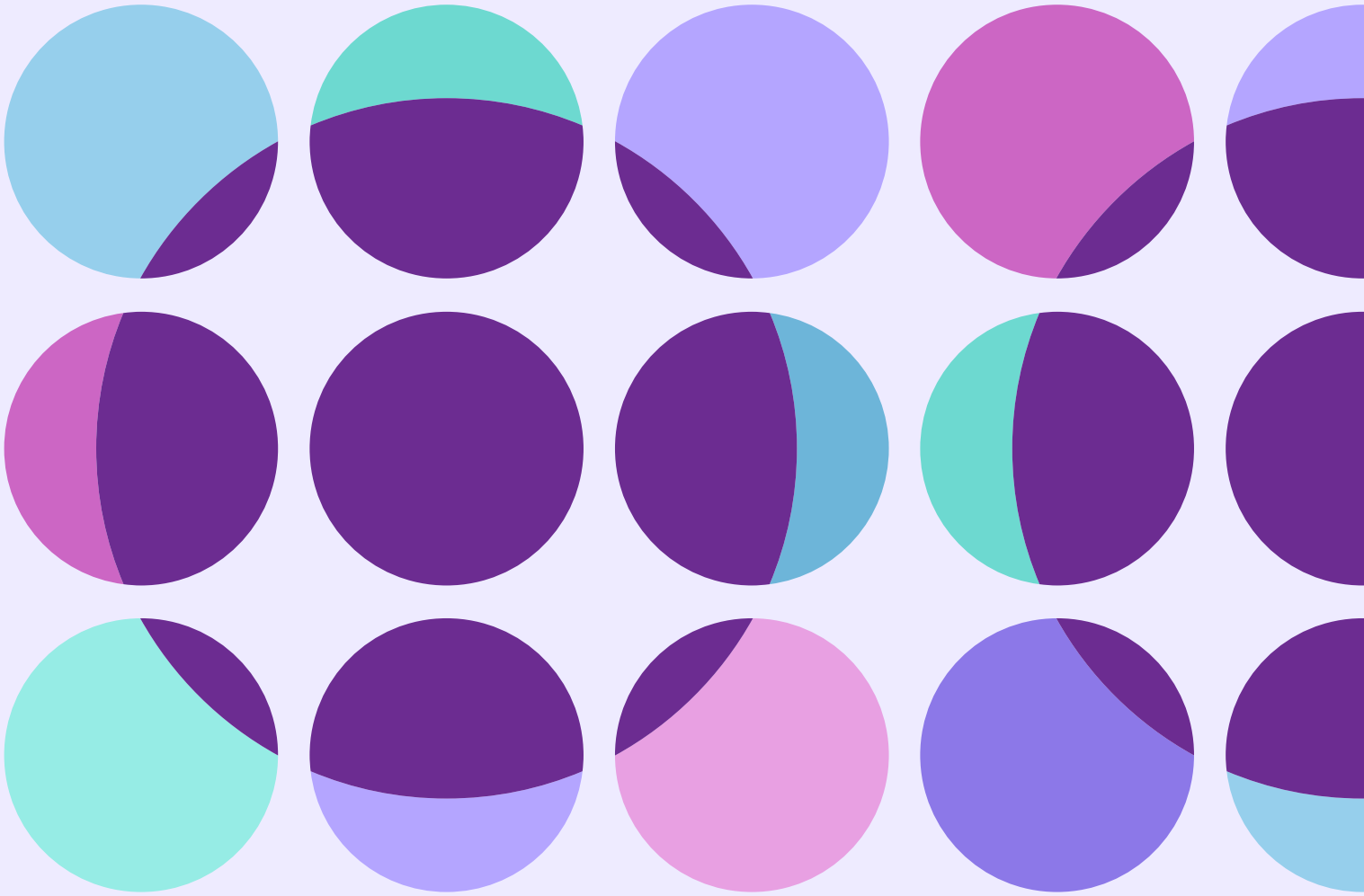
Resources

professional standards authority
for Health and Social Care

Improving the handling of sexual misconduct cases in fitness to practise

Collated insights and practical measures for fairer, safer and more trauma-informed fitness to practise processes



About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care (PSA) is the UK's oversight body for the regulation of people working in health and social care. Our statutory remit, independence and expertise underpin our commitment to the safety of patients and service-users, and to the protection of the public.

There are 10 organisations that regulate health professionals in the UK and social workers in England by law. We audit their performance and review their decisions on practitioners' fitness to practise. We also accredit and set standards for organisations holding registers of health and care practitioners not regulated by law.

We collaborate with all of these organisations to improve standards. We share good practice, knowledge and our right-touch regulation expertise. We also conduct and promote research on regulation. We monitor policy developments in the UK and internationally, providing guidance to governments and stakeholders. Through our UK and international consultancy, we share our expertise and broaden our regulatory insights.

Our core values of integrity, transparency, respect, fairness, and teamwork, guide our work. We are accountable to the UK Parliament. More information about our activities and approach is available at www.professionalstandards.org.uk.

Contents

Why we produced this report

This report sets out insights for improving the handling of cases involving alleged sexual misconduct in fitness to practise (FtP) processes and Accredited Register complaint processes.

In doing so we draw on learning and insights from our reviews of final FtP panel decisions, expert contributions on the impacts of sexual misconduct on victim/survivors, research and emerging good practice in the health sector and beyond. The report is intended for regulators, Accredited Registers, and others in the health and care system with an interest in tackling sexual misconduct.

Some notes on frequently used terms in this report

- **'Section 29':** our power to review and appeal regulator fitness to practise panel decisions comes from **Section 29 of the NHS Reform and Health Care Professions Act 2002**. This is why we often use 'Section 29' as our shorthand when referring to this power.
- **'Fitness to practise/FtP':** Throughout the report, we use the term 'fitness to practise' inclusively with Accredited Register complaint processes.
- **'Witness':** We use the term 'witness' to represent those providing evidence as part of an FtP process. This includes victims/survivors of sexual misconduct and others, including those who may have raised concerns with a regulator or Accredited Register and/or have witnessed misconduct.

1 Introduction

2021/2022 **11%** of appeals related to decisions relating to sexual misconduct

2025/2026 **26%** of appeals related to decisions relating to sexual misconduct

This report provides insights and learning to help regulators and Accredited Registers (ARs) respond to the challenges that arise in FtP cases and complaints processes involving allegations of sexual misconduct.

We are issuing the report building on a number of different sources of evidence:

- Insights from our Section 29 process for reviewing final panel decisions
- A series of webinars and other discussions organised by the Professional Standards Authority (PSA) between September 2024 and December 2025
- A conference in May 2026 organised by the PSA, focusing on issues arising in these cases.

