Neutral Citation Number: [2023] EWHC 2391 (Admin)

Case No: CO/1129/2023

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 28/09/2023

Before :

THE HONOURABLE MR JUSTICE LINDEN

- -

Between :

PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE

Appellant

- and -

(1) GENERAL MEDICAL COUNCIL
(2) DR EWERE ONYEKPE

Respondents

- -
- -

Fiona Paterson KC (instructed by **Browne Jacobson LLP**) for the **Claimant**
Eleanor Grey KC (instructed by **General Medical Council**) for the **First Defendant**
James Counsell KC (instructed by **Weightmans LLP**) for the **Second Defendant**

Hearing dates: 2nd and 4th August 2023

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 28th September 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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THE HONOURABLE MR JUSTICE LINDEN

Judgment Approved by the court for handing down.

MR JUSTICE LINDEN:

INTRODUCTION

1. This is an appeal by the Professional Standards Authority for Health and Social Care ("the PSA") against the decision of the Medical Practitioners Tribunal of the General Medical Council ("the MPT of the GMC") to impose a sanction of six months' suspension of the Second Respondent, Dr Onyekpe's, registration. That decision was taken on 19 January 2023 and the MPT's Order came into effect 28 days later, with a review to take place at the end of the six month period. It followed disciplinary proceedings in which Dr Onyekpe admitted that in June and July 2020 he had had a sexual relationship with Patient A which began after he had treated her in his capacity as a locum registrar in the Accident and Emergency ("A&E") department at the Whittington Hospital in London. The MPT found that the charges against him, all of which he admitted, amounted to a course of conduct which amounted to "serious misconduct". Dr Onyekpe also conceded that his fitness to practise was impaired by reason of this misconduct, and the MPT agreed.

2. The PSA's challenge to the decision of the MPT was originally on four grounds, three of which were then pursued by Ms Fiona Paterson KC at the hearing before me. These were:

   i) First, that the decision of the MPT was wrong and/or unjust because of a serious procedural irregularity in that the charges against Dr Onyekpe did not adequately reflect the seriousness of his misconduct. The particular criticism which the PSA makes is that there should have been an allegation that Dr Onyekpe knew or ought to have known that Patient A was vulnerable or likely to be vulnerable. The lack of such an allegation meant that the full gravamen of his misconduct was not considered by the MPT ("Ground 1").

   ii) Second, that the sanction of 6 months' suspension of Dr Onyekpe's registration was unduly lenient and insufficient for the protection of the public in any event. In particular, nothing short of erasure would have been sufficient to maintain public confidence in the profession, as well as proper professional standards and conduct for members of the profession ("Ground 2").

   iii) Third, that the reasons given by the MPT for its decision on sanction were inadequate ("Ground 3").

3. I heard argument on Wednesday 2 August 2023 and reserved judgment. In the light of the fact that Dr Onyekpe's position was due to be reviewed by the MPT on 11 August 2023, and his suspension order to expire on the 18th, I indicated that I would endeavour to give my decision on Friday 4 August 2023 although my reasons might not be ready to be handed down given that I was on vacation duty and my workload was therefore unpredictable.

4. In the event, I was able to consider the matter carefully and then give my decision in open court at 1pm on 4 August at a hearing which the parties attended by CVP. In short, I allowed the appeal on Ground 1 and quashed the MPT's decision, I decided not to express a concluded view on Grounds 2 and 3, and I remitted the matter to a freshly constituted MPT. What follows are my reasons for that decision.

OUTLINE OF THE FACTS

5. Dr Onyekpe was born in Nigeria. He qualified in 2003 at Kharkov State Medical University in Ukraine and began his medical practice in Nigeria, mostly in the Nigerian army. In 2008 he came to the United Kingdom where he undertook a Masters degree in Public Health at the London School of Hygiene and Tropical Medicine. He began medical practice here in 2010. Between 2013 and 2018 he undertook a post graduate diploma in emergency medicine at Manchester Metropolitan University and, from 2016, he entered a formal training programme in emergency medicine. He completed his ST3 training in 2019 and worked night shifts in the A&E department at the Whittington from August to November 2019 and again from 4 March to 3 July 2020, having been supplied by an agency.

6. On 5 June 2020, Patient A attended the A&E department at the Whittington presenting with symptoms which may have indicated cauda equina syndrome, including severe back pain. Dr Onyekpe examined her, diagnosed right sided sciatica and discharged her back to her GP for follow up care. The examination included an intimate examination which was clinically indicated (cauda equina syndrome is a potential neurological surgical emergency affecting the nerves in the lower back) but he carried it out without a chaperone present. The Consultant in Emergency Medicine who advised the GMC Case Examiners for the purposes of the charges against Dr Onyekpe accepted that no chaperone was present because the female nurses were busy, but said that he should have waited until one became available. The explanation of the need for the examination, the lack of a chaperone and the efforts made to locate one, as well as the Patient's informed consent and agreement to proceed without one, were not recorded by Dr Onyekpe in her medical notes. However, it was accepted that he had Patient A's oral consent.

7. Although Dr Onyekpe told his then employer, the Royal Free London NHS Foundation Trust ("the Trust"), during a subsequent disciplinary investigation, that nothing at all inappropriate took place during the examination of Patient A, he had told her in a WhatsApp message on 10 June 2020 that he had *"tried to be professional with you but you are so fucking sexy. Great [reference to her national origins] arse"*. Before the MPT Dr Onyekpe accepted in cross examination that there was *"chemistry"* between him and Patient A at the time, and that he was attracted to her and thinking of her in a sexualised way. Before she left the Hospital, Patient A approached Dr Onyekpe and gave him a piece of paper with her mobile phone number on it, saying words to the effect that this was *"in case you want to be friends"*.

8. In the small hours of 6 June 2020, i.e. that night, Dr Onyekpe initiated contact with Patient A on his personal mobile phone number by WhatsApp, ostensibly to check that she had got home safely and was feeling better. He used his first name and she told him that she *"would like to know"* him and signed off with a kiss. Although their exchanges, the last of which was after 3am, were not overtly sexual at this stage, it is clear from them that Dr Onyekpe was not observing professional boundaries in his dealings with her.

9. There are no documented exchanges between Dr Onyekpe and Patient A on 7 June 2020, but in the early afternoon of 8 June 2020 she made contact. They then had lengthy exchanges, to the detail of which I will return, but which were personal in nature. She referred to him as *"hun"*, they discussed where each of them was from,

she suggested that they go dancing and they discussed their personal and family circumstances.

10. There are no documented exchanges on 9 June 2020 but Patient A attended A&E at the Whittington on the night of 10 June. Dr Onyekpe was on duty. She contacted him by WhatsApp at 8.09pm to let him know she was in A&E and he arranged for her to be seen by a colleague 40 minutes later. His evidence to the MPT was that this was because he *"could feel where it was going"* and that he tried, though not very hard and not very successfully, to steer her away. However, there were numerous WhatsApp exchanges between her and Dr Onyekpe whilst she was in the Hospital which quickly turned graphically sexual after Dr Onyekpe introduced the subject of sex, asking her *"Do you not have sex? It's important to – helps pain"*. Shortly after this he said *"You know I want to ...but I could get into trouble….In the UK its not allowed doctor and patient"*. The conversation culminated in them having sex in the toilets at the Hospital at around 10.20pm after Dr Onyekpe had said that he wished to perform oral sex on her before she left the Hospital.

11. The graphic WhatsApp exchanges then continued until shortly after 11pm. By this point they had agreed to meet at Patient A's house in the morning, when Dr Onyekpe finished his overnight shift, to celebrate Patient A's birthday. Dr Onyekpe's evidence to the MPT was that this was because he felt that he could not extricate himself but that, looking back, he accepted that part of him also wanted this to happen.

12. Dr Onyekpe duly went to Patient A's house on 11 June 2020, taking alcoholic drinks with him. He spent the morning there and they had sex together. As will be apparent, this was during the Covid-19 pandemic. Her children were therefore at home at the time.

13. There is another gap in the WhatsApp exchanges between Dr Onyekpe and Patient A until 17 June 2020 and then a handful of exchanges between 17 and 19 June in which she called him *"baby"* and said she missed him, and he advised her to chase the Hospital for her referral letter.

14. There is then another gap followed by numerous WhatsApp exchanges of a graphically sexual nature on 23 June 2020. These were initiated by Dr Onyekpe sending Patient A links to extreme pornographic videos which he encouraged her to view. He suggested that they engage in sexual acts seen in the videos and in a threesome, which she said she had not tried but might if she got her confidence back. These exchanges were curiously interspersed with Patient A complaining about her constant pain and seeking his medical advice, although he appears from the messages to have been more interested in discussing sexual activities between them.

15. There is then a long gap in the WhatsApp exchanges followed by detailed exchanges about Patient A's medical condition on 13 and 14 July 2020 in which Dr Onyekpe gave his advice. These were followed by exchanges on 16, 20-22 and 24 July 2020 which were initiated by Dr Onkyekpe and were graphically sexual. He also sent more pornographic links to Patient A and they discussed a threesome. Again, their exchanges included discussion of Patient A's condition and the pain relieving treatment which she was receiving.

