Introduction

Allegations of sexually motivated misconduct are perhaps the most dreaded accusations which a regulated professional can be forced to confront.

Much like findings of dishonesty, sexual misconduct can be career-defining; sanction guidance almost invariably places them towards the top of the hierarchy of seriousness and the prospect of suspension or removal from the register will often be a very real, very unwelcome anxiety.

But allegations of sexually motivated behaviour can destroy marriages and families too - when a husband or wife's infidelity is suddenly brought into the open or worse, when a loved one's proclivity to sexually predatory behaviour, unwanted and unreciprocated by their victim, reveals a darker side to a person you thought you knew.

And reputations can be shattered - there's no way back for Neil Parish (Con: Tiverton and Honiton) whose fitness to practise as an MP has been thoroughly undermined by his predilection for tractors, which somehow ploughed a furrow to a pornographic website while he sat waiting to vote. Twice. [Interestingly, a doctor called Mr Harry did something similar 8 times on computers in the surgery in which he worked, twice whilst in

between patients - 6 months suspension: **R (Harry) v GMC 2006 [EWHC] 3050 (Admin)**.]

Yet for these career-defining and often career-ending allegations, almost every regulator insists on no more proof than the balance of probabilities. 51/49%.

Like Brexit. And we know how that's turned out.

The Statistics [SCREEN 1]

The Office of National Statistics provides an insight into how wide the problem of sexual misconduct is in our society, where that misconduct amounts to a criminal offence:

- The Crime Survey for England and Wales (CSEW) provides the best measure of victimisation, and estimated that for the year ending March 2020 there were 773,000 adults aged 16 to 74 years who were victims of sexual assault (including attempts) in the last year, with almost four times as many female victims (618,000) as male victims (155,000)

- To put that into perspective, the volume of sexual offences recorded by the police has almost tripled in recent years, although these figures actually represent a tiny decrease - less than a single %.

- But there remains a huge problem in the reporting and thereafter the prosecution of the misconduct. Latest estimates from the CSEW showed that fewer than one in six (16%) female victims and fewer than one in five (19%) male victims aged 16 to 59 years of sexual assault by rape or penetration since the age of 16 years reported it to the police.

- This reluctance to report, we might imagine, is likely to be mirrored in the workplace or as a service user where there will often be a disinclination to complain to employer or a regulator. Why? A lack of confidence in a just outcome, a complainant's fear that they will be accused of lying or consenting, embarrassment, shame - and in FTP proceedings, like in the criminal justice process, the inordinate and inexcusable delay in getting these cases to a final hearing with the unconscionable prolonging of anxiety for both the complainant and the registrant.

For many, the pandemic the world has endured since March 2020 has been like a reset button - a time to reflect on what's important to us, how

we treat others, how we protect each other by recognising the rights of individuals and respecting them.

[SCREEN 2]

But according to a Rights of Women survey from January 2021, 45% of women surveyed in England and Wales said they had been sexually harassed on online work platforms since March 2020 lockdown. Nearly half.

That's up significantly from the 29% of the UK population in employment experiencing some form of sexual harassment in their workplace or work-related environment in 2019, according to the Government Equalities Office: 2020 Sexual Harassment Survey, following the Government's pledge to tackle workplace sexual harassment.

So, sexual misconduct is very much a blight on modern society, undimmed and unfettered by the pandemic restrictions. Serious and prevalent.

The Variety of Sexual Misconduct

In a fitness to practise context then, we commonly have to deal with sexual misconduct alleged to have occurred in a variety of ways.

Serious Criminal Cases

Misconduct that amounts to a serious sexual criminal offence are, perhaps, more rare, but at the very top of the tree. Dentist upon patient, doctor upon nurse, psychiatrist upon vulnerable subject. Aggravated by what most regulators regard as a predatory abuse of position on the part of the assaulter, the misconduct goes against the very fabric of society let alone the fabric of a profession.

But often these allegations of rape and serious sexual assault will be the subject of parallel criminal proceedings and the issue of guilt/innocence is often done and dusted by the time an FTP hearing takes place.

