

Agenda item:	7
Report title:	Embedded Learning from Sexual Abuse cases update
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Action:	For consideration

Executive summary

The ELSA programme was set up to deliver the learning from the review of historical child sexual abuse cases that Council commissioned in 2017. It was expanded to cover all forms of sexual misconduct, including sexual harassment, and to includes cases that involve adults as well as children.

The ELSA programme has three main aims: to implement improvements to how we identify, evidence and progress cases of sexual misconduct and sexual harassment; improve our support for complainants and vulnerable witnesses to help them understand and participate in our investigations, as well as our support for doctors, employers, and our staff in identifying and raising concerns; and to raise awareness of how we deal with cases of sexual misconduct and sexual harassment.

This paper provides an update on activity already completed and the activity that will continue into 2020 to deliver further improvements.

Recommendations

The Board is asked to:

- a** To note progress of the ELSA programme.
- b** To note the future governance arrangements.

Background

- 1 Following an external review by Sir Anthony Hooper of our handling of the case of a convicted paedophile Dr Morris Fraser, Council commissioned a review of all child sexual abuse cases to assure ourselves that we had taken all feasible steps to mitigate any risk to the public.
- 2 The Hooper review identified that the GMC is a very different organisation since the case of Morris Fraser, with much stronger powers and the determination to use them to protect patients. However, we recognised that there is always room for improvement, and therefore we reflected on the wider lessons from the review and set up the Embedding Learning from Sexual Abuse cases (ELSA) programme of work. The programme aims to address the following areas:
 - **Assurance** – improve how we identify, evidence and progress cases involving sexual misconduct and sexual harassment.
 - **Supporting others** – improve our support for complainants and vulnerable witnesses to understand and participate in our investigation of sexual misconduct cases, as well as our support for doctors, employers, and our staff in identifying and raising concerns about sexual misconduct and sexual harassment.
 - **Raising awareness** – raise awareness with our staff, doctors and the public about our professional guidance and how we deal with cases involving sexual misconduct and sexual harassment.
- 3 Following the Hooper review, we also committed to making a detailed submission to the Independent Statutory Inquiry into Child Sexual Abuse in England (IICSA) setting out what the review found, the learning we have drawn from it and the further steps we are taking to improve our handling of these cases. The submission was sent in July 2019 and it included information on the actions we are taking in the ELSA programme.

Progress update

- 4 In April 2018, Council agreed an action plan outlining further work required to address the risks and opportunities identified by the historic review. An updated action plan is in Annex A updating on action to deliver that plan and to outline the links with the activity in the ELSA programme. A summary of progress against the ELSA programme's three aims is below.

Assurance

- 5** We conducted a further targeted review of cases from January 2017 to January 2019, and engaged with operational teams, in order to identify specific improvements that could be made in the areas highlighted in the Council action plan (Annex A). We did this because we identified that there had been several changes to our policies and processes since the cases that were included in the historical review, and we expanded the programme to also include cases of sexual misconduct and harassment involving adults.
- 6** This identified further improvements to our existing guidance for staff on our decisions to investigate concerns. We updated our guidance on anonymous and confidential complaints to link to guidance on how decision makers can consider a doctor's fitness to practise history. We also updated our guidance to decision makers on the factors to consider when they are deciding whether or not to waive the rule that says that no allegation can proceed if it is more than five years since the allegation, unless it is in the public interest – 'the five-year rule'. This included adding information on why it might take a complainant more than five years to raise their concerns with us – for example in cases involving traumatic events and/or sexual misconduct or harassment. We also identified an opportunity to make changes to our systems to be able to better track and report these decisions.
- 7** We will update our decision maker's guidance on taking into account a doctor's fitness to practise history to improve the guidance and provide more training and case studies for decision makers, which would include cases of low-level sexual misconduct. We are also developing new guidance on sexual misconduct and sexual harassment cases, to support decision makers in understanding the challenges these cases can present and how that may impact their decisions.
- 8** Finally, we identified good practice in relation to our use of expert reports in clinical cases that involve allegations of inappropriate clinical examinations or behaviour and we plan to capture this existing best practice in guidance.
- 9** Most of this work has been delivered or is on track to be delivered by the end of 2019. Improvements around consideration of a doctor's previous fitness to practise history is due to conclude in quarter two 2020 and we expect the new guidance for decision makers to be rolled out in quarter three 2020 to coordinate with the training that we are developing, referred to below.

Supporting others and raising awareness

- 10** Reviewing and improving our policies and processes alone is not enough to ensure that we are able to appropriately progress and evidence cases involving sexual misconduct and harassment. We want to improve how we support all those involved in these cases, including witnesses, complainants, doctors, employers and our staff and we have shared our learning with other regulators.
- 11** Support is already available throughout our processes, but we focussed on exploring further improvements and identifying any gaps. This has resulted in the following initiatives:
 - a** *Witnesses and complainants.* We are exploring working with a charity, such as Victim Support, to co-produce information about fitness to practise processes specifically aimed at victims and survivors of sexual misconduct. This will complement the wider work to improve our support for witnesses by the Legal team in the last few years. We are in discussion with other regulators on the possibility of taking this forward as a joint initiative.
 - b** *Employers.* We are facilitating the development of case studies and supporting guidance for employers working with ROs and other GMC associates with expertise in this area. This was based on feedback from ROs at their network meetings about what we could do to support them in handling these cases. This is also another area we in discussion with other regulators about taking this forward as a joint initiative.
 - c** *Doctors.* We are aiming to provide more content on sexual misconduct and sexual harassment in our review of the Sanctions Guidance, to support doctors by providing more detail about types of sexual misconduct and harassment, the seriousness of these concerns and how it impacts on our overarching objective to protect the public. We will be working with colleagues in the outreach teams to identify where case studies or content on sexual harassment and sexual misconduct cases could be incorporated into existing awareness programmes for doctors, such as Welcome to UK Practice and Professional Behaviours and Patient Safety. We are also aware of potential research, being proposed by the Equality Diversity and Inclusion team for the 2020 research plan, into the prevalence of sexual harassment in the workplace and will monitor how the work develops and identify opportunities for collaboration.

