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Sexual offences

Avoiding patient allegations of sexual assault

HEALTH LAW
REVIEW

In an age where healthcare professionals are under increasing pressure to justify their clinical decisions and actions, it is imperative that they are aware of the present law on sexual assault and rape and the proposed reforms. This article provides a brief synopsis of the current law of rape and indecent assault and draws attention to the new *Sexual Offences Bill*.

Current law

Under s.1 of the *Sexual Offences Act 1956* it is an offence for a man to rape a woman or another man. Rape is committed if he has sexual intercourse with a person (whether vaginal or anal) who at the time of the intercourse does not consent to it, and at the time he knows that the person does not consent to the intercourse, or is reckless as to whether the person consents to it.

When considering the defence of 'consent' the House of Lords in *DPP v Morgan*¹ determined that the defendant's belief in the complainant's consent needed to be an honest one although not necessarily reasonable. However, subsequent legislation in s.1 *Sexual Offences (Amendment) Act 1976* ensured that a jury could take account of the circumstances at the time to consider whether the defendant could have honestly held that belief. This section did not affect the general principle that it was for the complainant to adduce evidence of her lack of consent, and such evidence may include assertions that threat or force was used, or evidence that by reason of drink, drugs, sleep, age or mental handicap, the complainant was unaware of what was occurring and/or incapable of giving consent.

In cases where the alleged sexual assault has not involved penile penetration, the act may amount to assault under s.14(1) *Sexual Offences Act 1956* where the circumstances are considered as 'indecent' by a right-minded individual and where it can be shown that the defendant intended to commit the assault.

Such circumstances may be proven by facts relating to the relationship of the defendant to the complainant and how and why the defendant has come to embark on the alleged course of conduct. The above principles in relation to consent and its related defence would apply to allegations of indecent assault.

Proposed legislative reform

It is against this background that the *Sexual Offences Bill* was drafted. This bill was introduced to the House of Lords on 28 January 2003 and establishes the following new offences:

1. The offence of rape will be broadened so that it encompasses penile penetration in general i.e. of the mouth, anus and/or vagina.
2. A new offence of sexual assault by penetration (non-penile) of the anus and genital area. Both this offence and rape (as in (1) above) would carry a maximum penalty of life imprisonment.
3. A new offence of sexual assault would be created to replace all other non-penetrative sexual touching which is currently contained in the offence of indecent assault.

Continued overleaf

¹ (1976)AC 182

Sexual offences continued

Clearly the offence of sexual assault by penetration will have the most serious implications for healthcare professionals as this could cover the circumstances in which a patient is internally examined by instrument or digit(s).

The *Sexual Offences Bill* does, however, acknowledge that there may be legitimate reasons for internal examinations and the Bill requires that the penetration is 'sexual' before an offence is established. Clause 80 of the Bill states that an activity is sexual if:

- a) the reasonable person considers that the nature of the activity *may* (at least) be sexual, and
- b) the reasonable person would consider that it is sexual because of its nature, circumstances or the purpose of any person in relation to it (or all or some of these considerations)

This clause is clearly relevant to healthcare professionals and allows the opportunity for demonstration that the activity was not of a sexual nature and, furthermore, that the patient consented to it. Although some may automatically assume that an intimate examination in a doctor's surgery is not of a sexual nature, with increasing numbers of allegations of inappropriate conduct against doctors, examination in a surgery (i.e. circumstances and purpose) cannot always be considered as an automatic defence to such a charge. We have suggested a number of practical considerations below to ensure that readers are aware of the protection offered by clause 80.

As with current legislation, the absence of consent is a fundamental component of the above offences. The bill sets out, at clause 78, a non-exhaustive list of circumstances where consent cannot be deemed to be present including, but not limited to, where a person:

- a) submits or is unable to resist because of force or fear of force
- b) was asleep or otherwise unconscious
- c) could not communicate whether they consented due to a physical disability
- d) did not understand or was deceived as to the nature and purpose of the act

An offence is established where a Defendant did not believe that the Complainant was consenting, was reckless as to their free agreement or did not even consider whether they freely agreed at the time.

Other Criminal offences

Increasing awareness of the abuse of vulnerable people have led to proposed criminal offences relating to those with mental disorders and learning disabilities. The Bill establishes an offence for a care worker (whether paid or unpaid) to engage in or incite any sexual activity with such individuals (whether in-patient or out-patient). The definition of care workers includes those who work in care homes, for independent clinics and NHS bodies who regularly provide care to the patient. These offences have a statutory defence of pre-existing relationships.

