

Guidance on making referrals to the Independent Safeguarding Authority

Introduction

1. This guidance provides a general outline of the obligation for the GMC to refer information to the Independent Safeguarding Authority (ISA).
2. This guidance is a living document which will be revised periodically, including at the conclusion of the government review of the Vetting and Barring Scheme, which is to be conducted over the second half of 2010. It will also be reviewed in light of any bilateral agreement reached between ISA and the GMC.
3. This document outlines the two conditions which must be met before a referral to ISA must be made. The document provides a number of case studies and guiding principles for decision makers to apply when assessing each of the two conditions. Each case should be assessed individually against the referral criteria – this guidance is intended to ensure a level of consistency in decision making.
4. A separate scheme, overseen by Disclosure Scotland, has been established in Scotland commencing from February 2011. A separate guidance document has been prepared for referrals to Disclosure Scotland under the Scottish Scheme.

The Vetting and Barring Scheme

5. The Safeguarding Vulnerable Groups Act 2006 (the Act) and the Vetting and Barring Scheme were established as a result of the Bichard inquiry, which was commissioned following the deaths of Jessica Chapman and Holly Wells. The key focus of the legislation is to strengthen the way employers recruit people to work with children and vulnerable adults.
6. ISA is a non-departmental public body established under the Act, and is responsible for vetting all individuals who want to work or volunteer with vulnerable people. ISA operates across England, Wales and Northern Ireland.
7. The Scheme requires ISA to maintain two 'barred lists' – a 'children's list' and a 'vulnerable adults list,' and ISA has the power to place individuals on these lists where it deems the individual poses a safeguarding risk. Anyone appearing on one (or both) of these lists cannot work with children and/or vulnerable adults.

8. The three referral categories – autobar offences, Relevant Conduct and the Harm Test should be applied the same across England, Wales and Northern Ireland. That is, the same thresholds for harm and the future risk of harm apply across the three jurisdictions. However, the trigger points for considering referrals in Harm Test cases differ in England and Wales and in Northern Ireland.

Jurisdiction of the Scheme and application of this guidance document

9. The obligation to refer information to ISA covers cases where:
- a. The relevant facts of the case materialised in England, Wales or Northern Ireland;
 - b. If (a) cannot be applied, a case will originate from England, Wales or Northern Ireland if the doctor's registered address is in one of these three jurisdictions.

Application of the Scheme to the medical profession

10. The Scheme regulates a number of settings where the government has deemed that individuals may pose a high level of risk to vulnerable groups. The majority of these 'high risk' settings include those which offer frequent contact between individuals and children or vulnerable adults. Any form of healthcare, treatment or therapy is covered by the Scheme.

11. For the purposes of the Scheme, a child is a person who is under 18 years of age.

12. The Scheme describes 'vulnerable adults' as adults who receive any form of healthcare, including treatment, therapy, or palliative care of any description. In this regard, all patients are covered by the Scheme as 'vulnerable adults' or children.

13. Note that in June 2010 the Government announced a review into the vetting component of the Scheme, and this guidance will need to be reviewed and changes made where appropriate in due course.

Role of the GMC in the Scheme

14. While ISA has adjudicatory functions (to decide who is included on the lists) it has no investigatory powers. ISA's barring decisions rely on information acquired and referred by a range of other bodies and the public. The GMC and other healthcare regulators are required to comply with legal duties to refer information to ISA when two conditions, explained in this guidance document, are met.

15. ISA will only progress cases through its decision making process when it has sufficient evidence to suggest that the person poses a future risk of harm to vulnerable groups. ISA have advised that this should be reflected in the timing of referrals from the GMC and other healthcare regulators. ISA have specified that they wish to receive referrals from the GMC when we have made a registration decision however there may be exceptional circumstances where the risk is such

that an earlier referral may be desirable. Later parts of this document will provide further detail on the referral trigger points.

16. It is important to note that the remit of ISA is to remove those individuals who pose a safeguarding risk from working with children or vulnerable adults in any regulated settings (such as teaching, children's groups, coaching children's sporting teams etc). ISA does not have a role in regulating the professions or setting the standards for professional practice. ISA have indicated that they do not wish to receive any referrals where the matters are purely clinical in nature, or where action taken by the GMC is solely to maintain confidence in the profession. These issues are explored further in Parts Two and Three of this document.

17. Note that where the referral conditions are met, the GMC must make a referral to ISA regardless of whether we know that another body (such as the doctor's employer, the police or a relevant court) has already made a referral in relation to the doctor.

Regulated Activity

18. In addition to healthcare and primary care settings, Regulated Activity covers teaching, fostering, childcare, coaching children's sporting teams, providing transport services for children and vulnerable adults, care homes, supervision, advice and treatment.

19. Doctors involved in the treatment of patients are conducting Regulated Activity for the purposes of the Scheme.

20. For healthcare activities to be Regulated Activities, they must be undertaken 'frequently' (once a month or more), intensively (undertaken in 4 or more days in a 30 day period) or overnight (between 2:00am and 6:00am).

Controlled Activity

21. Controlled Activity covers support services in general health settings, the NHS or in schools, including cleaners, caretakers, shop workers, catering staff and receptionists. It is unlikely that doctors will be involved in Controlled Activity.

22. Similar to Regulated Activity, for an activity to be controlled, it must be undertaken 'frequently' (once a month or more) or in 2 or more days in a 30 day period. Activity can also be controlled if it gives a person an opportunity for:

- a. any form of contact with children (except in private arrangements) or
- b. access to the health records of children or vulnerable adults.

23. Given this, it is possible that, for example, a secretary at a private GP clinic could be engaged in Controlled Activity and thus covered by the Scheme. However, it is only under rare circumstances that we receive information which is about people other than doctors and raises safeguarding concerns.

Children

24. The Act defines any person under the age of 18 years as a child, meaning that any interactions with children are regulated for the purposes of the Scheme. For example, if a doctor physically assaults a child, regardless of whether the conduct happens as part of a Regulated or Controlled Activity (i.e. pursuant to the doctor/patient relationship) or in everyday life, the conduct is likely to result in a referral to ISA.

Vulnerable adults

25. The Act defines vulnerable adults broadly. The definition includes any person over the age of 18 who receives any form of healthcare including treatment, therapy or palliative care of any description. A person will also be vulnerable as a result of a number of scenarios that are quite distinct from the doctor-patient relationship, including those:

- a. in residential accommodation;
- b. in sheltered accommodation;
- c. in receipt of domiciliary care;
- d. under a criminal supervision order; or
- e. in lawful custody.

26. In the majority of the GMC's cases, the source of a person's vulnerability will arise from the doctor/patient relationship. However, decision makers should be alert to the possibility of the source of a person's vulnerability arising from one of the other scenarios listed above.

27. For example, we might receive an enquiry about a doctor who stole from his/her neighbour, who is in receipt of state-provided housing and is therefore a vulnerable adult. If the doctor did not know, or could not have reasonably been expected to know about the neighbour's vulnerability, it is unlikely that the doctor's actions raise safeguarding concerns (and thus a referral to ISA will not be warranted). However, if the doctor knew about the neighbour's vulnerability, and intentionally targeted the neighbour because of his/her vulnerability, safeguarding concerns are more likely to exist.

28. In cases where the source of the person's vulnerability arises from a scenario other than the doctor/patient relationship, the key to determining whether wider safeguarding concerns exist will depend on whether the doctor knew about the person's vulnerability (or ought reasonably to have known) and/or acted with the intention to exploit that vulnerability.

The referral conditions

Introduction

29. Before a referral to ISA needs to be made, decision makers must be satisfied that both of two conditions are met. They should be applied in succession – if the first condition is not met, there is no need to consider the second condition.

30. The first condition has three parts and as such can be met in three alternative ways. If the first part is not met, decision makers should move on to consider the second and third parts sequentially. If the first part is met, the decision maker need not consider the subsequent two parts.

The first condition

PART 1: AUTOBAR OFFENCES: where the GMC receives notice that a doctor has been convicted of, or cautioned in relation to an autobar or connected offence (see paragraphs 38–51 below); **or**

PART 2: RELEVANT CONDUCT: where the GMC ‘thinks’ that a doctor has engaged in Relevant Conduct (see paragraphs 52–71 below); **or**

PART 3: THE HARM TEST: where the GMC ‘thinks’ that a doctor poses a future risk of harm in relation to children or vulnerable adults (see paragraphs 72–88 below).

31. If the decision maker is satisfied that the doctor has committed an autobar offence, a referral to ISA can be made without the decision maker having to consider the second condition. In relation to autobar offences only, referrals can be made as soon as the decision maker holds evidence to suggest that the doctor has been cautioned in relation to, or convicted of an autobar or connected offence.

32. If the GMC decision maker decides that the second or third parts are met (the doctor has engaged in Relevant Conduct or satisfied the Harm Test) the decision maker must go on to consider the second condition (refer paragraph 85 for more detailed discussion, and for a summary of the second condition, see the box below).

The second condition

FIRST PART: The decision maker must be satisfied that the doctor was (in the past), is currently or may engage at some point in the future in Regulated or Controlled Activity: **and**

SECOND PART: The decision maker must be satisfied that ISA may bar the doctor because of the matters that resulted in the first condition being met.

33. Flow-charts, at Annex A, set out the referral conditions and the referral trigger points for each condition.

The first condition

34. The first condition can be met in three different ways. Firstly, decision makers need to consider whether an auto-bar offence has occurred. If an auto-bar offence has occurred, a referral to ISA can be made without considering the second condition. If an auto-bar offence has not occurred, decision makers must go on to consider whether Relevant Conduct or alternatively the Harm Test can be applied.

35. The next part of the guidance deals with the three alternative parts of the first condition, and later parts of the guidance cover the second condition.

First part: Auto-bar offences

36. The Act prescribes a list of serious criminal offences, the majority of which relate directly to children and vulnerable adults. The current list of auto-bar offences is contained at [Annex B](#). Most of the offences are sexual in nature, or involve violence against the person or property, fraud and forgery and offences involving some abuse of trust or authority.

37. Decision makers should note that the list of Auto-bar offences is categorised by jurisdiction — England and Wales auto-bar offences are grouped together (as they are made by the same statute) and Northern Ireland offences are listed separately, recognising the different titles of auto-bar offences in this jurisdiction. When deciding which category of offences to apply, decision makers should examine the jurisdiction in which the offence took place, rather than the doctor's place of work or ISA registration. This can be done by noting the jurisdiction of the court that convicted the doctor, or the municipality of the police service that issued the relevant caution.