That said, there's no automatic obligation to postpone FTP proceedings until the conclusion of a related criminal trial, despite the criminal jurisdiction's more restrictive rules of admissibility and the higher burden of proof (making a jury "sure" of guilt is the standard required for conviction) - unlike for example in coronial proceedings where the default position is to stop everything while the wheels of criminal justice slowly turn.

The Court of Appeal in **Mote v Secretary of State for Works and Pensions [2007] EWCA Civ 1324** confirmed that the privilege against self-

incrimination, a person's right to demand the state proves its case against him or her, doesn't apply in civil proceedings and because of modern requirements of defence disclosure in criminal cases, defending oneself in a regulatory setting is unlikely to mean revealing something that might otherwise prejudice your criminal trial. The test is whether allowing proceedings to run concurrently would give rise to a real risk of prejudice to the defendant in criminal proceedings.

But assuming the FTP proceedings are postponed pending the criminal outcome, there's still the difficult hurdle of Interim Order to get over - would the right thinking member of the public, upon discovering that a jury or FTP panel eventually found proven an allegation of rape, be horrified that pending those decisions the practitioner was allowed to carry on seeing service users unfettered? You can get away with it quite often when the accusation is first made, but once a formal charge is levied, it's not an easy battle.

And if we get to a final hearing without a criminal conviction, the issues in the most serious cases are generally straightforward - consent, or fabrication. One word against another.

There's no need to worry about whether the conduct is sexually motivated either - serious criminal offending like rape or penetrative assault is so obviously "sexual" that the motivation need not be specified.

Touching

But the lines begin to blur a little as the conduct alleged becomes less clear cut and more open to explanation or justification.

In a healthcare context, in which serious criminal sexual offending is thankfully rare, its far more common for FTP Panels to have to consider allegations of inappropriate touching - during a consultation or physical examination or even an operation - touching that is alleged to have been sexually motivated because of the part of the body touched or because its nature was not clinically indicated or required.

These sorts of allegations until recently would have been drafted to set out the touching that was not clinically indicated and, in a separate allegation, that the conduct was “sexually motivated.”

[SCREEN 3]

For example:

1. "On [date], during your consultation with Patient A you:

    a. undertook a vaginal examination that was not clinically indicated;

b. pulled down Patient A's underwear;

c. leaned against Patient A's side as you examined her;

d. thrusted your pelvis against Patient A's side as you were examining her;

e. stared at Patient A's pubic area;

2. Your conduct described at paragraphs 1a-e above was sexually motivated."

The definition of "sexually motivated" was considered in **Basson v General Medical Council [2018] EWHC 5050 (Admin)**. Mostyn J said:

"A sexual motive means that the conduct was done either in pursuit of sexual gratification or in pursuit of a future sexual relationship."

That concept relies upon a determination as to what was the state of mind of the registrant in acting as he/she did. Mostyn J went on:

"In *Edgington v Fitzmaurice* (1885) 29 Ch D 459 Bowen LJ famously said that the state of a man's mind is as much a fact as the state of his digestion. Therefore, in civil proceedings that fact, the state of the man's mind, is to be proved in the usual way by the necessary body of evidence on the balance of probabilities."

That approach has a problem though, doesn't it, because it leaves open the door for a registrant to say that if the conduct alleged occurred, he was not pursuing sexual gratification or a sexual relationship - and, if a Panel felt the registrant's evidence was compelling for whatever reason, it could find overtly and obviously sexual acts not "sexually motivated" on that definition.

And that was the problem identified by Mrs Justice Foster in the **General Medical Council v Dr Raied Haris [2020] EWHC 2518 (Admin)**, a case in which the GMC appealed when a Medical Practitioners Tribunal found allegation 1 (above) proved (along with similar allegations levied by a second patient) but that sexual motivation was not proved.

Despite the Tribunal finding the Dr RH's evidence "at various times defensive, evasive and contradictory" it accepted evidence from a psychiatrist and others that the Dr claimed to be "asexual" and without "any interest in sexual relationships."

