Section 29 Case Meeting

30 November 2020

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

Christian Hanson

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director of Scrutiny and Quality, Professional Standards Authority
Graham Mockler, Assistant Director of Scrutiny and Quality (Performance), Professional Standards Authority

In attendance
Michael Standing, Legal Advisor, 39 Essex Chambers

Observers
Rebecca Moore, Scrutiny Officer, Professional Standards Authority
Briony Alcraft, Scrutiny Team Co-ordinator, Professional Standards Authority

1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

2. Purpose of this note

2.1 This meeting note records a summary of the Members' consideration of the relevant decision about the Registrant made by the regulator's Panel, and the Authority's decision whether or not to refer the case to the court under Section 29 of the Act.

3. The Authority's powers of referral under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

- to protect the health, safety and well-being of the public
- to maintain public confidence in the profession concerned, and
- to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the Panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscillo*[1]).

4. Conflicts of interest

4.1 The Members did not have any conflicts of interest.

5. Jurisdiction

5.1 The Legal Advisor confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the High Court and the statutory time limit for an appeal would expire on 4 December 2020.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 29 September 2020.

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determination of the Panel dated 29 September 2020
- The Authority's Detailed Case Review
- Transcripts of the hearing dated 21-29 September 2020
- Counsel's Note dated 27 November 2020
- GMC's Bundle
- GMC Case Examiners' Decision
- The GMC MPTS Indicative Sanctions Guidance dated 18 Nov 2019
- The Authority's Section 29 Case Meeting Manual

[1] CRHP v Ruscillo [2004] EWCA Civ 1356

8. Background

8.1 At the material time, the Registrant was employed as a Specialty Doctor in Emergency Medicine at the Rotherham General Hospital ("the Hospital"). On 5 June 2019 the Registrant was working on a night shift at the same time as Ms A, a nurse in the Paediatric Department, with whom he had worked without incident prior to the events. Ms A was the only nurse working in the Department after 22.30, and the Panel found that the Registrant knew she was working alone.

8.2 At around 03:00 on 5 June, Ms A, was passing through a double door and became aware of the Registrant behind her. She reported that he had placed his hands on her hips and then walked with her, guiding her, and led her through the door to a doctor's room. This was supported by CCTV footage.

8.3 On entering the room, the Registrant sat on a chair by the desk whilst Ms A looked for some keys. As she walked back towards the door, the Registrant grabbed her by the hips and pulled her towards him. He clamped his knees around her legs, put his hands on her hips towards her bottom and asked if he could see her out of work. She replied that that would not be appropriate, and pushed him back, going to open the door. This caused the Registrant to stand up and push the front of his body against her back and hold her hips, towards the top of her bottom, whilst whispering something in her ear. She pushed him away and left the room.

8.4 Immediately after the incident, Ms A rang the nurse in charge to report what had occurred with the Registrant.

8.5 The Tribunal found that the Registrant's actions were unwanted by Ms A, and that they were sexually motivated. It found that the Registrant's fitness to practise was impaired by way of his misconduct and imposed a ten month suspension order, with a review, considering this to be proportionate in the circumstances. It did not consider his misconduct to be fundamentally incompatible with remaining on the register.

8.6 The Registrant did not attend the hearing and was not represented. He denied the allegations against him.

9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal advice.

9.2 The Members noted at the outset that the sanction imposed by the Panel, and how this decision was reached, were the only aspects of the decision which required its consideration, and discussed the following concerns about the decision:

The seriousness of the misconduct

9.3 Firstly, the Members considered that it did not appear that the Panel had placed any particular weight on any of the aggravating or mitigating factors it had identified, and that it was not clear from its determination which factors they found to be particularly relevant. The Members believed that there were

potentially further aggravating factors which did not appear to be addressed by the Panel in determining sanction, such as the seriousness of the Registrant's conduct, noting that neither was any reference made by the Panel to the section in the SG regarding the seriousness of the findings against the Registrant.

9.4 The Members considered that the extent to which the Registrant had departed from GMP was considerable, and that the risk to public confidence is high. Further, they noted that although the Registrant's conduct was not sustained, it was completely unacceptable behaviour for which he has not apologised, and which had a considerable impact on Nurse A, who did not return to work for her next shift following the incident, and was subsequently given medication and had to take seven weeks off work as she was struggling to cope.

9.5 This struck the Members as very serious misconduct in which serious harm was caused to a colleague, and in which the Registrant abused his position of Trust. Nurse A could be considered to have been temporarily vulnerable, having been led away somewhere quiet by a man much greater in physical stature than her, and where there was inevitably a power balance. The Members considered that inherent within that is a level of vulnerability, which appears to have been overlooked by the Panel in determining the level of seriousness.

9.6 The Members considered that there is a strong public interest that doctors should not behave in such a way, and that the Panel failed to take this into account in determining whether suspension, despite being a serious sanction, is a sufficiently robust sanction which sends the appropriate signal to the public and other members of the profession. They concluded that the lack of weight being placed on this important aspect indicated the Panel had erred in its decision on sanction.