16. There are no further documented exchanges after 24 July 2020.

17. On 27 July 2020, Patient A made a complaint of rape to the police which the MPT found was based on the sexual encounter in the toilets of the Whittington Hospital on the night of 10 June 2020. On 3 August 2020, Dr Onyekpe was arrested at his home. He admitted the two sexual encounters but said that they were consensual.

18. The following day, the police referred the matter to the GMC and, on 5 August 2020, Dr Onyekpe referred himself. The police provided the WhatsApp exchanges to which I have referred to the GMC. These had come from Patient A as Dr Onyekpe had deleted the messages as he went along. His evidence to the MPT was that this was in case they were seen by his wife. In email exchanges with the GMC in February 2021, Dr Onyekpe's solicitors indicated on his behalf that the WhatsApp messages which had been shown to him by the police during their investigation did not represent the totality of the WhatsApp exchanges between him and Patient A. He believed that a number of messages which had been sent to him by her did not appear to be in the possession of the police. This was also his evidence to the MPT.

19. Also on 5 August 2020, Dr Onyekpe started in a new post at the Trust. He was suspended whilst the Trust carried out an investigation, and the outcome of the investigation was that he was dismissed for gross misconduct in November 2020. He was also made the subject of an Interim Order of Conditions by the MPTS Interim Orders Tribunal. This required, amongst other things, that he only carry out certain examinations in the presence of a chaperone and that he logged such examinations.

20. In20 August 2020, having interviewed Dr Onyekpe and completed their investigation, the police notified the GMC that the matter had not been forwarded to the Crown Prosecution Service because it did not pass the evidential threshold for a decision to charge him. As Mr James Counsell KC submits, this decision was unsurprising given Dr Onyekpe's account and given that the WhatsApp messages strongly supported him on the issue of consent.

THE RELEVANT GMC GUIDANCE

21. As is well known, the GMC publishes the professional standards which are expected of practitioners in the form of *"Good Medical Practice"* and associated explanatory guidance on specific aspects of medical practice. It has also published *"Sanctions guidance for members of medical practitioners tribunals and for the General Medical Council's decision makers"* ("the Sanctions Guidance"). The Sanctions Guidance it is not to be construed or applied as if it were a statute (*General Medical Council v Ahmed* [2022] EWHC 430 (Admin) at [85]) but its aim is to assist decision makers to make fair, consistent and transparent decisions. A MPT is not at liberty to disregard it, and adequate reasons must be given for any departure from it: see *The Professional Standards Authority v (1) The Health and Care Professions Council and (2) Doree* [2017] EWCA Civ 319 at [26]-[27].

22. There is no question that Dr Onyekpe's conduct was in breach of the professional standards expected of practitioners as set out in Good Medical Practice and its associated guidance. Paragraph 53 of Good Medical Practice provides:

> *"53. You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them."*

23. There is further GMC guidance in *"Maintaining a professional boundary between you and your patient"* which includes the following passages:

> *"3. Trust is the foundation of the doctor-patient partnership. Patients should be able to trust that their doctor will behave professionally towards them during consultations and not see them as a potential sexual partner'*
>
> *5. If a patient pursues a sexual or improper emotional relationship with you, you should treat them politely and considerately and try to re-establish a professional boundary. If trust has broken down and you find it necessary to end the professional relationship, you must follow the guidance in "Ending your professional relationship with a patient".* (emphasis added)

24. Also of relevance to this appeal are the following passages from *"Maintaining a professional boundary between you and your patient"*:

> "8. *Personal relationships with former patients may also be inappropriate depending on factors such as:*
>
> > *a. the length of time since the professional relationship ended..*
> >
> > *b. the nature of the previous professional relationship*
> >
> > *c. whether the patient was particularly vulnerable at the time of the professional relationship, and whether they are still vulnerable (see paragraphs 11-13)*
> >
> > *d. ...*
>
> *You must consider these issues carefully before pursuing a personal relationship with a former patient.*
>
> …
>
> *11. Some patients may be more vulnerable than others and the more vulnerable someone is, the more likely it is that having a relationship with them would be an abuse of power and your position as a doctor.*
>
> ...
>
> *13. Whatever your speciality, you must not pursue a personal relationship with a former patient who is still vulnerable. If the former patient was vulnerable at the time that you treated them, but is no longer vulnerable, you should be satisfied that:*
>
> - *the patient's decisions and actions are not influenced by the previous relationship between you*
> - *you are not (and could not be seen to be) abusing your professional position."*

25. Endnote 3 states, in a passage which also appears in *Good Medical Practice:*

> *"3. Some patients are likely to be more vulnerable than others because of their illness, disability or frailty, or because of their current circumstances (such as bereavement or redundancy). Children and young people younger than 18 years should be considered vulnerable. Vulnerability can be temporary or permanent…*"

26. As far as sanctions for misconduct are concerned, the Sanctions Guidance issued by the GMC provides at [92] that:

> *"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)."* (emphasis added)

27. [97] of the Sanctions Guidance states:

> "*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, 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."*

28. [108] provides:

> *"108. Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor."* (emphasis added)

29. [109] then lists factors which may indicate that erasure is appropriate. These include *"abuse of position"* and *"violation of a patient's rights/exploiting vulnerable people"*.

30. Later in the Sanctions Guidance there is a section entitled *"Cases that indicate more serious action is likely to be required"*. This states at [142]-[144]:

> *"**Abuse of professional position***
>
> *142. Trust is the foundation of the doctor-patient partnership. Doctors' duties are set out in paragraph 53 of "*Good medical practice" *and in the explanatory guidance documents "*Maintaining a professional boundary between you and your patient" *and "*Ending your professional relationship with a patient".
>
> *143. Doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.*
>
> *144. Personal relationships with former patients may also be inappropriate depending on:*
>
> .....
>
> *c. the vulnerability of the patient (see paragraphs 145-146)…"*

31. [145]-[146] provide:

> *"**Vulnerable patients***
>
> *145. Where a patient is particularly vulnerable, there is an even greater duty on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of certain characteristics or circumstances, such as :*
>
> *a. presence of mental health issues*
>
> *b. being a child or young person aged under 18 years*
>
> *c. disability or frailty*
>
> *d. bereavement*
>
> *e. history of abuse or neglect.*
>
> *146. Using their professional position to pursue a sexual or improper emotional relationship with a vulnerable patient is an aggravating factor that increases the gravity of the concern and is likely to require more serious action against a doctor."*

32. [147]-[148] of the Sanctions Guidance also provide:

> *"**Predatory behaviour***

147. If a doctor has demonstrated predatory behaviour, motivated by a desire to establish a sexual or inappropriate emotional relationship with a patient, there is a significant risk to patient safety, and to public confidence and/or trust in doctors. More serious action is likely to be appropriate where there is evidence of (this list is not exhaustive):

a. inappropriate use of social networking sites to approach a patient outside the doctor-patient relationship

b. use of personal contact details from medical records to approach a patient outside their doctor-patient relationship

c. visiting a patient's home without an appointment or valid medical reason.

148. More serious action, such as erasure, is likely to be appropriate where a doctor has abused their professional position and their conduct involves predatory behaviour or a vulnerable patient, or constitutes a criminal offence."

THE ALLEGATIONS AGAINST DR ONYEKPE

33. On 18 January 2022 the GMC's Case Examiners decided to refer the matter to a medical practitioners tribunal pursuant to paragraph 8 of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 ("the FTP Rules 2004"). It is apparent from their decision document of that date ("the January 2022 decision document") that the first of the original charges against Dr Onyekpe was that at all material times Patient A was vulnerable (Allegation 1(a)), and he knew that she was (Allegation 1(b)). The charges also included allegations that Dr Onyekpe performed an intimate examination of Patient A on 5 June 2020 without offering her a chaperone (Allegation 2(a)) and without one being present (Allegation 2(b)). Allegations 3-8 were to the effect that he conducted a sexual, inappropriate and unprofessional relationship with Patient A and each of Allegations 3-7 highlighted aspects of that relationship.

34. At this stage, the Case Examiners had a case summary from the police and a statement from Patient A which she had prepared for the GMC. In the latter she said that she suffered from mental health problems including depression, anxiety and a personality disorder. At the time when they had sex at the Hospital she was in shock, felt confused and was intoxicated on medication. She felt that he had taken advantage of this.