- d** *Our Staff.* We will work with a specialist external provider to develop staff training package for all Fitness to Practise Directorate staff. We are proposing a model of training specialist internal champions who will then be able to appropriately tailor training to the needs across the different teams and provide a more sustainable source of expertise in handling these cases in the future. This directorate wide training will build on specialist CPS Rape and Serious Sexual Offence (RASSO) training already provided to some legal colleagues.
- e** *Regulators.* Following the submission of our report to IICSA, we shared our learning with other UK health professional regulators (SRA, GDC, NMC, GPhC), which resulted in potential opportunities for joint initiatives in supporting employers and supporting complainants and witnesses highlighted above.

12 This work is expected to be delivered throughout 2020.

Future programme governance

- 13** The delivery of the ELSA programme is being governed by a board consisting of senior management in Fitness to Practise and other stakeholders from across the business. The board convenes to review and approve updates to guidance and processes and provide direction on programme activities. This arrangement will continue into 2020 until the programme concludes.

7 – Embedded Learning from Sexual Abuse cases update

7 - Annex A

Child Sexual Abuse Review - Issues identified and work to address these issues

Annex A: Child Sexual Abuse Review – Issues identified and work to address these issues

Theme and summary of key issues	What has been introduced since the issues were raised to address these?	What further improvements can be implemented to address any gaps?	Link to current work in ELSA programme
<p>1. Use of section 35A powers to obtain disclosure during investigation/evidence gathering</p> <p>Only a small amount of cases throughout the reviews used powers under section 35A of the Medical Act. This meant that we often relied on ‘chasers’ to the police. The outcome of this was that we often ceased to send chasers and did not obtain relevant information and/or evidence from the police, which could have been gained through a request under our section 35A power.</p>	<ul style="list-style-type: none"> Standard letters used by operational staff to request information from the police were updated in December 2014 to make reference to our powers under section 35A, requiring the disclosure is made within 14 days. The updated templates were supported by the introduction in 2015/16 of bespoke guidance on the use of section 35A addressed to operational staff as well as a defined protocol for the escalation and enforcement of such requests by a dedicated legal resource. The criminal convictions teams have also established a database of disclosure contacts for each police force which is regularly updated and helps us liaise effectively with individual police disclosure units and obtain information in a more timely and effective manner. 	<p>We have not identified any further action required around this point:</p> <ul style="list-style-type: none"> Section 35A powers are now effectively used to obtain disclosure from the police, reducing the delays previously experienced in obtaining information about criminal investigations. 	<ul style="list-style-type: none"> N/A. No further work was identified in this area.
<p>2. Extent of evidence gathering and appropriate application of the standard of proof</p> <p>In seven review reports, we were criticised for our inability to appropriately liaise with the police and/or social services in order to obtain the best evidence. In these cases there was legitimate opportunity to gain more information gathered by the police or social services which could have provided valuable insight into the allegations made by the complainant or, alternatively, disproved the allegations.</p> <p>In some cases we were also criticised for not taking further action in instances where the Crown Prosecution Service (CPS) took no further action for evidential burden reasons post 2008 (when the burden of proof in professional misconduct cases moved from away from criminal to civil standard of proof), or where criminal cases have failed on legal technicalities that would not have prohibited us from taking further action (including some where the doctor has admitted the conduct). The review reports highlight that we could have obtained further evidence and that our regulatory remit would have enabled us to pursue other evidential avenues that could have met the realistic prospect test.</p>	<ul style="list-style-type: none"> We have introduced a comprehensive and effective approach to obtaining information from the police and other organisations in the UK using our powers under section 35A of the Medical Act, as detailed under theme 1. In January 2018, we published guidance for staff on sharing information with the police and sharing information with social services. Although this guidance primarily focuses on disclosure of information from the GMC to these organisations (rather than the other way around), it helps promote effective information sharing practices and working relationships between us and the police/social services. In 2015, we published guidance for case examiners on police cases resulting in acquittal/decision not to proceed to trial. This assists decision makers in weighing the fact of an acquittal/no further action decision against the other relevant factors in deciding whether allegations meet the realistic prospect test and should be referred to a hearing. The guidance clearly flags the different standards of proof used in criminal and GMC proceedings. In 2016, we published a criminal offences manual which provides guidance for staff on obtaining information from the police so we can consider allegations against doctors under the FTP procedures. This includes cases where no further action has been taken by the police or the doctor 	<p>Further work:</p> <ul style="list-style-type: none"> Reviewing our approach and guidance relating to cases where the police and CPS have taken no further action, including an emphasis on the different burdens of proof in criminal and GMC proceedings, to ensure that we are gathering all the required evidence and processing cases appropriately e.g. not giving more weight than appropriate to the fact of an acquittal or no further action decision. This review will include the guidance for case examiners on police cases resulting in acquittal/decision not to proceed to trial. Reviewing the criminal convictions manual which includes a list of things that investigation officers should obtain when they write out to police to ensure it adequately reflects the relevant information required in sexual abuse cases. 	<ul style="list-style-type: none"> We reviewed our approach and guidance to cases where the police and CPS have taken no further action and have not identified any other improvements. The guidance was recently updated in 2018 based on external Counsel input. We conducted a full review of evidence gathering including data and case analysis and review of team processes and guidance. We identified that median time for sexual misconduct investigations is higher than for other cases; however there is a significant variation due to a number of factors relating to the complex nature of these cases and the impact this has on obtaining information from the police mainly. We did not identify any further improvements that could be made to guidance or processes; however we noted the importance of the