38. Before the auto-bar 'part' of the first condition is met, decision makers will need to make sure that the doctor has, in fact, been convicted of or cautioned in relation to an auto-bar (or connected) offence.

39. The following types of activity are considered to be 'connected' to the commission of auto-bar offences and will give rise to a referral: a **caution** in relation to such an offence, **attempting** to commit, **conspiring** to commit, **inciting** another to commit, **aiding or abetting** in the commission of an offence, or **counselling** or **procuring** the commission of an auto-bar offence.

40. The vast majority of 'criminal conviction' cases received by the GMC involve a doctor being convicted of an offence, rather than an offence connected to a criminal offence. Although it will be rare for a doctor to be convicted of an offence in connection to an auto-bar offence, decision makers should be alert to the possibility of a connected offence having been committed.

41. If a doctor commits an auto-bar or connected offence, he or she will be automatically included in a barred list held by ISA. In relation to some offences, the doctor may make representations to ISA and seek to be removed from a barred list. This, however, should not be considered in making a referral to ISA. Decision makers simply need to be satisfied that there is sufficient evidence to suggest that

the doctor has been convicted of, or cautioned in relation to an autobar or connected offence.

Trigger point for considering a referral

42. The GMC must make a referral under the 'autobar' part of the first condition when we receive one of the following authoritative documents:

- a. **Notice of police caution** – does the police caution indicate that the doctor has been *cautioned in relation* to any of the autobar (or connected) offences at Annex B?
- b. **Notice of criminal conviction** – does the court notice indicate that the doctor has been *convicted* of any of the autobar (or connected) offences at Annex B?
- c. **Overseas determination** – does the determination indicate that the doctor has *been convicted of* or been *cautioned* in relation to a criminal offence in another jurisdiction, which if committed within the UK, would amount to an autobar (or connected) offence (see paragraph 47 for further information about overseas offences)?
- d. **Any other authoritative document** – in the absence of the above documents, do we have any other documents that provide evidence of a conviction? For example, a letter from police confirming details of the conviction.

43. It does not matter whether we received the document pursuant to a self referral made by a doctor, a referral from a trust, or whether it was obtained as part of a doctor's application for restoration of his/her registration. As soon as we receive one of these documents which indicates that an autobar offence has been committed an ISA referral must be made.

44. In most cases, the nature of the conviction or caution will be obvious – it will be a clear-cut autobar offence, or an offence other than an autobar.

45. However, in other cases, the wording of the relevant offence contained within the police caution or the notice of criminal conviction may be slightly different to the wording of the relevant autobar offence at Annex B. See Annex C for further guidance on interpreting police cautions and notices of criminal conviction in relation to autobar offences.

46. If a doctor has been cautioned in relation to or convicted of an autobar offence and the facts of the case do not appear to raise safeguarding concerns contact the ISA Referral Officer.

Overseas offences

47. It is important that decision makers consider the jurisdiction in which the offence took place (and thus where the conviction was made). The list of autobar

offences at Annex B covers offences in England, Wales and Northern Ireland. If we have information to suggest that a doctor has committed an offence in another jurisdiction (excluding Scotland), decision makers will need to consider whether, if the conduct which underpins the criminal conviction or caution was carried out in England, Wales or Northern Ireland, it would give rise to an auto-bar offence.

48. In most cases, the only reliable way to know if a doctor has been cautioned in relation to or convicted of an offence in another jurisdiction is through receipt of a determination made by an overseas regulator, which can contain details of convictions or cautions in relation to a criminal offence. While we expect these cases to be few (we receive less than 10 overseas determinations cases per annum), on receipt of such a case the decision maker will need to consider whether the referral conditions are met.

49. In some cases, this decision will be clear-cut. For example, a minor driving offence committed in New Zealand would not amount to an auto-bar offence if the conduct took place in England, Wales or Northern Ireland. Such cases clearly would not lead to a referral to ISA as the Act does not list minor driving offences as 'auto-bar' offences. In other cases more subjective judgement will be needed, for example, where the nature of the conviction or caution listed in the overseas determination is unclear or unknown. In these cases, decision makers should consult the ISA Referral Officer.

Second part: Relevant Conduct

50. If the auto-bar criteria are not satisfied, the Relevant Conduct criteria should be applied to the case.

51. The legislation defines Relevant Conduct in broad terms. By definition, for there to be Relevant Conduct, the doctor must have engaged in some kind of act or omission in the past which has caused actual harm directly in relation to children and or vulnerable adults, or exposed these groups to the risk of harm.

52. Relevant Conduct can be any act or omission on the part of the doctor that:

- a. Endangers a child or vulnerable adult or is likely to do so;
- b. If repeated against or in relation to a child or a vulnerable adult, would endanger such a child or vulnerable adult or would be likely to do so;
- c. Involves sexual material relating to children (including possession of such material);
- d. Involves any sexually explicit images (however produced and whether real or imaginary) depicting violence against human beings (including possession of such material), if it appears to ISA that the conduct is inappropriate; or
- e. Is of a sexual nature involving a child or vulnerable adult.

53. The legislation places some definition around the term 'endangerment'. It says that a person's conduct endangers a child or vulnerable adult if the person:

- a. Harms a vulnerable adult or child;
- b. Causes a vulnerable adult or child to be harmed;
- c. Places a vulnerable adult or child at risk of harm;
- d. Attempts to harm a vulnerable adult or child; or
- e. Incites another to harm a vulnerable adult or child.

54. Many different actions and omissions may cause actual or potential harm. What constitutes harm within the Act is deliberately left unspoken. There are a few points of guidance to consider when determining whether harm (or the risk of harm) has been caused:

- a. The dictionary definition of harm includes hurt, injury, damage, loss, pain, trouble and distress.
- b. Case law indicates that harm goes beyond external or internal bodily injury (DPP v Smith [2006] EWHC 94 (Admin) and R v Chan-Fook [1994] 1 WLR 689 at 695).
- c. Harm can be physical or mental, it can be caused by action or inaction and it can involve a single episode or a sustained course of conduct.
- d. The detriment, damage, loss, pain, distress danger etc caused by the action or inaction must be real – that is, more than just trivial or fleeting.

55. The ISA guidance on referrals lists the following types of harm applicable to vulnerable adults, and (a) through to (d) also apply to children:

- a. **Emotional/psychological** – such as threatening behavior, bullying, intimidation, harassment, grooming, deliberate isolation and deprivation causing severe and persistent mental anguish or adverse effects on a child's emotional development.
- b. **Physical** – such as hitting, pushing, shaking, failure to arrange medical treatment or medication, under/over-prescribing and inappropriate restraint resulting in pain, injury or discomfort.
- c. **Sexual** – such as any inappropriate touching or coercion to participate in sexual acts, even without contact (including sexualised messages), and any form of sexual activity with a child under the age of consent.
- d. **Neglect** – such as failure to identify/meet basic physical, psychological or care needs, failure to protect from danger, ignoring a patient's or a

resident's requests, poor hygiene or untreated weight loss likely to result in serious impairment of health or development.

e. **Verbal** – such as demeaning, disrespectful, humiliating, racist/sexist, abusive comments causing distress.

f. **Financial** – such as misuse of money, valuables or property, theft, exploitation and pressure regarding wills or inheritance.

56. From this it is clear that what constitutes harm is subjective, and greatly dependent on the context of the action or omission which caused the harm or exposed the vulnerable person to harm.

57. The seriousness of the harm (or risk of harm) need not be considered extensively at this stage. Rather, GMC decision makers must simply consider whether the doctor's past conduct has caused actual harm to a child or adult patient; placed either at risk of endangerment; has not, on this occasion caused actual harm, but if repeated would be likely to do so in the future; or involves possession of 'inappropriate sexual material'. Conduct involving inappropriate sexual material is defined by the legislation to include the following:

a. Any conduct that involves sexual material relating to children, including possession of such material;

b. Conduct involving sexually explicit images depicting violence against human beings, including possession of such material if it appears to ISA that the conduct is inappropriate; and

c. Conduct of a sexual nature involving a child or vulnerable adult.

58. It is likely that conduct involving inappropriate sexual material will involve an autobar offence. However, on occasion we receive employer referrals which indicate that a doctor has accessed inappropriate sexual material using employer resources. If this is the case, and a criminal case has not been progressed, GMC decision makers will need to consider whether the doctor's actions meet the Relevant Conduct criteria.

Harm relating directly to children and/or vulnerable adults

59. If a doctor's conduct does not harm a child or vulnerable adult, or place such a person at risk of harm, the doctor's actions will not amount to Relevant Conduct. For instance, in the vast majority of cases the Relevant Conduct 'part' of the first condition will generally not be met where a doctor assaults another person in the street.

60. However, in cases outside the doctor/patient relationship, the person who is harmed by the doctor might be a vulnerable adult by virtue of some other setting (refer paragraph 23 above for discussion on vulnerability). In these cases, where a GMC registrant has harmed a person who is vulnerable by virtue of some other setting, it is likely that Relevant Conduct will have occurred. In these cases the GMC

decision maker must go on to consider whether the second condition is met, and at this stage decision makers can consider whether the doctor knew, or ought reasonably to have known about the person's vulnerability at the time the conduct took place.

61. The vast majority of our drink driving and drug possession charges/convictions/cautions will not amount to Relevant Conduct as the doctor's actions indicate generally risky behaviour rather than directly exposing children and/or vulnerable adults to harm or the risk of harm. Where a doctor is charged with driving under the influence of alcohol or possession of a banned substance and, pursuant to personal arrangements, has a child (or children) or a vulnerable adult in his or her immediate care at the time of the arrest, Relevant Conduct will not have occurred as the matter is private and does not raise safeguarding concerns.

62. The Relevant Conduct 'part' of the first condition will be met, however, if at the time of arrest the doctor was driving a bus load of children to a sports day, or taking a group of elderly patients to the shopping centre in a hospice bus. In these cases the decision maker should proceed to consider the second condition.

63. A further list of case studies is contained at [Annex D](#).

64. At this stage of the process, it appears that the Scheme captures most of the GMC's cases, including those which relate to the doctor's clinical competence. However, the second condition (described at Part Three of this document) provides a mechanism for 'filtering out' the less serious cases, and matters exclusively related to clinical competence.

65. Decision makers should note that Relevant Conduct applies only to conduct which occurs in England, Wales or Northern Ireland. Unlike 'autobar offences' Relevant Conduct does not include any conduct that occurs outside these jurisdictions. However, the 'exceptional application' of the Harm Test may be considered in cases where a doctor has engaged in conduct in a jurisdiction other than England, Wales or Northern Ireland but the conduct would have been Relevant Conduct had it occurred in one of the three jurisdictions covered by the Scheme. If any of these cases arise, decision makers should consider the 'legal technicality' exception to the Harm Test (refer paragraph 81 below).