35. The Allegations had been sent to Dr Onyekpe in draft and the Case Examiners noted that he denied that his conduct before 10 June 2020 was sexually motivated but made various admissions. Allegation 1 was denied by him. He said that he was not aware of her alleged vulnerability at the time of the examination. His account was that she had not told him of this and he had not recorded it in her notes. The Case Examiners said that there was a conflict of evidence in relation to this Allegation which it was not their function to resolve. They directed themselves correctly as to the test to be applied – *was there a realistic prospect of establishing that the doctor's fitness to practice is currently impaired to a degree which justified action on his or her registration* - and they concluded:

> *"While allegations 1), 2a), 3a) and 6) may not in isolation be sufficient to meet the realistic prospect test, taken in context of the full allegations against Dr Onyekpe, we consider that all the allegations should be considered by a medical practitioners tribunal."*

36. It is noteworthy that at no stage did the Case Examiners, in the January 2022 decision document, consider what the notes made by Dr Onyekpe did say about what she had told him. Nor did they consider what she had said to him in the WhatsApp messages. The Allegations attached four Schedules of the WhatsApp messages relied on by the GMC but these were not relied on for the purposes of Allegations 1(a) and (b). They were relied on to evidence the relationship and to show that it and Dr Onyekpe's actions were sexual, inappropriate and unprofessional. Consistently with the overall approach of the Case Examiners, these Schedules set out multiple messages from Dr Onyekpe to Patient A but not one message from her to him.

37. By the time of the hearing before the MPT, Allegations 1(a) and (b) had been dropped. Paragraph 22(a) of Ms Eleanor Grey KC's skeleton argument on behalf of the GMC says that these Allegations were based *"specifically"* on Patient A's *"statement that she suffered from mental health problems including depression, anxiety and a personality disorder"*. At the time when it was decided to include these allegations it would not have been apparent that Patient A would not be called to give evidence. Ms Grey also notes that Patient A's allegation of vulnerability was disputed by Dr Onyekpe and that the medical note made by him only referred to *"anxiety"*. Paragraph 22(b) of her skeleton goes on to say that in the summer of 2022 the Allegations against Dr Onyekpe were reconsidered by the GMC and its Counsel. At that stage it was decided that Patient A could not be called as a witness for the GMC, given the discrepancies in her account, and the matter would have to proceed on the basis of written material only. *"There was also a decision that the allegation of vulnerability, based on Patient A's own account of her mental vulnerabilities, could not be sustained."*.

38. Amended charges were therefore served on 2 September 2022. The Allegations relating to the intimate examination of Patient A on 5 June 2020 were now focussed on his failure to document an explanation of why the examination was needed and his exchanges with Patient A on this issue, including her consent to the examination, his offering her a chaperone and her agreement to proceed without one. But these allegations were also subsequently dropped on the grounds, according to Ms Grey's skeleton argument, that they did not amount to serious misconduct and therefore could not lead to a finding of impaired fitness to practise (see *Schlodlok v General Medical Council* [2015] EWCA Civ 769). Re amended charges were therefore served on 15 December 2022.

39. The six Allegations which were ultimately before the MPT are set out at Appendix 1 to this judgment but, in summary, they alleged that Dr Onyekpe engaged in an improper emotional and then sexual relationship with Patient A between 6 June and 25 July 2020. During this period he had sent her inappropriate and unprofessional WhatsApp messages. He had been sexually motivated. He had steered the conversation towards private and sexual matters and engaged in a sexual relationship. He had given her medical advice using an inappropriate method and he had not made any record of his medical advice. The charges were accompanied by Schedules which set out the WhatsApp messages from Dr Onyekpe to Patient A to which each

Allegation referred but, tellingly, it remained the case that these Schedules did not include any messages sent by Patient A to him.

40. On 23 December 2022, Dr Onyekpe signed a statement which was highly apologetic, admitted each of the Allegations and gave explanations in relation to some of these admissions. These explanations included, somewhat unconvincingly, the suggestion that he had contacted Patient A because *"Perhaps initially naively, I thought it polite to contact the patient and enquire as to her wellbeing having been provided with her number"*. He now accepted that when Patient A re-initiated contact on 8 June 2020 his conduct was sexually motivated – he must have been in pursuit of a possible future sexual relationship, or at least been curious to see where things might lead - albeit he said that he did not realise this at the time.

THE HEARING BEFORE THE MPT

41. The hearing before the MPT took place between 9 and 19 January 2023. It was divided into two parts. The first – Stages 1 and 2 - dealt with fact finding and the issues of misconduct and impairment of fitness to practise. The MPT gave its decision on these issues on 12 January 2023. It then moved on to deal with the question of sanction, and its decision was given on 18 January 2023.

42. There was no oral evidence in Part 1. Counsel (Ms Duckworth for the GMC and Mr Counsell for Dr Onyekpe) made submissions on the basis of the written materials which included Dr Onyekpe's admissions and the following *"Agreed Admissions"*:

    i) The allegation of rape made by Patient A was *"false"*;

    ii) It was evident from the WhatsApp messages that the sexual activity which took place on two occasions was consensual;

    iii) Patient A was not being called by the GMC *"because she could not be put forward as a witness of truth"*; and

    iv) Dr Onyekpe had no criminal convictions or cautions and no previous disciplinary findings against him.

43. The materials before the MPT also included the medical notes made by Dr Onyekpe in relation to Patient A and a transcript of the WhatsApp exchanges between them which had been provided to the GMC by the police. The MPT did, therefore, have all of the available messages from her to him.

44. In relation to sanction, Dr Onyekpe called his then current clinical supervisor at Medway NHS Trust Emergency Department, Dr Ashike Choudhary, who spoke highly of his clinical skills and commitment. Dr Onyekpe also gave evidence and was cross-examined. He relied on the statements and other documents which he had written. His evidence included an acceptance that he was responsible for what had happened, evidence about insight and the steps which he had taken to address his shortcomings, evidence of remorse and mitigation including the conditions under which Dr Onyekpe was working given the Covid-19 pandemic and other aspects of his personal history. He also relied on written character evidence from Pastor Segun Davis, a senior pastor at the Celestial Church of Christ in Florida, and from Dr

Onyekpe's wife. There was also a bundle of 9 testimonials from colleagues who attested to his diligence, his integrity and his high qualities as a doctor.

45. Consistently with the fact that the GMC was not making any allegation that Patient A was vulnerable, the parts of the medical notes made by Dr Onyekpe which went to this issue were not put to him by Ms Duckworth in cross-examination. Although he was taken to some of the WhatsApp messages, these did not include the particular messages which Ms Paterson submits were indicative of vulnerability on the part of Patient A and it was not put to him that she was vulnerable, nor that what she said in the course of their exchanges indicated to him that she was vulnerable. The cross-examination proceeded on the basis that this was an entirely consensual sexual relationship between adults, albeit one in which Dr Onyekpe steered the conversation in the direction of sex and in which he should not have become involved because of his professional position.

46. That is not to say that Ms Duckworth failed to challenge Dr Onyekpe. She did. He was taken to various passages from his written evidence going back to a statement which he made to the Trust on 8 October 2020 in the course of the disciplinary investigation to which I have referred, and it was suggested that he was seeking to minimise his own responsibility and culpability for what had happened, that some of the things which he had said were not entirely true and that there was a degree of victim blaming on his part.

47. At the end of Dr Onyekpe's evidence the Chair of the MPT asked a number of questions beginning with the following:

> *"THE CHAIR: Doctor, I do have a few questions to ask you which I hope will help us understand some of your answers that were given earlier. First of all, when you first met Patient A on the evening of 6 June, just to set the scene, she was attending the hospital because she was suffering from back pain.*
>
> *A Yes, sir.*
>
> *Q She had been suffering from that for some time.*
>
> *A Years.*
>
> *Q For years. She is a 37-year old woman.*
>
> *A That is correct.*
>
> *Q I think from your notes you went through her history and you knew that she was divorced with two children.*
>
> *A Yes.*
>
> *Q There is also a message at page 54 of bundle C1 and the timing of the message is towards the bottom of that page at 14.19 and 17 seconds, and she says:*
>
> > *"I really don't leave the house, when I got divorced he give me years of stress and I still fell …"*

I assume that means "felt":

"... that I am not safe going out by myself."

You then go on to give her advice – perhaps described as being wellbeing advice about "the world is yours", and changing mindset. So with all of that in mind what was your impression of Patient A? Would you say that she was a vulnerable woman when she came into A&E and you attended upon her? (emphasis added)

A (Pause) No, no, I didn't think so. From what I recall she was young, she was fit and in complete control of her faculties so I didn't think that at the time that she was vulnerable, no."

48. The Chair then moved on to other questions. I note that in this passage some of the indications of vulnerability relied on by Ms Paterson were canvassed with Dr Onyekpe i.e. her chronic pain and the situation with her ex-husband. But, as I will come on to explain, there were others. The questions which the Chair asked also rolled up the question of Dr Onyekpe's impression of Patient A with the question whether she was actually vulnerable. His answer was that at the time he didn't think she was vulnerable. He was not then challenged on the basis that, in the light of the WhatsApp messages, it must have appeared to him that she was.

