the Practice. But I never said on 10 May 2019 that I *had* been so told. Therefore, I did not lie, and I was not dishonest.'

162. Ms Hearnden accepted in her oral submissions that – at least in hindsight - this part of the allegations had not been happily drafted. She therefore acknowledged that for the allegation in [6(a)] to 'work', and for the MPT's decision to be sound, [5(a)] had to be read as meaning something like, 'you knew you had not been told to adopt the Practice, and you did not genuinely believe from an interpretation of your conversation with Mr Hubbard that it would be acceptable'.

163. There are at least two difficulties with that re-interpretation. First, it is not what [5(a)] says – it simply says 'told'. Secondly, Dr Ibrahim admitted [5(a)], no doubt on the basis that he had never said he *had* been 'told' by Mr Hubbard. If [5(a)] had been drafted in the way Ms Hearnden now says it has to be read for the allegation to work, Dr Ibrahim would not have admitted it, because his case was always that he *did* have a genuine belief that the Practice was authorised as a result of how he interpreted his conversation with Mr Hubbard.

164. Hence, [5(a)] cannot be fairly or properly read in the manner Ms Hearnden suggested.

165. I have read and re-read the relevant passages in the Determination dealing with [6(a)], namely [72]-[76], and I am far from satisfied that the MPT grasped the subtlety of the facts surrounding this part of the allegation. There is no recognition in those paragraphs that Dr Ibrahim had never said that he had been 'told', which was vital for a proper

resolution of the issue. I see the force in Mr Vullo's submission that the MPT may simply have misunderstood matters. Be that as it may, its findings on this aspect of the case cannot properly support a conclusion of dishonesty in [6(a)].

166. In [73]-[75] the MPT twice found that Dr Ibrahim did not have a genuine belief that the Practice was authorised (my emphasis):

> "73. As set out above, as demonstrated by his actions in completing his timesheets in a manner which implied that he had been present at the end of the shift, *the Tribunal considered that Mr Ibrahim was fully aware that the Trust would not have condoned this practice*. The Tribunal did not accept Mr Ibrahim's evidence that he could not find time for a break and that in any event, this would not have provided an excuse for his leaving before the end of the shift when he was still required to supervise the juniors on his team.
>
> 74. Mr Ibrahim stated in his evidence that it did not occur to him that the additional time spent in the morning should be added to his shift time until after the Trust began its investigation. The Tribunal accepted that he did not believe he was so entitled when he was completing his timesheets. The Tribunal did not accept that Mr Ibrahim believed that as he arrived early, he could leave early.
>
> 75. The Tribunal, having taken all of the above into consideration, deliberated over what an ordinary decent person would think if they had the facts before them. It concluded that a doctor deciding to routinely adopt a practice whereby he deducted his lunch break from the end of his working day so that he could leave work early *when he knew that he had no authority to do this*, would be seen as dishonest."

167. Hence, if the allegation of dishonesty had been based on an allegation that Dr Ibrahim had falsely claimed on 10 May 2019 to have had a genuine belief that he had approval, then the GMC's case would have been on more certain ground. The italicised words in [73] and [75] were a clear rejection of the suggestion that Dr Ibrahim had had any such genuine belief.

168. But that was not the GMC's case. It alleged dishonesty on the falsity of something which Dr Ibrahim had never said, and never said he said.

169. Ground 2 therefore succeeds.

170. That said, having reflected carefully, the allegation in [6(a)], whilst being one of dishonesty and so inherently serious, strikes me as being significantly less serious in the context of the case as a whole than the allegations of dishonesty arising from the persistent and repeated submission of fraudulent claims for hours not worked (per [3(a)] and [3(b)]

of the allegations). In fact, I note that in his closing submissions, the GMC's counsel did not really address it, save to say that Dr Ibrahim's explanation based on his conversation with Mr Hubbard had been 'contrived' (Bundle, p240, pp244-5). It was therefore a relatively small part of the case. Later on, I will consider whether the quashing of the finding of dishonesty in [6(a)] has any impact on the other parts of the MPT's Determination.

Ground 1 – finding of dishonesty in [3(a)] and [3(b)] wrong or unfair

171. The essential issues on Ground 1 are whether the findings of dishonesty in [3(a)] and [3(b)] were correct in light of the evidence and the MPT's findings. I am satisfied that they were correct, for the following reasons, and Ground 1 therefore fails.

172. There were, as Mr Vullo conveniently labelled them, three strands to Dr Ibrahim's defence to the allegations of dishonesty over the timesheets: (a) the 'break' defence; (b) the 'Maidstone' defence; and (c) the 'offset' defence.

173. Dr Ibrahim dealt with the 'break' defence at [6]-[8] of his first witness statement of 24 March 2022:

> "6. When working at the Trust I would drive to work in my car and park in the staff car park. I frequently arrived at work (before 8:00 AM) and commenced my duties which included preparing for the hand over meeting which is scheduled for 08:00 AM every day. I refer you to the original records of the Car Park at Tunbridge Well Hospital that shows the times of entering the Car park as well as times of leaving. This will show that I claimed less time than I actually claimed from the Trust on my Time Sheets. I also routinely worked without taking a break during my shift either because I was busy and/or because there was no one else of sufficient seniority who was willing to provide cover whilst I took my break.
>
> 7. As I did not routinely take a break, I would often and in lieu of this leave the Trust prior to my scheduled end time. Before doing this, I would always ensure that there was someone who was able to take over my duties. I also spoke to the on-call doctor to let them know that I was leaving and to tell them about any concerns or investigation results that were due if there was any
>
> 8. When completing my time sheets I would generally record having left the Trust at my scheduled end time although as set out above I would have often left work some time before, in order to allow for the fact that I did not take a break and/or that I had commenced work early. The difference in timings between leaving work and the recorded time on the sheet was because I was unable to take

my 30-minute breaks, and this 30 minute was deducted from every shift as shown on all time sheets.

…

12. I adopted the above practice in regard to completion of my time sheets following a conversation that I had with Mr T Hubbard in 2007 who at the time was the interim Deputy General Manager for Surgery. I should start by saying that I did not ask Mr Hubbard, as is alleged whether I could list the break time at the end of his shift and write down a later finish time or alternatively finish early.