Relevant Conduct: trigger points for considering referrals

66. A case which meets the Relevant Conduct criteria must be referred when:

- a. Case Examiners issue a warning, agree undertakings or decide to refuse an application for restoration;
- b. A fitness to practise panel issues a warning, imposes conditions, suspends or erases a doctor or refuses an application for restoration; and
- c. An Assistant Registrar of the Registration and Resources directorate refuses to register a doctor.

67. Specific guidance covering each of these decision points will be issued in conjunction with this general guidance document.

68. Decision makers generally need not consider the Relevant Conduct criteria when:

- a. Case Examiners decide that the Realistic Prospect test is met and refer the case forward for a fitness to practise panel hearing; or
- b. A case is referred to an Interim Orders hearing or where an IOP makes a decision to suspend the doctor or impose conditions on the doctor's registration.

69. In general, ISA wish to receive referrals once the case has been concluded and a decision has been made, on the balance of probabilities that the doctor did in fact engage in Relevant Conduct. However, there may be exceptional circumstances where the risk is such that an earlier referral may be desirable.

Third part: The Harm Test

70. The Harm Test should only be applied to cases which do not meet the autobar offence or Relevant Conduct criteria. In general, the Harm Test is prospective, meaning it cannot be met in cases where there has been past conduct (act or omission). Rather, the Harm Test can be met where there has been no act or omission but a doctor has communicated something about their thoughts, beliefs or attitudes to indicate that they pose a future risk of harm directly in relation to children and vulnerable adults (usually patients). However, the Harm Test can be applied to 'conduct cases' in exceptional circumstances, (see paragraph 81 below).

71. At times it may be difficult to distinguish between the application of the Relevant Conduct provisions and the application of the Harm Test. The following points may be useful in guiding decision makers:

- a. The Harm Test need only be applied in cases where a doctor has not done anything in the past (including actions or omissions) to cause actual harm or the risk of harm (i.e. endangerment). There are only two situations where the Harm Test may be applied to 'conduct cases' and these are outlined at paragraph 81 below.
- b. Once a doctor has done something (or in the case of an omission has failed to do something that he/she should have done) and the result is actual harm to a child or vulnerable adult or exposure of such a person to risk of harm (i.e. endangerment), then the Relevant Conduct provisions need to be applied.
- c. For clarity, verbalising thoughts, beliefs or attitudes is not considered to be an act by the doctor.

72. To give an example, the Harm Test would be met in situations where a doctor working on a paediatric ward of a hospital tells a colleague that he/she is sexually

attracted to children, but has not yet acted on those thoughts. It would also be met where a doctor tells his/her therapist, for example that he/she has a desire to cause harm to, for instance, elderly patients, but has not yet actually done so. A referral to ISA is, of course, subject to one of the Harm Test 'referral trigger points' being met (refer paragraph 85 below).

73. In both examples GMC decision makers can assume the autobar provisions have not been met as the doctor has not been convicted of, or cautioned in relation to an autobar offence. Further, the Relevant Conduct part of the first condition is not met as there has not been past conduct (act or omission) that has caused direct endangerment to a child or vulnerable adult (patient) or the risk of endangerment to these groups. However, the doctor's state of mind indicates that he/she poses a future risk of harm to children and vulnerable adults (patients).

74. The important factor in these cases is that the doctor has not yet done anything to cause actual harm, or to place children or vulnerable adults at risk of harm (i.e. the doctor has not yet engaged in risky behaviour) but he or she may do so in the future. The role of the Harm Test is to identify these cases and to allow ISA to consider taking action where it deems safeguarding concerns exist.

75. We consider that these 'harmful thoughts' cases will come to light only in very rare circumstances. Nonetheless, the legislation requires us to make referrals to ISA when they arise.

Cases involving a general risk of harm

76. The Harm Test will not usually apply in cases where the doctor's expression of his/her thoughts, attitudes or beliefs indicates merely a general risk of harm rather than a specific risk in relation to children and vulnerable adults. For instance, a doctor may express, publicly or to a colleague in general conversation that 'the management should be taken out and shot'. The expression of a general belief such as this will not indicate that the doctor poses a safeguarding risk in relation to children or vulnerable adults.

77. In the examples provided in paragraph 74, the Harm Test is likely to be met as the case involves a clear risk directly in relation to children.

78. Generally, factors GMC decision makers can consider in making a decision about whether the Harm Test applies include:

- a. What specifically is the person deemed to be at risk of doing in the future? How does this link to harm or risk of harm to a child or vulnerable adult?
- b. What are the chances of the behaviour which underpins the 'harmful thoughts' actually materialising?
- c. What is the likely level of harm if it does? Is it more than trivial or fleeting?

Exceptional application of the Harm Test

79. On an exceptional basis, there are only two circumstances where cases involving conduct should be referred to ISA under the Harm Test rather than the Relevant Conduct criteria. These are:

- a. In Relevant Conduct cases, where there is an undue delay in the GMC's fitness to practise process (i.e. in concluding the case) and the GMC believes the person poses a future risk to children or vulnerable adults such that the ISA may bar the person; or
- b. A case where there has been an allegation of Relevant Conduct but for some technical reason the Relevant Conduct criteria are not met and the GMC believes the person poses a future risk to children or vulnerable adults such that the ISA may bar the person.

80. Although these cases are conduct based, they are to be considered as part of the Harm Test, and accordingly, the trigger points for referring these exceptional cases under the Harm Test will be the same as the ordinary application of the Harm Test (i.e. cases where there has not been past conduct but something has been verbalised which indicates that the doctor poses a future risk of harm). The general trigger points for the Harm Test in England and Wales are set out below. Discussion on the application of these trigger points to exceptional Harm Test cases is at paragraphs 85–88.

81. The GMC aims to conclude 90 per cent of its fitness to practise cases within 15 months of the enquiry being received. For the purposes of the exceptional application of the Harm Test, a case will be unduly delayed when 24 months have lapsed since the date the case was opened and the case is yet to be finalised within the fitness to practise process. Note that referrals should not be 'automatically made' in cases involving undue delay. In 'undue delay' cases, decision makers should consider:

- a. Whether there is evidence to suggest that the doctor poses a future risk of harm directly in relation to children or vulnerable adults; and
- b. Whether both parts of the second condition are met.

82. We may also hold information from a foreign court, police service or overseas regulator that suggests that a doctor who is registered with the GMC has engaged in conduct that may have been Relevant Conduct had it occurred in England, Wales or Northern Ireland.

83. These cases cannot be referred to ISA under the Relevant Conduct provisions as the Scheme only covers conduct occurring in England, Wales and Northern Ireland. However, in these rare cases decision makers should consider making a referral to ISA under the exceptional application of the Harm Test. Before this, the decision maker should consider:

- a. Whether there is evidence to suggest that the doctor poses a future risk of harm directly in relation to children or vulnerable adults; and

- b. Whether both parts of the second condition are met.

The Harm Test: Trigger points for considering referrals in England, Wales and Northern Ireland cases

84. Decision makers should note that the Harm Test has different trigger points in England and Wales than in Northern Ireland. In England and Wales, the Harm Test can only generally be met when One of the following outcomes is reached:

- a. Case Examiners issue a warning, agree undertakings or refuse an application for restoration;
- b. FTP panel issues a warning, imposes conditions, suspends or erases a doctor or refuses an application for restoration; or
- c. An Assistant Registrar decides to refuse an application for registration; or where

85. Once the trigger point is met for the Harm Test, decision makers must go on to consider the second condition.

86. At that stage, cases which do not meet the threshold for seriousness would not need to be referred to ISA. This is discussed further in later parts of this document.

The second condition

87. The second condition need only be applied in cases where the GMC decision maker is satisfied that there has been Relevant Conduct or that the Harm Test is met.

88. Decision makers should note that in Northern Ireland, when applying the Harm Test, the second part of the condition need not be applied because the short-cut provisions override it.

First part: Was, is or may engage in Regulated or Controlled Activity

89. The first part of the second condition requires the GMC to consider whether the doctor:

- a. Was engaged in Regulated Activity at the time the Relevant Conduct occurred or the circumstances that gave rise to the Harm Test being satisfied arose; and/or
- b. Is engaged in Regulated or Controlled Activity at the time the second condition is being considered by the GMC decision maker; and/or
- c. May engage, in the future, in Regulated or Controlled Activity.

90. A doctor will be engaged in Regulated and Controlled Activity if he/she has contact with patients (children or adult) in any primary care or healthcare setting,

regardless of whether the care is delivered through the NHS or other private arrangements.

91. It is likely that the vast majority of the GMC's cases will satisfy the first part of the second condition. In particular, most doctors referred to the GMC are likely to have been involved in Regulated Activity at the time that the Relevant Conduct occurred or the circumstances that gave rise to the Harm Test being satisfied arose.

92. If a doctor was not engaged in Regulated or Controlled Activity at the time the 'incident' took place, decision makers must consider whether the doctor is engaged in Regulated or Controlled Activity at the time the second condition is being considered by the GMC. Decision makers can assume that a doctor is engaged in Regulated or Controlled Activity if the doctor's Siebel record indicates that he/she is currently employed as a doctor, or in more rare circumstances, where we hold information to suggest that the doctor is engaged in another type of Regulated or Controlled Activity (refer to paragraphs 20–25 above for a description of Regulated and Controlled Activity)

93. If a doctor was not engaged in Regulated or Controlled Activity at the time the 'incident' took place, and is not currently engaged in Regulated or Controlled Activity, GMC decision makers should consider whether we hold information that suggests that the doctor may engage in such activities in the future.

94. Note that doctors may engage in forms of Regulated or Controlled Activity for which he/she does not need to be a registered doctor. For example, this would be met if we held specific information to the effect that the doctor also manages a care home (or plans to do so) or is a scout master or coach of a children's sports team. We are not required to investigate to obtain this information.

95. It is likely that doctors will be engaged in Regulated or Controlled Activity at the time the 'incident' took place. In practice, it is likely that the only situation where decision makers will be required to consider whether a doctor may engage in Regulated or Controlled Activity in the future is where a doctor has committed an autobar offence in a jurisdiction other than England, Wales or Northern Ireland (refer to paragraphs 120–123) or where the Harm Test has been applied on an exceptional basis because of conduct that has occurred in another jurisdiction which has given rise to a future risk of harm to children and/or vulnerable adults (refer to paragraph 124). This is because in these two situations the doctor in question is unlikely to have been engaged in Regulated or Controlled Activity at the time of the incident, nor is the doctor likely to be presently engaged in such activity, and thus the only remaining option to consider is whether the doctor may engage in Regulated or Controlled Activity in the future.