	<p>has been acquitted following a criminal trial as the criminal burden of proof was not met.</p>		<p>existing work in the Fitness to Practise Directorate to improve working relationships with police units such as the Metropolitan Police.</p> <p>No further work in this area is being taken forward in the ELSA programme.</p>
<p>3. Admissibility and consideration of previous similar allegations</p> <p>In a number of reviews we were criticised for our failure to consider the admissibility of previous or similar allegations against the doctor. In these cases, some doctors had a history of similar sexual misconduct allegations or simultaneous allegations that should have been considered as part of the case. This included allegations made directly to the GMC, allegations made by the police, and allegations received from other regulatory bodies. In some circumstances, the panel/tribunal were also criticised for failing to take into account previous allegations when determining a sanction, and in several cases there were issues around GMC registration where it appears that sufficient weight was not placed on current or previous FTP investigations when granting registration to a doctor who had current or previous allegations of sexual misconduct.</p>	<ul style="list-style-type: none"> ▪ In 2015, we produced internal case examiner guidance on police cases that result in acquittal/decision not to proceed to trial. This sets out some of the factors to consider when deciding whether a police case that has been acquitted may still be relevant for GMC investigation, and highlights the need to ensure that sufficient evidence has been gathered to make a decision. ▪ The removal of exceptional circumstances from the 5 year rule in 2016 is likely to mean that we will investigate some cases that we would not have been in a position to investigate previously. ▪ In February 2018, we produced guidance for decision makers on when to take a doctor’s fitness to practise history into account. This sets out the circumstances in which previous history, including similar previous allegations, as well as findings from other regulatory bodies, should be considered. The production of this guidance means that patterns of similar allegations (either in the past or present) are more likely to be considered, and an allegation is less likely to be viewed only on its own merits. This guidance also sets out the factors to consider when a doctor has a number of low-level complaints that, taken together, may mean that the allegations are viewed in a more serious light or amount to impaired fitness to practise. ▪ Within their current operational process, the registration team would now generally wait for the outcome of an investigation by another organisation before making a decision about a doctor’s registration. 	<p>Further work:</p> <ul style="list-style-type: none"> ▪ Reviewing the application of the new guidance for decision makers on when to take a doctor’s fitness to practise history into account six months after its implementation to determine the impact it has had on the consideration of patterns of similar sexual misconduct allegations and update it as necessary to ensure this aspect is addressed. ▪ Reviewing the sanctions guidance and consider whether any changes are needed in line with the new guidance for decision makers on when to take a doctor’s fitness to practise history into account with a view to provide clarity on the way in which tribunal members can and should consider previous similar allegations at the sanctions stage. 	<ul style="list-style-type: none"> ▪ We reviewed the implementation of guidance on a doctor’s fitness to practise history. The guidance was published in January 2018 and has had limited time to embed in relation to the cases that we reviewed. We identified that further work is needed to engage and train decision makers on this guidance. The ELSA programme includes a workstream to take this forward. ▪ The Sanctions Guidance review project is taking forward work to improve the clarity of how decision makers and tribunals should take a doctor’s fitness to practise history into account based on the ELSA programme review findings. The current proposal includes clarity about the seriousness of sexual misconduct and sexual harassment, the threshold for serious behaviour at impairment and sanction stages even for doctors with no previous fitness to practise history. <p>This work is included in the ELSA programme.</p>
<p>4. Cases concluded with health conditions or undertakings or reliance on health assessment</p> <p>In some cases serious conduct/conviction allegations were not referred to a Medical Practitioner Tribunal (MPT)/panel, and undertakings were offered instead. Another issue was that serious offences, e.g. child pornography, were treated less seriously due a perception that the motivation wasn’t sexual gratification but the</p>	<ul style="list-style-type: none"> ▪ Since some of the historic allegations were raised, we have further clarified our position on sexual misconduct allegations in the sanctions guidance and set out that such cases indicate that more serious action is likely to be required. A further review of this issue has recently commenced. ▪ The introduction of the guidance for decision makers on when to take a doctor’s previous history into account in February 2018 means that decision makers should also consider new allegations in light of previous complaints/FTP action. 	<p>Further work:</p> <ul style="list-style-type: none"> ▪ Reviewing the health and conduct guidance to consider the need to explicitly cover the matter of motivation relating to sexual misconduct. Although this is not specifically covered, the guidance sets out clearly what is considered to be misconduct as well as the automatic referral process to an MPT in all cases of serious misconduct. This review will however not delay the publishing of the guidance which is deemed 	<ul style="list-style-type: none"> ▪ We conducted a review of the health and conduct guidance and a sample of cases involving allegations of both health and sexual misconduct. The review identified that decision making was of a high standard and good use of template and wording to explain decisions. In addition, training was provided in early 2019 to decision