This work is in a context of increasing awareness of sexual misconduct in health and care settings, and of rising numbers of allegations involving sexual misconduct being made to regulators, with active discussion being led by the PSA in the sector on different aspects of misconduct, covering prevention, reporting and FtP.

In recent years, there has been an increasing proportion of final FtP hearings involving sexual misconduct allegations, with sanctions more fully reflecting the seriousness of the misconduct. This includes more incidents involving colleagues, the patient and service-user safety implications of which are being more fully understood and recognised. However, there has also been a rise in the number and proportion of final hearing decisions that the PSA has appealed in this type of case, because they are insufficient for public protection and/or public confidence in regulation. We are issuing this report to highlight areas that may help regulators and ARs to achieve appropriate, fair outcomes through processes that support those involved.

The report includes a definition of sexual misconduct and discusses the specific challenges of cases involving sexual misconduct (Section 3). It discusses the evidence that we see through our reviews of final hearings and the learning indicated by these reviews (Section 4). It summarises examples of emerging learning in both our sector and beyond (Section 5) to address in

particular the evidential challenges that arise in these cases. This includes ways to support witnesses so that they are able to give the best possible evidence. It provides a range of measures that we encourage regulators and ARs to explore, which may help to provide that support more effectively, and to enhance the quality of decision-making (Section 6). These measures have the potential to strengthen both public protection and procedural fairness.

Having drawn conclusions for FtP (Section 7), we include a discussion of the wider context and issues relating to this kind of misconduct, and its prevention (Section 8). In a bibliography and the appendix to the report we provide more detail on some of the wider background research that is the context for our work on this subject, and more detailed data arising from our Section 29 process.

Key themes for FtP that emerge include:

- The central importance of trauma-informed practice
- Recognition that traditional adversarial processes may impair evidence quality
- The importance of early and ongoing tailored support for witnesses
- A consistent need to challenge myths, stereotypes, and flawed assumptions at all stages of FtP
- The need to shift to a more responsive and flexible approach to supporting vulnerability throughout the process
- The importance of fully reasoned and well recorded decision-making at every stage
- The importance of accurate and comprehensive charging.

We strongly encourage regulators and ARs to consider how our suggested improvements and other similar measures could apply to and enhance their FtP processes and AR complaint processes, where they are not already doing so.

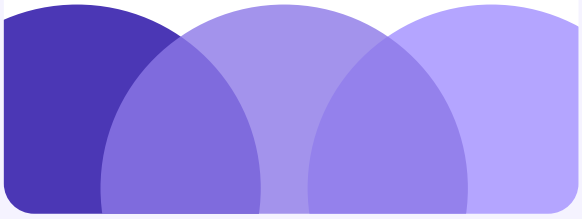
2 Definition of sexual misconduct

Sexual misconduct is not defined in FtP and is an umbrella term. However, it is widely accepted as covering any unwanted or non-consensual conduct of a sexual nature. This encompasses both behaviour towards colleagues and patient/service-users and ranges from inappropriate comments to serious criminal conduct. It also encompasses behaviour in a registrant's private life which may not be towards colleagues or patients and service-users.

Sexual harassment is defined under the Equality Act 2010 as unwanted behaviour of a sexual nature – verbal, non-verbal or physical – that creates an intimidating, hostile, degrading, humiliating or offensive environment.

This can include:

- Unwelcome sexual advances or propositions
- Inappropriate comments relating to appearance
- Suggestive gestures or remarks
- Intrusive questioning about personal relationships
- Sending sexually explicit communications
- Physical contact or assault.



> Sexual misconduct is an umbrella term, widely accepted as covering any unwanted or non-consensual conduct of a sexual nature. This encompasses both behaviour towards colleagues and patients and service-users.

In some circumstances (for example in the case of grooming) the behaviour may not be experienced as unwanted or non-consensual at the time. Perpetrators may rely on a power asymmetry to exploit their victim, and victims/survivors may not recognise the behaviour as exploitative until a later date.

3 Key challenges to the fitness to practise process

Fitness to practise cases with charge relating to sexual misconduct

115 2021/22

224 2025/26

Sexual misconduct cases within FtP present distinctive challenges. If these are not addressed effectively, they risk undermining witness engagement and evidence quality, and therefore the fairness of outcomes.

These challenges arise largely from the nature of the situations in which sexual misconduct arises, which often result in:

- Limited corroborative evidence
- Power imbalances between registrant and witness(es)
- High reliance on witness testimony
- Significant emotional and psychological impact
- Witness vulnerability and the impact of trauma.

Trauma and its impact on evidence

Understanding trauma is central to understanding its effect on giving evidence as a witness. Trauma affects memory, recall, and consistency of testimony; repeated questioning of a traumatised witness can undermine confidence and accuracy. This is particularly the case where witnesses have already recounted what happened to them repeatedly before the matter even reached the regulator.

Witnesses may present fragmented accounts, delayed reporting and apparent inconsistencies. These are normal effects of trauma, not indicators of unreliability. Trauma can impair communication, attention and emotional regulation. Court, tribunal and hearing processes themselves can re-trigger trauma and distress, with the risk of causing 'secondary harm'.[1]

Risks of misinterpretation and bias

Research and expert advice consistently highlight the role of myths, stereotypes and unconscious bias as potentially influencing case presentation, decision-making and interpretation of evidence. This includes incorrect assumptions about consent, behaviour, and witness credibility. However, lack of a clear recollection or discrepancy between multiple written accounts given over time does not in and of itself indicate unreliability; absence of explicit refusal does not imply consent; and delayed reporting is not indicative of falsity.[2]

Witness experience and engagement

Research has shown a consistent gap between witness expectations and actual experience. Witnesses have reported feeling treated as 'evidence, not a person'. They have experienced poor communication and lack of contact, and confusion about processes and outcomes. This can result in distress and disengagement, reduced trust in regulators, and the loss of key evidence for the process. Research has shown that the FtP process requires significant and effortful 'witness work' – preparing statements, attending hearings, and repeatedly recounting often distressing events. Without support, this burden of effort can lead to withdrawal, reduced quality of evidence, and at worst, case failure.[3]

Structural issues in adversarial processes

Traditional adversarial approaches in FtP may discourage effective participation, increase distress and reduce the quality of evidence that witnesses are able to provide. A shift away from aggressive cross-examination is required and that judges and panels must play a more proactive role in enabling witnesses to give the best possible evidence.

Legal and procedural challenges

Key challenges that arise in these cases include evidential difficulties (lack of witnesses or documentation), managing cases where police take no further action, maintaining witness engagement over time and balancing open justice with witness protection.

