Neutral Citation Number: [2021] EWHC 588 (Admin)

Case No: CO/4514/2020

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/03/2021

Before:

MR JUSTICE CHAMBERLAIN

- -

Between:

PROFESSIONAL STANDARDS AUTHORITY for HEALTH AND SOCIAL CARE — **Appellant**

- and –

(1) GENERAL MEDICAL COUNCIL
(2) CHRISTIAN HANSON — **Respondents**

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- -

Michael Standing (instructed by **Browne Jacobson LLP**) for the **Appellant**
The Respondents did not appear and were not represented

Hearing dates: 9 March 2021

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Approved Judgment

MR JUSTICE CHAMBERLAIN:

Introduction

1 This is an appeal by the Professional Standards Authority for Health and Social Care pursuant to s. 29 of the National Health Service Reform and Health Care Professions Act 2002 as amended ("the 2002 Act").

2 The decision appealed against was made by the Medical Practitioners Tribunal of the General Medical Council ("the Tribunal") at a substantive misconduct hearing on 29 September 2020. It concerned Dr Christian Hanson, a specialist in emergency medicine who had worked at the Rotherham General Hospital ("the Hospital"), part of the Rotherham NHS Foundation Trust ("the Trust").

3 The Tribunal found that, on 5 June 2018, while working at night, Dr Hanson had committed misconduct in the form of unwanted, non-consensual, sexually motivated behaviour towards a nurse, Ms A. The Tribunal determined that Dr Hanson's fitness to practise was impaired. It imposed a 10-month suspension with a review.

4 The Appellant says that the Tribunal failed to recognise the seriousness of Dr Hanson's conduct and therefore failed to impose a sanction that provides sufficient protection of the public, maintains public confidence in the profession and maintains proper professional standards and conduct for members of the profession. It invites me to allow the appeal and substitute for the 10-month suspension an order that Dr Hanson's name be erased from the register.

5 Dr Hanson did not engage with the Tribunal process at all. He did not appear and was not represented at the hearing. He has also not engaged with proceedings in this court. The appeal papers were sent to him by first class post on 4 December 2020, but were returned, marked "refused". A process server was instructed. He confirmed in a witness statement that he had attended Dr Hanson's address and had attempted to serve the papers on two occasions. There had been no answer on either occasion, although there were obviously people inside. In those circumstances, I am satisfied that proper notice of the proceedings has been given. That being so, the court has an implied power to proceed in his absence: *General Medical Council v Theodoropolous* [2017] EWHC 1984 (Admin); [2017] 1 WLR 4794, [26]. As Dr Hanson has chosen not to engage with the proceedings before the Tribunal or before this court, nothing would be gained by an adjournment. I therefore indicated that I would proceed with the appeal in his absence.

The Tribunal's findings

6 The Tribunal made the following findings of fact about what had happened on a night shift at around 3am on 5 June 2018, when Dr Hanson was working as a doctor at the Hospital. Knowing that Ms A was working alone as a nurse in the Paediatric Department, Dr Hanson followed her from the front desk in the reception area of the Department, grabbed her hips as she was walking though the double doors leading out of the Department and guided her through those doors. Dr Hanson then followed Ms A into an office, pulled her towards him by grabbing her hips, clamped his knees around her legs, put his hands on her hips/bottom, asked her when he would see her again, told her that he missed her, asked to see her outside work, pushed his body against hers when he stood

up, whispered in her ear and held her hips with his hands when he stood up. His conduct was sexually motivated.

7 The Tribunal indicated that they found Ms A to be a truthful and reliable witness and accepted her account of the event. This included that Dr Hanson had pushed his body against Ms A's, whispered in her ear and held her hips after she had told him that what he was doing was inappropriate and pushed him away.

8 The Tribunal noted that there was a power imbalance between Dr Hanson and Ms A by reason of their respective professional positions, age and physical stature. The incident took place in the early hours in an otherwise empty department and in circumstances where Ms A was likely to have felt isolated. The event had an impact on Ms A's emotional well-being both immediately after the event and subsequently. The Tribunal concluded that Dr Hanson would have known, or at the very least should have known, that he was putting Ms A through a potentially frightening experience. The Tribunal held that Dr Hanson's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to meet the threshold for misconduct.

9 As to impairment, the Tribunal noted that Dr Hanson had flatly denied any misconduct in his description of events in statements given during the investigation by the Trust. Because he had not engaged with the proceedings, the Tribunal had no evidence before it to suggest that he had developed any insight into his misconduct or taken any effective steps towards remediation. There was no evidence of contrition.