<p>result of a health issue. There was also an overreliance on current health undertakings being regarded as sufficient for public protection, even where new evidence had come to light around serious misconduct charges which would have been sufficient to open a Rule 12 review. Finally, there were also concerns that recent health issues have not been investigated despite a history of health and conduct issues in one case.</p>	<ul style="list-style-type: none"> In 2018, we plan to release new guidance on health and conduct cases which highlights that serious conduct should be referred to an MPT, even where the conduct is connected to a health issue. Sexual misconduct falls into one of the presumption of impairment categories set out in the case examiner guidance, meaning it should be referred to tribunal unless there are exceptional circumstances. Even where a doctor’s health is considered to be an ‘exceptional circumstance’ with respect to the presumption of impairment rule, the guidance states that an offer of undertakings would only be likely to be appropriate where the conduct is at the lower end of the spectrum. Child pornography offences, for example, would still be referred to an MPT. This guidance will also address the issue of health undertakings being regarded as sufficient for public protection where new conduct issues have come to light. This is because it sets out the factors to consider when deciding whether; a) the health is connected to the conduct, and b) whether the conduct can be resolved via health undertakings or whether the case must be referred to a MPT. 	<p>urgent due to the issues it addresses, and will take place separately.</p>	<p>makers and operational teams on the guidance, which included a sexual misconduct case study.</p> <p>No further work in this area is being taken forward in the ELSA programme.</p>
<p>5. Inappropriate attitude/comments by staff</p> <p>In a couple of older cases (not older than the 1990s), the reviewers have criticised inappropriate comments made by GMC decision makers such as a case in which the health screener refers to a doctor’s paedophilia as a ‘private matter’, i.e. not a fitness to practise matter that the GMC should concern themselves with. In another case, the Chairman of a Professional Conduct Committee (PCC) panel gave advice to a doctor prior to a restoration hearing about what evidence he should present. The evidence presented was around re-training but the doctor had been erased for indecent assault. It was inappropriate for the Chairman to provide this advice.</p>	<ul style="list-style-type: none"> Since the cases in question, fundamental changes have been made to the fitness to practise process in particular to appoint professional decision makers against clear, transparent competencies and to support them with training and detailed guidance. Auditing of the decisions has also been introduced. Prior to this, fitness to practise decision making such as the medical health screeners were often carried out by elected council members. Since the introduction of the 2004 rules, sexual misconduct carries a presumption of impairment, which ensures that cases of this nature must be heard at tribunal and are not subject to personal views of staff. The PCC ceased to exist in 2004 and the legal team is currently looking into the identified Chairman’s role and whether they are still employed by the GMC. It is no longer acceptable for panel/tribunal members to provide advice to doctors on how to get restored to the register. We now direct doctors to their medical defence organisation or a lawyer regarding this as advised on the restoration pages of our website as well as in the guidance to doctors on restoration. 	<p>We have not identified any further action required around this point.</p>	<ul style="list-style-type: none"> N/A. No further work was identified in this area.
<p>6. Psychiatric care</p> <p>This relates to allegations against a doctor working as a psychiatrist or treating patients with mental</p>	<ul style="list-style-type: none"> The current sanctions guidance introduced since some of these cases were heard by the PCC in 2001 lists abuse of professional position, particularly with vulnerable patients including those under the age of 	<p>Further work:</p> <ul style="list-style-type: none"> To consider the need for further safeguards, both in relation to GMC guidance as well as that of other relevant bodies such as the Royal 	<ul style="list-style-type: none"> Scoping of this work identified that the patient protection issues are mainly in the independent sector