Second part: May ISA bar the doctor?

96. The second part of the second condition requires the GMC to think about whether ISA may consider it appropriate to bar the doctor because of the circumstances in which we think the first condition is met. The second part of the second condition will only be met where the decision maker decides that ISA may bar the doctor because of his/her conduct or circumstances which gave rise to the relevant conduct criteria or the Harm Test being met.

97. A set of guiding principles for considering the second part of the second condition are set out below, and a list of cases are attached at Annex D. The key guiding principles are also explained hereafter. It is important to note that each case must be considered individually using the guiding principles. If you have any concerns about whether the may bar test is met, you should contact the ISA Referral Officer.

Guiding principles on the 'may bar' test

98. The may bar test will not be met in cases where the purpose of GMC action is solely to maintain confidence in the profession.

99. The may bar test will not be met in cases solely concerning professional competence. In such cases, there will not be wider safeguarding issues for vulnerable groups as the action taken by the regulator will remove any risk of harm. A referral to ISA will not be required.

100. The may bar test will be met where 'non-professional' safeguarding concerns for vulnerable groups are present (such as sexual or violent behaviour) or where the individual may be unsuitable to work with children or vulnerable adults in the future because they have demonstrated such a 'callous disregard' for procedure that if repeated outside a professional setting would put children or vulnerable adults at risk of harm.

101. A callous disregard for procedure can be evidenced through a pattern of behaviour or a one-off incident. For a callous disregard for procedure to demonstrate wider safeguarding risks, it must be serious and deliberate or reckless.

102. The may bar test will be met in situations where the doctor has abused his or her position of trust to harm children or vulnerable adults. This can include the various types of endangerment listed at paragraphs 51–53 above. In particular, if a doctor defrauds a patient, the may bar test will be met (note, however, if the doctor defrauds his/her employer for example, there will be no Relevant Conduct as the doctor's behaviour indicates a general risk rather than wider safeguarding concerns. In these cases, the may bar test need not be considered).

103. The may bar test will not generally be met as a result of risks taken within private settings, unless it was established that the doctor somehow intended to cause harm or the risk of harm to a child or vulnerable adult. For example, if a doctor is charged with drink driving, or possession of banned substance and has a relative, neighbour or friend with him/her at the time of the arrest, and that person happens to be a child or vulnerable adult, the may bar test will generally not be met as the arrangements are private. The may bar test is more likely to be met if the doctor is taking responsibility for children or vulnerable adults at the time of arrest in a more formal setting (i.e. driving a bus of scouts or elderly people) as the doctor's behaviour indicates wider safeguarding concerns in relation to vulnerable groups.

104. Where a doctor assaults a person, for example at a football match and the person turns out to be a vulnerable adult, although Relevant Conduct has occurred

whether the may bar test is met will depend on the doctor's state of mind at the time of the assault.

105. If the doctor knew about the person's vulnerability, or ought reasonably to have known (because, for instance of a visible physical disability), it is likely that the may bar test will be met as the doctor's behaviour raises wider safeguarding concerns.

106. If the doctor did not know that the person was vulnerable, or could not reasonably be expected to have known about the vulnerability, it is unlikely that the may bar test will be met. For instance, if the person was subject to a criminal supervision order, it is reasonable for GMC decision makers to assume that the doctor would not have known about the person's vulnerability (unless specific information suggests otherwise) and thus the may bar test will not be met as the doctor's actions are generally risky, rather than posing wider safeguarding concerns in relation to vulnerable people.

107. The may bar test is unlikely to be met in cases involving low-level or trivial harm. For example, where a doctor makes an insensitive remark, or displays low-level rudeness or sarcasm towards a patient. Any risk arising from such cases will not be sufficiently serious to raise safeguarding concerns. However, the may bar test may be met if a doctor engages in serious or persistent verbal abuse of a patient – such action would demonstrate a wider safeguarding risk such that ISA may bar the doctor from working with these groups.

108. False reporting could give rise to a referral if the false report is in relation to a safeguarding matter, for instance, if there is an incident in the workplace involving Relevant Conduct (i.e. sexual harassment of a patient) and the doctor intentionally made a false report (for instance, to cover up the harassment). These circumstances (although rare) demonstrate behaviour that, if repeated, would be likely to create a safeguarding risk.

109. False reporting without intent to mislead or false reporting where the report is not related to a safeguarding matter would not trigger a referral to the ISA as the actions of the doctor (who gave the false report) do not create a safeguarding risk.

110. Similarly, in the majority of cases, poor record keeping skills and lying on a CV are professional matters and in most cases action taken by the GMC will remove the risk of harm to vulnerable groups.

111. A case where a doctor has lied on his/her CV might exceptionally raise wider safeguarding concerns, for instance, if it was proven that a doctor lied on his/her CV to gain employment with the aim of taking advantage of vulnerable people. An example of this might be where a doctor lied on his/her CV to gain work in paediatrics specifically to exploit children. Such cases will be rare and the doctor's intentions will be difficult to prove, but decision makers should remain alert as to the possibility of such cases. Note that if intent to cause harm cannot be proven, it may be the case that a referral will be triggered by some other kind of safeguarding issue that has materialised (i.e. theft from patients, sexual abuse of patients).

112. Intoxication within the workplace raises safeguarding risks in relation to children and vulnerable adults. These risks cannot be mitigated solely by action taken by the GMC and would meet the may bar test. For clarity, intoxication within the workplace includes consumption at work and arriving at work intoxicated.

113. If a doctor holds a purely academic or research role, and does not work with patients, intoxication within the workplace will generally not give rise to safeguarding concerns as there is no direct risk in relation to children and/or vulnerable adults. Similarly, substance abuse outside the workplace indicates a general risk of harm rather than placing children and/or vulnerable adults at a direct risk of harm and therefore would not meet the may bar test.

114. Affective disorders in and of themselves would not satisfy the referral criteria, but behaviour caused by an affective disorder could do so. If an affective disorder causes a doctor to endanger a child or vulnerable adult (or cause risk of endangerment) or satisfy the Harm Test, then the may bar criteria would need to be considered on the grounds of the risk posed by the doctor's behaviour. For instance, if a doctor had an affective disorder which caused him/her to physically assault a patient, the decision maker would need to assess whether the doctor poses a risk such that ISA may bar the doctor from working with children and or vulnerable adults.

General points

115. This part of the guidance is intended to give general guidance on various points of the legislation and the operation of the Scheme, as well as the interaction between the Scottish Protection of Vulnerable Groups (PVG) Scheme and the Vetting and Barring Scheme in England, Wales and Northern Ireland.

Cross border protocol

116. The PVG Scheme operates in Scotland.

117. This Scheme is established under separate legislation and requires a separate process for making referrals to Disclosure Scotland, the body responsible for making barring decisions in Scotland. Separate guidance has been issued covering the GMC's referral power in relation to this scheme.

118. If a doctor is barred under the England, Wales and Northern Ireland Scheme, he/she will be automatically barred in Scotland, and vice versa. This means that, despite there being two separate schemes, GMC decision makers will not need to make dual referrals to ISA and Disclosure Scotland. The following principles should be applied:

Relevant Conduct and the Scottish PVG Scheme referral grounds

119. In cases involving Relevant Conduct (or in Scotland, the referral grounds being met), decision makers should look at the place in which the ‘conduct’ took place.

120. For instance, if the conduct took place in England, Wales or Northern Ireland, refer to ISA. If the conduct took place in Scotland, refer the matter to Disclosure Scotland.

The Harm Test

121. All Harm Test cases should be referred to ISA. There is no equivalent of the Harm Test in the Scottish PVG Scheme.

Bundling ‘Prescribed Information’ for referral to ISA

122. The legislation gives a broad definition of ‘Prescribed Information’ and it does not require us to collect any new information or documents for the purposes of making referrals to ISA. Rather, the Act requires us to share information which is in our possession as a result of our day-to-day business.

123. The scope of our legal duty to pass on pre-existing information to ISA is wide. It applies to “any prescribed information ... relating to” the doctor in question. This will include basic information which is used to identify the doctor, including name, last known address, date of birth, gender, GMC registration number, PVG Scheme registration number and the doctor’s National Insurance Number.

124. Broadly speaking, we will also be required to provide ISA with any information in our possession which is relevant to ISA’s barring decision, and this covers the following documents:

Allegation (complaint)	Performance assessments
Rule 7 letter	Victims’ medical records
Doctor’s response to the allegation and R7 letter	Charges, including heads of charge
Employer comments	References and testimonials
Expert reports	Decisions letters and IOP/Panel determinations
Health reports	Full disciplinary record
FTP Panel hearing minutes	

125. In situations where a referral has not already been made, or where we are unsure about whether a referral has been made, we will need to ensure that we provide ISA with all of the prescribed information that we hold in relation to the relevant doctor. To do this, decision makers should ensure that the hardcopy bundle includes all of the information, listed above, at the time the referral is being made.

126. We are not required to generate any new information when making a referral to ISA. In particular, we do not need to extract details from any of the abovementioned documents to draw ISA’s attention to the details of the type of regulated work that

the doctor was undertaking at the time the incident took place (for example). ISA can deduce this information from the documents we provide as part of the referral.

127. We should not provide ISA with any precedent used as part of the Fitness to Practise Panel hearing which led to the doctor's erasure – it is unlikely that this is relevant to ISA's consideration of the relevant doctor's case.

128. In some cases, we will have collected sensitive Family Court documents as part of our investigation process. You should **not refer any Family Court documents to ISA** as part of the bundle. If we hold Family Court documents as part of our investigation, the covering letter to ISA should state that we hold restricted Family Court information which may be relevant to the ISA barring decision, and ISA should contact us for further information (refer to paragraph 138 below). You should alert GMC Legal to such cases.

Completing and posting the hardcopy referral form

129. You will need to complete the referral form, which is available on the ISA website at <http://www.isa-gov.org.uk/default.aspx?page=379>, and attach all hardcopy Prescribed Information to the form.

130. Staff completing the referral form should note that the referral form is a generic form prepared with all referring bodies in mind. We are only required to complete the fields of the form where the requested information is readily available to the GMC – i.e. from our investigation process. Any sections of the form which are irrelevant to the GMC, such as employment history, should include the words 'not applicable,' or simply be left blank.

131. The primary contact officer on the form should be the ISA Referral Officer. Part 6 of the form requires us to sign a declaration in relation to the referral; this must be done by the ISA Referral Officer. The form should list the GMC's 'relation to the person being referred' as a 'Keeper of a Relevant Register under section 41(7) of the Safeguarding Vulnerable Groups Act 2006 and article 43 of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007'.