10 The Tribunal found Dr Hanson's fitness to practise impaired by reference to all three of the objectives set out in s. 1(1B) of the Medical Act 1983 as amended, namely: (a) to protect, promote and maintain the health, safety and well-being of the public, (b) to promote and maintain public confidence in the medical profession and (c) to promote and maintain proper professional standards and conduct for members of that profession. It said:

> "Dr Hanson's sexually motivated behaviour would have been unacceptable in any working environment. It amounted to sexual harassment. Such conduct falls far below the standard to be expected from a medical practitioner."

11 As to sanction, the Tribunal first considered the mitigating factors: there was no evidence that Dr Hanson had engaged in similar misconduct or behaved in a similar manner in the past or since; and the index event represented a single, isolated incident of relatively short duration.

12 Against that, Dr Hanson's unwanted, sexually motivated behaviour involved an abuse of a position of power and trust. His misconduct was very distressing for Ms A and had a significant and enduring effect on her emotional well-being. There was no evidence that Dr Hanson had acknowledged his wrongdoing or expressed any remorse or regret. The Tribunal had no evidence that Dr Hanson had shown any insight into his misconduct.

13 The Tribunal referred to paras 91-93 and 97 of the GMC's Sanctions Guidance. It acknowledged that there was no evidence that Dr Hanson had admitted fault, shown insight or taken steps to mitigate his actions, but equally there was no evidence of a

significant risk of repetition. It determined that erasure would be disproportionate. Dr Hanson's misconduct was "serious but not so serious as to be fundamentally incompatible with continued registration". Suspension for 10 months, with a review shortly before the end of the period of suspension, would be sufficient.

Good medical practice and the Sanctions Guidance

14 The GMC's *Good medical practice* requires doctors to "treat colleagues fairly and with respect" (para. 36), to "be aware of how your behaviour may influence others within and outside the team" (para. 37) and to "make sure that your conduct justifies your patients' trust in you and in the public's trust in the profession" (para. 65).

15 The GMC's Sanctions Guidance sets out at para. 25 examples of mitigating factors: (a) evidence that the doctor understands the problem and has insight, (b) evidence that the doctor is adhering to important principles of good practice and the doctor's character and the previous history, (c) circumstances leading up to any incidents that raise concern, (d) personal and professional matters, such as work-related stress, (e) lapse of time since the incident occurred.

16 Examples of aggravating factors are given at paras 50 *et seq*. The first is lack of insight. At para. 52, the Sanctions Guidance provides that a doctor is likely to lack insight if they (a) refuse to apologise or accept their mistakes, (b) promise to remediate, but fail to take appropriate steps, or only do so when prompted immediately before or during the hearing, (c) do not demonstrate the timely development of insight, (d) fail to tell the truth during the hearing. Aggravating factors likely to lead the Tribunal to consider taking more serious action include sexual misconduct: see para. 55(e). See also paras 149-150, which provide as follows:

> "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…
>
> 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."

17 The paragraphs referred to by the Tribunal include the following, about suspension:

> "92. Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the Tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

> 93. Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the Tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The Tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–49).
>
> 97. Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.
>
> > 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, e.g. because of previous unsuccessful attempts or a doctor's unwillingness to engage.
> >
> > f. No evidence of repetition of similar behaviour since incident."

18 As to erasure, the Sanctions Guidance provides as follows at para. 109:

> "Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).
>
> > a. A particularly serious departure from the principles set out in *Good medical practice* where the behaviour is fundamentally incompatible with being a doctor.
> >
> > b. A deliberate or reckless disregard for the principles set out in good medical practice and/or patient safety.
> >
> > c. Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients…
> >
> > 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').
> >
> > …
> >
> > j. Persistent lack of insight into the seriousness of their actions or the consequences."

The proper approach on appeal

19 The question in this appeal is whether the decision appealed from is "wrong": CPR r. 52.21(2)(a). The principles to be applied in an appeal under s. 29 were set out by Foster J in *Professional Standards Authority for Health and Social Care v Health and Care Professions Council & Roberts* [2020] EWHC 1906 (Admin), at [3]. The court approaches Tribunal determinations of sanction with diffidence, because they are evaluative decisions in the sense described in *General Medical Council v Bawa-Garba* [2018] EWCA Civ 1879, [2019] 1 WLR 1929, at [61]-[67]. However, the weight to be attached to the Tribunal's expertise in performing this evaluation depends on the type of misconduct in question. Where, as here, the misconduct does not relate to standards in treating patients, the court is likely to consider that it can assess what is needed to protect the reputation of the profession more easily: *Khan v General Pharmaceutical Council* [2016] UKSC 64, [2017] 1 WLR 169, [36].