<p>health issues. There were quite a few cases in which the doctor had an inappropriate relationship/conduct or made sexualised comments to a mental health patient, quite often teenagers but also some minors in the strictest sense. There were at least two cases involving prominent child psychiatrists, including Dr Fraser.</p>	<p>18, as an aggravating factor to consider when determining a sanction against a doctor.</p> <ul style="list-style-type: none"> ▪ The GMC has also acquired a right of appeal over decisions made by the tribunal brought about by the Section 60 amendment order to the Medical Act in December 2015. ▪ In 2013 we introduced guidance for doctors on maintaining a professional boundary with patients. ▪ The burden of proof change in 2008 as well as the introduction in 2015 of guidance for case examiners on police cases resulting in acquittal/decision not to proceed to trial would also lead us to investigate concerns further in cases where no action was taken by the police, had these arisen today. ▪ In February 2018, we introduced guidance for decision makers on when to take a doctor’s fitness to practise history into account which includes seven categories of concerns whereby a presumption of impairment of the doctor’s fitness to practise is likely to be made if the allegations are proven. Allegations of improper emotional and sexual relationships, sexual assault and indecency fall into these categories. 	<p>College of Psychiatrists, to protect patients engaged in a therapeutic relationship with their doctor. This should take into consideration the nature of the care provided as well as the vulnerability of the patients involved.</p> <ul style="list-style-type: none"> ▪ Driving forward information sharing across the four countries to ensure that the whole scope of a doctor’s practice (both NHS and private care) is included in their appraisal, as recommended in the Pearson report on revalidation. This recommendation is particularly pertinent in relation to cases where there has been a pattern of concerns but we have not been able to pursue past allegations. However, it may not be sufficient to ensure protection of the public in circumstances where a doctor works solely in private practice such as in one of the cases highlighted by the review. Further consideration would need to be given as to how this could be addressed. ▪ Review our operational approach to information sharing with the police in cases where the doctor has had sexual contact with a patient who is vulnerable by reason of a mental health problem. 	<p>where the safeguards may not be as strong compared to the NHS. The GMC already has a project to identify and mitigate the risks to patient protection in the independent sector and to address support for information sharing between Responsible Officers (ROs). Therefore, this work will be picked up as part of the wider work by these wider projects as the scope of the issue is beyond sexual misconduct allegations.</p> <p>No further work in this area is being taken forward in the ELSA programme.</p>
<p>7. Restoration to the register</p> <p>There are three cases of doctors currently on the register who have been restored following erasure for disciplinary action relating to child sexual abuse (CSA). There are a further five doctors no longer registered, who were erased and restored and erased at least once, some multiple times.</p>	<ul style="list-style-type: none"> ▪ These cases all pre-date the Amendment Order to the Medical Act 1983 made in 2000 which extended the amount of time which must lapse before a doctor can apply to re-join the register from ten months to five years. Under current procedures, if a doctor applies for restoration following erasure by a tribunal or voluntary erasure, they must submit an application and provide evidence relating to their application. This evidence may include things like testimonials and information demonstrating the steps the doctor has taken to keep their medical skills and knowledge up to date. If the doctor was erased at a FTP hearing, then their application will be referred to a MPT to consider. The tribunal will consider a number of factors when deciding whether to restore the doctor’s name to the register including the circumstances which led to the erasure, the doctor’s insight into the matters and what they have done to address these matters. The onus is on the doctor to demonstrate why their name should be restored and that they are fit to practise. ▪ If the doctor was voluntarily or administratively erased and there were outstanding ftp issues or ftp issues have come to light, then their application will be referred to the Case Examiners. Further investigation can be carried out at that stage and the application may be referred to a MPT. 	<p>Further work:</p> <ul style="list-style-type: none"> ▪ Considering the need for guidance to tribunal members on the criteria to consider before a doctor’s licence is restored. 	<ul style="list-style-type: none"> ▪ This has been completed as part of the Restoration Guidance project. Guidance for tribunals has been developed and published (1 November 2019) on restoration following disciplinary erasure. This includes cases where a doctor was disciplinary erased based on sexual misconduct allegations. <p>No further work in this area is being taken forward in the ELSA programme.</p>

	<ul style="list-style-type: none"> ▪ However, if a doctor was voluntarily or administratively erased and has a previous FTP allegation (including one relating to child sexual abuse) which did not result in a conviction and was not considered by a Panel/Tribunal hearing, then this would not act as a barrier to the doctor being restored. If a doctor has a conviction for child sexual abuse, then the guidance suggests that Case Examiners should reject a restoration application. ▪ There is now a process in place whereby the legal team will verify the testimonials before the restoration hearing is heard. This process involves contacting the person who has provided the testimonial to confirm they have submitted it and to check that they are fully cognisant with the allegations that the doctor faces. The tribunal is also made aware of which testimonials have been verified and which ones have not before deciding if a doctor can be restored. 		
<p>8. Perceived conflict of interest</p> <p>Potential for a conflict of interest between those employed or representatives of the GMC and those involved in the case. This issue arose in one case, where a legal assessor failed to declare that he was the father of the 15 year old girl whose allegations we did not pursue. The legal assessor was aware of the police case, albeit not the GMC's consideration of the allegation, and had met with the doctor on at least one occasion to discuss his daughter's care.</p>	<ul style="list-style-type: none"> ▪ Tribunal members' training, including legal assessors, covers conflict of interest declarations. There is a register of interests for all tribunal members and a process is in place to support tribunal members in raising conflicts of interest prior to a hearing as well as during a hearing. The process also tackles borderline conflicts which revolve generally around perception. ▪ Tribunal members, the GMC and doctors' representatives are all mindful of potential conflicts of interest. Tribunal members are now reviewing hearing bundles up to ten days before the hearing commences to help identify any that might exist. 	<p>We have not identified any further action required around this point.</p>	<ul style="list-style-type: none"> ▪ N/A. No further work was identified in this area.