132. Part 3 of the form requires the author to give extensive written information about the referral. To complete this part of the form, the author should use the first 'box' to state the grounds for making the referral – whether it is triggered by an autobar offence, Relevant Conduct or Harm Test. You should also give a single sentence description of the case. You need not complete the remainder of Part 3; this information is provided within the referral bundle which we will provide ISA as part of completing the referral.

133. Part 5 of the form asks for the details of the referring party. The referring party, in all cases should be listed as the GMC, in our role as a 'Keeper of a Register' under section 41 of the Safeguarding Vulnerable Groups Act 2006.

134. The person who completed the ISA referral form will also need to sign a covering letter to ISA, which identifies the doctor being referred and provides a list of

the documents attached as part of the referral bundle. A copy of the ISA referral cover letter is at Annex E.

135. If the relevant case includes restricted Family Court documents, the covering letter to ISA should include the following paragraph:

'The abovementioned case includes documents which the GMC has obtained from [insert name of court] under an order made by that court. While these documents may be material to the Authority's decision making process, the GMC is not legally entitled to share the documents outside the terms of the order in which the documents were obtained. Should the Authority wish to have sight of these documents, please contact the GMC officer listed below'.

136. The hardcopy referral form, at page 13, should also give an indication that we hold sensitive information.

137. The covering letter and bundle should be double-enveloped and posted to the following address:

Independent Safeguarding Authority
PO Box 181
DARLINGTON
DL1 9FA

138. Finally, the signed referral form, bundle and covering letter should be scanned and added to SIEBEL. The bundle should be presented in chronological order, indexed and converted into a PDF document.

139. Once a doctor has been referred to ISA, an alert needs to be placed on the doctor's SIEBEL registration record. The relevant alert is titled 'Dr has been referred to ISA'. The alert will also state 'This information is not to be disclosed to third parties'. Separate guidance on ISA referrals and barring decisions has been circulated to GMC Legal, legal assessors and panellists.

Notifying the relevant doctor

140. Our policy is to notify each doctor that we refer to ISA that the referral has been made, and this will generally be done through a standard information letter. A copy of the standard letter is at Annex F.

141. If a doctor has health concerns, the letter at Annex G should be used. If we are unsure of the accuracy of the doctor's last known address, the letter at Annex H, which is drafted in more general terms than the other doctor notification letters, should be used

ISA requests for information

142. On occasion, ISA may exercise their power under s42 of the SVG Act (or article 44 of the Northern Ireland Order) to request that we provide them with information

about a doctor that they are considering placing on a barred list. Before we comply with such a request, we must be certain that the request is being made under s42. If ISA's letter does not quote s42, or quotes a provision other than s42, we should respond to ISA's letter asking them to clarify under which provision they are making the request.

143. In general, if the incoming ISA letter lists the appropriate provision and the person they have requested prescribed information in relation to is listed on the List of Registered Medical Practitioners, we should provide the prescribed information that we hold in relation to the doctor (note earlier principles around provision of Family Court information also apply to ISA requests for information, which should not be sent to ISA).

144. Where we provide information to ISA pursuant to a request made under s42 of the Act or article 44 of the Northern Ireland Order, we should advise the doctor (unless we have already referred the matter to ISA, in which case we do not need to write to the doctor a second time). Either of the letters at Annexes F, G or H can be used to advise the doctor, depending on which standard letter is most appropriate (although note that some adaptations will need to be made to reflect the fact that we are complying with a s42 request rather than initiating a referral under s41 of the Act or article 43 of the Order).

145. If decision makers have any concerns about an ISA request for information, contact the ISA Referral Officer.

Follow-up questions from ISA or doctors

146. In some cases, particularly those involving Relevant Conduct or the Harm Test, the doctor who has been referred to ISA may contact the GMC with a request that we provide him/her with the bundle that we provided to ISA in making the referral.

147. In general, there will be no issues with providing this information to the doctor. ISA have advised that their decision making process will not be undermined if we disclose the information to the referred doctor.

148. If a doctor requests that the GMC provide him/her with information about the doctor's referral to ISA, the disclosure request should be forwarded to the Information Access Team, who will handle the request under the relevant legislation. Any response put together by the Information Access Team should be recorded on Siebel.

Annex A – Flow chart which illustrates the two referral conditions

Annex B – List of Autobar offences

Annex C – Autobar guidance

Annex D – List of case studies

Annex E – ISA referral cover letter

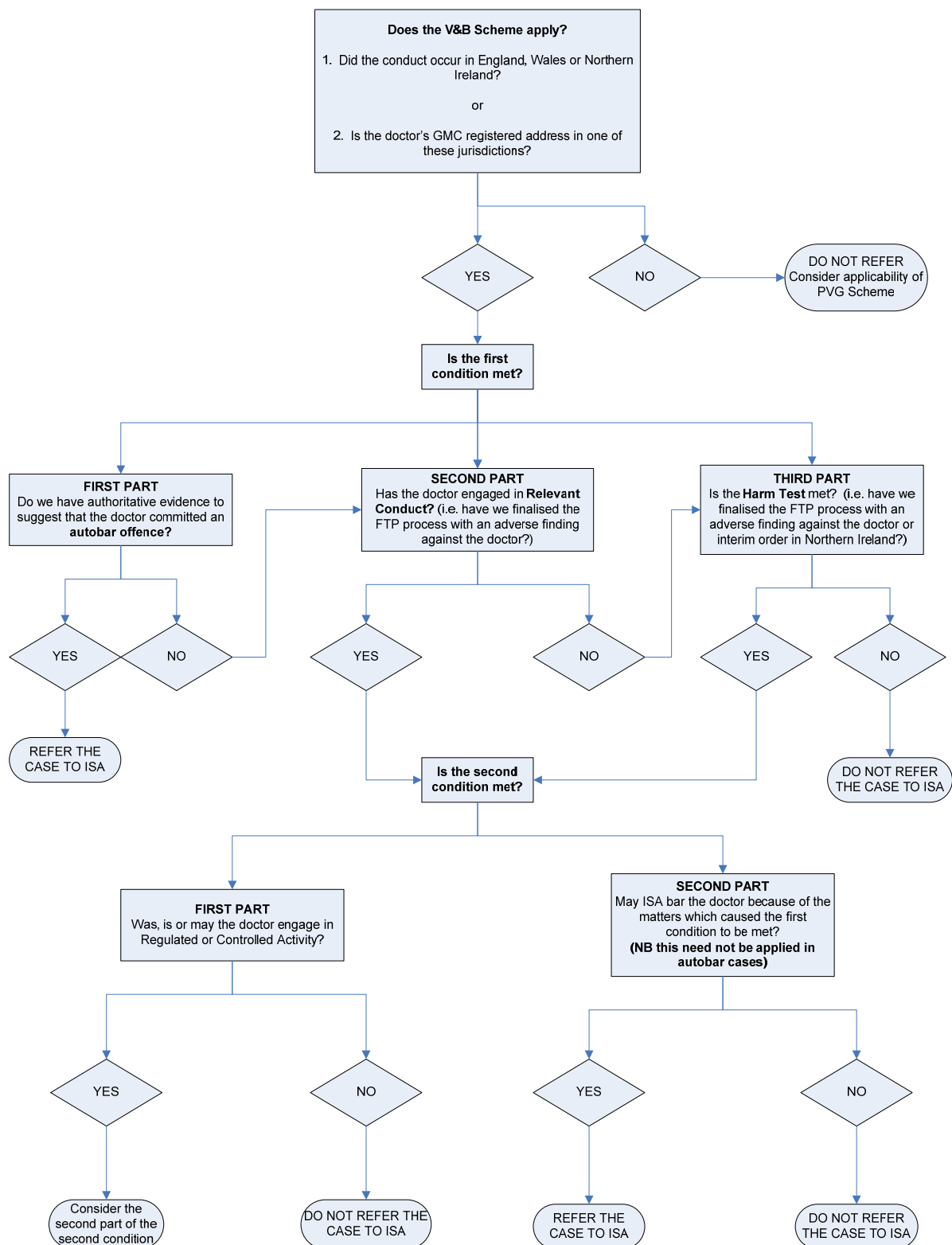
Annex F – Standard doctor information letter

Annex G – Doctor information letter (health concerns)