SCREEN 4

Mrs Justice Foster however concluded that "it is in my judgement clear beyond argument that the intimate touching of Patients A and B was sexual and that answering a question as to the motivation of the toucher, the only

available answer is yes, the motivation must have been sexual. This is another was of saying the only reasonable inference from the facts is that the behaviour was sexual. This derives from:

- The fact that the touching was of the sexual organs
- The absence of a clinical justification
- The absence of any other plausible reason for the touching
- The absence of any suggestion of accident and the absence of any consent gives further colour to the acts." [§47, 48]

The Tribunal fell into error because of the "over-complication of the decision making process" and in making that observation, the Judge suggested a different form of drafting in cases involving conduct like this, much more akin to the criminal definition of sexual assault [§57, 58].

SCREEN 5

The criminal offence is described thus in the Sexual Offences Act 2003 s 3:

1) A person (A) commits an offence if—
(a) he intentionally touches another person (B)
(b) the touching is sexual,
(c) B does not consent to the touching, and

(d) A does not reasonably believe that B consents

As to "sexual" in subsection (1)(b), section 78 of the 2003 Act provides two ways to determine whether the touching is sexual thus:

78 "Sexual"

For the purposes of this Part …. touching or any other activity is sexual if a reasonable person would consider that—
(a) whatever its circumstances or any person's purpose in relation to it, it is because of its nature sexual, **or**
(b) because of its nature it **may** be sexual **and** because of its circumstances or the purpose of any person in relation to it (or both) it is sexual." [My emphasis].

"*Pleading "sexual motivation" is unhelpful*", she said. Similarly to look for "*sexual gratification may be misleading and overcomplicating*."

Mostyn J's analysis in Basson as to the pursuit of gratification was "*not helpful in my judgement in promoting the public interests at stake here. These criteria set the bar too high and I respectfully disagree that they represent the law.*"

Instead, Foster J found clarity and concision in pleading "sexual touching" which, absent accident, consent or any clinical or other justification, would inevitably have led the Tribunal to the proper and obvious conclusion that Dr RH's touching of his patients was "sexual."

Strictly speaking, Foster J's observations on the drafting of allegations, about which she acknowledges at her §56 that she did not hear submissions, are obiter but it will be interesting to see going forwards whether her suggestions are followed by regulators.

Certainly the GMC hadn't caught on in a case I defended in February which continued to allege sexual motivation despite an allegation of the touching of a patient's thigh and kissing her, amongst other things.

Other sexual misconduct

There remains a residual category of sexual misconduct that covers a multitude of sins and where it is difficult to see anything other than "sexually motivated" being the appropriate rider - circumstances in which there is no sexual touching per se, but other conduct which, taken alone or cumulatively, might be motivated by sexual desire or gratification. Some are more obvious than others.

SCREEN 6

Voyeurism - criminalising conduct done “for the purpose of obtaining sexual gratification” [s.67 Sexual Offences Act 2003] - watching a patient take off their clothes which they believed was in private or surreptitiously recording an intimate examination?

Perhaps less likely, Upskirting [s.67A], the purpose of which is “obtaining sexual gratification” or “humiliating, alarming or distressing” the subject

More likely in a healthcare regulatory context:

Harassment, including stalking, sexting, unwelcome or suggestive conversations;
Exposure;
Abuse of professional position - boundaries blurring eg by employing a patient or providing pro bono therapy sessions with an ulterior motive that a sexual relationship might develop (grooming?)

And still others in which the patient consents:
engaging in an improper personal or sexual relationship with a service user - often said to breach a fundamental tenet of the health professional/ patient relationship and worse still if the patient was vulnerable.

Or even in a Major Administrative Action case before the Army Board I recently defended, having a sexual relationship with a subordinate's spouse.

How to deal with sexual misconduct allegations in FTP proceedings?

These are not easy cases for a regulator to bring, and not easy cases for a registrant to defend.