Witnesses have reported feeling treated as 'evidence, not a person'

Decision-making

Particular issues in regulatory decision-making and reasoning, which we have seen through our reviews of final hearing decisions, include:

- Bias, where cases hinge on testimony, recollection of events, and credibility assessments. This can unintentionally shift the emphasis onto the victim/survivor's conduct and their ability to account for it, rather than the alleged perpetrator's, with a risk of introducing cultural biases or 'rape myths' that implicitly question why the victim/survivor did not prevent the incident or react in a certain way.
- Inconsistent categorisation of misconduct (failure to charge sexual motivation or sexual harassment), leading panels to understate the seriousness of the conduct.
- Lack of consideration by panels as to the patient safety risk associated with sexual misconduct involving colleagues. It is increasingly recognised and understood that harassment or abuse within healthcare teams erodes performance, impacts effective teamworking and therefore can create a risk to patient and service-user safety.
- Similarly, lack of consideration of impact on public interest in sanction decisions.
- Inadequate reasoning in panel determinations. Some FtP determinations lack clear, structured reasoning tying findings to each charge and fully articulating why misconduct is or is not considered impairment, and why a given sanction is warranted and others are not. Some FtP determinations also fail to consider the allegations holistically, instead only addressing each charge in turn when assessing overall seriousness. The combined impact of the allegations may be greater than the sum of the individual parts.

Further reading:

- *Improving patient, family and colleague experience of Fitness to Practise proceedings* Witness to Harm Project NIHR
- *Tackling Rape Myths and Stereotypes in the Crown Prosecution Service Rape and Sexual Offences Prosecution Guidance* The Crown Prosecution Service

4 Insights from checking and appealing fitness to practise decisions (the Section 29 process)

70%

of substantive hearings involving sexual misconduct result in suspension or striking off

In this section we present further detail on how both the challenges above, and wider trends in the recognition and reporting of sexual misconduct, emerge through the FtP process as we see it from our Section 29 process for reviewing the outcomes of final panel hearings.

Background to Section 29

The 10 health and social care regulators we oversee each have an FtP process for handling complaints or concerns about health and care professionals on their registers. The most serious cases are referred to formal hearings known as FtP panels, tribunals or committees. The regulators send us the final decisions made by their FtP panels.

The role of the PSA's Section 29 team is to consider whether the FtP panel decisions we review are sufficient to protect the public. This involves consideration of whether the decision is sufficient: (a) to protect the health, safety and wellbeing of the public; (b) to maintain public confidence in the profession concerned; and (c) to maintain proper professional standards and conduct.

If we consider that a decision poses a risk to public protection, does not maintain public confidence, and/or uphold professional standards, we can appeal it to the relevant court for further consideration. We will only appeal panel decisions to court if there is no other effective way of protecting the public.

Where we have identified concerns with a panel decision but decide not to refer it to court, we will share our concerns and any 'learning points' with the regulators.

What the data and statistics show

PSA data over the last five years indicates an upward trend in final FtP panel decisions involving sexual misconduct, both in absolute numbers and as a proportion of the FtP caseload. Sexual misconduct cases for all 10 health and social care regulators rose from 9.5% of total final substantive (non-review) hearing decisions in 2021/22 to 18.1% in 2024/25, with a small drop to 16.6% in 2025/26 (see Chart 1, below).

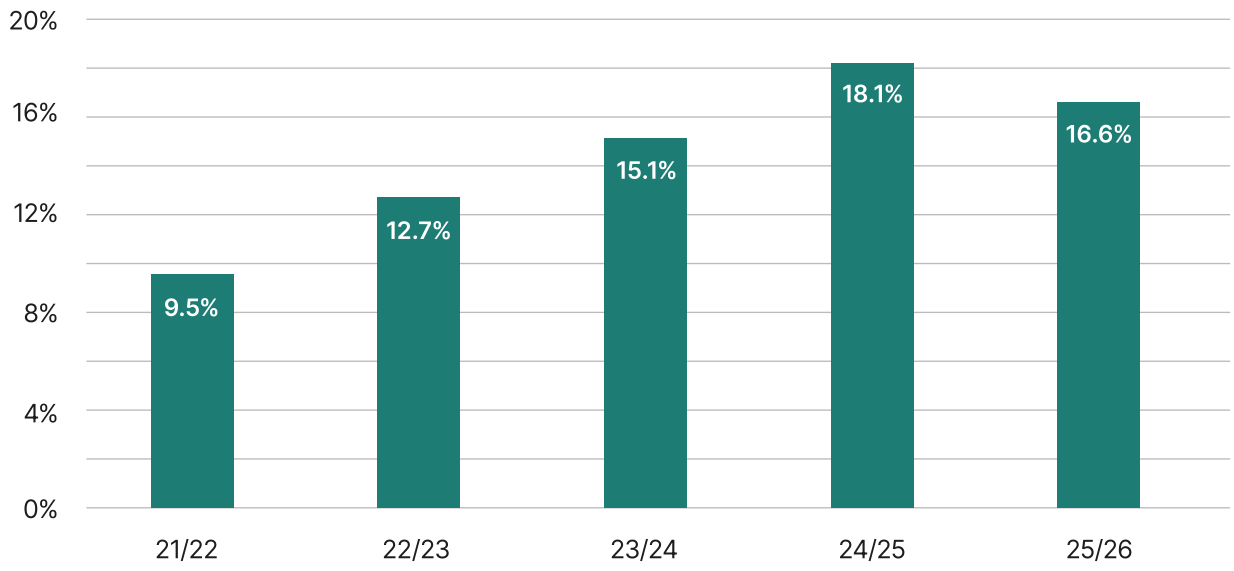
In Data Tables 1 and 2 (in the Appendix), we provide more detailed data on total cases received from regulators over the past five years.

It is not possible to say definitively what is behind this increase over time, but it may reflect the influence of:

- greater awareness of unacceptable conduct
- increased confidence in reporting
- stronger regulatory and employer responses, especially in relation to certain types of conduct/individuals (e.g. harassment towards colleagues)
- possible increasing prevalence of this kind of misconduct
- evolving case law and guidance.

Chart 1

% of substantive FtP cases with a charge relating to sexual misconduct as a proportion of all cases, 2021-26



Outcomes and sanctions

Regulatory outcomes across the board show a shift towards more severe sanctions.

Approximately 70% of substantive hearings involving sexual misconduct result in suspension or striking off. Striking-off orders have increased in recent years, and are the most common outcome in sexual misconduct cases. There has been a decline in findings of no impairment or no misconduct since 2021/22.