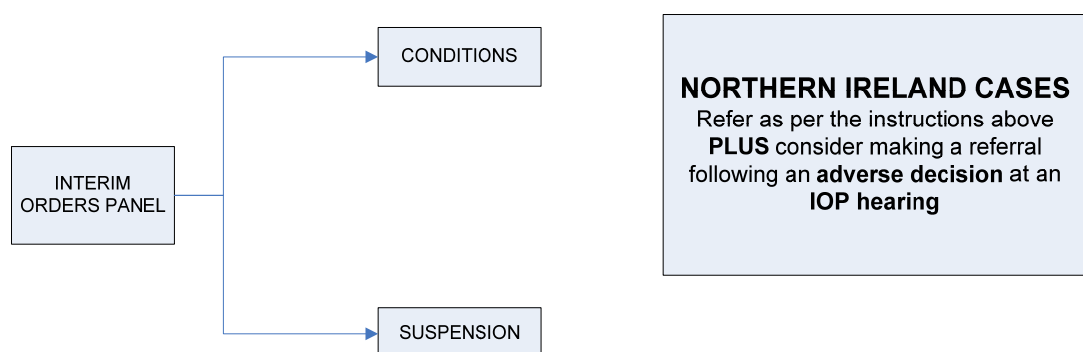
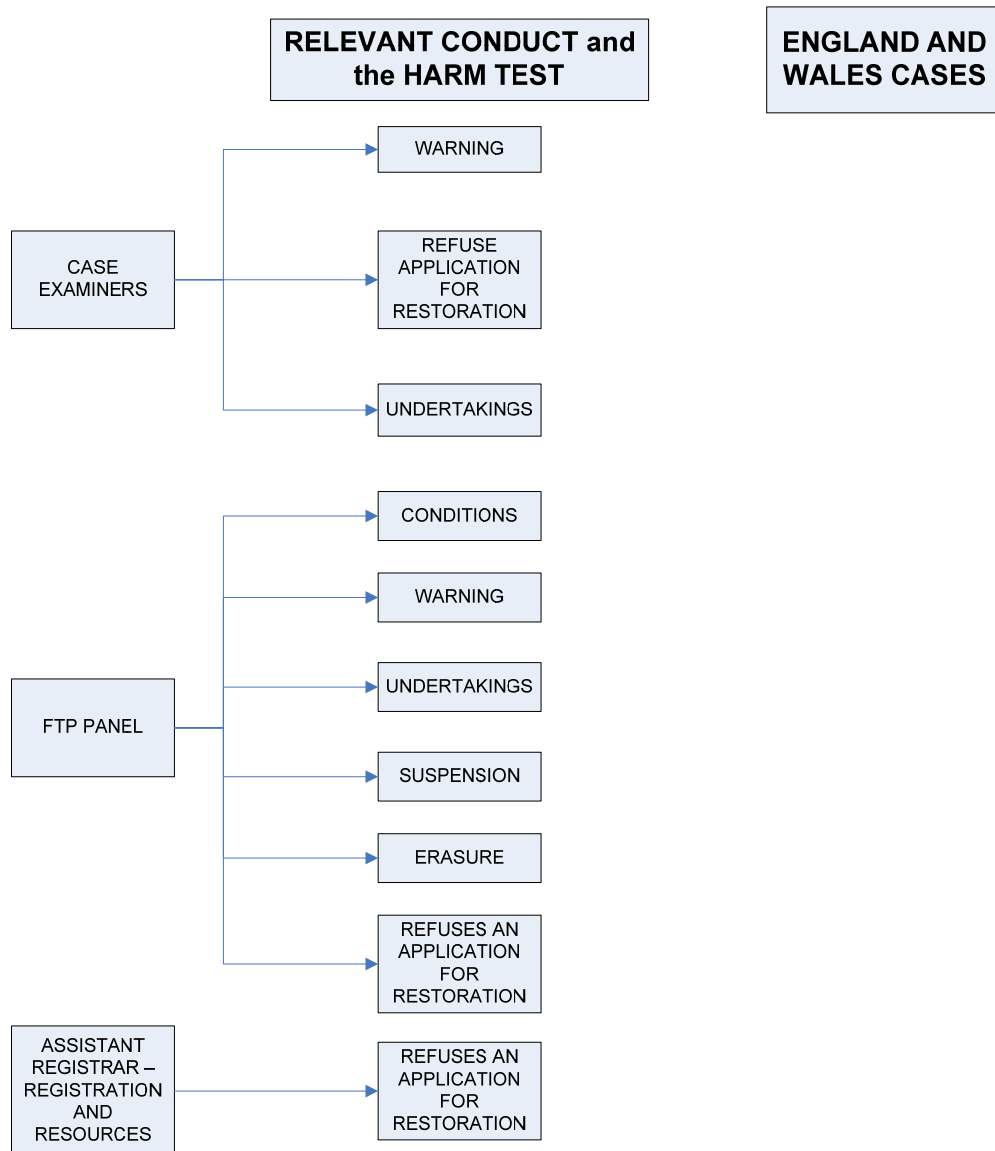
Annex H – Doctor information letter (uncertain of accuracy of address)

Guidance on making referrals to the ISA — Annex A

149. Diagram showing the decision making process for assessing the legal duty to refer information to ISA in England and Wales cases:



150. Trigger points for considering referral to ISA (assume the referral conditions are met):



Guidance on making referrals to the ISA — Annex B

Guidance on wording of autobar offences:

	Wording of certificate of conviction or notice of police caution	Is it an autobar or not?
1	Dr A was cautioned on X date for sexual assault – intentionally touch female – no penetration contrary to the Sexual Offences Act 2003.	Depends on jurisdiction – if UK – section 3 of the Sexual Offences Act 2003 – if NI – article 7 Sexual Offences (Northern Ireland) Order 2008.
2	Doctor B was convicted on X date of causing or procuring an act of cruelty to a child or young person.	Depends on jurisdiction – if UK – section 1 of the Children and Young Persons Act 1933; s20. If NI – Children and Young Person’s (NI) Order 1968. If Scotland – s12 Children and Young Person’s (Scotland) Act 1937.
3	On X date doctor C was convicted of 10 counts of making indecent photographs, or pseudo photographs of children, and a further offence of having possession of indecent photographs or pseudo photographs of children.	Depends on jurisdiction of offence – if UK – s160 Criminal Justice Act 1988. If Scotland – s52 Civic Government (Scotland) Act 1982. If NI – Article 15 Criminal Justice Order (Evidence etc) (Northern Ireland) Order 1988 and it could also fall under (UK) Protection of Children Act 1978, (NI) Protection of Children (NI) Order 1978.
4	On X date doctor D was charged under a foreign law with aggravated sexual abuse – interstate travel with intent to engage in sexual act with a child under the age of 12.	As the offence was not committed in the UK, it is not contained in the list. You will need to decide if the offence occurred in the UK, whether it would be an autobar offence. If it happened in the UK, this offence could be caught by ss14-15 of the Sexual Offences Act 2003 or if in NI, art 21-22 of the Sexual Offences (Northern Ireland) Order 2008.
5	On X date doctor E appeared	This is not an autobar offence.

before X court charged with driving a motor vehicle with excess alcohol. He was found guilty and sentenced as follows (sentence listed).

- 6 On X date doctor F was found guilty of being drunk in a public place while in charge of a child under the age of 7 years.

This is not an auto-bar offence.

Guidance on making referrals to the ISA — Annex C

Case Studies

Guidance on the 'may bar test' – section 41(4)(b) of the Safeguarding Vulnerable Groups Act 2006

Introduction

151. The purpose of this document is to provide guidance on the types of cases which would lead healthcare regulators to think that the ISA 'may bar' an individual as a result of conduct or other circumstances that have given rise to the first condition, at section 41(2) of the Safeguarding Vulnerable Groups Act (the Act) and article 43 of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, being met.

152. This document is supplementary to the ISA guidance document titled 'Independent Safeguarding Authority Guidance for Keepers of Registers on section 41 referrals'. This document includes a description of cases received by the GMC. The GMC has provided an assessment about whether the 'may bar' test within section 41(4)(b) is met in relation to each of these cases, and ISA has given an opinion about the 'may bar' test in each case and whether a referral should be made. The document does not deal, in depth, with referral trigger points or the first condition.

153. The following case studies are intended as a general guide to help decision makers decide which cases raise safeguarding concerns and therefore may require referral to the ISA. The examples should not be construed as prescriptive guidance for use in all cases, and decision makers should consider each case on its merits in deciding whether the referral criteria are met.

154. In each of these broad case types, assume the GMC has concluded its fitness to practise process and where appropriate imposed restrictions on the doctor's registration (including a warning, undertakings, conditions, suspension or erasure).

The cases

Case one — doctor attitude

Broad case type	GMC position	ISA comments	Agreed guiding principles
Doctor displays low-level rudeness towards patients, including sarcastic remarks.	The may bar test is not met as the harm is low level and the matter does not raise any safeguarding concerns to lead the GMC to think the ISA 'may bar' the relevant doctor. Accordingly, the GMC would not refer this case to the ISA.	Agree with GMC, this type of behaviour is low level and does not present a risk of harm to vulnerable groups.	Behaviour that includes low level rudeness and sarcasm or similar does not meet the may bar test as it does not indicate the type of harm that would indicate safeguarding concerns for vulnerable groups.

Case two — verbal bullying of colleagues

Broad case type	GMC position	ISA comments	Agreed guiding principles
Doctor verbally bullies work colleagues, not patients.	There is no relevant conduct as there has been no harm or risk of harm directly in relation to children or vulnerable adults. The doctor's behaviour indicates a general risk of harm, opposed to a risk specifically in relation to children or vulnerable adults. As such, the GMC would not refer this case to the ISA.	There is no relevant conduct and the Harm Test is not satisfied as the conduct is not directed at children or vulnerable adults. The ISA would not be in a position to progress this information.	For the first condition to be met, the doctor's 'relevant conduct' or the factors that gave rise to the Harm Test being met must indicate a direct risk in relation to children and vulnerable adults. The condition will not be met where the doctor's actions indicate a general risk to the population.

Case three — inappropriate prescribing because of incompetence

Broad case type	GMC position	ISA comments	Agreed guiding principles
<p>Doctor prescribes wrong medication to a patient as a result of incompetence (where there is no intention to cause harm). For clarity, incompetence can include:</p> <ul style="list-style-type: none"> - errors caused by poor training, stress; - one-off out of character errors; and - ignorance or confusion; 	<p>The may bar test is not met as the matter is purely related to the doctor's clinical competence and the action taken by the GMC will remove the future risk of harm to children and vulnerable adults. As such, the GMC would not refer this case to the ISA.</p>	<p>This case would not meet the referral criteria as it is a professional competency issue and the GMC / employer would remove any potential risk of harm through their own actions e.g. retraining, improved supervision.</p>	<p>Where a registrant has caused harm to a patient out of his or her professional incompetence, and there is no evidence of a wider risk of harm (i.e. outside the professional setting), the action taken by the regulator or employer will remove the risk of harm and a referral to the ISA will not be required.</p> <p>In cases where a registrant poses an ongoing risk of harm (i.e. outside the regulated setting) directly in relation to children or vulnerable adults despite action taken by the regulator, a referral will need to be made to the ISA.</p>

Case four — inappropriate prescribing, intent, recklessness or repeat behaviour

Broad case type	GMC position	ISA comments	Agreed guiding principles
<p>Doctor prescribes wrong medication to a patient as a result of intention to cause harm or</p>	<p>If the GMC was able to establish that the doctor held an intention to cause harm, or demonstrated a pattern of harmful behaviour indicating a callous disregard for procedure, and action taken by the GMC does not</p>	<p>The case outlines where a doctor uses their position to harm a vulnerable person. It would be difficult to make this distinction without admittance</p>	<p>The may bar test is likely to be met in situations where the doctor has abused his or her position of trust to deliberately harm children or vulnerable</p>

such a callous disregard for procedure as to make the doctor a safeguarding risk. This may include where a pattern of harmful behaviour is demonstrated.	remove the risk of harm to children and vulnerable adults, the may bar test is likely to be met. As such, a referral to the ISA would be likely to be made in these cases.	from the doctor or on the balance of probabilities due to repeated behaviour. Where a doctor continues this type of behaviour after the GMC and other bodies have exercised their powers to retrain etc, then the risk has not been removed and a referral is likely.	adults. This may be a 'one off' occurrence or it may be where a pattern of harmful behaviour has emerged.
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Case five — failure to diagnose correctly