13. My conversation with Mr Hubbard centred around whether I should be paid for the entire time I worked during a shift as I did not consider that time for a break should be deducted when I had not taken one. Mr Hubbard's response was that I could not be paid for the entire shift and that I was required to take a break. I did also ask Mr Hubbard whether there was any specific time when I had to take a break and he confirmed that there was not and that it depended on working conditions.

14. Following my conversation with Mr Hubbard I adopted the practice of taking my break at the end of the day which resulted in me completing time sheets with end times later than when I actually left the car park."

174. The MPT correctly understood the break defence. It set out the gist of it at [36] and [40]:

"36. Mr Ibrahim started his oral evidence by telling the Tribunal how his practice of leaving the Trust early was adopted as a result of a discussion with Mr Hubbard previously, probably in 2017, when Mr Hubbard was Deputy General Manager for Surgery.

..

40. Mr Ibrahim understood that he was required to be on site for the entirety of his shift if it was busy. However, he said that if he was satisfied that everything was in order, he was not on call and he had completed his work, he would leave early:

"I was looking after 15,20,30 patients and I was satisfied my work was complete and I was entitled to leave early. My mistake was to not take this in writing from management. Not a conventional approach but I stayed contactable and how else would I recoup the breaks otherwise? Not a very helpful approach but

> that was the only way I could get my hours back. I took the conversation with Mr Hubbard and my right to take the breaks into account." "I accept however that I should have discussed my working arrangements and claims in respect of lost break times with the Trust's management more formally and obtained their specific agreement to allow me to claim a period of compensatory equivalent rest which is what I did and what was provided for in my staff bank contract. I did not do this because I had worked at the Trust for a number of years and trusted the advice, I had received from Mr Hubbard without thinking I needed to receive it in writing."

175. At [56], [63]-[67] the MPT said (my emphasis):

> "56. It was clear from Mr Ibrahim's evidence (and that of Mr Hubbard), that Mr Ibrahim was unhappy that the break was no longer a paid one (as it had been when he was an agency doctor) and that he felt that he was unable to take his 30 minutes on his terms. He stated that he 'decided' that he would take it at the end of the day, a practice that he then implemented as routine. He knew he was entitled to a break but at no point sought to clarify if he could leave early in the manner he adopted. Indeed, the timesheet required a specific start and 'finish' time. The Tribunal considered that by filling in the timesheet in the way he did, he was not accurately recording the practice he had adopted.
>
> …
>
> 63. The Tribunal deliberated over whether Mr Ibrahim was able to take a break during his shifts. He had stated that he 'never' had time for a break. The Tribunal took into account Mr Ibrahim's explanation of what his average working day looked like. He had stated in his evidence that there were no elective clinics to attend, and he was not requested to work in the operating theatre. It did not seem likely to the Tribunal that he would be too busy on every shift and unable to take a break. The Tribunal did not accept Mr Ibrahim's evidence that even in a 12-hour shift he would not take a break. The Tribunal was of the view that while Mr Ibrahim could get a break on many occasions, either he chose not to take a break as he was not getting the break on his terms, or he did take a break but did not disclose it.
>
> 64. *The Tribunal did not accept that Mr Ibrahim thought he was entitled to behave in this way or that he believed that the Trust would have accepted his choosing to work in this way. This was evidenced by the manner in which he*

> *completed his time sheets which would have misled the Trust into thinking he had been present in the hospital at the end of his shift.*
>
> …
>
> 66. The Tribunal, having taken all of the above into consideration, deliberated over what an ordinary decent person would think if they had the facts before them. It concluded that a doctor deciding to routinely leave work early and submitting timesheets with incorrect shift end times which resulted in him being paid money to which he was not entitled to, would be seen as dishonest.
>
> 67. Accordingly, the Tribunal found paragraph 3 to be proved in its entirety.*"*

176. Paragraphs 56 and 64 therefore contained findings: (a) that Dr Ibrahim had submitted timesheets which were misleading, in that they would have misled the Trust into believing that he was present, on-site, until the finish time as shown on the timesheet; and (b) that he knew them to be misleading. In other words, the timesheets did not accurately record the Practice he said he had adopted. It also found he knew the Trust would not have agreed to what he was doing, had he told it.

177. Those findings, in my judgment were correct and are sufficient to uphold the findings of dishonesty in [3(a)] and [3(b)], at least so far as the 'break' defence is concerned.

178. The timesheets were unquestionably misleading. It was clearly implicit from the timesheets that the shift end time (or 'Finish Time' as it was labelled) was the time up until which the person completing the form was representing they had worked on site at the hospital. That was made clear by the declaration which I quoted earlier. The ordinary reasonable reader of the timesheet would understand the 'Finish Time' to be the time the person had worked until before leaving the hospital.

179. The point here is not so much whether by not taking a break, and then leaving early to make up for that, Dr Ibrahim was claiming something to which he was not entitled. As Mr Vullo said, breaks often *were* identified on the timesheets. The key point is whether Dr Ibrahim was completing the time sheets in a manner which misled the Trust. He plainly did.

180. As to the doctor's belief, the MPT heard him give evidence and were entitled to conclude that he knew what he was doing was unauthorised. The simple point is that if he thought leaving early in *lieu* of a break was acceptable, he could have discussed the with management and/or filled in his timesheets accurately. The only inference to be drawn is the timesheets were false because he was covering-up what he was doing.

181. At [26] of the Grounds Mr Vullo argued, with reference to [56], [63] and [64] of the Determination that (original emphasis):

> "… the Tribunal clearly did not reject the Appellant's evidence that he had taken his break during the last 30 minutes of his shift; ie the Tribunal did not find as a matter of fact that he had not taken his break during that period of time"

182. This in my view is a red herring, as I said during the hearing. If the evidence had showed that Dr Ibrahim had only ever left 30 minutes early in *lieu* of a break then, mathematically at least, the defence would have 'worked'. He would have been correctly paid for hours worked. (I leave aside for now other issues, like patient safety and the requirement for him to stay on site until the end of his shift).

183. But he did not only ever leave 30 minutes early. As the MPT found, and was not disputed, there were many occasions when he left far earlier (even when he could not have been travelling to Maidstone, as the MPT found). So, for that reason alone, the break defence cannot provide an honest explanation for his early departures.