This indicates a stronger regulatory stance and increasing recognition of the seriousness of such conduct. Both the PSA and regulators have undertaken work in this area in recent years, with regulators making significant updates and improvements to various guidance and further panel training.

The data suggests that the guidance has influenced regulatory practice and outcomes.

In Chart 4 (in the appendix), we provide more detail on sanctions applied, in aggregate across all regulators.

Increasing proportion of appeals

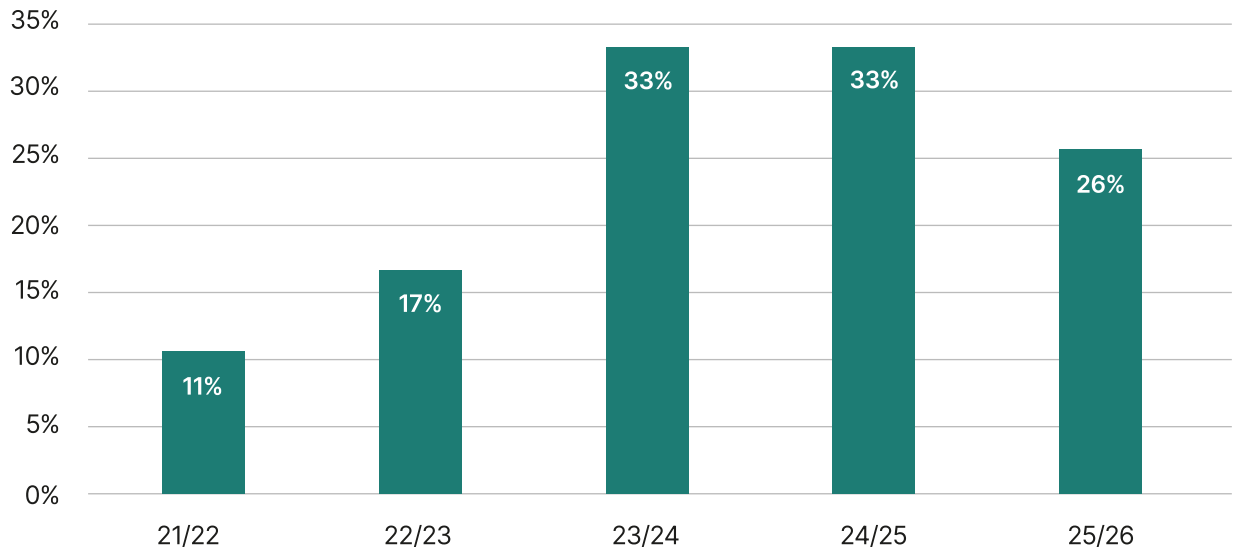
Sexual misconduct cases also, however, form a growing proportion of PSA appeals.

Around one-quarter to one-third of PSA appeals from 2023/24 to 2025/26 have involved sexual misconduct. This represents a significant increase in such appeals over time, both in absolute numbers and as a proportion of all appeals (see Chart 2, below).

More detail on the number of appeals brought by the PSA is provided at Table 4.

Chart 2

% of appeals brought by the PSA which relate to sexual misconduct, 2021-26



Common grounds of appeal

A common factor in our appeals is where we consider decision-making to be insufficient, including:

- a failure to consider the full seriousness of the misconduct at the impairment and sanction stages leading to a sanction which is insufficient to protect the public
- inadequate consideration and application of sanctions guidance
- error in the application of relevant legal principles
- insufficient consideration of the public interest
- excessive weight given to mitigation
- inadequate reasons for decisions, particularly at the impairment and sanction stages.

To some extent these points reflect the issues that we have described above, and can be addressed through focused training and guidance to panels. But our appeals also highlight the importance of robust and transparent decision-making more generally, and of panels clearly and thoroughly recording their reasoning throughout.

The cases also highlight the importance of charging. Accurate and comprehensive charges are critical. Charges must reflect the full seriousness and motivation of the conduct. Accurate and sufficient charging forms the basis of the case and thus informs how regulators and panels manage their investigation and inquiry. Clear charging supports appropriate outcomes and public confidence.

These points have been underlined by recent court decisions. The PSA is more likely to appeal where they have not been adequately addressed.

Read through case studies for further details

Appeal outcomes

Looking more closely at recent final panel decisions that the PSA has appealed, between April 2023 and March 2026, 26 out of the 86 appeals we made were in relation to cases that had a concern relating to sexual misconduct.

Twenty of these 26 appeals have since concluded, and we have been successful in 15 of them. We withdrew one appeal after the registrant was struck off at review hearing and three after new information came to light after we lodged the appeal. One appeal was dismissed.

Further detail on the 15 successful cases is as follows:

The court substituted its decision in six of 15 cases and remitted (sent the case back for reconsideration by a panel) the remaining nine cases.

In all of the six substituted cases, a sanction was imposed where previously there was no sanction, or a more restrictive sanction was imposed. A sanction of suspension or strike off was imposed in five out of six of those cases.

In seven of the 15 cases, the original panel had made no findings or imposed no sanction, of which all decisions were quashed by the court.

Patients and service-users and colleagues

PSA appeals are now broadly split evenly between cases involving patients and service-users and colleagues as the target or victim of misconduct. However, in 2024/25, five of seven sexual misconduct cases we appealed involved at least one charge relating to colleagues. Cases involving sexual misconduct against both patients and service-users and colleagues can raise serious concerns regarding power imbalance, vulnerability and impact on patient and service-user safety.

We have seen an increase in the number of cases involving colleagues, which may indicate that these incidents are being taken more seriously, and their impacts on patient and service-user safety are better recognised and understood.

Learning points

We have seen a substantial increase in learning points arising from sexual misconduct cases in recent years. We issue learning points when we have identified an issue, weakness, or area for improvement in a case, but the issue is not material to the overall outcome or sufficiently serious to justify an appeal.

Eighteen per cent of cases in which we identified learning points in 2025/26 included a charge relating to sexual misconduct. This has increased from 6% in 2021/22 (see Chart 3, below).