<p>9. Sexual motivation charging/proving</p> <p>In four review reports, we were criticised for not alleging sexual motivation in the charges. There are also review reports criticising panels/committees/tribunals who found sexual motivation not proven but do not provide alternative motivation/reasoning for the inappropriate conduct which was found proven, for example a pinching of the nipple for which there is no clinical reason indicated.</p>	<ul style="list-style-type: none"> ▪ We introduced draft charges guidance which states that allegations must be clearly elucidated so that both the inappropriateness of the conduct and the allegation that it was sexually motivated are responded to by the doctor and considered by case examiners and tribunal members. ▪ Case examiners can also seek advice from the legal team (via a template advice document) on whether the realistic prospect test is met in relation to sexual misconduct allegations should they require additional assurance. ▪ We have also introduced guidance on warnings and how they should be framed which reduces the risks of the case being closed with a warning which does not clearly outline the background of the allegations. ▪ The MPTS has guidance in place regarding the reaching of decisions and the writing of determinations which is regularly refreshed through quality assurance reviews as well as continuing training and professional development. ▪ The GMC has acquired a right of appeal over decisions made by the tribunal brought about by the Section 60 amendment order to the Medical Act in December 2015 and could therefore challenge tribunal decisions of this nature should they arise today. 	<p>Further work:</p> <ul style="list-style-type: none"> ▪ Reviewing our approach and guidance relating to cases where the police and CPS have taken no further action to clarify that we can still pursue the sexually motivated allegations in the presence of new information/evidence and that this does not constitute an abuse of power or double jeopardy. ▪ Reviewing the process by which we obtain medical opinions (whether expert reports or advice from a clinical case examiner) to ensure that a view on whether the examination was clinically indicated is consistently requested in cases where the allegations relate to an inappropriate examination. This would support decision makers consider more fully whether the doctor’s conduct was sexually motivated when determining the outcome of the case. ▪ Considering what further learning could be provided to decision makers (case examiners and tribunal members) to support them in reaching the appropriate outcome on cases involving sexual misconduct allegations. 	<ul style="list-style-type: none"> ▪ See update above in line 2 related to the policy and CPS no further action guidance. ▪ We conducted a review of all cases investigated in 2017/2019 where there was an overlap between performance and sexual misconduct allegations to identify whether there were any issues related to obtaining medical expert opinions. In all cases expert advice was sought appropriately. We have identified an opportunity to consolidate our guidance in this area and create policy guidance underpinning the principles relating to our use of expert reports. ▪ We identified an opportunity to create guidance for decision makers relating to sexual misconduct and sexual harassment and to develop training for Fitness to Practise staff and tribunal members. <p>This work is included in the ELSA programme.</p>
<p>10. Inability to prove that the doctor accessed child sexual abuse material</p> <p>There were a notable amount of child sexual abuse materials review reports in which the police/CPS and then the GMC were unable to prove that the doctor was the person who uploaded, downloaded or made pornographic images of children, for example where other people could have had access to the computer. Our handling of the cases was criticised in eight of these instances.</p>	<p>We have not identified any changes that have addressed these issues due to their very specific nature.</p>	<p>Further work:</p> <ul style="list-style-type: none"> ▪ Exploring how best to support the criminal team in obtaining information relevant to their investigation because the police require a high level of specificity about which documents are required in order to respond to a section 35A request. The reasons for this are two fold – firstly requests are generally being handled by data protection departments in the police and they are cautious about which materials they share. Secondly, the person handling requests under the Data Protection Act is a civilian so may not understand. In addition, when the new data protection laws come in this year, the police may be subject to fines if they share information unnecessarily and will be applying proportionality criteria before disclosing information which should also be taken into account in the review. The above should also be considered within the context of our duty to act fairly under the principles of natural justice 	<ul style="list-style-type: none"> ▪ See update in item 2 related to evidence and information gathering. <p>No further work in this area is being taken forward in the ELSA programme.</p>

		<p>as well as Article 6 of the European Convention of Human Rights (ECHR) and to ensure that any evidence that supports findings and/or action meets the required evidential standard.</p>	
<p>11. Record keeping</p> <p>It was noted by our reviewers that there were some difficulties in ascertaining whether letters had been sent and/or conversations had been had with complainants and/or external agencies due to, at times, incomplete record keeping or inconsistencies in good practice. There were also a few instances in which decisions had not been recorded, and others where only the outcome had been noted. In at least one instance, files were missing altogether. This did not make a substantial difference to their Red Amber Green rating but did alter their confidence in providing conclusions on our handling of the cases.</p>	<ul style="list-style-type: none"> ▪ The GMC now uses an online records management system (SIEBEL) with service requests that need to be completed in relation to each activity or decision. Staff members are trained on how to use the system and have regular meetings with their line managers about their cases. ▪ Case files are regularly peer reviewed to ensure that they are accurate and complete. This information is also reviewed by external auditors. ▪ We also have a records retention and disposal policy. 	<p>We have not identified any further action required around this point.</p>	<ul style="list-style-type: none"> ▪ N/A. No further work was identified in this area.
<p>12. GMC processes or adherence to processes</p> <p>A number of process issues were raised by reviewers around the following areas:</p> <ul style="list-style-type: none"> ▪ Not applying the correct guidance ▪ Disclosure of a complaint to the doctor before a referral to the Preliminaries Proceedings Committee (PPC) ▪ Applying undertakings to unrelated health reasons ▪ Criticism of a 5 year rule decision ▪ Implementation of rule 7 ▪ Closing cases which relate to a doctor with a past FTP history at the enquiry stage 	<ul style="list-style-type: none"> ▪ The case examiner decision now follows a two stage approach to ensure that each decision is quality assured; the first case examiner will draft the decision which is then reviewed and agreed or amended by the second case examiner, in discussion with the first. ▪ The process involving the PPC is no longer in existence with the introduction of the fitness to practise rules (2004). ▪ Under the fitness to practise rules which were introduced in 2004, cases where a doctor has been convicted of accessing child sexual abuse materials and received a custodial sentence (immediate or suspended) the Registrar has to refer the conviction directly to a tribunal under rule 5. If the doctor did not receive a custodial sentence, they are still likely to be referred to hearing by the Case Examiners because of the presumption of impairment in sexual allegations, but the rules do not make this compulsory. ▪ 'Exceptional circumstances' was removed from the 5 year rule in 2016 and the rule may be waived in the public interest. 	<p>Further work:</p> <ul style="list-style-type: none"> ▪ Considering what can be done to better/further explore at the enquiries stage complaints where insufficient information is available but which relate to a doctor with a past fitness to practise history for sexual misconduct involving a minor. This could include considering whether we can lawfully explore such concerns at the rule 4 stage. 	<ul style="list-style-type: none"> ▪ We reviewed our processes and guidance at the early enquiries stage and identified that improvements could be made to our five year rule decision guidance and the anonymous and confidential complaints guidance. The guidance documents have been updated to link to our guidance for decision makers on taking fitness to practise history guidance into account. The five year rule guidance has also been updated to reflect the specific challenges surrounding sexual misconduct allegations to support decision makers when considering the lapse of time factor. We have also clarified the guidance on how decision makers should consider and document how they have weighed each of the factors that must be considered when making a decision on the five year rule. We have also updated the template for decisions to not waive the five year rule to ensure clarity and consistency in the way decisions are captured, and our case management system Siebel has been amended to enable us to identify and report on decisions to