184. Counsel for the GMC made this point in his opening to the MPT at Bundle, p119:

> "It's the GMC's case in respect of this that it would have been obvious to anybody, and especially Dr Ibrahim, that leaving before the end of his shift, claiming to have worked the full period simply because he hadn't taken a lunch break, is utterly unacceptable, especially on the number of occasions that the doctor adopted that practice for. We say even if this was the doctor's practice and the practice that he had adopted, there were a number of other occasions when his departure time is significantly in excess what could be accounted for by a period of his break, significantly in excess of the half an hour time that he would expect to have taken a break for. If one looks perhaps at the evidence provided at page 82, within the first month on 20 March 2018, we see that his car is exiting the car park 53 minutes before the end of his shift. On 28 March, just a few days later, it's leaving 62 minutes in advance of the end time for the shift that he's written down on his timesheets which were provided to the Trust. 2 April 2018, 153 minutes before the end of his shift. Those are just three examples. When one looks at the entire schedule, one will see a number of similar examples where the doctor is leaving a significant period before the shift time, far in excess of the 30-minute break that might have been the practice that he said he had adopted."

185. Hence, even allowing for the legitimacy of the break defence for some days (despite the false timesheets), Dr Ibrahim's actions were nonetheless plainly dishonest on many other occasions.

186. Even by leaving 30 minutes before his shift ended Dr Ibrahim was doing what he knew he was not allowed to do. He said (Bundle, p205):

> "Q. You are in the hospital. You say it is a busy hospital and emergencies happen all the time. There is an expectation that you are there the entirety of your shift period, is there not ?
>
> A Yes, yes. When I finish my work, I mean, if I am satisfied that everything is in order, yes, I should be there."

187. This, I think, is an important indicator that he knew what he was doing was against the expectations of management and staff and/or that it was unlikely to be agreed to if he had asked explicitly to be permitted to leave early in lieu of a break (which he did not do).

188. I set out some of Mr Hubbard's evidence on this earlier. He was quite clear that leaving for the day before the end of a shift was not permitted.

189. The MPT said of Mr Hubbard's evidence at [27]:

> "27. Mr Hubbard was unsure as to the type of contract Mr Ibrahim was on when he first started with the Trust (agency or bank) but once he was on the bank contract, it was fairly standard. He would be contracted to work for the Trust and be paid via timesheets. This was not a flexi time contract but one with set times. The expectation was that a doctor would be on site for the duration of the shift."

190. This paragraph is based on evidence which Mr Hubbard gave in answer to questions from a member of the Tribunal (Bundle, p184):

> "Q. Can you say that your understanding is the doctors were expected to be there between the hours of the shift?
>
> A. Yes, they would be, absolutely; and if there was a reason they couldn't be we would have expected to have been informed of that.
>
> Q. So it's your understanding, is it, that the contract isn't what you'd describe as a 'flexitime' contract?
>
> A. No, no; it's a shift pattern – yes, so against a rota, you're expected to be on site for the duration of your shift"

191. That is not to say that a doctor, having handed their bleep over for the duration of their break, and having notified a colleague that they were going on their break, could not then pop out to the bank, or wherever. However, that is a different thing from (a) Dr Ibrahim leaving the hospital for the day well before the end of his shift and (b) then being uncontactable by colleagues who, if they had checked the rota, would have been misled into thinking he was still working on site not gone for the day; and (c) then submitting a timesheet which fundamentally misstated the position.

192. Mr Vullo referred to *Williams v General Dental Council* [2022] EWHC 1380 (Admin) where Ritchie J held that if a regulator is going to hold a registrant to a rule, that rule must (a) be established in the first place, and (b) known to the registrant (if there is a dishonesty element to the charge). On the evidence, both of these limbs were satisfied.

193. It is clear that the MPT was troubled by the fact that Dr Ibrahim left the hospital early in order to – on his account – take his break, and that concern was irrespective of whether he had worked through the rest of the shift without a break. The issue was that he left junior staff and patients unsupported since, as far as the Trust was concerned, he should have been on site and available. It said at [58]:

> "58. The Tribunal noted that Mr Ibrahim's early exits from the hospital had had an impact on other doctors as well as the potential impact on patients. The Tribunal noted that as Mr Ibrahim stated in his own evidence, of his conversation with Dr A, "there would always be patients to be looked after". The Tribunal considered that Mr Ibrahim could not properly regard his work as complete when he elected to leave the hospital. Based on the evidence Mr Ibrahim had given, the Tribunal concluded that Mr Ibrahim was seeking to recoup pay he was not entitled to because of his dissatisfaction over his contractual terms and, as a consequence, he decided to leave his work before his shift was complete."

194. Although not referred to by the MPT, I have regard to evidence which Dr Ibrahim gave during the Trust's internal disciplinary process. He was asked during the disciplinary hearing as follows (my emphasis):

> "I asked you why your early starts were not reflected in your signed timesheets. You said that this was because it would create confusion and would need Jelena's approval. *I asked you why you did not seek approval for the apparent differences in your timesheets and what you actually worked and you said that it would not be approved.* You said that it never occurred to you that it would be necessary to discuss these matters with Jelena. You went on to say that you had no intention to mislead anyone regarding your working times and repeated that you assumed it was acceptable to take your break at the end of the working day."

195. As I said during the hearing, if there had been a genuine problem with Dr Ibrahim not being able to have time for breaks whilst on shift, then the solution would have been for him to have raised it with Trust management to find a mutually acceptable solution. It was not honestly open to him to do as he did, which was to leave early (and often very early) and then submit a timesheet falsely representing that he had worked until the end of his rostered shift. His answer at Bundle, p206 was telling as to his real motivation:

> "I could still be contactable by my mobile. It is not conventional, but how would you recoup this half hour. A half hour in five days is two and a half hours. How do you get this two-and-a-half hours back?'

196. He did what he did because he felt he had to 'recoup' his (unpaid) hours, even though that meant acting dishonestly.

197. I turn to the Maidstone defence.

198. As I have said, the MPT noted that there were nine occasions when Dr Ibrahim left more than 90 minutes prior to the end of his shift, and four occasions when the period was in excess of 120 minutes.