SCREEN 7

Difficulties for the regulator:

Lack of evidence - the MO of the sexual offender is to save their conduct for when nobody is watching. If a complainant does comes forward, very often they are the only witness and the case turns on who makes the better impression on the tribunal.

When there are contemporaneous documents, like a diary account, they are generally created by the complainant and so arguably self-serving.

By contrast, there is often delay in the reporting of the misconduct or omissions and inconsistencies in the development of the complainant's account that can be exploited by the other side to undermine credibility

and reliability, despite the common legal directions [see for e.g. **Miller [2010] EWCA Crim 1578 and D [2008] EWCA Crim 2557**] that try to dispel what are often misconceptions that a complainant should report immediately, should demonstrate distress and should have a consistent account from the start.

In a healthcare context, there may be a clinical reason why an intimate examination was performed in a way about which complaint is brought.

Very often, a tribunal will be dealing with a professional of previously exemplary character, against whom no complaints had been made in the past. Although the Supreme Court in **re SB (Children)(Care Proceedings: Standard of Proof) [2010] 1 AC 678** reaffirmed that there is but a single, civil standard of proof, Lady Hale did recognise the obvious common sense position that "If an event is inherently improbable, it may take better evidence to persuade the judge that it has happened that would be required if the event were a commonplace."

While that's clearly different from saying there's a heightened standard of proof in these sorts of cases, it reinforces the need for cogent, good quality evidence if a regulator is to get home on an allegation of sexual misconduct against a highly thought of registrant for whom such conduct would be a shocking aberration.

There are difficulties for a registrant too:

Why would a complainant put herself/himself through the often harrowing ordeal of giving evidence and being cross-examined if the complaint was not true?
Do witnesses really make things up for financial gain?
There's often no other witness or contemporaneous evidence, so it really is one person's word against another, when the stakes are so very high.
Delay may mean that evidence has gone missing or recollections are diminished such that convincing answers are more difficult to provide.

And then the modern anxiety, over and above the natural concerns every accused professional has when facing FTP proceedings, that tribunals are particularly sensitive now to the #MeToo movement, afraid to say a case isn't proven for fear that conclusion might be misinterpreted as a finding that a complainant, who might be vulnerable, is lying.

Much of my practice is the defence of regulated professionals rather than presenting cases against them so I thought it might be useful to those of you in a similar position to know what I think is the key to a successful challenge; and those of you acting for the regulatory body might benefit from knowing how and where we find the flaws in your case when the matter is contested.

And it really comes down to the 3 Ds:

- Drafting
- Detail
- Disclosure

D1 - Drafting

Careful drafting of the allegations is crucial. We've seen already Mrs Justice Foster's steer in respect of acts of physical touching, but scrutiny of the facts alleged themselves is often critical. For example, AJ and I defended a head of house at a very well known public school for a variety of allegations, including running naked around the quads at night and licking whipped cream off the naked torso of a 6th form boy. Not proved, said the tribunal, because the teacher's account was that he licked the cream from the top of the pile of cream on said boy's chest and not off the boy's torso itself - teacher's tongue and torso of boy never coming into contact with each other.

I pause for a moment because that hearing was a good example of what, in reality, can make the difference in these cases. This particular man was an outstanding teacher. He was otherwise a credit to the school and we called witness after witness to testify as to how he had turned their life around and, but for him, they would not be the successes they were.

From experience, I do not doubt that medical and healthcare panels can be persuaded to be pre-disposed towards a professional who is likeable, good at their job and in every respect other than the allegations against them, a positive credit to their profession. Whether they realise it or not, it is more difficult to find a case proved against a decent clinician of impeccable character than one who does little to enhance the service or the reputation of their profession.

Never under-estimate the power of outstanding character testimonials - they are relevant and admissible at the fact finding stage and, remember, in some circumstances can even be considered as part of the half time submission. They've less weight, in sexual misconduct cases, when it comes to sanction, so from a Registrant's point of view, we really need to be winning these on the facts.