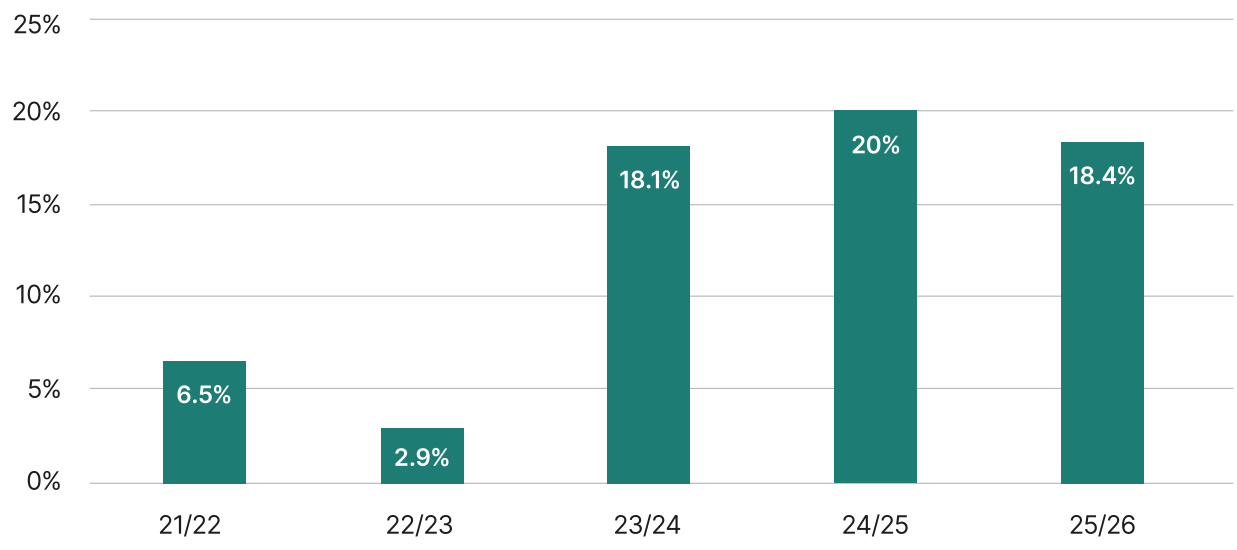
We most frequently raised learning points in relation to insufficient panel reasoning. However, we also regularly raised these in relation to sanction decisions (particularly in relation to the application of sanctions guidance) and cases closed inappropriately, including failure to make additional applications/adduce additional evidence to support a charge.

Further reading:

- Case study - A social worker who sexually harassed his female colleagues but the HCPC's fitness to practise panel concluded that his behaviour was not sexually motivated
- Case study - A doctor who sexually assaulted a nurse during a night shift
- PSA Fitness to Practise Learning points bulletin
- *Appealing fitness to practise decisions - the year in focus 2024/25*

Chart 3

% of learning points issued on cases with a charge relating to sexual misconduct



5 Emerging good practice

The following table summarises a number of areas of emerging good practice in relation to some of the challenges described, both in our sector and beyond.

Table 1
Areas of emerging good practice

Area of good practice	Description
Trauma-informed, participation-focused approach	A consistent shift is emerging from 'categorical' vulnerability models to individualised, needs-based support. This involves early assessment of witness needs, tailored communications and support plans, and ongoing review throughout proceedings.
Holistic understanding of vulnerability	Modern guidance recognises vulnerability as situational and dynamic, not as fixed or categorical. It should be identified early, reviewed continuously and addressed proportionately.
Enhanced witness support models	Effective approaches include dedicated support services providing emotional support, procedural guidance and continuous contact. They also include advocacy and intermediary support and pre-hearing preparation and information. These measures improve engagement, enhance evidence quality and increase trust in the process.
Use of special measures and intermediaries	Special measures include video links, pre-recorded evidence, intermediaries and private hearings. Intermediaries facilitate understanding and communication, provide tailored recommendations, and support effective participation. They are particularly valuable where trauma affects communication, complex needs exist, or evidence risks being misunderstood.
Ground rules hearings and case management	Ground rules hearings allow: • agreement on questioning style • identification of support needs • adaptation of the hearing environment. They are helpful to: • protect witness welfare • ensure effective evidence • maintain fairness.

These are primarily in relation to creating conditions in which witnesses in these cases are able to give the best possible evidence, and were highlighted by expert presenters at our conference on sexual misconduct in FtP in May 2026.

Further information on their contributions can be found on our website at:

Key takeaways from PSA conference on sexual misconduct and fitness to practise

Further reading:

- Key takeaways from PSA conference on sexual misconduct and fitness to practise
- *Preventing and responding to sexual misconduct in health and social care settings* - a series of insights compiled from our webinar series on tackling and preventing sexual misconduct
- Tackling and preventing sexual misconduct webinar series – resources

6 Practical measures for improvement

In this section we provide practical suggestions for how FtP processes could respond to the challenges, learn from our case review insights and apply the emerging good practice and insights we have described.

In doing so, there is the potential to improve the handling of cases involving allegations of sexual misconduct and more generally, to contribute more effectively to wider regulatory aims of protection and safety.

We recognise that many organisations are already making good progress in this direction. The information that follows as Table 2 is not exhaustive – this is an evolving area of improving understanding and practice, and we will continue to engage with the sector in identifying the best way forward.

Table 2

Codes of conduct and guidance

(For further discussion of prevention and early action, please also see Section 8)

Potential improvement actions:

- Clarify in codes of conduct to clearly and comprehensively state that sexual misconduct is unacceptable.
- Adopt in codes of conduct a broad definition that encompasses such behaviour as grooming and other boundary violations.
- Ensure guidance covers both patients and service-users and colleagues, and other circumstances where a registrant's actions may constitute sexual misconduct, including outside the work environment.
- Ensure guidance clarifies registrants' responsibility to act on concerns about the behaviour of colleagues.
- Cover in guidance on charging decisions the approach to sexual motivation and sexual harassment, in accordance with relevant caselaw and legislation.
- Include in sanctions guidance targeted, specific considerations relating to how remediation should be assessed in sexual misconduct cases.
- Consider how specifically targeted CPD can assist with a better understanding of sexual misconduct and its impact on victims/survivors and the wider public.
- Collaborate with employers to support the implementation of primary prevention strategies in workplaces, for example promoting initiatives that encourage staff to speak up and challenge misconduct early.

Triage/screening

Potential improvement actions:

- Provide support at triage/screening stage for those reporting concerns.[4]
- Ensure that consideration is given to the possible requirement for an interim order.
- Treat sexual misconduct allegations as high-risk cases: for instance, establishing dedicated triage processes or flagging mechanisms so that such cases are promptly reviewed, triaged, investigated, heard and adjudicated on by appropriately trained and experienced staff and panels.

Investigation

Potential improvement actions:

- Adopt trauma-informed evidence gathering.
- Provide clear explanations of processes and timely updates.
- Avoid repeated unnecessary questioning.
- Recognise impact of delay and effects of repetition on memory.
- Apply approaches such as ‘structured curiosity’ to the registrant’s account, probing for patterns in how they initiated or escalated interactions, interpreted consent, or justified their conduct (e.g. grooming tactics, similar past complaints).
- Avoid placing undue emphasis on scrutiny of the witness.