199. Dr Ibrahim's alternative explanation for why it was permissible for him to leave early, particularly where he left early by more than 30 minutes, was that he may have been asked to leave the Tunbridge Wells site early to go and assist at the Maidstone site.

200. Ms Pochin's evidence on this was as follows (Bundle, pp170-171):

> "Q. Dr Ibrahim has said in relation to some of the earlier finishes that he was asked to work clinics in Maidstone Hospital. I wondered, to your knowledge, what documentation would the Trust have to confirm whether he'd worked at Maidstone Hospital on certain days?
>
> A There were occasions where Dr Ibrahim was asked to transfer over to Maidstone, very, very occasionally, just to support the clinic, and on those occasions he would have been added to the electronic rota as attending the clinic, and that would have been trackable and auditable through things like clinic letters that would have – obviously be with the clinic.
>
> Q. Okay. So, there is no documents that have been put in that were in the Trust investigation or any documents I've seen with regard to Dr Ibrahim working at Maidstone Hospital. Does that mean the Trust doesn't have those documents, to your knowledge?
>
> A. We couldn't find any evidence on the occasions that we noted that he'd left early that he'd gone over to Maidstone Hospital to undertake a clinic.
>
> Q. Again, to your knowledge, what documentation, if any, would a doctor at this point have in time in terms of evidence to show that they had worked clinics at Maidstone Hospital?
>
> A. What evidence would the doctor have?

> Q. Yes.
>
> A. So, frankly, I'm not sure he would have much evidence beyond the specific request which would have likely come in the format of email if they were booked in advance or text message if it was a short-notice change.
>
> Q. Thank you.
>
> A. But, generally speaking, when a doctor was on a specific site – sorry.
>
> Q. No, sorry, carry on.
>
> A. Generally speaking, when a doctor was on a specific site, we would try and keep them on that site because it is a huge upheaval travelling between sites and we recognise that."

201. As I explained earlier, she had been unable to find anything to corroborate Dr Ibrahim's Maidstone defence.

202. Dr Ibrahim was also unable to produce any evidence to show he had gone to Maidstone on days when he had left Tunbridge Wells especially early, for example, evidence from colleagues at that site that he had told them he was going over to Maidstone, or evidence from colleagues at Maidstone that he had assisted there.

203. Nor was he able to produce any emails or texts to support his account. He said that he usually used the visitor car park at Maidstone, and so there were no records of him entering the staff car park there, and that would be asked to go over by telephone call. Perhaps most notably, he did not add anything to his timesheets to the effect that part of the shift was completed at the other hospital.

204. He simply said (Bundle, p211)

> "Q, Seventeen occasions when you left the hospital more than 60 minutes prior to the end of your shift, nine when you had left more than 90 minutes before the end of your shift. You are saying you think that might have been Maidstone. They haven't been able to adduce the evidence that that's the case.
>
> A. Well, I cannot see myself leaving an hour and a half to two hours and claiming for it unless I was working."

205. When considering the Maidstone defence, the MPT found that it was credible that Dr Ibrahim could have been going over to Maidstone if he left before 3pm ([61]), but if he had left after 3.30pm then the Maidstone defence was not credible ([62]).

206. As Mr Vullo submitted, there does appear to be a discrepancy between the times of 3pm in [61] and 3.30pm in [62]. I am prepared to assume in Dr Ibrahim's favour that the MPT should be taken as having found that on the days he left earlier than 3.30pm, then that could have been because he was going to the Maidstone site. Whilst the MPT did not expressly say that it accepted Dr Ibrahim's evidence that he travelled to Maidstone, it did find that, 'the Trust had not established that [the Appellant] had not travelled to Maidstone' ([61]).

207. In his Grounds, Mr Vullo argued at [34] that the 'cut-off' time selected by the MPT was arbitrary and not properly explained. However, I consider that the MPT gave a clear rationale for its finding at [62].

208. Its reasoning plainly was that the Maidstone site is approximately 20 minutes' drive away from Tunbridge Wells, and most of the Appellant's shifts concluded at 5pm or 5.30pm. Given Ms Pochin's evidence about the disruption caused by swapping sites as a reason why doctors were only occasionally re-deployed, swapping sites for a very short attendance was unlikely.

209. In my judgment, the MPT's treatment of this issue was fair, measured, balanced and justified. It found, in effect, that the GMC had *not* proved that Dr Ibrahim had *never* gone to Maidstone, but that this explanation could not account for all of the discrepancies in the timings between his declared 'finish' time and the car park records where he had left before 3.30pm.

210. There was space on the timesheet for 'comments' and it would have been very easy for Dr Ibrahim, on the days he was called to Maidstone, for him to have made an appropriate entry on the timesheet to that effect. He did not do so.

211. In the circumstances, the MPT made findings of primary fact on the basis of the evidence before it. Necessarily, that included an assessment of Dr Ibrahim's credibility. The Tribunal had the advantage of oral evidence and specialist knowledge, and reached a conclusion which was logical and fell within the 'generous ambit' of the available conclusions: *Dutta*, [21(5)].

212. I turn to the 'offset' defence. In essence, Dr Ibrahim argued before the MPT that he had been entitled to leave early because sometimes he had arrived early and that the one could be off-set against the other. I set out parts of his witness statement dealing with this earlier. He also said at [9] of that statement:

> "9. Having become aware of the concerns regarding my time recording I have carried out an analysis of whether I have claimed for time worked at the Trust which was more than the time I worked. When considering the time, I arrived at the Trust and my lack of taking a break I am confident that I did not claim for any time in terms of the number of hours worked that I had not actually worked."

213. The MPT plainly correctly understood this aspect of Dr Ibrahim's defence. It said at [59]:

> "59. The Tribunal noted that Mr Ibrahim said:
>
> > "When Trust has now accused me of taking more money than I deserve what about my good work for turning up early for a meeting that concerned all in the department and ensuring things ran in a smooth way. I would turn up early and that's why I asked for entry times too at beginning of the day."
>
> The Tribunal accepted that while on most occasions Mr Ibrahim had arrived early for his shift, this was not unusually early for an 8:00AM start time. The car park entry times, mainly between 7:40AM-7:50AM, were consistent with those to be expected for someone who had to park their car, walk to the office, and be on time for the morning handover. The Tribunal agreed that this could not be offset against the exit times for the car park. In fact, the true leaving time from the ward would be even earlier than that reported in the available statistics, taking into account walking to the car park, getting into his car and driving up to the barrier."