D2 - Detail

Sexual misconduct cases, whether physical touching or long term sexual harassment or contested boundary crossing, very often turn on the credibility or reliability of the complainant. The only way of taking apart a complainant whom a registrant says is lying is in the detail (it's the same way of taking apart a lying registrant if you're acting for the regulator).

Despite the now common Miller-type direction, a focus on the detail and in particular omissions and inconsistencies in developing accounts can

bear much fruit from a registrant's perspective in a case in which credibility is in issue.

In a case before the MPTS earlier this year, I spent 3 days cross-examining a complainant who accused the doctor of sexually motivated touching, sexual harassment, discrimination and crossing of boundaries with a view to a sexual relationship. He had employed her in his property management company while she was still a patient and, after a tempestuous working 12 weeks, she walked out. Her complaint to his medical employers began with a request for a refund on medication he had prescribed for her; to the next person in the investigation, it developed into allegations of being asked repeatedly for dinner and kissed at the car door; to the next person she added that he had visited her flat late and drunk and invaded her personal space, stroking her arm as if he wanted to have sex with her; to the next, she said added that he had stared at her legs and made comments about her boots; by the time of the employment tribunal, he had allegedly asked her for sexual favours and by the time of her statement to the GMC, he had groped her leg as she sat in theatre awaiting an operation.

That inconsistency was one thing, drawn out by careful scrutiny of the detail of every account she had given to anyone who would listen. Another thing was her hesitation when I asked her with which hand he had groped her leg. An otherwise confident and belligerent witness,

claiming to be able to picture in her mind's eye the awful event, and she was unable to answer what was a 50/50 option that I couldn't have challenged whatever her response, given my doctor's case was that it was entirely fabricated by her.

And, the panel found, the inconsistencies and her inability to look them in the eye and be clear and cogent on the key details were such that they did not think it more likely than not she was truthful with them.

D3 - Disclosure

You'll have gathered in that last example we had access to material from the employment tribunal to which the complainant took the doctor in furtherance of her constructive dismissal claim. In my experience, disclosure in sexual misconduct cases is fundamental and often overlooked both by the regulator and the defence.

In criminal proceedings, it's the starting point of breaking down every case a defendant faces. It is habit and it is an essential one for every criminal defence lawyer.

In FTP proceedings, I often find that disclosure is overlooked. There's a not infrequent acceptance that what's on the face of the papers is….well….it.

While there's no positive obligation on regulators to go out and pursue a variety of lines of inquiry, as there might be on the police, most have power to summons a witness to produce material that might be relevant to the issues in proceedings.

If the existence of such potentially important material can be identified and request made of the regulator, then if necessary on the direction of a panel, a regulator can be compelled to obtain it - see for eg **Holton v General Medical Counsel [2006] EWHC 2960 (Admin)** in respect of medical notes and hospital records that went directly to the credibility of the main witness against the Doctor.

In **R (McCarthy) v Visitors of the Inns Of Court [2013] EWHC 3253 (Admin)**, the Bar Standards Board was admonished by the Court of Appeal for not having disclosed a first draft of a complainant's witness statement that contained material inconsistencies from a later served version cross-examination upon which, it concluded, would have been capable of undermining the witness's credibility.

The Royal College of Veterinary Surgeons Procedure and Evidence Rules 2004 contains a provision which mirrors criminal law - that the College will disclosure "any evidence that might assist the respondent's case or harm the College's case."

Disclosure can be particularly important in cases involving sexual misconduct. Past complaints against others by the same complainant, whether upheld or particularly if rejected; early draft witness statements; documents from other legal proceedings; text messages, emails; or in my last GMC case, evidence that suggested that the complainant had made similar complaints against previous employers, motivated by money.

And the topic shouldn't be left without a passing mention of open source investigation and obtaining the evidence directly - social media content is sometimes a goldmine of material to undermine a witness and will forever be so unless and until people remember that they are publishing to the world and for all time.

But if it all goes wrong?

If there's no defence to sexual misconduct allegations, or not one that has found favour with the Panel, the outlook is often bleak.