Broad case type	GMC position	ISA comments	Agreed guiding principles
<p>Doctor incorrectly diagnosed a patient due to incompetence (no intention to cause harm). For clarity, incompetence may include:</p> <ul style="list-style-type: none"> - errors caused by poor training, stress; - one-off out of character errors; - ignorance or confusion. 	<p>The may bar test is not met as, although the potential future harm is serious, the matter is purely related to the doctor's clinical competence. In the absence of wider safeguarding risks, the action taken by the GMC has removed the future risk of harm to children and vulnerable adults. As such, the GMC would not refer this case to the ISA.</p>	<p>This case would not meet the referral criteria as it is a professional competency issue and the GMC / employer would remove any potential risk of harm through their own actions e.g. retraining, additional supervision.</p>	<p>Where a registrant has caused harm to a patient out of his or her professional incompetence, and there is no evidence of a wider risk of harm (i.e. outside the professional setting), the action taken by the regulator or employer will remove the risk of harm and a referral to the ISA will not be required.</p>

Case six – false reporting and giving false evidence

Broad case type	GMC position	ISA comments	Agreed guiding principles
<p>Doctor provides a false report, for instance, as a response to an internal investigation into an incident conducted by the doctor's employer.</p>	<p>The GMC considers that this case does not meet the first condition within section 41. Although there has been conduct on the part of the doctor, it is difficult to see any direct harm in relation to children and vulnerable adults.</p> <p>The GMC also considers that the may bar test is not met in these cases. False reporting indicates a general risk of harm caused by general dishonesty, opposed to a specific risk of harm to vulnerable groups. In the absence of information to suggest that there are wider safeguarding risks, in these cases the action taken by the GMC will mitigate any future risk of harm in relation to children and vulnerable adults. As such, the GMC would not refer this case to the ISA.</p>	<p>In most cases the GMC position would be correct. The only case where the duty to refer may be applicable would be if the false reporting was in relation to an incident where the GMC would otherwise think a referral to the ISA was appropriate. E.g. An employee is referred to the GMC due to relevant conduct. The doctor provides a false report in favour of the employee to attempt to mislead the GMC findings, potentially allowing someone who presents a risk to the vulnerable to continue in employment. The GMC's determination would need to conclude that the false report was intentional and that the consequences of the GMC making an erroneous decision based on that evidence, would compromise the safety of children or vulnerable adults.</p>	<p>False reporting without a deliberate aim to mislead would not trigger a referral to the ISA as the first and second conditions are not met.</p> <p>False reporting could give rise to a referral if the false report is in relation to a safeguarding matter, i.e. an incident involving relevant conduct and the false report was intentional. These circumstances (although rare) demonstrate behaviour that, if repeated, is likely to result in harm directly in relation to children or vulnerable adults.</p>

Case seven — false claims to experience on doctor's CV

Broad case type	GMC position	ISA comments	Agreed guiding principles
<p>Doctor lies on his/her CV to claim experience which he/she does not have in order to gain employment or promotion.</p>	<p>For clarity, the GMC considers that there is relevant conduct in such cases as the doctor's dishonesty has caused or potentially caused actual harm or placed patients at risk of harm.</p> <p>The may bar test is not likely to be met as the GMC's action is likely to have removed the risk of harm to children and vulnerable adults.</p> <p>The GMC considers that cases involving general dishonesty are not of the seriousness to meet the 'may bar' test, particularly if no actual harm has materialised. As such, the GMC would not be likely to make a referral to the ISA in such cases.</p>	<p>The ISA does not want to be inundated with instances where a doctor has been less than honest on their CV. The lie must raise a serious safeguarding risk to vulnerable groups such that the ISA may consider barring the person.</p> <p>This would be relevant conduct as it is an action that MAY endanger children or vulnerable adults. The dishonesty is in relation to providing health care and under the definition of a vulnerable adult any person who is receiving health care is a vulnerable adult.</p> <p>It is unlikely however to meet the second part of the second condition as the GMC (or the employer), on discovering the falsehood would take action against the doctor to remove the risk of harm to patients.</p>	<p>Cases involving a general risk of harm (including general dishonesty) rather than a specific risk in relation to vulnerable groups will not meet the may bar test.</p> <p>Lying on a CV is a professional matter, action taken by the regulator can remove the risk of harm to vulnerable groups.</p>

Case eight — lying on CV to exploit vulnerable people

Broad case type	GMC position	ISA comments	Agreed guiding principles
<p>Doctor lies on his/her CV to claim experience which he/she does not have in order to gain access to vulnerable people to take advantage of them.</p>	<p>In these cases the first condition will be met as the doctor will have either placed children or vulnerable adults at the risk of harm or caused actual harm.</p> <p>If the doctor has not yet raised other safeguarding concerns (by causing actual harm – for example financial or sexual exploitation of children or vulnerable adults, which would meet the first and second conditions) a referral will depend on whether it can be established that the doctor had the intention of harming children or vulnerable adults when lying on his or her CV. If this is established the GMC considers that the may bar test will be likely to be met.</p>	<p>Agree with GMC position</p>	<p>This type of case should be handled on a case by case basis depending on the circumstances.</p> <p>Cases where the GMC is able to establish that a doctor has lied to deliberately exploit children and/or vulnerable adults there will be a direct risk of harm in relation to these groups.</p> <p>If intention to exploit vulnerable groups can be established, it is likely that the may bar test will be met as the action taken by the GMC cannot remove the risk of harm to vulnerable groups.</p>

Case nine — failure to maintain adequate medical records

Broad case type	GMC position	ISA comments	Agreed guiding principles
<p>Doctor has poor record keeping skills, including for instance, a failure to properly record consultations.</p>	<p>In general, the risk of harm posed by the doctor will not be sufficiently serious to lead the GMC to believe that ISA may bar the doctor from working with vulnerable groups. As such, the GMC would not be likely to refer the majority of these cases to the ISA.</p> <p>Although there is a potential future risk of harm, the risk is connected to the doctor's professional status and thus the action taken by the GMC will mitigate the risk. However, if we hold specific information to suggest that the doctor plans to work in another form of Regulated or Controlled activity, such as managing a care home, the risk of harm may be extended to a setting outside the medical profession and thus the GMC's action may not have removed the risk of harm to children and vulnerable adults in a wider context. Again, the extent of the remaining risk will depend on the seriousness of the doctor's poor record keeping skills. Low-level record keeping skills are unlikely to ever result in a referral to ISA.</p>	<p>Generally agree with GMC position.</p> <p>However, it should be noted that there may be some circumstances where poor record keeping skills may impact on wider regulated / controlled activity such that a child or vulnerable adult may be put at risk of harm. E.g. the GMC had specific information to indicate that the doctor was also responsible for medical records / medicines at a care home.</p>	<p>Cases involving a general risk of harm (including poor record keeping skills) rather than a specific risk in relation to vulnerable groups will not meet the may bar test.</p> <p>Poor record keeping skills are a professional matter, and in most cases action taken by the regulator can remove the risk of harm to vulnerable groups. In these cases the risk of harm is not sufficiently serious to lead the GMC to think that ISA may bar the doctor.</p>

Case ten — lack of further investigation

Broad case type	GMC position	ISA comments	Agreed guiding principles
Doctor fails to conduct follow-up investigations into a patient's condition – due to incompetence.	The GMC considers that the may bar test is not met in these cases. Although the potential risk of future harm is serious, the matter is purely related to the doctor's clinical competence and the future risk of harm is confined to the professional setting. In the absence of wider safeguarding risks, the action taken by the GMC will have removed any potential future risk of harm in relation to children and vulnerable adults. As such, the GMC would not refer these cases to the ISA.	Agree with GMC position.	Poor clinical skills are a professional matter, action taken by the regulator can remove the risk of harm to vulnerable groups.

Case eleven — driving under the influence of alcohol, possession of a banned substance

Broad case type	GMC position	ISA comments	Agreed guiding principles
Doctor charged and convicted of, or cautioned in relation to driving under the influence of alcohol or possession of a banned substance.	<p>The GMC considers that there is no relevant conduct in such cases as there has been no harm or risk of harm directly in relation to children or vulnerable adults.</p> <p>The doctor's behaviour indicates a general risk of harm, opposed to a risk specifically in relation to children or vulnerable adults. As such, the GMC would not refer these cases to the ISA.</p>	Agree, no relevant conduct in this situation	<p>For relevant conduct to be established, there must be harm or risk of harm directly in relation to children or vulnerable adults.</p> <p>Drink driving and possession charges/convictions/cautions will not amount to relevant conduct and cannot meet the Harm Test as there has not been harm specifically in relation to vulnerable groups.</p>

Case twelve — driving under the influence of alcohol, possession of a banned substance with child (or children) in immediate custody

Broad case type	GMC position	ISA comments	Agreed guiding principles
<p>Doctor charged with driving under the influence of alcohol or possession of a banned substance and has a child (or children) in his or her immediate care at the time of arrest.</p>	<p>In these situations the GMC would need to consider the facts of each individual case.</p> <p>Example 1 If the doctor has his or her own child in the car when arrested for drink driving, we do not consider that the may bar test is met. This indicates general risky behaviour rather than risky behaviour specific to vulnerable groups.</p> <p>Example 2 If the doctor is taking responsibility for other children, for instance, a scout group at the time of arrest, the may bar test is likely to be met as the doctor's behaviour indicates a specific safeguarding risk in relation to vulnerable groups.</p> <p>A referral to the ISA is likely to be made in the second example, but not in the first.</p>	<p>Both examples would involve relevant conduct; it does not matter if it is the doctor's own child. The definition of relevant conduct is not restricted to actions within regulated or controlled activity. The Act treats children as being vulnerable by virtue of their being under the age of 18.</p> <p>If there is harm or risk of harm to a child or vulnerable adult then relevant conduct has occurred irrespective of the setting or the relationship between the person and the child or vulnerable adult.</p> <p>However, where the drink driving incident relates to a purely private arrangement involving the doctor's own child the may bar test is unlikely to be met.</p> <p>Depending on the circumstances, the ISA would</p>	<p>This type should be handled on a case by case basis depending on the circumstances.</p> <p>If there is harm or risk of harm to a child or vulnerable adult then relevant conduct has occurred irrespective of the setting or the relationship between the person and the child or vulnerable adult.</p> <p>In general where the drink driving incident relates to a purely private arrangement, the may bar test is unlikely to be met.</p> <p>Factors to consider in deciding whether the may bar test applies include: are there any aggravating and mitigating circumstances? What were the doctor's intentions? Was it a deliberate act? Did the doctor know the person was vulnerable? What was the doctor's relationship with the</p>