49. Ms Paterson also argues that the answer which Dr Onyekpe gave was worryingly superficial bearing in mind the nature of vulnerability and the indications that Patient A was vulnerable in the present case. I agree that it was superficial but in my view it would be unfair to conclude from this answer that Dr Onyekpe did not fully understand the nature of vulnerability given that the matter was not properly explored with him. For reasons which I will explain, however, I also agree with Ms Paterson that these exchanges with the Chair of the MPT did not provide a sound basis on which to make a finding that Patient A was not vulnerable, as the MPT subsequently did, and/or to decide that the issue need not be considered further (although the MPT's Reasons do not in fact say that this is what it decided: the question was not addressed).

50. In her closing submissions, Ms Duckworth responded to this part of the Chair's questions by saying the following about the Sanctions Guidance:

"Paragraph 145 deals with aggravating features concerning vulnerable patients. This is a matter, sir ,that you particularly touched on in terms of your questions asked of the doctor. May I make it clear that this is a case where it is not alleged – and it has never been a specific allegation in this case – that Patient A was vulnerable, due to factors which are included in the guidance such as the presence of mental health issues, her age, a disability or frailty, bereavement or a history of abuse or neglect. So her position in this case is by virtue of her being a patient; that the GMC cannot invite you to conclude that she is a vulnerable patient. Had that been an indication to you it would have been a specific allegation that we would have put to the doctor at the outset." (emphasis added)

51. Ms Duckworth therefore positively steered the MPT away from the issue of vulnerability and indicated that it was not open because it had not been alleged or put to Dr Onyekpe at the outset. She went on to deal with the issue of predatory behaviour

which she said was a matter for the MPT, but she argued in detail that the conduct of Dr Onyekpe did not fit within any of the three examples of *"predatory behaviour"* given in [148] of the Sanctions Guidance, which I have set out at [32], above.

52. Ms Duckworth's overall position in her closing submissions was consistent with her cross-examination and the Agreed Admissions, as one would expect. She submitted that the relationship was an abuse of Dr Onyekpe's position as a doctor but it was consensual and legal and Patient A had not been harmed. So, she submitted, the question of insight would be at the heart of the Tribunal's assessment. Dr Onyekpe had demonstrated developing, as opposed to fully developed, insight and the evidence from him of deeper insight had come relatively late in the proceedings. Had he maintained some of the positions which he had taken up earlier in the proceedings, when there was some deflection of responsibility and he had claimed that he was not sexually attracted to Patient A from the outset, the Tribunal might have concluded that only a sanction of erasure could properly follow. As it was, her concluding submission was as follows:

> *"So this is a case where, as I have said, you have a stark choice, in my respectful submission, between suspension and erasure, and if you are satisfied that now the doctor has shown sufficient insight into the misconduct to reduce the risk of repetition and to be able to effectively remediate then you will then pause or even stop at the sanction of suspension, although there are grounds upon which you could consider erasure."*

53. Mr Counsell then replied. In relation to vulnerability he said this:

> *"My learned friend quite right concedes that this isn't a case of a doctor who has abused their position towards a vulnerable patient because this patient cannot be described as a vulnerable patient. Of course she is a patient, that is why it is serious, but not a vulnerable patient. Nor, in my respectful submission, is this realistically a doctor who indulged in predatory behaviour. Predatory behaviour is when somebody preys on someone else….."*

54. At no stage during closing submissions did the Tribunal and the parties discuss the question whether the issue of the actual or apparent vulnerability of Patient A should be considered by the Tribunal as an Allegation. Nor was this question addressed in its Reasons.

THE MPT'S REASONS

55. The first 68 paragraphs of the MPT's Reasons are concerned with Stages 1 and 2: fact finding, the determination of the issues of misconduct and impairment of fitness to practise. The MPT then summarised the evidence which was specific to the issue of sanction and set out the arguments on each side. It noted that:

    i) *"Ms Duckworth made it clear that it was not the GMC's case that Patient A fell into the 'vulnerable person' category"* [74];

    ii) *"Mr Counsell KC referred the Tribunal to paragraphs 148 and 150 of the [Sanctions Guidance] and submitted that this was not a case where more*

serious action is likely to be appropriate as it does not involve a vulnerable patient, predatory activity or a criminal offence" [88].

56. The MPT set out the applicable legal principles and what it saw as the aggravating and mitigating factors. Although it said that it had taken the Sanctions Guidance into account and borne in mind the overarching objective, understandably it did not set out [145]-[148] or any of the other guidance on the issue of vulnerability. The aggravating features were said to be the following:

- *"This is a case involving sexual misconduct, which is a category of misconduct which is especially serious;*
- *Dr Onyekpe had sex with Patient A on hospital premises when Patient A had attended for medical case and when he was on duty;*
- *It was Dr Onyekpe's suggestion that they have sex in the hospital before Patient A left;*
- *Dr Onyekpe visited Patient A at her home only a few hours later when he finished his shift and the purpose of that visit was to have sex with her, which he did;*
- *Dr Onyekpe abused his position of trust by pursuing a sexual relationship with his patient;*
- *The misconduct took place over a period of six weeks;*
- *A short while before he had sex with Patient A in the hospital, Dr Onyekpe indicated in a text message to Patient A that he knew his professional obligations did not permit him to have sex with a patient."*

57. The mitigating features were found to be Dr Onyekpe's full and early admissions, his remorse for his actions and a good level of insight:

"although not complete because there were times during the course of his oral evidence when he appeared to have lost sight of the extent of his misconduct and appeared to fall back on personal factors which might have caused his judgement to fail;"

58. The Tribunal then rejected *"no action"* and a conditions of practice order as appropriate sanctions, for reasons which it explained. It set out the guidance on suspension at [92] and [97(a)] and [97(e)-(g)] of the Sanctions Guidance which I have cited at [26] and [27] above, but it did not set out the guidance on erasure. It went on to say:

"118. The Tribunal considered that this was a particularly serious case, involving abuse of trust, sexual misconduct, and the other aggravating factors identified above. In particular, the Tribunal considered that a member of the public would view a doctor having sex with a patient whilst on duty and on hospital premises to be deplorable. The Tribunal also took into account that shortly before having sex with Patient A, Dr Onyekpe acknowledged in a WhatsApp message to her that it was not allowed for a doctor to have sex with a

patient. In light of this, the Tribunal also had regard to the duration over which Dr Onyekpe's misconduct took place and considered that the six week period was not merely a momentary lapse of judgement. The Tribunal accepted however that this was not a vulnerable patient and that there was no harm to the patient. (emphasis added)

119. The Tribunal considered the mitigating factors determined above and noted in particular that is was a consensual relationship. The Tribunal determined that Dr Onyekpe had demonstrated remorse and good insight (albeit still incomplete) and determined that the risk of repetition was likely to be low.

120. The Tribunal was satisfied that a period of suspension was sufficient to mark the seriousness of the misconduct and to satisfy the overarching objective, in particular the need to protect the medical profession from reputational harm. The Tribunal was of the view that during a period of suspension, Dr Onyekpe would have the time and opportunity to develop the remaining area of insight that the Tribunal considered lacking and to fully remediate his misconduct.

121. The Tribunal did not consider that the misconduct was fundamentally incompatible with future practice and considered all of the factors it had identified, alongside the guidance, concluding that imposing a sanction of erasure would be disproportionate in the circumstances of this case.

122. The Tribunal went on to consider the length of the period of suspension. The Tribunal gave credit for the remediation achieved, the impressive testimonials, and positive evidence from Dr Chowdhury, and decided that a period of suspension for six months would properly and proportionately mark the seriousness of Dr Onyekpe's misconduct and give effect to the overarching objective."

59. At [123] the Tribunal ordered that there would be a review of the case at the end of the six month period when Dr Onyekpe would be required to demonstrate how he had addressed the Tribunal's concerns. It then went on to consider whether Dr Onyekpe should be subject to an immediate order. Mr Counsell argued, somewhat optimistically, that there should not be but this was rejected.

THE STATUTORY FRAMEWORK AND THE JURISDICTION OF THE HIGH COURT IN THIS APPEAL.