			<p>waive the five year rule. Refresher training is also being provided for decision makers on the five year rule guidance and decision templates.</p> <p>This work is included in the ELSA programme.</p>
<p>13. Criticism of the committee, panel or tribunal</p> <p>There were a number of cases in which the panel or tribunal are criticised by the reviewers for the following reasons:</p> <ul style="list-style-type: none"> Referring to an outdated version of Good Medical Practice (GMP). Not providing an explanation of their decision not to find sexual motivation in a doctor’s conduct. Undue leniency in a case where sexual motivation was found in a doctor’s conduct. Undue leniency in a case where accessing child pornography was admitted. A decision to take no action in a case where impairment was found, 	<ul style="list-style-type: none"> Hard copies of the current version of GMP are now available in hearing rooms. There are structured methods in place at the MPTS such as monthly quality assurance sampling of decisions made, to identify issues and address them through panel circulars, annual training and performance reviews. Guidance for tribunals on capturing their reasoning when drafting the determinations is also in place. The Sanctions guidance was updated in 2015 to require a far more robust justification for finding impairment and taking no action. The guidance also explains that convictions should be considered to determine if the circumstances amount to an impairment of the doctor’s fitness to practise. A further review of the guidance which will include a focus on sexual misconduct cases has recently commenced. A right of appeal was also acquired by the GMC in December 2015 enabling an outcome to be appealed if it was felt that a tribunal decision did not adequately protect the public. In any case where the GMC’s sanction submission is not met, the MPT decisions are reviewed. This allows for feedback to the MPTS on hearings, even if the decision is taken not to appeal against the decision. 	<p>Further work:</p> <ul style="list-style-type: none"> Considering changes to the sanctions guidance to support tribunal members to reach the appropriate outcomes on cases. 	<ul style="list-style-type: none"> See update above in line 3 related to the work in the Sanctions Guidance project. We also identified improvements to our five year rule guidance and our anonymous and confidential complaints guidance which will be delivered through the ELSA programme. <p>This work is included in the ELSA programme.</p>
<p>14. Hearing issues</p> <p>Criticism or lack thereof of our preparation and conduct at the hearing stage. The issues raised in these cases appear to be quite specific and it cannot be ruled out that the decisions made by the investigations/legal teams were reasonable in the circumstances of the cases.</p>	<ul style="list-style-type: none"> Where GMC sanction submissions are not met, feedback on the cases is requested from the relevant legal representative to inform the consideration of the Decision Review Group (DRG). DRG will then consider the circumstances of the case and whether there are any lessons to learn or any feedback to provide to MPTS on the tribunal’s handling. 	<p>We have not identified any further action required around this point.</p>	<ul style="list-style-type: none"> N/A. No further work was identified in this area.
<p>15. Historic nature of complaints and treatment of vulnerable witnesses</p> <p>Many allegations of child sexual abuse were historic in nature. These instances can be traumatising and disclosure of them, often for the first time, can be disturbing for the complainant. This does have an effect on our processes such as the five year rule, and complexities in evidence gathering especially</p>	<ul style="list-style-type: none"> The words “in the exceptional circumstances of the case” were removed from Rule 4(5) in 2016 eliminating the requirement for there to be exceptional circumstances in the case for the 5 year rule to be waived. Instead the test became one of public interest alone making it easier for historical allegations of sexual abuse to proceed to the investigation stage. 	<p>Further work:</p> <ul style="list-style-type: none"> Considering how the gathering of information at a local level could lead to a greater likelihood of being able to pursue allegations against a doctor, especially in the case of numerous concerns, even where the witnesses are reluctant to come forward with the support of existing effective processes such as the role of the Responsible Officer (RO) and revalidation. 	<ul style="list-style-type: none"> We held workshops with ROs to explore what more we could do to support them addressing sexual misconduct and sexual harassment concerns at a local level. They made a number of suggestions which we will support under the ELSA programme to facilitate the

