Section 29 Case Meeting

17 March 2023

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

Ewere Onyekpe

Members present

Marcus Longley (in the Chair), Board Member, Professional Standards Authority
Mark Stobbs, Director or Scrutiny and Quality, Professional Standards Authority
Graham Mockler, Assistant Director of Scrutiny and Quality, Professional Standards Authority

In attendance

Nicola Kohn of 39 Essex Chambers

Observers

Juliet Oliver, Board Member, Professional Standards Authority
Rebecca Moore, Scrutiny Officer, Professional Standards Authority
Louise Appleby, Accreditation Officer, Professional Standards Authority
Georgina Devoy, Senior Scrutiny Officer, 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 of Justice of England and Wales and the statutory time limit for an appeal would expire on 24 March 2023.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 19 January 2023.

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 19 January 2023
- The Authority's Detailed Case Review
- Transcripts of the hearing
- Counsel's Note dated 15 March 2023
- The GMC's Code
- The GMC's Indicative Sanctions Guidance
- The Authority's Section 29 Case Meeting Manual
- Response from the GMC dated 16 March 2023

7.2 The Members and the Legal Advisor were provided with a copy of a response from the GMC to the Authority's Notification of s.29 Meeting. The Members

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

considered the response prior to the start of the meeting and on Counsel's advice.

8. Background

8.1 The Registrant was employed as a locum registrar working in the emergency department of the Whittington Hospital ("the Whittington") during the tail end of the Covid-19 summer lockdown in June 2020.

8.2 On 5 June 2020 in the course of a nightshift, the Registrant treated a female patient and, in the absence of a chaperone, carried out an appropriately indicated intimate examination to determine the cause of back pain from which she had been suffering from some weeks.

8.3 By the Registrant's account, on leaving the consultation the Patient then gave him her number "in case you want to be friends". He made initial contact via WhatsApp, enquiring after her wellbeing. Her responses were immediately friendly; the conversation soon became more personal and sexualised at the Registrant's instigation.

8.4 On 10 June 2020 the Patient attended the Whittington once more, complaining of chest pains, and notified the Registrant of her presence. They recommenced texting; at the Registrant's instigation, communication became sexualised. Between 10.20pm and 10.38pm the Registrant and the patient met up in a toilet cubicle of the Whittington Hospital and engaged in sexual intercourse. The Registrant remained on shift and on duty in the emergency department throughout this time. They then arranged to meet again at the Patient's home the next morning where they again engaged in sexual intercourse.

8.5 Thereafter the Registrant and Patient continued text messages for a number of weeks, during which the Patient continued to complain of ill health and pain; the Registrant sent her a number of unsolicited, pornographic and scatological images along with some medical advice.

8.6 The Registrant subsequently deleted all messages from his phone. After a number of weeks, the relationship apparently petered out. The Registrant and the Patient did not meet in person again during this time.

8.7 On 3 August 2020 the Registrant was arrested on suspicion of rape. The case against him was not progressed but resulted in a police referral to the GMC. On 5 August 2020 the Registrant also self-referred to the GMC.

8.8 The Registrant attended the hearing and was represented. The Registrant accepted the allegations against him. The panel found the facts relevant to impairment proved; that they amounted to misconduct and that the Registrant's fitness to practise was impaired by reason of misconduct. The panel then imposed suspension for 6 months with a mandatory review.

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 discussed the following concerns about the decision:

Possible Under-Prosecution

9.3 The Members were concerned that the Tribunal had failed to properly assess the vulnerability of the Patient and in doing so had failed to properly address the seriousness of the Registrant's actions.

9.4 The Members firstly considered whether or not the Registrant would have been aware that the Patient was vulnerable. They noted that at the time the Patient presented at hospital, the Registrant had been provided with and made notes and took a medical history, including details of medication she was taking.

9.5 The medical history and notes taken by the Registrant indicated that she suffered from various chronic, long-term conditions. Later text message conversation from the Patient to the Registrant also stated that she required a Personal Assistant to help her as her conditions left her unable to look after her children or work, which the Members considered was suggestive of vulnerability.

9.6 The Members referred to the GMC guidance on vulnerable people and noted that this included those suffering from mental health issues, disability of frailty. The Members agreed that the Patient did fall into at least the category of being frail, that the Registrant was aware of such and that the Tribunal in simply asking the Registrant whether or not he believed that the Patient was vulnerable, had accepted his answer of "no" without fully exploring the evidence that was before them which could have suggested otherwise.

9.7 The Members were concerned that the GMC had misinterpreted their own guidance and that they were incorrect in their submissions to the Tribunal that they could not invited them to say that she was vulnerable.