As with any allegation, a falling on one's sword and a demonstrable degree of insight, reflection and apology never does a regulated professional's case harm, but in any case of proven sexual misconduct, FTP impairment is commonplace and likely.

Culpability is an important consideration although reduced culpability needs to be very carefully addressed so as not to amount to "victim blaming." In a recent case involving a series of convictions (and imprisonment) for sexual harassment of a minor TV celebrity by a doctor, the MTPS Tribunal was persuaded (unlike the sentencing judge) with the help of expert evidence that the doctor's psychiatric fragility diminished their culpability for their conduct to such an extent that misconduct was not found and the doctor was impaired only on the grounds of health.

But for the most part, it is difficult to see how misconduct will not be found in instances when sexually motivated conduct has been proven - a serious falling short of standards expected from a regulated professional, or conduct that might be regarded as deplorable by other members of the profession: **Nandi v GMC [2004] EWHC 2317 (Admin) per Collins J.**

In terms of impairment of fitness to practise, it is again difficult to conceive of sexual misconduct that would not either (a) suggest that the perpetrator is a risk of harm to the public, colleagues or patients by repetition or (b) seriously undermine public trust and confidence in the profession.

That view is supported by the approach of regulators (at least those in the healthcare professions) to sanction in matters of sexual misconduct.

The HCPC's Sanctions Guidance says this at §76 and 77:

76 **Sexual misconduct is a very serious matter which has a significant impact on the public and public confidence in the profession**. It includes, but is not limited to, sexual harassment, sexual assault, and any other conduct of a sexual nature that is without consent, or has the effect of threatening or intimidating someone. The misconduct can be directed towards: • service users, carers and family members; • colleagues; and • members of the public.

77. Because of the gravity of these types of cases, where a panel finds a registrant impaired because of sexual misconduct, **it is likely to impose a more serious sanction. Where it deviates from this approach, it should provide clear reasoning.**

The GMC's Guidance is not dissimilar at all, at its §149 and 150:

149 This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child sex abuse materials) to sexual misconduct with patients, colleagues, patients' relatives or others. See further guidance on sex offenders and child sex abuse materials at paragraphs 151–159.

150 **Sexual misconduct seriously undermines public trust in the profession.** The misconduct is particularly serious where there is an abuse

of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases.

The NMC likewise:

Conduct ranging from criminal convictions for sexual offences to sexual misconduct with patients, colleagues or patients' relatives could undermine a nurse, midwife or nursing associate's trustworthiness as a registered professional.

The level of risk to patients will be an important factor, but the panel should also consider that generally, **sexual misconduct will be likely to seriously undermine public trust in nurses, midwives and nursing associates**.

[Panels] will very often find that in cases of this kind, the only proportionate sanction will be to remove the nurse, midwife or nursing associate from the register. If the panel decides to impose a less severe sanction, they will need to make sure they explain the reasons for their decision very clearly and very carefully.

The Royal College of Veterinary Surgeons Disciplinary Committee Guidance regards any culpability as **aggravated by sexual misconduct**,

with offences of a sexual nature being "**behaviour fundamentally incompatible with being a veterinary surgeon**."

The General Optical Council at its §22.1 of its Hearings and Indicative Sanctions Guidance says this:

A wide range of conduct is encompassed in this category, from criminal convictions for sexual assault, sexual abuse of children (including child pornography), to sexual misconduct with patients, patients' relatives, or colleagues.

The risk to patients is vitally important and the misconduct is particularly serious where there is an abuse of the registrant's special position of trust, or where a registrant has been registered as a sex offender.

More serious action, such as erasure, is likely to be appropriate in such cases.

The General Dental Council's Guidance makes for similar reading [§73-75]:

73. Sexual misconduct encompasses a wide range of conduct from criminal convictions for sexual assault or sexual abuse (in the case of

children, including child pornography) to sexual misconduct with patients or colleagues.