Practical considerations

In summary, it is becoming all the more important for doctors to ensure that they have arrangements in place, including chaperons, to provide themselves with adequate protection should allegations of sexual assault be made. Therefore, on a practical basis, healthcare professionals must ensure that their patients are aware of the extent of any examination to be undertaken and the methods that will be used. Most importantly, it is vital that doctors ensure, and record where possible, the fact that the patient has freely consented and agreed to the examination in the first place.

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Threats and harassment

Legal remedies when staff need protection from patients

RadcliffesLeBrasseur is regularly asked to advise on the legal remedies available to ensure, as far as possible, that patients who have demonstrated or threatened violence do not return to the premises of the healthcare provider and put staff at further risk. Enquiries are often raised as to whether a patient can be prevented by Court Orders from entering not only a hospital or GP premises, but also a wider area around the premises. Such remedies are available both under the Protection from Harassment Act 1997 and the general jurisdiction of the Courts under the common law.

What constitutes harassment?

The *Protection from Harassment Act 1997* makes it an offence for a person to pursue a course of conduct 'which amounts to harassment of another'. In order to catch a wide variety of conduct, the Act intentionally does not define the term 'harassment'.

A breach of the legislation occurs when the person responsible for the course of conduct knows, or ought to know, that the conduct amounts to harassment of the other person. It is therefore not a defence for a person to claim, for example, that due to his mental state he was not aware that the conduct amounted to harassment.

In addition, the legislation makes it an offence for a person to conduct himself in a way that 'causes another to fear, on at least two occasions, that violence will be used against him' if the person responsible for that conduct knows or ought to know that his course of conduct would cause the other person to be in fear on those occasions.

What Orders can the Courts make?

Where a criminal Court finds a person guilty of an offence under the 1997 Act, it can make a Restraining Order prohibiting the person found liable of the offence from further conduct which amounts to harassment or will cause fear of violence, in order to protect the victim of the offence.

Such an Order, which might include a provision restraining the person guilty of the offence from entering a certain area, may have effect for a specified period or until the Court makes a further Order. If the accused breaches the terms of the Order, this in itself constitutes a criminal offence.

Which legal route is available?

A limitation of the *Protection from Harassment Act* is that it contemplates that the person who is involved in the harassing behaviour directs his actions towards specified individuals. Where a patient threatens or acts violently towards staff in a hospital or a GP practice, his behaviour may not be focused upon any specific individual but be of a more general nature. In these circumstances, if an injunction is to be obtained excluding the patient from the relevant premises an injunction will have to be sought via the common law.

If a healthcare provider is faced with a patient whose behaviour may give grounds for considering such legal proceedings, it is advisable that accurate records are kept of any such incident, together with details of the individual involved so that, if necessary, witness evidence can be sought for the purpose of a court application.

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Coroners' services

Modernising coroners' services and death certification

Last year a review of coroners' services and death certification was commissioned by the Home Office in the aftermath of the Shipman case, the Bristol Inquiry and the Alder Hey Inquiry. The Home Office issued a consultation paper 'Review of Coroners and Death Certification' and is now considering the submissions.

The consultation paper identifies a significant number of areas of concern in the present system of registering and inquiring into deaths. It states:

- the registration system and the inquiry system are too separate, and fail to focus on assessing patterns and trends in relation to deaths generally as well as inquiring into particular cases.
- there is a lack of understanding by the public of the system in general, and in particular as to when post-mortem examinations and inquests are needed
- the whole inquest process suffers from a lack of clarity and predictability
- doctors are insufficiently trained and monitored as to their role in death certification

The consultation paper proposes the setting up of a Medical Audit Service for each district to train, assess and monitor doctors in death certification, identify local mortality patterns, decide when post-mortem examinations should be carried out and inquests should be held, and provide independent medical advice at inquests.

The paper also proposes far-reaching changes to inquests, including:

- ending the exclusive role of the coroner and allowing judges to preside over inquests
- establishing a formal appeal structure to determine disputed questions of law and procedure, including whether an inquest should be held at all and whether a second inquest should be held
- altering, or perhaps abolishing entirely, inquest verdicts.

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RadcliffesLeBrasseur's inquest services

We have developed a specific service to advise clients on inquests, including meeting staff beforehand to brief them and explain the process. We attend inquests to represent our healthcare clients, and we provide the advocacy services ourselves – avoiding the need to instruct counsel.

Specialised lawyers in our Health Group also lecture frequently on inquests and their importance in relation to risk management programmes. We assist in training staff in statement writing and inquiry procedures.

If you require any further information regarding the issues mentioned in this bulletin, please contact info@rlb-law.com

Readers should take professional advice before taking any action based on this bulletin.