214. The MPT accepted the evidence of Mr Hubbard that Dr Ibrahim worked on a rota system rather than flexi-time (Determination, [27]):

> "27. Mr Hubbard was unsure as to the type of contract Mr Ibrahim was on when he first started with the Trust (agency or bank) but once he was on the bank contract, it was fairly standard. He would be contracted to work for the Trust and be paid via timesheets. This was not a flexi time contract but one with set times. The expectation was that a doctor would be on site for the duration of the shift."

215. The MPT was therefore entitled to find that he should have been at work, and available, within those set times (whether he had arrived early or not).

216. Mr Vullo suggested that it was unfair for the GMC to be able to point to examples of Dr Ibrahim leaving 10 or 20 minutes early, but not for him to be able to do the same in terms of early arrival times (Grounds, [37(b)]). In other words, if he arrived 30 minutes earlier than his rostered shift start time, it was acceptable for him to leave 30 minutes before his rostered finish time (but submit a timesheet falsely putting that rostered time as his actual finish time).

217. I consider that Ms Hearnden was correct to submit that this argument misses the point, which was that Dr Ibrahim was contracted for and booked to work particular shifts, which he was not doing if he left early - with the result that junior colleagues and patients were left unsupported. To repeat the point made earlier: his was not a 'flexi-time' contract.

218. One can demonstrate the fallacy of Dr Ibrahim's argument by the following example. Suppose, the evening before a shift, Dr Ibrahim had spent three hours preparing for it,

eg, reviewing patient records, or planning surgery, or prescribing, or whatever it might be. Would it then have been justified and acceptable for him to have left his shift the following day three hours early by way of recompense? The answer is obvious that it would not.

219. The short answer to the offset defence is that Dr Ibrahim was a professional, on a professional contract, with rostered start and finish times, for which he was paid (less a 30 minute break period) and during which he was required to be on site or, briefly off-site during his break, to return in time for the end of his break. If he did work outside those hours, whether of necessity or through choice, then that was inherent in the professional nature of his work and of his contract and the responsibilities which he held.

220. Trust management made this point during the disciplinary process (Bundle, p330) (my emphasis):

> "Mr Ibrahim asserted that he regularly arrived at work before his start time of 8am, as evidenced in the car park data, as mitigation for leaving early. The data shows the time that Mr Ibrahim entered the staff car park, not the time that he started work. The vast majority of these times are between 7.40 – 7.50am and Mr Ibrahim would have then needed to park and walk from the staff car park to the Ward and commence work, a fact that substantially alters the picture. *Additionally, an early commencement is a voluntary action on the understanding that the paid period has not started and does not give Mr Ibrahim the right to unilaterally end his shift early and further not record this accurately.*"

221. This point was also made by the Deputy Medical Director in her letter to Dr Ibrahim following the disciplinary hearing in August 2019 (Bundle, p347) (my emphasis):

> "I asked you, if we accepted your explanation that you were adding your break on to the end of your working day, how you accounted for the examples where you had left more than 30 minutes earlier than your signed timesheet indicated. You stated that this was due to your starting work early. *I questioned that an early start time does not allow a unilateral early end time and that starting early is a voluntary action on the understanding that the paid period has not commenced.* You said that there is a requirement for you to commence work prior to 8.00am in order to ensure that the day's list is adequately prepared or you will be viewed by consultant staff as not having conducted your role adequately"

222. Perhaps more importantly, the MPT did not accept that Dr Ibrahim genuinely believed at the time when he arrived early, he was entitled to leave early ([74]). *Ivey*, [74], shows that a person's subjective belief about their conduct is an important part of the process of determining whether they acted dishonesty. The MPT said:

> "74. Mr Ibrahim stated in his evidence that it did not occur to him that the additional time spent in the morning should be added to his shift time until after the Trust began its investigation. The Tribunal accepted that he did not believe he was so entitled when he was completing his timesheets. The Tribunal did not accept that Mr Ibrahim believed that as he arrived early, he could leave early."

223. In other words, the offset defence was a contrived *ex post facto* rationalisation by Dr Ibrahim to meet the accusation of dishonesty arising from him submitting timesheets with false finish times.

224. In conclusion, the MPT made the general overarching point, having considered the three strands of Dr Ibrahim's defence, that ([66]):

> "67. The Tribunal, having taken all of the above into consideration, deliberated over what an ordinary decent person would think if they had the facts before them.a doctor deciding to routinely leave work early and submitting timesheets with incorrect shift end times which resulted in him being paid money to which he was not entitled to, would be seen as dishonest"

225. In my judgment this conclusion was correct on the facts as found by the MPT in relation to the three strands of Dr Ibrahim's defence.

226. I turn to the point about financial gain not having been pleaded. At [66] of the Determination, the MPT referred to the fact that Dr Ibrahim's dishonesty had resulted in illegitimate financial gain. That point was picked up in the GMC's submissions at the impairment stage ([85]) and accepted by the MPT at [103]-[104]:

> "103. The Tribunal noted that as a result of his dishonesty, Mr Ibrahim had gained a financial advantage. The dishonesty had been sustained over a period of approximately a year and had become a habit. Mr Ibrahim had not stopped his behaviour of his own volition; rather, he stopped the dishonest behaviour when his actions were discovered.
>
> 104. Taking these factors into consideration, the Tribunal concluded that Mr Ibrahim's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor and amounted to misconduct which was serious."

227. The fact that the scale of any financial gain was modest was acknowledged at the sanction stage (at [133]):

> "133. Mr Lodge told the Tribunal that the allegations of dishonesty were serious, even if the sum of money was not

> significant in terms of overall financial gain. This had not been a 'one-off' incident; the steps had been repeated over a period of 12 months."