74. Sexual misconduct seriously undermines public confidence in the profession. The misconduct should be viewed as even more serious if: a) there is an abuse of a position of trust and/or b) the Registrant has been required to register as a sex offender.

75. The PCC should be aware of the potential risks to patients, the wider public and to public confidence in the profession. I**n cases of serious sexual misconduct, the PCC may reasonably determine that there is a real prospect of current impairment and that erasure might be the appropriate sanction.**

The takeaway from all of this is that sexual misconduct is treated with the utmost seriousness by most regulators and particularly within the healthcare professions where there is perhaps greater and closer contact with the service user than, for example, within the legal professions.

Some examples:

SCREEN 8

Yasin v GMC [2018] EWHC 677 (Admin): 2 sexual assaults on junior female nurses on the same day - erasure necessary to uphold and maintain standards and to promote public confidence

GMC v Khatyar [2018] EWHC 813 (Admin): sexually motivated pestering and harassment of one patient; sexual assaults of two others, fondling breast under guise of medical examination - suspension quashed, erasure substituted

Wentzel v GMC [2004] EHWC 381 (Admin): (sexual relationship with psychiatrically vulnerable patient, valuable asset to profession much needed by NHS, no risk of repetition - erasure).

See also **GMC v Stone [2007] EWHC 2534 (Admin)** - again relationship with vulnerable patient while continuing to treat her (and also some dishonesty).

By contrast there are some cases involving relationships with patients that can attract suspension:

SCREEN 9

Yeong v GMC [2009] EWHC 1923 (Admin): challenge to suspension following relationship with former patient fails - "general public interest

in clearly marking proper standards of behaviour so as to uphold public confidence in the medical profession….was by far the weightiest factor" and remediation unlike in clinical cases was much less significant. Suspension upheld.

Warren v NMC [2010] EWHC 678 (Admin) - former drug addict patient for whom nurse was key worker. Contact made 6 months after nurse resigned and a sexual relationship followed. 12 month suspension.

General Medical Council v Ahmed [2022] EWHC 403 (Admin): Contacting a a 14 year old patient on Facebook, leaving a friend request and sending messages to another patient, the latter of which was found to be sexually motivated, albeit there was no physical relationship. The matters were 6 years old by the hearing. This conduct "fell towards the less serious end" and "erasure is not an automatic consequence in a case involving sexual misconduct. It all depends on the relevant facts" Murray J 2 month suspension - GMC's appeal dismissed despite serious professional misconduct.

And if a Tribunal makes a decision that appears perverse in respect of a finding of sexual motivation or of sanction, the Professional Standards Authority is quick these days to step in - see **Professional Standards Authority v Health and Care Professions Council (HCPC) and Leonard Ren-Yi Yong [2021] EWHC 52 (Admin)** for a very recent example where a

Panel's decision that a social worker's harassment of female colleagues was not sexually motivated was overturned.

Conclusions

In 2009, the PSA published guidance for patients and professional with the aim of helping them avoid becoming a victim or a perpetrator respectively. That didn't seem to change things so 10 years later, the PSA commissioned further research to enhance its understanding of how, when and why sexual misconduct occurs. Its Director, Christine Braithwaite, described the new study, by **Professor Rosalind Searle Chair in Human Resource Management and Organisational Psychology at the University of Glasgow** as highlighting "the correlation between sexual misconduct and an imbalance of power - patient versus professional, senior versus junior - and described the slippery slope that leads from commonplace workplace incivility to patient harm."

Wherever there is that kind of imbalance, there will always be some people who overstep boundaries of social decency and respect and trespass into the underworld of sexually predatory behaviour.

The consistent sanctions guidance across the healthcare professions, despite addressing sexual misconduct as a standalone and very serious

topic, doesn't seem to provide adequate deterrence for those who follow that slippery slope.

Without increased awareness and vigilance within the professions themselves promoting and supporting self-regulation at the coalface, we are destined to see little change in the coming years and the regulatory bodies will have to pick up the pieces.

By then, of course, the damage is already done.

Mark Harries QC

Serjeants' Inn Chambers

4th May 2022