<p>when our burden of proof remained at a criminal standard. Some review reports criticised our failure to rely on police evidence such as transcripts, interviews, witness statement and videos, to take forward a case in absence of engagement from the complainant/witness.</p> <p>We were also criticised for the handling of complainants, victims and witness who we needed to make reasonable adjustments for. These cases involved instances where we did not provide, within our powers, support or appropriate environments for witnesses to provide evidence.</p>	<ul style="list-style-type: none"> ▪ A change to Rule 34 in May 2013 makes it now easier to rely on hearsay evidence at MPT hearings. The tribunal has the discretion to admit evidence which is fair and relevant to the case before them, in accordance with article 6 of the ECHR. ▪ In 2017, the legal team introduced a requirement that to prosecute sexual misconduct cases on behalf of the GMC, Counsel must have received training to prosecute rape and serious sexual offence cases (RASSO). ▪ The legal team are also exploring the possibility of piloting a more flexible approach to the gathering and presentation of evidence in cases relating to sexual abuse. However, this is on the assumption that the complainant will be willing to be cross examined at an MPT hearing so their evidence can be tested. An opportunity to test the evidence through cross examination is a recognised safeguard for defendants in proceedings. ▪ The Youth Justice and Criminal Evidence Act 1999 introduced a range of special measures to help vulnerable witnesses give their best evidence, measures later incorporated into the 2004 fitness to practise rules under Rule 36. ▪ The Patient Liaison Service was introduced in 2015, providing much better engagement with complainants from the outset as well as greater opportunity to discuss/allay concerns. ▪ Over the last year, a significant project to improve our interaction with witnesses has been underway. A witness tool has been developed for use by staff, setting out standards for witness interaction, requirements at each stage of the process and lines to take, together with guidance and resources on interviewing complainants and witnesses. A needs assessment form has also been developed so that staff can discuss with witnesses things like specific needs, preferred contact methods and times, if a preference as to the sex of the interviewer and considerations around Rule 36 (vulnerable witnesses). Both tools are due to launch on 9 April 2018 .The GMC legal team are also planning further follow on care for witnesses with the introduction of a single point of contact. ▪ There will be a second phase of the project, which will focus on the facilities at the MPTS hearing centre such as an improved witness waiting area. ▪ Triage have improved the clarity of recording closure through non-decisions, and how these are communicated to complainants, following a process audit. In 2017, they also developed guidance for staff on the steps to follow when trying to obtain further information, including making use of both written and telephone contact and sending chasers. 	<p>This could be explored as part of the local first programme.</p> <ul style="list-style-type: none"> ▪ Reviewing how we can further improve the support provided to vulnerable witnesses/complainants by considering the use of the specialist investigations team in cases involving vulnerable witnesses/complainants. We could also explore the creation of a 'vulnerable witness journey service' to help support vulnerable witnesses/complainants throughout the end to end fitness to practise journey which could be achieved by the extension of the patient liaison or the witness support services. These actions would help reduce the instances where witnesses/complainants stop engaging due to a lack of support, improving case management. 	<p>development of case studies and supporting guidance with ROs. We are exploring the possibility of working across health regulators in this area.</p> <ul style="list-style-type: none"> ▪ Extensive work has been done by the Legal team in relation to supporting witnesses over the last few years, including expanding the support provided under the Independent Witness Support service and providing continuity of support to witnesses throughout an investigation and hearing. The work in this area has essentially covered the aspects of a 'vulnerable witness journey service'. We are exploring in the ELSA programme (and with other health professional regulators) co-producing information for complainants and witnesses about health professional regulation with a charity to further support witnesses and complainants. <p>This work is included in the ELSA programme.</p>
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<p>16. Credibility of vulnerable witnesses</p> <p>In some cases, the comments made about child sexual abuse in the course of investigations were sometimes inconsistent with our accepted approach towards vulnerable patients/complainants. There appeared to be an attitude that allegations of child sexual abuse were trivial and that the complainant’s account was overly questioned and scrutinized. Often this occurred when an allegation was made by a complainant who was receiving psychiatric care. In these instances there was, at times, a presumption that the complainant was incorrect and the allegation was a symptom of their mental health issue. Typically, the doctor’s account or other party’s accounts were given more weight, sometimes without justification.</p>	<ul style="list-style-type: none"> ▪ The 2008 burden of proof change from criminal to civil standard of proof in professional misconduct cases means that evidence of previous allegations which would not have been regarded as admissible in the past due to a higher evidential bar would now more likely be considered. ▪ There is now much more explicit guidance for case examiners on handling cases with a presumption of impairment such as sexual assault or improper sexual relationships, which would require exceptional reasons for not referring to a tribunal; or, if the evidence base was of concern, detailed reasoning of the decision not to pursue. ▪ The recent transfer of responsibility for the investigation case plans from triage to the investigations teams should lead to a more proactive and targeted approach to evidence gathering. 	<p>Further work:</p> <ul style="list-style-type: none"> ▪ Reviewing our approach and guidance relating to cases where the police and CPS have taken no further action to provide clearer guidance to cases examiners on managing conflicts of evidence and the decision whether to refer the case to the MPTS or dispose of it. 	<ul style="list-style-type: none"> ▪ See update above in line 2 related to the policy and CPS no further action guidance. <p>No further work in this area is being taken forward in the ELSA programme.</p>