228. Dr Ibrahim relies upon *Fish*, which also concerned timesheets. In *Fish*, dishonesty was expressly pleaded in the charges in respect of a deletion of a declaration on a timesheet. As the Respondent correctly identified, the problem in *Fish* was that the case put by the GMC to the doctor, and the findings made by the MPT did not match. The MPT's conclusion was found to be illogical because it did not properly engage with the doctor's motive: was there a reason for removing the declaration if the hours he claimed were correct (an allegation of overclaiming not having been substantiated?. Foskett J said at [70] that:

> "… no-one should be found to have been dishonest on a side wind or by some kind of default setting in the mechanism of the inquiry. It is an allegation that must be articulated, addressed and adjudged head-on."

229. I consider that the allegation that Dr Ibrahim was motivated by financial considerations was clearly part of the GMC's case from the outset, notwithstanding the absence of an express averment to that effect in the allegations. No-one could have been in any doubt about the matter.

230. The first thing to point out is that by the time of the MPT hearing, Dr Ibrahim had already been through the Trust's internal disciplinary process which covered much of the same ground. Some of the papers in the Bundle came from that process. Much has been redacted, however one allegation was 'Fraudulently claiming for hours not worked.'

231. Bundle, p332 is the management's response to Dr Ibrahim's grounds of appeal following his summary dismissal in August 2019. It states:

> "It was evidenced that remuneration was claimed for time Mr Ibrahim had not worked; by his own admission on many of these occasions he was leaving to go home. It was not the panel's belief that the timesheets were completed in error and the volume of occasions suggests this is not human error. Furthermore it is Mr Ibrahim's responsibility to submit accurate signed timesheets"

232. At Bundle, p349, under 'Mitigation' it said:

> "You denied fraudulently claiming for hours not worked and stated that there had been no intent to deceive the Trust. You stated that your exclusion had caused you to be unable to generate an income and that this had caused you to go into debt, had affected your health and that you have been unable to travel to visit your children."

233. In her evidence before the MPT, Ms Pochin (who carried out the investigation for the Trust) said this:

> "Q. Turn to page 46, please. This is part of your report to the Trust following your investigation. Say when you have it, Ms Pochin.
>
> A. I have page 46, thank you.
>
> Q. Under the heading, 'Fraudulently claiming for hours not worked', second paragraph, you type, you write: "Mr Ibrahim was interviewed on 10 May 2019 ..." We've just looked at the interview notes: "... and acknowledged that the car park exit information was different to the times noted on his timesheets …"

234. Thus, well before the MPT hearing, Dr Ibrahim knew what he was being accused of, which was fraudulently claiming for hours he had not worked, in order to dishonestly obtain a financial benefit. Indeed, Dr Ibrahim's counsel before the MPT understood the point. He asked Ms Pochin in cross- examination (Bundle, p156, pp158-9):

> "Q. You calculated the difference in minutes, and then on the basis Mr Ibrahim is remunerated as a locum at a rate of £1.08 per minute, you suggested that he is effectively defrauding the Trust of that amount of money. Yes?
>
> A. Yes, that's right.
>
> …
>
> Q. You compiled that document to raise a case against Mr Ibrahim which you tell us was in your guise as an independent and objective case investigator, that he was defrauding the Trust because he was claiming for time spent at work when in fact he hadn't worked that time. Yes?
>
> A The decision of fraud was not mine, I simply wrote the facts, and we have to assume that staff have the opportunity to take a 30-minute break.
>
> Q. Let's just take it in stages. The document that we just looked at, that document suggests that in leaving at the times at which he did, Mr Ibrahim was overcharging the Trust. Yes?
>
> A. Yes.
>
> Q. For each day it's suggested he overcharged the Trust, there's a number of minutes. Yes?
>
> A. Mmm.

Q. And a financial amount. Yes?

A. Yes."

235. Furthermore, right from the time of the internal disciplinary process up to giving evidence before the MPT, it was Dr Ibrahim's case that he had claimed for less time than he actually worked and therefore he should have earned more from the hospital and so he had not been dishonest. He therefore clearly understood that on this aspect of the case, his alleged dishonesty was directly linked to the allegation of fraudulently claiming for hours not worked and that they were the two sides of the same coin. He said at the end of his evidence (Bundle, p237):

> "I just want to add one thing. Some of this data doesn't look too well. I - my usual routine or my usual practice is to fill up my timesheets end of the week or even the following week, so I did most of it from memory so to speak; that's a bad mistake, I acknowledge that, and I accepted that it was my mistake and nobody else, and I should have made my own diary of when to start and when to finish so things will be accurate, and that's a practice I start adopting after all this. Secondly, that whatever mistakes has been - happened there was not intentional, it was not intentional. I have been ... I have been practising for over 30 years and a large part of that 30 years was a locum, filling in timesheets and stuff like that, and I've never had this problem before. I don't know, maybe when people get a bit older and reach my age, the memory does not serve them right most of the time. But there was no, I assure you and I swear, that there was no intention of being dishonest at all, and if you take the time that when I arrived to the time I left, you will come to the conclusion that I did not really claim more than what I actually earned from the hospital, I claimed less. I apologise for this and I just hope you can, you know, see the mistakes I made, and, believe me, it was not intentional at all. I'm a quite religious person and I do not believe in making - in earning something that is not your right, because some people will say karma does happen, you will be punished for that even before you meet your maker."

236. In *Yassin*, Cranston J said at [25]:

> "25. Allegations of dishonesty need to be carefully formulated and specific allegations need to be made. That does not mean that a Panel cannot fairly consider someone's state of mind in relation to false claims, save by reference to the circumstances of a specific case. The key is fairness. In *Sheill* v. *General Medical Council* [2008] EWHC 2967 (Admin) the doctor was accused of dishonestly and falsely claiming that his failure to notify a particular patient's general practitioner of his prescribed treatment was at the

> patient's request. Foskett J held that the charge of dishonesty against the doctor did not specify the circumstances in which it was alleged that he had made a false claim and it was not clear that the Panel had directed itself to the key issue of whether, when the claim was made, it was being made dishonestly: see [63]. Foskett J set aside the finding of dishonesty but nonetheless upheld the doctor's erasure, given his other misconduct."

237. I do not consider there was any unfairness to Dr Ibrahim in the way in which the case against him was put. In all the circumstances of the case, the allegations against him provided sufficient information to enable him to know, with reasonable clarity, the case he had to meet, and he knew enough about the charges to prepare his defence.