9.8 The Members were further concerned that the GMC failed to call the Patient as a witness and were concerned that there seemed to be a suggestion that she was a untruthful witness and that she was unharmed by the experience. In fact making an allegation of rape in itself would suggest that the Patient was severely traumatised by what had happened to her.

9.9 In addition to their concerns surrounding vulnerability, the Members also considered whether the Registrant's actions had been predatory in nature, and whether the Tribunal had failed to consider such.

9.10 The Members referred to the GMC guidance on predatory behaviour which stated that if there was evidence of some predatory behaviour – for example using a Patient's contact details, then there is a risk of more serous action being taken and that erasure could be appropriate.

9.11 The Members noted that in the course of the conversations, it was the Registrant who had instigated the sexual elements and had sent the pornographic images. The Members considered that this could be seen as leading behaviour and indicated that the Registrant was abusing his position of trust.

9.12 The Members concluded that the failure to properly present the evidence surrounding potential vulnerability and predation could amount to under

prosecution and that, in any event, the Tribunal had not considered these points. Had it done so, it this may well have led to a different outcome overall.

Mismatch between the findings on the nature of the wrongdoing and sanction

9.13 The Members were concerned that there was a clear disconnect between the findings of impairment and those on sanction.

9.14 The Members noted from the GMC's sanctions guidance for erasure that erasure may be appropriate where the following where present: Abuse of trust, putting their own interests before others, exploiting vulnerable people, causing harm to others and a deliberate disregard for the principles in Good medical practice. The Members agreed that all of these factors were present in this case and that the Tribunal had failed to provide sufficient reasons as to why suspension over erasure was appropriate. In the Members' opinion, the significant aggravating factors indicated that erasure might be the appropriate sanction.

9.15 The Members were concerned thatthe Registrant's actions in having sexual intercourse with a vulnerable Patient, whilst on shift in A&E, causing that Patient severe emotional harm, was likely to be fundamentally incompatible with continued registration. The Tribunal had not provided an appropriate level of analysis dealing with that.

9.16 The Members were further concerned that the Tribunal had failed to fully explain how the Registrant's actions would have affected other patients and staff who attended and were working on an A&E shift that evening. The Members also noted that the misconduct took place at a time when the United Kingdom was under Covid-19 restrictions, which the Registrant had clearly breached. The Members were concerned that the failure to take all of the above into proper consideration had the potential to undermine public confidence in the profession.

Was the GMC wrong not to call the Patient to give evidence.

9.17 Whilst the Members had concerns that the Patient was not called to give evidence and considered the GMC had placed an over-reliance on the police interview she gave, they were satisfied that there was sufficient evidence available to the GMC and the Tribunal to suggest that she was vulnerable and that she had suffered distress from the Registrant.

Did the approach taken by the Legally Qualified Chair result in a procedural Irregularity?

9.18 The Members noted the Legally Qualified Chair had emailed the Tribunal members on 14 January 2023, outside the hearing, setting out a concern with the Sanctions Guidance and arguing it did not follow the approach in Fuglers v SRA [2014] EWHC 179 (Admin). In doing so, he suggested an alternative approach which may have had the effect of leading the panel members to miss the stage of considering whether the conduct was in itself itself so serious that erasure was required in the absence of cogent arguments to the contrary. As a result, the Tribunal arguably fell into error.

9.19 The Members considered that the Chair's actions were highly irregular and inappropriate. They could have had the effect of misdirecting the panel. However, it was not clear that this had been the actual impact.

Conclusion on insufficiency for public protection

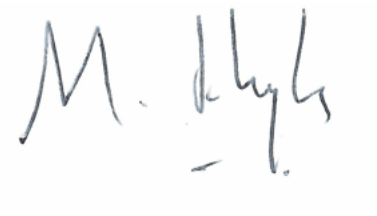
9.20 The Members concluded that the Tribunal's failure to properly consider the vulnerability of the Patient and the predatory nature of the Registrant's actions was a serious procedural irregularity which meant the Members were unable to determine whether the outcome of the case was sufficient because these matters were simply not considered. Moreover, the Tribunal's departure from the GMC's Sanctions guidance and failure to provide sufficient reasons as to why the conduct was not fundamentally incompatible with continuing registration suggested that the decision was insufficient to maintain public confidence in the medical profession and to maintain proper professional standards and conduct. The decision was, therefore, insufficient to protect the public.

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.



Marcus Longley (Chair)

4 April 2023

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 (MPTS)	A Medical Practitioners Tribunal Service (MPTS)
The Registrant	Ewere Onyekpe
The Regulator	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 19 January 2023
The Court	The High Court of Justice of England and Wales
The Code	Regulator's Code of Practise
The SG	Regulator's Sanctions Guidance