Did the Panel correctly interpret and understand the Sanctions Guidance?

9.7 The Members had serious concerns about the way the Panel interpreted the SG, and referred to paragraph p22 of the Panel's determination on sanction in which the Panel considers whether suspension would be appropriate. The Members noted that the Panel appeared to consider points a, e, f and g of the SG to be engaged (as they were the only paragraphs quoted), which state:

a. A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.

e. No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.'

f. No evidence of repetition of similar behaviour since incident.

g. The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'

9.8 The Members agreed that paragraphs *b*. and *d*. of the SG were not engaged but focussed its concern on the irrational decisions of the Panel regarding paragraphs *e*. and *g*. when it appeared evident that remediation is unlikely given the Registrant has completely failed to engage with the proceedings, nor shown any evidence of insight or remorse.

9.9 Further, they noted that the factors at paragraph *g*. are actually in contrast to the Panel's earlier comments in determining impairment, that there was no evidence before the Panel that the Registrant had admitted fault, shown insight or taken steps to mitigate his actions. The Members could see no correlation between this conclusion and the Panel finding at impairment stage that there is no evidence of a significant risk of repetition, indicating that the Panel had completely lost sight of its earlier finding, meaning that it failed to address the actual risk of repetition in light of the lack of admissions, insight and remediation.

9.10 The Members noted that there is no evidence this type of conduct had occurred previously, but certainly could not use this as a basis for concluding that it would not happen again. The Members therefore concluded that despite quoting from the SG, the Panel appeared to misinterpret it and failed to explain how it had reached the decisions that it had; and consequently concluded that the Panel's finding was wrong.

Should the Panel have considered and made express reference to the Sanctions Guidance in respect of erasure?

9.11 The Members went on to discuss the lack of express reference to the SG in the Panel's decision on whether erasure would be appropriate, noting that the GMC had submitted for erasure, (given the seriousness of the misconduct, the inability to rule out the risk of repetition and the potential damage to public trust in the profession). Instead the Panel merely referenced the mitigating factors, which the Members considered to be minimal, and that the misconduct was serious but not so serious as to be fundamentally incompatible with continued registration.

9.12 The Members further noted that the Panel must have overlooked the opening wording of the SG in relation to suspension, which states that 'some or all' of the factors being present would indicate suspension may be appropriate, whereas in contrast, for erasure, it states 'any' of the factors may indicate erasure is appropriate. This led the Members to believe there was clearly an intention by the GMC for Panels to take a different approach in respect of each sanction, and that the appropriate approach had not been taken by the Panel.

9.13 Further, its approach, especially when bearing in mind the absence of factors indicative of suspension versus the more weighty list of factors indicative of erasure, appeared to the Members to indicate that the Panel had already reached a decision that suspension was the appropriate sanction rather than taking the necessary steps to reference the SG in relation to erasure, to

consider the factors that were engaged, and to expand on its decision on why it found the Registrant's conduct was not fundamentally incompatible with continued registration.

9.14 The Members therefore concluded that in failing to provide reasons, and failing to consider the factors for erasure set out in the SG and give them the appropriate weight, the Panel failed to fully demonstrate it had paid due regard to the SG, and, ultimately, to reach the correct conclusion that this was a case of fundamental incompatibility.

Conclusion on insufficiency for public protection

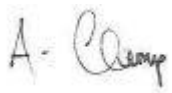
9.15 The Members concluded that the Panel's decision to suspend the Registrant without giving any weight to the aggravating factors or the seriousness of the misconduct, without providing any reasons for not considering erasure, and having made errors in its interpretation of the SG, was insufficient for public protection.

10. Referral to court

10.1 Having concluded that the Panel's Determination was insufficient for public protection, the Members moved on to consider whether they should exercise the Authority's discretion to refer this case to the relevant court.

10.2 In considering the exercise of the Authority's discretion, the Members received legal advice as to the prospects of success and took into account the need to use the Authority's resources proportionately and in the public interest.

10.3 Taking into account those considerations, along with advice on the prospects of success, the Members agreed that the Authority should exercise its power under Section 29 and refer this case to the High Court of Justice of England and Wales.



Alan Clamp (Chair)

04/01/21

Dated

11. Annex A – Definitions

11.1 In this note the following definitions and abbreviations will apply:

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	A Medical Practitioner's Tribunal Service of the General Medical Council
The Registrant	Christian Hanson
The Regulator	The General Medical Council
Regulator's abbreviation	GMC
The Act	The National Health Service Reform and Health Care Professions Act 2002 as amended
The Members	The Authority as constituted for this Section 29 case meeting
The Determination	The Determination of the Panel sitting on 29 September 2020
The Court	The High Court of Justice of England and Wales
The SG	GMC's Sanctions Guidance in force at sanction stage dated November 2019
GMP	The GMC's Good Medical Practice document