60. Section 1(1A) of the Medical Act 1983 provides that the GMC's overarching objective in exercising its functions is the protection of the public. Section 1(1B) provides:

"(1B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives –

(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."*

61. Under section 29 of the National Health Service Reform and Health Care Professions Act 2002, the PSA is entitled to refer a decision of the MPT to the High Court *"if it considers that the decision is not sufficient (whether as to finding or penalty or both) for the protection of the public"* (section 29(4)). Section 29(4A) provides that:

> *"(4A) Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient-*
>
> *(a) to protect the health, safety and well-being of the public;*
>
> *(b) to maintain public confidence in the profession concerned; and*
>
> *(c) to maintain proper professional standards and conduct for members of that profession."*

62. Under section 29(7) of the 2002 Act, where a decision is referred to the High Court it is to be treated as an appeal against that decision and the body which made the decision is formally the respondent to the appeal. By section 29(8), the court may dismiss the appeal, allow it and quash the decision, substitute a decision which could have been made by the relevant body or remit the matter. CPR Rule 52.21 applies to such appeals, which are therefore by way of review. Rules 52.21(3) and (4) provide:

> *"(3) The appeal court will allow an appeal where the decision of the lower court was—*
>
> *(a) wrong; or*
>
> *(b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court.*
>
> *(4) The appeal court may draw any inference of fact which it considers justified on the evidence."*

63. As Ms Grey pointed out, the MPT is a specialist adjudicative body. Such a body, depending on the matters in issue, will usually have greater experience in the field in which it operates. Where the decision under challenge is an evaluative decision, the court should therefore proceed with caution. As Lord Burnett CJ put it in *General Medical Council v Bawa-Garba* [2018] EWCA Civ 1879, [2019] 1 WLR 1929 at [67]:

> *"An appeal court should only interfere with such an evaluative decision if (1) there was an error of principle in carrying out the evaluation, or (2) for any other reason, the evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide…"*

64. However, as Lord Burnett confirmed, the degree of deference to be accorded to the expertise of the adjudicative body will be affected by the issues in the case. Greater deference will be accorded in relation to matters of clinical or medical judgment than

in relation to issues which fall well within the court's sphere of expertise. Thus, in *General Medical Council v Jagivan* [2017] EWHC 1247 (Admin), [2017] 1 WLR 4438 Sharp LJ said at [40]:

> *"(v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standards in the profession and sanctions, with diffidence..*
>
> *(vi) However there may be matters, such as dishonesty or sexual misconduct, where the court "is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal ..."..As Lord Millett observed in Ghosh v General Medical Council [2001] 1 WLR 1915 , para 34, the appellate court "will accord an appropriate measure of respect to the judgment of the committee ... But the [appellate court] will not defer to the committee's judgment more than is warranted by the circumstances".*

GROUND 1

The arguments of the parties

65. Ms Paterson submitted that this is a case in which there was clear evidence to support allegations that Patient A was vulnerable and that Dr Onyekpe knew or ought to have known this. The GMC should have framed the charges in a way that raised the issue of Patient A's vulnerability and Dr Onyekpe's perceptions of her vulnerability. If the GMC did not, the MPT should have so as to ensure that this issue was fully ventilated and considered, particularly given that, as the Chair's questions highlighted above indicate, it was appreciated that the issue arose. It was wrong for the MPT to leave the matter hanging, fail to return to it and then make a finding that Patient A was not vulnerable, as it did. The effect of this was that the case that, at the very least, Dr Onyekpe must have perceived that she was vulnerable was not considered at all.

66. On behalf of the GMC, Ms Grey submitted that the formulation of the allegations against Dr Onyekpe inevitably involved the exercise of judgment on the part of the Case Examiners as to what, prospectively, had a realistic prospect of being accepted by a MPT. The history of the amendments to the charges showed that careful consideration was given to the question of what should be alleged in the light of the available evidence. *"In this case, it was a decision that was ultimately made in the knowledge that Patient A would not be called to give evidence and factual findings would have to be made based on written evidence only, together with any evidence from the Registrant"*. She said that she was not submitting that vulnerability could not have been alleged - there was room for different views on the matter – but the decision reached was a reasonable one and I therefore should not interfere with the views of the Case Examiners.

67. I had understood [22(a)] and [22(b)] of Ms Grey's skeleton argument, to which I have referred at [37] above, to be saying that Allegations 1(a) and (b) had been abandoned because it was considered that the evidence of Patient A's vulnerability came from

her GMC statement so that, to prove these Allegations, it would be necessary to call her as a witness. However, in her oral submissions Ms Grey emphasised that legal professional privilege had not been waived and said that I therefore did not have evidence to explain why Allegations 1(a) and (b) were abandoned. As I indicated to her, if correct, this was something of a double edged point as it meant that, by the same token, I did not have evidence of what consideration was given to the issue of vulnerability, nor that it was considered carefully as she asserted, nor as to why it was decided that it should not be raised on the basis of the written materials. The court will more readily defer to an assessment made by a decision maker where there is evidence that the approach to the decision was correct in principle and that the relevant considerations were taken into account.

68. Secondly, Ms Grey submitted that in any event the issue of vulnerability was considered at the hearing before the MPT. She highlighted that the medical notes and all of the available WhatsApp messages were before the MPT. The WhatsApp messages were referred to in cross-examination. The GMC had highlighted the fact that Dr Onyekpe had steered the conversation towards a sexual relationship. The Chair had raised the issue of vulnerability and it had been addressed by both sides in closing submissions, including by reference to the relevant parts of the Sanctions Guidance. The issue of predatory behaviour had also been left open by the GMC.

69. Third, whilst Ms Paterson criticised the MPT for leaving the issue of vulnerability *"hanging"* after the Chair's questions, Ms Grey submitted that the failure of the MPT to raise the issue further was an indication that it was satisfied with the answer which Dr Onyekpe gave. She did not dispute that there were indications that Patient A was vulnerable but she highlighted aspects of the evidence which she said might be put into the scales on the other side bearing in mind that the abuse of trust by Dr Onyekpe was recognised by the MPT and the issue was as to whether Patient A was vulnerable to a materially greater degree than is inherent in the doctor/patient relationship. These aspects included Dr Onyekpe's description of Patient A as young, fit and in complete control of her faculties, as well as evidence that she had a personal assistant.

70. Ms Grey submitted that, given all of these considerations, the MPT's reaction to the evidence, including Dr Onyekpe's denial, was reasonable. The question what impact the issue of vulnerability would have had required, and requires, to be assessed in the context of the evidence and arguments as a whole. This was not a case in which there was as serious procedural irregularity, nor one in which the real substance of the misconduct did not form part of the decision-making process. The gravamen of the case was before the MPT and was understood and accepted by it. Moreover, under paragraph 17(6)(b) of the FTP Rules 2004 the MPT could only have amended the Allegations if this could be done *"without injustice"*. Such an amendment would have affected the issues at Stages 1 and 2. It would be an usual case in which the MPT amended the Allegations at the sanctions stage given that it would have been necessary to reconsider the issues of misconduct and impairment, and make findings on these questions, before coming back to deal with sanction.

71. Ms Grey also submitted orally that, in any event, the issue of vulnerability would not have made a material difference to the outcome on sanction even if Allegations 1(a) and (b) had been included and had been accepted.

72. Mr Counsell adopted Ms Grey's submissions and added to them. Whilst he accepted that the question of vulnerability is one of degree in this context, he submitted that the bar is set quite high, if this is to be regarded as an aggravating feature, because of the vulnerability which is inherent in the doctor/patient relationship in all cases. Here, he submitted, a number of the features of the case relied on by Ms Paterson were commonplace amongst patients and the evidence did not warrant or support the allegations contended for by the PSA. Had vulnerability been charged it would not have made a material difference to the outcome. Moreover, it would have been unjust to amend the Allegations at the sanctions stage given that this would have necessitated the unwinding of Stages 1 and 2. The MPT was aware of the potential issue of vulnerability and had this in mind, and its approach was reasonable bearing in mind that the gravamen of the case was before it.

The caselaw on "under charging/prosecuting"

73. In *R (Council for the Regulation of Healthcare Professionals) v (1) General Medical Council (2) Ruscillo* [2005] 1 WLR 717, [2004] EWCA Civ 1356 the Court of Appeal considered the role of the High Court under the then version of section 29(4)(a) of the National Health Service Reform and Health Care Professions Act 2002. This provided that the Council could refer a decision to the High Court if it considered that it was *"unduly lenient, whether as to any finding of professional misconduct or fitness to practise on the part of the practitioner concerned (or lack of such a finding), or as to any penalty imposed, or both,…"*. It was not suggested before me that the difference in the formulation from the current version of section 29(4) makes a difference to the analysis in the present case. Indeed, Ms Paterson submitted that the changes to this provision were brought in to address concerns about the drafting of the relevant provisions which were expressed by the Court of Appeal in *Ruscillo*.

74. Giving the judgment of the Court, at [72] and [73] Lord Phillips MR said:

> *"72. It may be that the court will find that there has been a serious procedural or other irregularity in the proceedings before the disciplinary tribunal. In those circumstances it may be unable to decide whether the decision as to penalty was appropriate or not. In such circumstances the court can allow the appeal and remit the case to the disciplinary tribunal with directions as to how to proceed….,*
>
> *73. What are the criteria to be applied by the court when deciding whether a relevant decision was "wrong"? The task of the disciplinary tribunal is to consider whether the relevant facts demonstrate that the practitioner has been guilty of the defined professional misconduct that gives rise to the right or duty to impose a penalty and, where they do, to impose the penalty that is appropriate, having regard to the safety of the public and the reputation of the profession. The role of the court when a case is referred is to consider whether the disciplinary tribunal has properly performed that task so as to reach a correct decision as to the imposition of a penalty…. The test of undue leniency in this context must, we think, involve considering whether, having regard to the material facts, the decision reached has due regard for the safety of the public and the reputation of the profession."*

75. It is clear from, for example [75] and [82] of the judgment in *Ruscillo* that the public interest and the interests of patients are the key considerations. For this reason concerns about double jeopardy, when considering whether there should be an appeal and, if so, whether it should be allowed, do not carry significant weight in considering whether a sanction is unduly lenient. At [42] Lord Phillips said:

> *"The intervention of the Council under section 29, whether to put in issue an acquittal or the adequacy of a sentence, clearly places a practitioner under the stress of having his case reopened when it would otherwise be closed. This element of double jeopardy is, however, necessarily inherent in the scheme of review under section. The object of that scheme is the protection of the public and the Council can only refer a decision to the High Court when it considers that this is necessary for the protection of the public. We do not find it surprising that where this requirement is satisfied considerations of double jeopardy should take second place."*

76. However, he also said, at [76], that:

> "*the test of whether a penalty is unduly lenient in the context of section 29 is whether it is one which a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could reasonably have imposed."*

77. At [80] Lord Phillips noted that the fitness to practise procedures are more inquisitorial than the criminal process and said:

> *"The disciplinary tribunal should play a more proactive role than a judge presiding over a criminal trial in making sure that the case is properly presented and that the relevant evidence is placed before it."*

78. There could, therefore, be cases where the matter had been *"under prosecuted"* or relevant evidence had not been put before the tribunal, and the tribunal failed to address this, with the consequence that its decision was flawed [81].