238. For all of these reasons, I reject Ground 1.

239. I have reflected carefully on Mr Vullo's submission that the MPT's finding on [6(a)] must have coloured its approach to the other allegations of dishonesty in [3(a)] and [3(b)]. I do not think that it can have done. The allegations in [3(a)] and [3(b)] were separate and distinct allegations of dishonesty arising from a course of conduct over a year, from March 2018 – March 2019. In its Determination the MPT reached its conclusions on [3(a)] and [3(b)] well before it turned to the allegation at [6(a)]. My quashing of the finding of dishonesty in [6(a)] of the Determination therefore does not have a bearing on Ground 1.

Ground 3 – finding of misconduct wrong

240. Mr Vullo said that as a result of the wrongful findings on the facts, Grounds 1 and 2, the finding of misconduct was also wrong.

241. I have dismissed Ground 1 but allowed Ground 2. I do not consider that that affects the correctness of the MPT's finding of serious misconduct.

242. Although the alleged lie in Ground 2 was referred to in passing in this part of the MPT's Determination (eg at [101]), it was only a very minor or peripheral part of its reasons for finding serious misconduct. It is clear the MPT would still have found serious misconduct even if the alleged lie had never been part of the GMC's case. The central thrust of its reasoning is in [102]-[104] demonstrates this:

> "102. Dishonest acts are invariably serious matters for the Tribunal's consideration. The Tribunal noted that Mr Ibrahim, through Mr Cridland submissions, accepted that his actions amounted to misconduct which was serious.
>
> 103. The Tribunal noted that as a result of his dishonesty, Mr Ibrahim had gained a financial advantage. The dishonesty had been sustained over a period of approximately a year and had become a habit. Mr Ibrahim had not stopped his behaviour of his own volition; rather,

> he stopped the dishonest behaviour when his actions were discovered.
>
> 104. Taking these factors into consideration, the Tribunal concluded that Mr Ibrahim's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor and amounted to misconduct which was serious."

243. A standalone challenge is made to this finding on the basis that the MPT took into account financial advantage, which Dr Ibrahim says was not fully litigated at the facts stage, and this was unfair.

244. Mr Vullo's Grounds said at [50]-[51] (reference omitted):

> "50. Additionally, it should be noted that in their finding on misconduct, the Tribunal placed reliance at paragraph 103 of the determination, on the fact that 'as a result of his dishonesty, Mr Ibrahim had gained a financial advantage.' This followed on from a relatively brief suggestion made during submissions advanced on behalf of the GMC …, referred to at paragraph 85 of the determination … that as a result of his actions "Mr Ibrahim was paid money that he was not entitled to, for work not done."
>
> 51. As set out above in relation to ground 1, the suggestion that the Appellant had dishonestly gained a financial advantage was not pleaded at the facts stage and was thus not fully litigated (in fact evidence adduced by the Appellant as part of the 'offset' defence which was relevant to this issue was not analysed in detail by the Committee). It is submitted that it was accordingly unfair for the finding of misconduct to be based upon it, either in whole or in part."

245. I reject this complaint essentially for the reasons already given under Ground 1 about the lack of an averment of financial advantage in the allegations. It was and had been plain since 2019 that this case was about whether Dr Ibrahim had gained a dishonest financial advantage.

Ground 4 – finding of current impairment wrong

246. Mr Vullo also submitted that as a result of the wrongful findings on the facts and misconduct, particularised at Grounds 1, 2 and 3, the finding of impairment was also wrong.

247. I reject this submission. My allowing Ground 2 does not affect the correctness of the MPT's finding of impairment, which was not wrong. I consider that given its findings about the timesheets alone, the conclusion at [105]-[116] that Dr Ibrahim's fitness to practise was impaired was inevitable. I note that the allegation about the alleged lie did

not feature at all in the MPT's discussion on impairment, which focused entirely on the timesheets aspect of the case.

248. The statutory overarching objective as set out in s 1 Medical Act 1983 is to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

249. Judicial guidance as to how the issue of impairment of fitness to practise should be approached appears in a number of authorities. In *R (Cohen) v. General Medical Council* [2008] EWHC 581 (Admin) Silber J was concerned with serious professional failings by a consultant anaesthetist, on an isolated occasion, in relation to a patient undergoing major surgery. There was little dispute as to the facts, most of which appear to have been admitted. Against that background the judge said as follows, in relation to impairment of fitness to practise:

> "62. Any approach to the issue of whether a doctor's fitness to practise should be regarded as 'impaired' must take account of 'the need to protect the individual patient, and the collective need to maintain confidence [in the] profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the'(*sic*). In my view, at stage 2 when fitness to practise is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering whether by reason of the doctor's misconduct, his or her fitness to practise has been impaired. It must not be forgotten that a finding in respect of fitness to practise determines whether sanctions can be imposed: s 35D of the [Medical] Act [1983]."

250. In *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council* [2011] EWHC 927 (Admin), [74], having considered a number of authorities, Cox J said*:*

> "74. … In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."

251. The MPT's reasoning was impeccable and there was no error in its approach. It said at [109]-[111]:

> "109. The Tribunal took into consideration that at least two limbs of the statutory overarching objective were engaged. It considered what the public, and members of the profession, would think of the actions of a doctor who had left the hospital prior to the end of their shift and regularly submitted incorrect timesheets over a considerable length of time, and whether they would have confidence in that doctor. The Tribunal concluded that Mr Ibrahim's conduct would be regarded as deplorable by fellow professionals and the public alike, and that Mr Ibrahim had breached fundamental tenets of the medical profession by his dishonest behaviour.
>
> 110. The Tribunal concluded that public confidence in the medical profession would be undermined and that there would be a failure to uphold professional standards if a finding of impairment was not made.
>
> 111. The Tribunal accepted that there had been no incidents relating to patient safety during that time. However, on taking into account Dr Mudhar's evidence that he had been called by staff members for assistance as Mr Ibrahim could not be located, the Tribunal considered that there had been the potential for a risk to patient safety and the third limb of the overarching objective was engaged."

252. Nothing turns on the formulation of 'potential for a risk to patient safety' as opposed to 'risk to patient safety', and to contend otherwise is just semantics. Section 1(1B)(a) of the Medical Act 1983 refers to the objective 'to protect, promote and maintain the health, safety and well-being of the public'. That includes avoiding the potential for risks to patient safety.