Witness engagement and support

Potential improvement actions:

- Assign a named contact for each witness.
- Conduct early needs assessments.
- Develop tailored support plans.
- Provide accessible information and pre-hearing preparation.
- Ensure witnesses understand the process and can make informed decisions.

Evidence and decision-making

Potential improvement actions:

- Explicitly address:
  - trauma impacts
  - myths and stereotypes.
- Avoid:
  - over-reliance on consistency
  - binary credibility assessments.
- Use a holistic approach to evidence evaluation.

Hearing practice

Potential improvement actions:

- Use special measures as a standard consideration – such as pre-recorded evidence and cross examination.
- Implement ground rules hearings and adapted questioning (simple, structured).
- Limit aggressive or repetitive cross-examination.
- Provide for appropriate pacing, breaks and support throughout.
- Ensure sufficient legal expertise so that evidentiary rules (such as cross-admissibility of similar fact evidence) are properly applied.
- Ensure sanction consistency across regulators and professions (aligning sanctions guidance and sharing of self-learning and PSA feedback).

Specific advice to panels

Potential improvement actions:

- Recognise that sexual misconduct undermines public trust and can create a risk to patient and service-user safety no matter who the victim is in relation to the registrant.
- Take into account that sexual misconduct often stems from sustained attitudinal problems – such as abuse of power or lack of empathy – which can be difficult to remediate.
- Weigh factors like sexual predation, multiple incidents or victims, or refusal to recognise/ denial of the harmful impact of behaviour as strong aggravating factors requiring more severe outcomes.
- Consider the public interest and public confidence in the profession, including the impact on the profession and colleagues coming forward to raise concerns.
- Emphasise and prioritise public protection, deterrence, professional values and the message sent to professionals and the public.
- Have regard to the relevant sanctions guidance, and the seriousness such guidance places on sexual misconduct, when making and explaining decisions.
- When a sanction is imposed which allows the registrant to remain on the register, be clear as to what steps remain in terms of the registrant journey to full insight and remediation.

Cultural and contextual sensitivity

Potential improvement actions:

- Consider language barriers, cultural norms and power dynamics.
- Recognise cultural taboos around sexual matters.

Organisational learning and training

Potential improvement actions:

Provide training to panel members and staff involved in the process to ensure understanding of the particular considerations in sexual misconduct cases throughout the process, on subjects to include:

- trauma-informed practice and implementation into every stage of the FtP process, including for example on measures to mitigate the risk of retraumatisation
- unconscious bias and how this might affect decision-making and the assessment of evidence
- the psychology of sexual misconduct from the perspective of both victim/survivor and perpetrator, and how this should be reflected in the process at every stage, for example in the approach to investigation
- new preventative duty under the Worker Protection Act and consideration as to how this will impact on seriousness of misconduct, investigation carried out, sanction imposed and level of insight shown.

Embed:

- continuous learning from cases
- quality assurance mechanisms.

7 Conclusions for the fitness to practise process

Sexual misconduct in health and care is a complex, cross-sector problem demanding an expert, vigilant regulatory response, informed by understanding of the impacts on those who have been harmed.

The evidence from our review of FtP cases, research and expert contributions to our discussions on this issue demonstrates that:

- there are potential improvements at every stage of the regulatory process
- effective participation of witnesses is central to fairness
- better support for witnesses leads to better evidence and decision-making
- trauma-informed approaches are essential
- consistent, strong and well-reasoned sanctions are crucial to effectiveness.

A consistent theme emerges:

8 The wider context for this work

From September 2024 to December 2025 the PSA held a series of webinars on understanding and tackling sexual misconduct in health and care settings.

The webinars featured expert-led presentations and discussions on different aspects of sexual misconduct. We also included a series of presentations on this theme at our 2024 annual research conference.

Our purpose has been to engage with a wide range of stakeholder organisations and different perspectives in order to encourage learning, build evidence, and identify what more can be done to prevent and address this ongoing problem. The contributions came from different professional and disciplinary perspectives, including for example research that had taken place in specific settings, and how expertise in psychology could inform responses at every stage.

The discussions looked at every stage of this problem as it develops, from prevention, through early intervention, to reporting, and ultimately to regulatory processes. The discussions have shown that different stakeholders and processes can be mutually supportive and complementary in preventing these situations from arising, or where they have, in responding quickly before problems can become serious, entrenched and harmful.

The discussions brought forward particularly powerful insights into the impacts of being a victim/survivor of sexual misconduct. They highlighted a number of specific challenges for those investigating and adjudicating in these circumstances, within processes where the conventional approach to evidence and its credibility has relied on detailed recall, and assumptions about expected behaviour and responses in particular situations. The known effects of being a victim/survivor of sexual misconduct, and the trauma that may result, challenge these approaches. Recall of situations may focus on particular details at the expense of others which to an observer may seem more significant; memory can be fragmented in ways which make a linear narrative difficult to provide. Delays to reporting as events are processed, and their significance and impact becomes clear, can be misinterpreted as undermining the seriousness of what is alleged to have taken place.

The detailed information, emerging good practice and measures for improvement contained in this report illustrate ways in which we believe that the FtP process can evolve to reflect these insights and to better support witnesses in these cases. They show how vulnerability can be more thoughtfully understood and witnesses better supported, how evidence can be viewed in a way which reflects our understanding of the psychology of being a victim/survivor, and how the real and known effects of trauma can be managed with sensitivity. These measures will enhance the quality of evidence that witnesses are able to provide to the process.

Other discussions in our webinar series looked more closely at the circumstances of incidents of sexual misconduct, and how these might be better understood and therefore more effectively prevented. These discussions frequently referenced research, including PSA commissioned research from Professor Rosalind Searle, linked below.

Professor Searle and others have brought into these discussions the wider literature around counterproductive workplace behaviour, which shows among many other insights, that many different situations can result in abuse. The same preventative measures will not be effective in a situation where a purposeful and calculating perpetrator is seeking to exploit a vulnerable colleague compared to, for example, a situation where an exhausted, depleted and stressed clinician crosses a boundary with a patient and service-user because of a temporary failure of their own emotional and professional self-regulation. Above all else, our series of discussions showed that an effective preventative strategy needs to include a range of measures working in parallel.

However, they also showed that there are some interventions that will be effective whatever the circumstances driving unprofessional behaviour, once it begins to appear. One is the willingness of colleagues who observe even weak or early signals of risk to take rapid action, even at the level of simply asking questions where they witness behaviour that indicates concern, or where a patient and service-user has expressed unease about their interaction with a colleague. This has been described as a 'cup of coffee' intervention,[5] an early nudge which may be just enough for a clinician to realise the risks of causing harm that they are walking towards, and correct their course. Of course, all professionals must also be prepared to take more formal action where this is needed.