Submissions for the Appellant

20 Mr Michael Standing for the Appellant advanced six overlapping grounds of appeal. He submitted that the Tribunal failed to have proper regard to the seriousness of the misconduct found proved (ground 1), failed to provide any indication of the weight placed on any of the identified aggravating or mitigating factors (ground 2), failed to provide any or any adequate reasons why erasure was not proportionate (ground 3), failed to have proper regard to the Sanctions Guidance (grounds 4 and 5) and was wrong to conclude that suspension was the appropriate sanction (ground 6).

Discussion

21 I have to consider whether the Tribunal was wrong to impose the sanction it did. In reaching my decision I must bear in mind the evaluative nature of the Tribunal's decision and must accord it such weight as is appropriate in the circumstances. There are two features of this case which justify according it less weight than would be appropriate in some other cases: the misconduct found proven did not occur in the context of treating a patient but fell into the category recognised in the authorities as justifying less institutional deference to the Tribunal; and, because Dr Hanson did not appear before them, the Tribunal did not have the benefit of seeing and hearing Dr Hanson for themselves.

22 Against that background, I consider that the Tribunal fell into error in five respects.

23 First, although the Tribunal recognised that the misconduct found proven by the Tribunal was serious, it failed to recognise how serious. Dr Hanson, a doctor of many years' experience, was in a position of authority vis-à-vis Ms A, a relatively newly qualified nurse. He was a tall man; she was a small woman. He was many years her senior. He approached her at night, when he knew she would be alone. He deliberately guided her into a room away from others. His conduct on the way to the room and inside it was not limited to inappropriate remarks. It involved persistent and repeated touching, which was sexually motivated, and continued after she had made clear she considered it inappropriate and pushed him away. The experience caused her significant distress: she was off work for several weeks. If found proved to the criminal standard in a court, these

facts would have constituted the offence of sexual assault contrary to s. 3 of the Sexual Offences Act 2003.

24 Second, this was a calculated and deliberate abuse of power which foreseeably caused real harm to a fellow healthcare professional. Someone who has engaged in conduct of this kind poses a danger to the "health, safety and well-being of the public" (which includes co-workers), unless there is a proper basis for concluding that the conduct is unlikely to be repeated. The Tribunal should have focussed on the question whether there was such a basis.

25 Third, the Tribunal placed reliance on two "mitigating factors", but on analysis neither was properly to be regarded as such. The absence of evidence that Dr Hanson had engaged in similar conduct before or since was neutral. There was no positive evidence to suggest that the index event was an aberration because he had chosen not to engage with the proceedings. The description of the event as a "single isolated incident of relatively short duration" also did not constitute genuine mitigation, given the Tribunal's own findings that Dr Hanson had deliberately guided Ms A into a private room and assaulted her there and given its acceptance of her evidence that he had continued the assault after she had indicated that the conduct was inappropriate and pushed him away.

26 Fourth, as the Sanctions Guidance makes clear, a key question so far as mitigation was concerned was the extent (if any) of Dr Hanson's insight into what he had done. It is possible to demonstrate insight in a variety of ways, even where the conduct alleged is disputed. In this case, however, Dr Hanson's complete lack of engagement with the Tribunal meant that there was nothing to demonstrate any insight or contrition at all. This meant that the Tribunal could have no proper basis for concluding that the behaviour would not be repeated and other co-workers subjected to similar mistreatment. The Tribunal recognised this, but failed to identify its significance given the facts found proven.

27 Fifth, in all the circumstances, the Tribunal should have concluded that Dr Hanson's conduct engaged all of sub-paras 109(a)-(d) of the Sanctions Guidance and was fundamentally incompatible with continued registration. Suspension might potentially have been appropriate if there had been strong mitigation providing a basis for concluding that repetition was unlikely. But no such basis was advanced or apparent.

Conclusion

28 For these reasons, the appeal succeeds. In my judgment, on the material before the Tribunal, there was only one sanction that could properly be imposed: erasure. There is accordingly no point in remitting the question of sanction. I shall exercise the power in s. 29(7)(c) of the 2002 Act to substitute for the Tribunal's decision on sanction a decision that Dr Hanson's name be erased from the register.