79. In *R (Council for the Regulation of Healthcare Professionals) v (1) General Medical Council (2) Rajeshawar* [2005] EWHC 2973 (Admin) Sullivan J (as he then was) allowed an appeal in a case where examinations of two patients' breasts by the practitioner were not clinically justified. The case had been charged on the basis that the practitioner was incompetent and/or his behaviour inappropriate, but not that it was indecent or sexually motivated. The Fitness to Practise Panel found that the practitioner was not guilty of serious professional misconduct and imposed conditions on his registration for a period of 18 months. The submission on behalf of the Council for the Regulation of Healthcare Professionals was that if the Panel had concluded that the examination had been indecent or sexually motivated then that sanction would have been unduly lenient.

80. Sullivan J said that in the light or the patients' statements *"any reasonable assessment of the totality of the available evidence could have led to only one conclusion; that it was appropriate to allege a sexual and/or indecent motivation by way of amendment"* [11]. Accordingly, he remitted the matter for reconsideration. In so doing, he rejected a submission that it was necessary for the court to determine

whether a charge of indecency would have been upheld, holding that it was sufficient that, if such a charge had been proved, the sanction would have been unduly lenient [14]. He also noted that although this outcome meant double jeopardy for the practitioner, the Court of Appeal in *Ruscillo* had held that this was inherent in the legislative scheme and that the interests of the practitioner had to take second place to the overall aim of that scheme, namely the protection of the public [22].

81. *Rajeshawar* was applied by Beatson J (as he then was) in *R (Council for the Regulation of Healthcare Professionals) v (1) Nursing and Midwifery Council (2) Kingdom* [2007] EWHC 1806 (Admin) at [31]. This was a case in which a registered nurse was charged with: (i) producing a results letter showing she had passed a unit from a course on "Special and Intensive Care of the Newborn" at South Bank University when she had not; (ii) telling her line manager, that she had passed the unit when she had not; and (iii) producing false documentation regarding her qualifications to a member of staff at the South Bank University. These facts were admitted by the nurse but dishonesty was not specifically charged. The Professional Conduct Committee therefore considered that it was not open to it to make a finding of misconduct and did not do so.

82. Beatson J described the issue as being "*whether, on the material available to the Council, there was a serious prima facie case of dishonesty for her to answer"* [35]. At [31] he said:

> *"I have concluded that the failure to properly charge Ms Kingdom was a serious procedural error. As to the consequences, I bear in mind the judgment of the Court of Appeal as to the criteria of undue leniency, and have regard to the safety of the public and the reputation of the profession. I have concluded that if, applying Sullivan J's test in Rajeshwar's case, the issue of dishonesty had been on the charge sheet and been considered by the Committee and had been resolved against Ms Kingdom, the finding in this case that there had been no misconduct would undoubtedly have been unduly lenient."*

83. Taking into account the passages from *Ruscillo* to which I have referred, including the observations of the Court of Appeal as to double jeopardy, Beatson J held that the Committee should have amended the charges even after all of the facts had been proved. The case was therefore remitted.

84. The approach in *Rajeshawar* and *Kingdom* was also applied in *The Professional Standards Authority for Health and Social Care v (1) General Chiropractic Council (2) Briggs* [2014] EWHC 2190 (Admin) at [21]. Having also considered *Ruscillo*, Lang J said:

> *"21. On analysing these cases, the questions to be asked are:*
>
> *i) on the evidence, and applying its own rules, should the GCC have included the further allegations in the charge;*
>
> *ii) if so, did the failure to include those allegations in the charge mean that the Court is unable to determine whether the sanction was unduly lenient or not."*

85. Relying on the judgment of Saini J in *The Professional Standards Authority for Health and Social Care v (1) Health and Care Professionals Council (2) Wood* [2019] EWHC 2819 (Admin) at [51], all Counsel commended this passage from *Briggs* to me as correctly stating the questions which arose under Ground 1. Lang J added, in relation to the question whether the charges could be amended:

> *"22. Plainly, any further allegations must arise out of the same episode/s which form the basis of the existing charge, and be directly connected to the existing allegations, otherwise it would be unfair to the registrant."*

86. In *The Professional Standards Authority for Health and Social Care v (1) Health and Care Professionals Council (2) Doree* [2017] EWCA Civ 319 *Briggs* was cited with approval by the Court of Appeal. Lindblom LJ summarised the law as follows:

> *"10. An appeal may be allowed where there has been some serious procedural or other irregularity making it impossible to determine whether the decision as to sanction was unduly lenient or not (see the judgment of the court in Ruscillo , at paragraphs 79 to 83). This may be the consequence of "undercharging", where, if the case had been properly charged and the charge found proved, the penalty would not, or may not, have been unduly lenient (see, for example, Professional Standards Authority v General Chiropractic Council and Briggs [2014] EWHC 2190 (Admin))."*

87. It appears that Lindblom LJ considered that it was sufficient if charging the matter properly might have made a difference to the sanction. Thus, at [58] he said:

> *"the crucial question for us, I think, is whether it can be said that if the allegations had been amended.. and had then been found proved, this might have made a significant difference to the Panel's conclusions on misconduct and fitness to practise, or led them to impose a more severe sanction than they did."* (emphasis added)

88. That question was answered in the negative in *Doree*.

89. There are various examples of cases where undercharging has been found to be a serious procedural irregularity because the effect of the failure to make a given allegation has been that the full gravity of the case – the real burden or substance of what had gone wrong - was not bought to the attention of the panel or tribunal: see e.g. *The Professional Standards Authority for Health and Social Care v (1) Nursing and Midwifery Council (2) Jozi* [2015] EWHC 764 (Admin) at [22]-[28], *Wood* (supra) and *The Professional Standards Authority for Health and Social Care v (1) General Medical Council and (2) Battah* [2015] EWHC 764 (Admin) at [45]-[47]. These cases illustrate the fact that the procedural irregularity must be serious and result in the decision being unjust if the appeal is to be allowed. The mere fact that on one view a more serious charge could have been brought does not necessarily mean that the test under CPR rule 52.21(3)(b) is satisfied.

Discussion and conclusions on Ground 1

A note of caution at the outset

90. It is important to note, in relation to what follows, that I am not making findings about whether Patient A was vulnerable or whether Dr Onyekpe perceived her to be, nor about any of the other issues which will need to be considered by the MPT at the remitted hearing. It would be unfair of me to do so, or for anyone to interpret what I say in this way. Dr Onyekpe has not had an opportunity to give evidence about these issues and I have not seen him give evidence about the other issues in the case. The question which I address is limited to the case which ought to have been put before the MPT for it to consider. I express no view about what it should find and conclude at the remitted hearing.

The nature of vulnerability in this context

91. Obviously, a degree of vulnerability - heightened exposure to the possibility of harm - is likely to be present in all doctor/patient relationships because of the nature of the relationship, including the power imbalance between the parties and/or the fact that the doctor is in a position of trust. The statements about vulnerability in the GMC's guidance to which I have referred above are about patients who are *"particularly"* vulnerable i.e. those whose characteristics or circumstances mean that they are significantly more vulnerable than is inherent in the doctor/patient relationship. Although there is this threshold, if vulnerability is to be regarded as an aggravating feature of a doctor's misconduct, the extent to which it is aggravated will depend on the circumstances of the case. There are degrees of vulnerability, and the vulnerability of the patient may be more or less relevant to the sort of misconduct alleged. The approach to evaluation of the evidence about vulnerability should bear this in mind.

92. Second, without wishing to state the obvious, where a MPT is considering the seriousness of a practitioner's misconduct it should examine the evidence as to the culpability of the practitioner and the harm which their actions have caused. Evidence about vulnerability goes to both questions. What the doctor knew or ought to have known, or believed, about the degree of vulnerability of the patient at the relevant time will be directly relevant to the degree of culpability. Indeed, a doctor might be more culpable because they believed that the patient was more susceptible to influence, or the particular harm, although, in fact, the patient was not. Conversely, they might be less culpable if they were not aware that a patient was vulnerable when in fact she was. Whatever the doctor's understanding, the fact that a patient is particularly vulnerable may also mean that they are harmed to a greater degree by the doctor's actions than would otherwise be the case.