Teams also have a key role in prevention in looking out for each other, but also, in reaching a shared understanding of the particular risks that arise in the context of their work which may lead to boundaries with patients and service-users being violated. How does the kind of care that is being provided, and the structures and settings of that care, give rise to risk, and how are those specific risks being mitigated? Context also includes the kind of organisation within which the team works. For example, research in the ambulance sector has illustrated that risk increases in institutions which emphasise their own hierarchy. Teams have a crucial role in understanding the particular power dynamics that result, and mitigating the risks.

The role of employers, and the work that has been dedicated in particular to responding to the requirements of the Worker Protection Act, has also featured in the webinars. As well as meeting the requirements of legislation, employers have also been challenged to consider the importance of

trust in their processes – how can someone reporting a concern be confident that it will be treated with due seriousness, and investigated with both rigour and tact? Reporting hesitancy has long been observed as a problem, and sexual misconduct is known to be significantly under-reported. Employers should work to understand the particular causes in their organisation for people being reluctant to bring forward their concerns, and take necessary action.

Regulatory processes are intended to be preventative both in their nature and their effect, and we have heard how regulators are seeking to amplify their impact through their standards and guidance, the analysis and interpretation of data, and learning from FtP cases. A particular challenge that was articulated was whether a clearer line can be drawn from early action, through employer investigations to regulatory process, such that from the earliest stages with an employer the possibility of a case reaching the regulator was being anticipated, supporting efficient collaborative work and building trust.

We have distilled the webinar discussions into a series of insights for individuals, teams, employers, and regulators/other stakeholder organisations: ***Preventing and responding to sexual misconduct in health and social care settings***.

Further reading:

- Fitness to Practise and sexual misconduct – key takeaways from 21 May 2026 conference
- Webinar series on tackling sexual misconduct in healthcare
- ***Sexual behaviours between health and care practitioners: where does the boundary lie?***
- ***Sexual misconduct in health and social care: understanding types of abuse and perpetrators' moral mindsets***
- ***Bad Apples? Bad Barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK health and care***

9 Supporting materials

Insights from series of seminars on tackling sexual misconduct

On the PSA website we provide a range of supporting materials and reference points on different aspects of sexual misconduct. These can be found at Tackling and preventing sexual misconduct webinar series - resources | PSA. They are structured around the subjects of the presentations in our webinar series on sexual misconduct that ran from September 2024 to December 2025.

Section 29 conference May 2026

We also provide the majority of presentations that were made at our Section 29 conference focused on sexual misconduct in May 2026.

Speakers were as follows:

- Dr Jamie Orchard, General Counsel, The Australian Health Practitioner Regulation Agency *The approach to sexual misconduct by health practitioners*
- HHJ Anu Thompson, Circuit Judge *Vulnerable Witnesses in the Crown Court*
- Judge Fiona Monk, Chair of the Medical Practitioners Tribunal Service *Obtaining best evidence from vulnerable witnesses – experience from the Tribunals*
- Dr Nina Burrowes, The Consent Collective *Working with testimony in sexual misconduct cases*
- Professor Louise Wallace, Witness to Harm *Improving patient, family and colleague witnesses' experiences of Fitness to Practise proceedings: A mixed methods study*; and *Witness care and how we have taken forward practical approaches to influence how witness needs and support can be enacted in hearings*
- Dr Catherine O'Neill, Chair, Intermediaries for Justice *Effective Participation – understanding the role of the Intermediary*
- Elizabeth Jenkins, Assistant Director of Legal team, GMC *Fitness to Practise, General Medical Council*
- Emma Willis, Chris Scott, Leeann Mohamed, NMC *Supporting people to engage*
- Ros Foster, Partner, Capsticks *Consent and witness engagement.*

Bibliography to this report

In highlighting emerging good practice and measures for improvement specific to FtP in this report we have drawn on the wide range of resources referenced above, and in particular the following, including those that go to the wider context of research and enquiry into this form of misconduct. This list is not exhaustive – for a wider range of evidence please see the resources on our website. Please note that where speakers'/ authors' organisations are given this was accurate at the point that the presentation or article was written, published or delivered.

Research

- Professor Rosalind Searle and colleagues (PSA 2017) *Bad Apples? Bad Barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK health and care*. Available at: antecedent-amp-processes-of-professional-misconduct-in-uk-health-and-social-care.pdf
- Simon Christmas and Fiona Fylan (PSA 2018) *Sexual behaviours between health and care practitioners: where does the boundary lie?* Available at: sexual-behaviours-between-health-and-care-practitioners---where-does-the-boundary-lie.pdf
- Professor Rosalind Searle (PSA 2019) *Sexual misconduct in health and social care: understanding types of abuse and perpetrators' moral mindsets*. Available at: sexual-misconduct-in-health-and-social-care-understanding-types-of-abuse-and-perpetrators-moral-mindsets_1.pdf
- Wallace L, Ryan S, Searle R, Hughes G, Sorbie A, Ryan-Blackwell G, et al. *Witness to Harm-Holding to Account. Improving patient, family and colleague experiences of Fitness to Practise proceedings: A mixed-methods study*. Available at: https://journalslibrary.nihr.ac.uk/hsdr/SSPP1118.

10 Appendix: Statistics and data on fitness to practise appeals and sexual misconduct

Data table 1:

Sexual misconduct cases received 2021-26 (substantive hearings only)