253. I also do not think there was anything unfair about the MPT's approach. The issue of patient safety, whilst not explicitly part of the allegation, had been raised squarely in the evidence, and Dr Ibrahim and his counsel had therefore had a proper opportunity to deal with it. Indeed, it was put directly to Dr Ibrahim in cross-examination (Bundle, p206):

> "Q. But emergencies can occur. Junior doctors need assistance. If you are not there to provide that assistance, it creates a patient safety issue, doesn't it?
>
> A. You are not working for eight hours. You are working certain hours and eight, yes, by five o'clock you should finish your work. So I, looking after maybe 15, 20, 30 patients at any time before close that day, if I am happy that everything is in order and I am entitled to take half an hour's break. That was my understanding, that I should take a half hour break. It was perhaps misguided that I did not really

> get this in writing from the management and I am sorry for that."

254. Dr Ibrahim's response to Dr Mudhar's evidence was that he was motivated by a personal grudge arising from an incident in the doctors' room.

255. This topic was also dealt with directly by the GMC's counsel in his closing submissions:

> "This tribunal will no doubt conclude that the consequences of individual doctors, nurses, support staff leaving the hospital early, knocking off early because they didn't get a full uninterrupted break during the course of the day would simply lead to chaos within the hospital. The hospital management would simply not have any degree of certainty in terms of who was in hospital and who was available to perform important or crucial tasks. No doubt that would have an impact on patient safety, and no doubt some care is given to how shift patterns are put together and covered by doctors of every grade.
>
> We say that would have been obvious to the doctor himself that it simply would not be acceptable to leave early when hospital management, other staff members and colleagues are expecting an individual to be present and available to assist them should they be required, but that's exactly what the doctor did, what Mr Ibrahim, did. He was clearly not happy, it seems, that he was not being paid for that half hour break time."

Ground 5 – sanction

256. In considering the appeal against sanction, I adopt the approach set out by the Court of Appeal in *Sastry*, which I set out earlier. I have t o decide for myself whether the sanction imposed was wrong; that is, was it appropriate and necessary in the public interest. Because this is a case of financial dishonesty, I am well placed to assess what is needed to protect the public or maintain the reputation of the profession and I am consequently less dependent upon the expertise of the MPT. The need for me to assess matters for myself applies particularly in this case given that Ground 2 has succeeded, and I am therefore considering Dr Ibrahim's dishonesty on a slightly narrower basis than the MPT did.

257. As I noted earlier, Ms Hearnden submitted that even if the alleged lie in [6(a)]/Ground 2 fell away, erasure was still the only appropriate sanction.

258. In my judgment, assessing matter for myself, the sanction of erasure was appropriate and necessary in the public interest. Even allowing for the fact that the MPT did not completely rule out the Maidstone defence on some of the relevant dates, and leaving [6(a)] out of account, the MPT nonetheless found that Dr Ibrahim had committed persistent and repeated dishonesty over a significant period of time (about a year, and on many occasions) and so received payment for hours that he had not worked on the basis

of falsely completed timesheets. In other words, he had defrauded his employer. It found he had also potentially created a risk to patient safety by leaving early and sometimes being uncontactable when needed by colleagues.

259. Like the MPT, I consider that the relevant paragraphs of the *Sanctions Guidance* are as follows:

> "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.
>
> 109. Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive):
>
> (a) particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.
>
> (b) 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).
>
> …
>
> (j) persistent lack of insight into the seriousness of their actions or the consequences."
>
> *Considering dishonesty*
>
> 120 Good medical practice states that registered doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession.

> 121 In relation to financial and commercial dealings, paragraph 77 of Good medical practice also sets out that: 'You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals.'"
>
> …
>
> 124. Although it may not result in direct harm to patients, dishonesty related to matters outside the doctor's clinical responsibility (eg 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.
>
> 125 Examples of dishonesty in professional practice could include:
>
> (a) defrauding an employer
>
> …
>
> (e) failing to take reasonable steps to make sure that statements made in formal documents are accurate
>
> …
>
> 128 Dishonesty, if persistent and/or covered up, is likely to result in erasure (see further guidance at paragraph 120–128)."

260. So far as mitigation is concerned, the MPT listed the evidence and factors at [153]. It said at [161]-[163]:

> "161. The Tribunal took into consideration the nature of Mr Ibrahim's dishonesty and that this had not been a case of isolated dishonesty. It had been persistent and repeated over the period of one year, and there had been some financial gain. The Tribunal was of the view that this dishonesty was at the more serious end of the scale and marked a serious departure from the principles set out in GMP. It also demonstrated a deliberate disregard for those principles.
>
> 162. The Tribunal had previously concluded that Mr Ibrahim had limited insight into his misconduct. Any expressions of remorse and apology had come after the

> findings on the Facts and the Tribunal noted that even at that stage, expressions of insight, remediation, and remorse were somewhat muted. The Tribunal considered that Mr Ibrahim was focused on submitting timesheets accurately, something any doctor would be expected to do, and did not acknowledge the dishonesty involved in his actions or the more significant steps that would be required to remediate. The Tribunal took into account that dishonesty was not easily remediable. The Tribunal had set out its concerns over the risk of repetition at paragraphs 34-36 of its impairment determination.
>
> 163. While the Tribunal acknowledged the testimonials provided and was in no doubt as to Mr Ibrahim's clinical competence, this could not mitigate the nature and persistence of the misconduct. The Tribunal noted that it was suggested that the dishonest conduct was out of character for Mr Ibrahim, but this had to be balanced against his repeatedly submitting timesheets which led to overpayment for a period of one year, until an investigation uncovered his dishonesty."

261. At [166] the MPT noted the severe impact which erasure would have on Dr Ibrahim.

262. There is accordingly no doubt that the MPT had regard to the mitigation.

263. However, I consider that because the doctor's dishonesty in this case was so prolonged and repeated, and because it involved potential risks to patient safety on a number of occasions, the sanction of erasure was not wrong, but was appropriate and necessary in the public interest.

Conclusion

264. For these reasons, this appeal is dismissed save in relation to the allegation of dishonesty in [6(a)], which is quashed for the reasons given earlier.