93. Third, in a sexual misconduct case evidence about vulnerability may impact on other considerations such as whether there was predatory behaviour by the doctor, the likelihood of repetition, and consent. If a MPT were to conclude that a doctor perceived that the patient was vulnerable and that this presented an opportunity which they then chose to exploit, this would be important in considering the first two of these considerations. If the patient was vulnerable to being drawn into a sexual relationship this would provide important context in relation to the question of consent, even if they did in fact consent. One of my concerns about the approach of the Case Examiners, the GMC at the hearing, and the MPT in the present case is that these three questions and the question of harm were not considered in the context of any argument that the evidence showed that Patient A was vulnerable for the purposes of the GMC's guidance and/or that Dr Onyekpe perceived her to be vulnerable, and/or that this was a significant part of the explanation for what happened.

The evidence going to vulnerability

94. I start with the medical notes which were made by Dr Onyekpe on the night of 5 June 2020 and recorded what she told him. Patient A informed him that she was unemployed and divorced with two children. She told him that she had been diagnosed with fibromyalgia which caused her *"pain everywhere"*, osteoarthritis and cervical spondylosis, that she suffered from *"anxiety"*, that she had at least an eight-year history of migraines and was upset that her GP had not yet arranged for her head to be scanned, that she was undergoing investigations for bilateral carpal tunnel syndrome and that she was already known to a *"pain team"*.

95. In the final part of the entry, Dr Onyekpe recorded that the plan included to reassure Patient A and discharge her home. She was not active at all and she needed to consider weight loss, swimming, acupuncture, simple walks. She was already receiving *"Lidocaine infusions"* from her pain team and Dr Onyekpe indicated in the notes that it may be appropriate for her to now receive *"epidural injections"*.

96. The fact that Patient A handed the note of her mobile phone number to Dr Onyekpe was also unusual behaviour. Although it was not necessarily indicative of vulnerability in itself, it formed part of a picture, which built up in his dealings with her, of a person who was lonely and isolated because of her health conditions and other circumstances.

97. In the first WhatsApp exchange on the night of 5 June 2020, Patient A told Dr Onyekpe: *"I just can't thank you enough for giving your attention and diagnose (sic) me. I have been suffering with this back pain for over 15 years. Now I have answer (sic) for all the suffering."* (emphasis added) .

98. In the many exchanges between them on 8 June 2020 it was Dr Onyekpe who moved the conversation from the medical to the personal, asking her about her national origins and sharing information about his own background and family. After she asked him whether he liked dancing, he asked her whether she lived alone or with her children. She told him that she had not been out for nearly 3 years. She said that she preferred her teenaged children when they were younger and they needed her: *"now I need them"*. Evidently he felt that she was striking a gloomy note and he told her to take it easy, that she was a very young woman, that she was pretty and that life was still ahead of her. She said that she knew but that with the kids growing up it *"gets pretty lonely sometimes"*. He said that he didn't believe it and that she could choose anyone she wanted. She said, again, that she did not go out and that in the past year she had only left her home to hospital and appointments. When Dr Onyekpe advised her to change her mindset she said: *"When I [feel] like getting a social life pains always stop me from going anywhere"*. She added "*Sad when that pain happens, my kids need to help me up, I have a personal assistant that kind (sic) do everything for me"*, and he said that she was lucky to have a personal assistant. She added *"I will try everything to get out of all this pain, when I have a brake (sic) from the global pain, the[n] my back stop working"*. She emphasised that the back was the worst and that she had been *"dealing with this pain for so many years"*.

99. Immediately before Dr Onyekpe introduced the subject of sex on 10 June 2020, she had told him that it was her birthday the next day and that she had no plans at all. By now, Patient A had said a good deal to Dr Onyekpe to the effect that she was beset

with primarily physical but also mental or at least emotional health issues, was suffering from chronic and serious pain and had been for years, was socially isolated as a result, and was lonely. She had also said that was receiving significant pain relief treatment from a *"pain team"* and that she was incapacitated to such a degree as to require a personal assistant to do everything for her and assistance from her children. As the Chair of the MPT also picked up, she had told Dr Onyekpe that *"I really don't leave the house, when I divorced he gave me years of stress. And I still [feel] that I am not safe going out by myself"* i.e. she had undergone an acrimonious divorce and was frightened of her ex-husband.

100. It is not necessary to fit this evidence into the categories identified in Endnote 3 of *Maintaining a professional boundary between you and your patient"* and [145] of the Sanctions Guidance as if they were statutory provisions. They are not and, in any event, the characteristics or circumstances identified in these paragraphs are expressly said to be examples. But, in my view, it is difficult to see how consideration of the medical notes and the subsequent WhatsApp exchanges in the context of the evidence as a whole as at 10 June 2020 did not lead to the conclusion that there was at least a realistic prospect of establishing that Patient A had given Dr Onyekpe information which strongly suggested that she had significant disability, that there were or may be some mental health issues, that she may have a history of abuse and neglect, that she was feeling particularly isolated and lonely and that, as a result, she was more susceptible to sexual advances than is inherent in the doctor/patient relationship.

101. As to issues with the credibility of Patient A, the evidence that Dr Onyekpe was aware of this information about her was in documentary form, so that there was clearly a case that he must have perceived that she was vulnerable, or ought to have. Moreover, the possibility that what she had said to him was true could not simply be discounted. Why would she be lying or exaggerating? Although there was, for example, the possibility that she may have been presenting herself as emotionally vulnerable in order to attract him, this could not be assumed. The evidence of Dr Onyekpe's graphically sexual messages to Patient A and encouragement to imitate pornographic clips also added to the question what it was about her which led him to feel that he could act as he did.

102. It is no answer to these points to say that the circumstances which Patient A described are commonly encountered in the NHS. They may well be but, of course, it is common for doctors to treat vulnerable patients. The focus of the GMC's guidance, in my view, is not on the rarity or otherwise of the patient's circumstances but, rather, on the extent to which those circumstances mean that the particular patient is more susceptible to the misconduct or harm in question than is inherent in the doctor/patient relationship.

<u>The decision making in relation to vulnerability</u>

103. Dealing, first, with the GMC's decisions about the Allegations to be put before the MPT, as I have noted Ms Grey said that privilege was not waived and that I therefore do not have evidence as to the reasons for abandoning Allegations 1(a) and (b) which raised the issue of vulnerability. However, I do have the January 2022 decision document and there is then Ms Grey's account in her skeleton argument.

i) As far as the former is concerned, it is tolerably clear that the Case Examiners were proceeding on the erroneous basis that the only real evidence of vulnerability was what Patient A said in her statement to the GMC. This is why they said *"The GMC witness statement from Patient A is not consistent with Dr Onyekpe's recollection of events. In particular, there is a conflict in relation to allegation 1)…It is not our role to seek to resolve substantial conflicts of evidence"* and were less than confident that the allegation could be made good. There could be no conflict of evidence as to the contents of the medical notes and the WhatsApp messages, even if there could be arguments about what they showed and Dr Onyekpe would have an opportunity to give evidence about them. The discussion of the case in the January 2022 document makes no reference to the indications of vulnerability in these materials. The fact that the Schedules to the draft Allegations extracted what Dr Onyekpe said to Patient A, but did not include what she said to him, also indicates that this evidence was not regarded as significant.

ii) Ms Grey's skeleton argument tends to confirm this inference in that it links the decision to abandon Allegations 1(a) and (b) to the decision that Patient A could not be called as a witness. It says in terms that these Allegations were based *"specifically"* on Patient A's *"statement that she suffered from mental health problems including depression, anxiety and a personality disorder"* and goes on to say: *"There was also a decision that the allegation of vulnerability, based on Patient A's own account of her mental vulnerabilities, could not be sustained."* (emphasis added).

104. There is also no evidence to the effect that careful or any consideration was given to proving these Allegations based on the medical notes and WhatsApp messages, to put against the inference which I have drawn.

105. In my view, the GMC's approach to this issue was therefore fundamentally flawed from the outset. In addition to what Patient A said in her statement, what she was recorded as saying to Dr Onyekpe in the medical notes and what she said in the WhatsApp messages was evidence of vulnerability. It was also evidence of what he perceived about her and was therefore relevant to his culpability. Moreover, there was a need to look at the interactions and exchanges between Dr Onyekpe and Patient A as a whole and as they developed, as I have said, and to consider the questions of predatory behaviour, risk of repetition, consent and harm in this context.