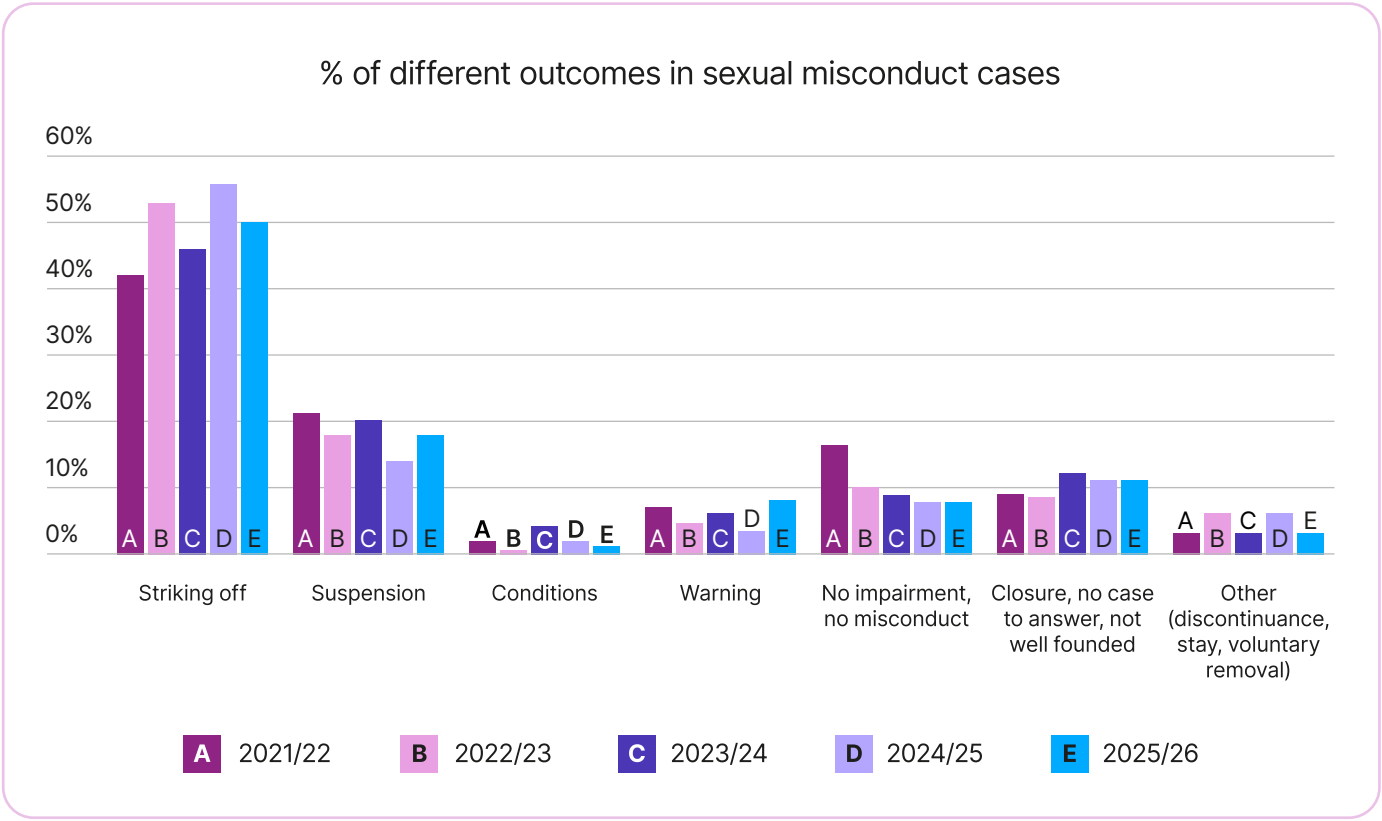
Year	Total final substantive cases received by PSA from regulators	Cases with a charge that we have identified as relating to sexual misconduct	% of total cases relating to sexual misconduct
2021/22	1216	115	9.5%
2022/23	1383	176	12.7%
2023/24	1373	208	15.1%
2024/25	1263	229	18.1%
2025/26	1350	224	16.6%

Data table 2:

Cases received by the PSA, by regulator (2021-26)

Regulator	Total substantive cases received	Total sexual misconduct cases	% sexual misconduct cases
General Chiropractic Council (GCC)	51	12	24%
General Dental Council (GDC)	460	29	6%
General Medical Council (GMC)	1136	253	22%
General Optical Council (GOC)	181	14	8%
General Osteopathic Council (GOsC)	62	12	19%
General Pharmaceutical Council (GPhC)	290	34	12%
Health and Care Professions Council (HCPC)	1084	220	20%
Nursing and Midwifery Council (NMC)	2759	334	12%
Pharmaceutical Society of Northern Ireland (PSNI)	27	0	0%
Social Work England (SWE)	535	44	8%
Total	**6585**	**952**	**14%**

Chart 4:
Sanctions applied by regulators in sexual misconduct cases 2021-26



Data table 3:
PSA appeals 2021-2026

Year	Number of appeals brought	Appeals with a charge that we have identified as relating to sexual misconduct	% of appeals
2021/22	19	2	11%
2022/23	18	3	17%
2023/24	30	10	33%
2024/25	21	7	33%
2025/26	35	9	26%

Endnotes

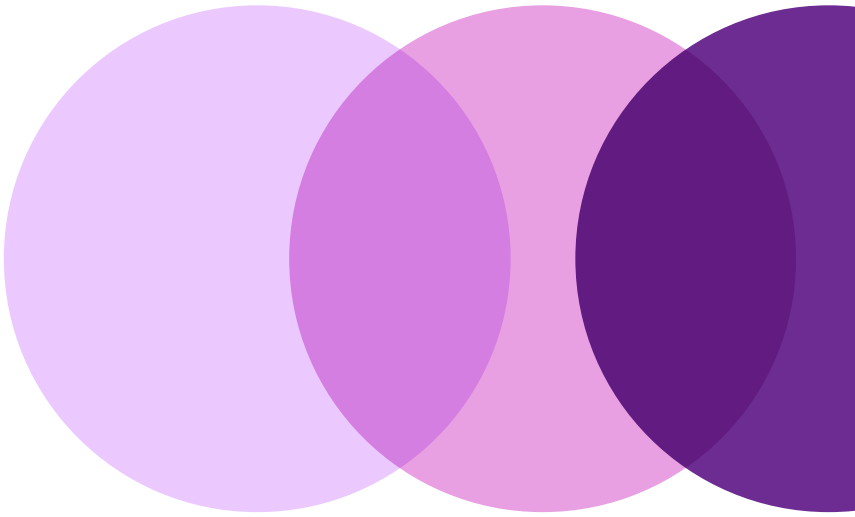
1 Also referred to in wider literature as, for example, 'retraumatisation' and 'secondary victimisation'; the harmful impact on those participating in processes that have been designed to investigate and/or adjudicate on harmful incidents.

2 See for example, Annex A Tackling Rape Myths and Stereotypes in the Crown Prosecution Service Rape and Sexual Offences Prosecution Guidance: Rape and Sexual Offences Prosecution Guidance - Full Page Version | The Crown Prosecution Service

3 Witness to Harm NIHR-funded research project

4 There is a range of resources available online providing insight and guidance on how to make processes more supportive to those who report. For example, the PSA's commissioned research on barriers to complaints identified four key measures to improve reporting arrangements: setting expectations and explaining the process; communications throughout the process; speed of response and action; accessibility and support, especially for at-risk groups. Barriers and enablers to complaining to health and care professional regulators

5 https://www.vumc.org/patient-professional-advocacy/promoting-professionalism-pyramid



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