106. Even if, contrary to my view, there was careful consideration by the GMC of whether Allegations 1(a) and (b) could be sustained on the basis the written materials alone, and the conclusion reached was that there was no realistic prospect of doing so, such a conclusion was in my view clearly wrong for the reasons which I have given. Either there was a failure to appreciate the meaning and effect of the relevant GMC guidance and the documentary evidence or, even making allowances for the fact that the decision was evaluative, a conclusion that there was no realistic prospect of sustaining an allegation that Patient A was vulnerable, and/or that Dr Onyekpe perceived or ought to have perceived her to be, was not open to the Case Examiners.

107. Moreover, given that the required evidential threshold was plainly crossed, failure to raise the issue was in my judgment contrary to the overarching objective under section 1(1A) of the Medical Act 1983. Quite apart from the question of patient

safety, it was obviously important, in terms of the duties to promote and maintain public confidence in the profession and to promote and maintain proper standards and conduct, that the issue was at the very least raised and adjudicated. The effect of not doing so was that the case was presented on the basis that this was a perfectly healthy relationship between consenting adults with no harm done to Patient A, albeit one which Dr Onyekpe should not have entered into and which had the aggravating features which the MPT identified. The full gravity of the case was not put before the MPT for its consideration and nor was it seen to be.

108. Nor, in my view, could such a decision be justified by saying that a finding that Patient A was particularly vulnerable, and/or that Dr Onyekpe perceived or ought to have perceived her to be, and/or that this was part of the explanation for his actions, would not make a material difference to the outcome of the case. Even leaving the evidence of vulnerability out of account, this was plainly a case in which, at best, Dr Onyekpe was facing suspension or erasure. As I have said, such a finding would be relevant to the issues of culpability and harm, predatory behaviour and risk of repetition; and it would potentially affect the weight to be given to the fact that Patient A consented. The GMC guidance to which I have referred also indicates repeatedly that there is an even greater duty on the doctor to safeguard patients who are particularly vulnerable. It therefore could not reasonably be thought that the vulnerability issue was immaterial.

109. I have carefully considered whether, in the light of the findings which the MPT did make and the fact that the Chair of the MPT raised the issue of vulnerability, submissions were then made and the MPT made a finding, the errors on the part of the GMC which I have identified can be said not to be serious or not to have caused the decision of the MPT to be *"unjust"*. Regrettably, this is not my view for the reasons which I have foreshadowed:

i) It was important and consistent with overarching objective that the issue was raised and properly adjudicated for the reasons set out above;

ii) The effect of the GMC's approach, including at the hearing, was that the evidence which indicated that Patient A was particularly vulnerable and/or that Dr Onyekpe perceived her to be vulnerable was not explored in the submissions on misconduct or impairment, nor in the cross-examination of him;

iii) When the Chair, to his credit, raised the issue, he referred only to some of this evidence; (with respect to him) the question which he put was not entirely clear as to whether he was asking about Dr Onyekpe's perception at the time or about whether Patient A was in fact vulnerable, or both; the answer which he received was superficial and not necessarily consistent with the evidence but this was not followed up by anyone;

iv) The submissions which the MPT then received were in effect that it was common ground that Patient A was not vulnerable and that it would be unfair for the MPT to find otherwise because no allegation on this issue had been pleaded or put to Dr Onyekpe. The question of what his perception of Patient A was in this regard, or ought to have been, was not addressed at all;

v) These considerations significantly undermine the MPT's finding on Patient A's vulnerability in terms of its reliability but also in terms of public confidence in its reliability. The fact that the finding is unexplained, still less explained by reference to the Sanctions Guidance, adds to the impression that the MPT was accepting the GMC's concession (possibly for pragmatic reasons given the agreed position of the parties, the lack of a charge and the stage of the proceedings which had been reached), rather than reaching its own fully considered conclusion;

vi) In any event, the MPT said that it accepted that Patient A *"was not a vulnerable patient and that there was no harm to the patient"*. Its finding did not address the question of Dr Onyekpe's perception of Patient A and the effect of the evidence of vulnerability on his culpability.

110. So I answer Lang J's first question at [21] of her judgment in *Briggs* in the affirmative. On the evidence, and applying its own rules, the GMC should have included the further allegations in the charges.

111. As to Lang J's second question, it has to be recalled that the sanction imposed by the MPT was a period of suspension of 6 months. I express no concluded view about whether this was unduly lenient even assuming that no issue arose in relation to vulnerability, but there is real force in Ms Paterson's arguments that the sanction was unduly lenient in any event, and/or that the justification for such a sanction required very careful explanation by the MPT in the light of, for example, [108] of the Sanctions Guidance (set out at [28], above). Notwithstanding the mitigating features of the case put forward by Mr Counsell, even if the sanction was not unduly lenient, it was at the outer limits of leniency. I am confident that a sanction of 6 months' suspension could not properly have been the outcome had the MPT found that Patient A was vulnerable and/or that Dr Onyekpe acted in the belief that she was. On the contrary, the outcome would likely, if not inevitably, have been erasure.

112. The arguments before me about whether the Allegations could have been amended in response to the Chair's questions about vulnerability did not seem to me to be of central importance. The serious procedural irregularity in this case was that, as a result of errors of approach and wrong decisions on the part of the GMC, the issues in relation to the vulnerability of Patient A were never properly before the MPT. That made the decision of the MPT *"unjust"* for the purposes of CPR r52.21(3)(b) in the light of the overarching objective. The question whether the procedural irregularity could have been corrected by the MPT itself is, therefore, of secondary importance given that it was not corrected.

113. But in my view an amendment to the Allegations could have been made *"without injustice"* at the hearing. Given that the MPT read into the case, there was no reason why the matter could not have been raised at the beginning of the hearing. Even at the stage when it was raised, an amendment could and should have been made bearing in mind the primacy of the public interest, as emphasised in the cases referred to above, and then case managed so as to ensure that Dr Onyekpe had a fair opportunity to deal with it. The difficulties which such an amendment would have caused would not have been insurmountable by any means. As matters have turned out, the fact that (through no fault of his) this was not done has not served Dr Onyekpe well either, and impact on him of the delay and uncertainty which has resulted is a matter of real regret.

CONCLUSION

114. In summary, my conclusion on Ground 1 was that the decision making of the GMC and the MPT in this case was fundamentally flawed because it did not give any or any adequate consideration to the evidence of what Patient A told Dr Onyekpe about her circumstances. In particular, there was a failure adequately to consider (a) whether she was vulnerable for the purposes of the Sanctions Guidance and, if so, the degree of her vulnerability and, (b) what Dr Onyekpe knew or ought to have known about these matters and what influence this had on his actions. These questions should have been raised by the Allegations which the MPT was asked to consider, and then fully litigated and considered in the context of the whole evidential picture, but they were not. I am not persuaded that, had this been done, it would have made no material difference to the sanction which the MPT imposed.

115. In the light of this, I decided not to express a concluded view on Grounds 2 and 3, which assume that the appeal fails on Ground 1, albeit they are free standing grounds. In my view the public interest and Dr Onyekpe's interests are best served by the case being fully considered by the MPT, which is the fact finding tribunal constituted for this task, on the basis of all of the evidence, and a decision reached on all of the issues. A decision by me on Grounds 2 and 3 on the narrower factual basis which was considered by the MPT would also potentially give rise to appeals or cross appeals and result in unnecessary delay and expense. The Court of Appeal will in any event be as well placed as I am to determine these Grounds 1 and 2 if there is an appeal on Ground 1.

116. I invite the parties to agree a draft order.

ANNEX 1: THE ALLEGATIONS BEFORE THE MPT

"That being registered under the Medical Act 1983 (as amended):

1. On 5 June 2020, you consulted with Patient A in your capacity as a doctor in Emergency Medicine and you performed an intimate examination on Patient A.

2. On 6 June 2020, you engaged in an improper emotional relationship with Patient A, in that on one or more occasion, as set out in Schedule 1, whilst you were still on shift you sent to Patient A`s personal mobile telephone number, from your personal mobile telephone number, WhatsApp messages which were both inappropriate and unprofessional.

3. On one or more occasion on 8 June 2020, as set out in Schedule 2, you behaved inappropriately and/or unprofessionally towards Patient A, in that you engaged in WhatsApp message communication with Patient A via her private mobile telephone number in which you:

a. gave her medical advice on the symptoms with which she presented on 5 June 2020;

b. diverted the topic of conversation from medical to private matters;

c. discussed both your and her private life;

d. called her ‘pretty’;

e. stated to her: ‘You can pick and choose. Anyone you want’.

4. Your conduct as set out at paragraph 3, subparagraphs b-e, was sexually motivated.

5. Between 9 June 2020 and 25 July 2020, on one or more occasion as set out in Schedules 3 and 4, you behaved inappropriately and/or unprofessionally towards Patient A, in that you:

a. gave her medical advice regarding the clinical issues for which you had not treated her since 5 June 2020;

b. used an inappropriate method (WhatsApp messaging) to give that medical advice;

c. failed to make a proper record in Patient A`s hospital records of the medical advice you gave to her.

6. Between 9 June 2020 and 25 July 2020, you engaged in a sexual relationship with Patient A as set out in Schedules 3, 4 and 5.

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.”