		<p>be likely to bar in the second instance (e.g. scout group), as the behaviour raises a greater safeguarding risk in relation to vulnerable groups.</p>	<p>person? Why was the person in the doctor's car? Was the incident a 'one off' or had it happened before? etc.</p> <p>There must be established harm or risk of harm to a vulnerable group not just a general risk to the public.</p> <p>Where harm is caused by a genuine accident, in general the may bar test will not be met.</p>
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Case thirteen — driving under the influence of alcohol with another adult in company

Broad case type	GMC position	ISA comments	Agreed guiding principles
<p>Doctor charged with driving under the influence of alcohol or possession of a banned substance and has a vulnerable adult (or adults) in the car at the time of arrest.</p>	<p>The GMC considers that there is relevant conduct as there has been harm or risk of harm directly in relation to a vulnerable adult. However, whether ISA may bar in these cases depends on the specific facts of the case.</p> <p>Example 1 The doctor has his aunty in the car when arrested. The doctor's aunty is a vulnerable adult because she lives in a care home. Although the doctor's aunty is vulnerable, and it is likely that the doctor would have</p>	<p>Both examples would involve relevant conduct; it does not matter the passenger is the doctor's relative. The definition of relevant conduct is not restricted to actions within regulated or controlled activity. It must simply involve a child, or an adult that is defined as vulnerable under the Act.</p> <p>If there is harm or risk of harm</p>	<p>If there is harm or risk of harm to a child or vulnerable adult then relevant conduct has occurred irrespective of the setting or the relationship between the person and the child or vulnerable adult.</p> <p>In cases where relevant conduct has occurred, whether ISA may bar the doctor will depend on the circumstances of the case.</p>

	<p>known about the vulnerability, the GMC considers that the may bar test is not met as the arrangements were private and the doctor's conduct indicates general risky behaviour rather than risky behaviour specific to vulnerable groups.</p> <p>Example 2 If the doctor is charged with drink driving while driving a number of elderly people to the shopping centre in a hospice bus, the may bar test is likely to be met as the doctor's behaviour indicates a specific safeguarding risk in relation to vulnerable groups.</p> <p>A referral to the ISA is likely to be made in the second example, but not in the first.</p>	<p>to a child or vulnerable adult then relevant conduct has occurred irrespective of the setting or the relationship between the person and the child or vulnerable adult.</p> <p>However, where the drink driving incident relates to a purely private arrangement involving, for example, a relative of the doctor, the may bar test is unlikely to be met.</p> <p>Depending on the circumstances, the ISA would be likely to bar in the second instance (e.g. hospice bus), as the behaviour raises a greater safeguarding risk in relation to vulnerable adults.</p>	<p>In general, where the drink driving incident relates to a purely private arrangement, the may bar test is unlikely to be met.</p> <p>Factors to consider in deciding whether the may bar test applies include: are there any aggravating and mitigating circumstances? What were the doctor's intentions? Was it a deliberate act? Did the doctor know the person was vulnerable? What was the doctor's relationship with the person? Why was the person in the doctor's car? Was the incident a 'one off' or had it happened before? etc.</p> <p>A referral is very unlikely to be warranted if a doctor verbally abuses a neighbour over his garden fence and the neighbour turns out to be subject to a criminal supervision order or if a doctor runs over a pedestrian while driving and the pedestrian turns out to be living in state-</p>
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			<p>provided accommodation.</p> <p>Such behaviour indicates a general risk of harm rather than a risk specifically in relation to children or vulnerable adults.</p> <p>A referral would be likely to be made if it was proven that the doctor knew a person was a vulnerable adult and deliberately harmed that adult (or attempted to cause harm). Such behaviour would indicate that harm caused to a child or vulnerable adult was not the result of a genuine accident.</p>
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Case fourteen — substance abuse outside the workplace

Broad case type	GMC position	ISA comments	Agreed guiding principles
<p>Doctor has alcohol/substance abuse issues, but the doctor's performance has not been affected and the doctor is competent in his/her work (for clarity, no child or</p>	<p>The GMC considers that there has been no relevant conduct in this case. The doctor's behaviour indicates a general risk of harm. There has been no act or omission that has caused harm or risk of harm directly in relation to a child or vulnerable adult. As such, the GMC would not refer such cases to the ISA.</p>	<p>Agree with GMC position, this is not relevant conduct.</p>	<p>For relevant conduct to be established, there must be harm or risk of harm directly in relation to children or vulnerable adults.</p> <p>Substance abuse outside the workplace indicates generally harmful behaviour rather than placing specific vulnerable</p>

vulnerable adult has been harmed).			groups at a direct risk of harm.
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Case fifteen — substance abuse within the workplace

Broad case type	GMC position	ISA comments	Agreed guiding principles
Doctor has abused alcohol or drugs within the workplace and someone has been harmed or the doctor's work performance / competence has been impaired	In many cases the GMC considers that the may bar test is likely to be met. By being intoxicated at work, the doctor has shown a callous disregard for procedure and good medical practice, the result of which is a direct risk of harm to children and vulnerable adults (or possible actual harm). The doctor's actions indicate an ongoing risk which cannot be removed by the GMC's action alone. As such, the GMC is likely to refer these cases to the ISA.	Substance misuse within the work place that has placed children or vulnerable adults at risk of harm is transferable to other environments. Where there is such a disregard for the safety of vulnerable groups, and the cause is not professional a referral should be made.	For relevant conduct to be established, there must be harm or risk of harm directly in relation to children or vulnerable adults rather than a general risk of harm to the population. Intoxication within the workplace falls seriously short of the standard expected of regulated professionals and raises ongoing risks of harm specifically in relation to children and vulnerable adults. These risks cannot be mitigated solely by action taken by the regulator.

Case sixteen — general fraud

Broad case type	GMC position	ISA comments	Agreed guiding principles
Doctor defrauds his/her employer, or another person who does not fall under the definition of vulnerable adult.	<p>The GMC considers that in these cases there is no relevant conduct as the doctor's dishonest behaviour has not caused harm or risk of harm directly in relation to children and/or vulnerable adults. Rather, the doctor's behaviour reflects a general risk of harm.</p> <p>For instance, there is a general risk that the doctor may defraud someone in the future, rather than a specific risk that the doctor may defraud a child or vulnerable adult in the future. As such, the GMC would not refer these cases to the ISA.</p>	Agree with GMC position.	For relevant conduct to be established, there must be harm or risk of harm directly in relation to children or vulnerable adults rather than a general risk of harm to the population.

Case seventeen — fraud of a patient

Broad case type	GMC interpretation of the referral criteria	ISA comments	Agreed guiding principles
Doctor defrauds one of his/her patients.	<p>The GMC considers that in these cases the may bar test is likely to be met. The doctor's conduct indicates a direct risk of harm in relation to children or vulnerable adults rather than a general risk.</p> <p>The doctor has sought out a vulnerable person for exploitation and this behaviour indicates a wider risk of such behaviour being repeated outside the professional setting.</p>	Agree with GMC position.	<p>For relevant conduct to be established, there must be harm or risk of harm directly in relation to children or vulnerable adults rather than a general risk of harm to the population.</p> <p>In cases where a person has abused a position of trust to exploit a vulnerable person,</p>

	Action taken by the GMC cannot remove the risk of harm to children or vulnerable adults, and as such, the GMC would be likely to refer these cases to the ISA.		there is likely to be the potential for wider risk outside the regulated setting which cannot be removed by action taken by the regulator alone.
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Case eighteen — doctor engages in sexually motivated behaviour towards patients

Broad case type	GMC position	ISA comments	Agreed guiding principles
Doctor undertakes an intimate examination that is clearly not clinically indicated, or engages in sexually motivated behaviour towards a patient.	<p>The GMC considers that in these types of cases the may bar test is likely to be met, although the facts of each individual case will need to be considered.</p> <p>In cases where a doctor undertakes, for instance, an intimate examination that is clearly not clinically indicated, the doctor's behaviour is likely to indicate a direct risk of harm in relation to children or vulnerable adults rather than a general risk of harm. Action taken by the GMC in these cases cannot remove the potential future risk of harm to children and/or vulnerable adults (wider safeguarding concerns may remain despite GMC action). As such, the GMC would be likely to refer these cases to the ISA.</p> <p>Where it is clear that the case is not sexually motivated, for example, where a doctor fails to use a chaperone when conducting an</p>	Agree with GMC position.	<p>For relevant conduct to be established, there must be harm or risk of harm directly in relation to children or vulnerable adults rather than a general risk of harm to the population.</p> <p>In cases where a person has abused a position of trust to exploit a vulnerable person, there is likely to be the potential for wider risk outside the regulated setting which cannot be removed by action taken by the regulator alone.</p> <p>Cases involving poor clinical skills are a professional matter, action taken by the regulator can remove the risk of harm to vulnerable groups.</p>

	intimate examination because of a lack of understanding of good practice, the GMC is not likely to consider that the may bar test is met. Any action taken by the GMC in such cases would remove any potential future risk of harm to children and vulnerable adults.		
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Case nineteen — affective disorders

Broad case type	GMC position	ISA comments	Agreed guiding principles
Doctor has an affective disorder (e.g. bipolar)	<p>The GMC considers that an affective disorder in and of itself cannot meet the may bar test.</p> <p>In certain circumstances, an affective disorder may cause a doctor to engage in relevant conduct, or satisfy the Harm Test. For instance, if a doctor’s affective disorder triggered him/her to assault a patient, the GMC would be likely to consider that the may bar test is met and a referral would be likely to be made to the ISA.</p>	<p>Agree with GMC position. These types of cases must be viewed on a case by case basis.</p>	<p>Affective disorders in and of themselves cannot satisfy the referral criteria.</p> <p>If the affective disorder causes the individual to endanger a vulnerable person (or cause risk of harm or satisfy the Harm Test, then the may bar criteria would need to be considered on the grounds of the behaviour. The regulator could consider the role of the disorder, among other factors, in assessing the likelihood of a future risk of harm.</p>

Case twenty — withholding treatment

Broad case type	GMC position	ISA comments	Agreed guiding principles
<p>Doctor withholds treatment from a patient, e.g. because the treatment conflicts with the doctor's personal views or beliefs.</p>	<p>The GMC considers that cases falling into this category would need to be assessed against the may bar test on an individual basis, particularly in light of the action taken by the GMC and our assessment of any residual risk.</p> <p>The key consideration is the seriousness of the matter, which will indicate whether the matter is clinical or raises wider safeguarding concerns which cannot be removed by action taken by the GMC.</p> <p>The may bar test is not likely to be met where a doctor withholds treatment because it conflicts with the doctor's personal opinion or interests (i.e. doctor prescribes one kind of drug from a range of appropriate drugs because he has a financial or other interest in doing so). In these cases, the GMC would not be likely to make a referral to the ISA.</p> <p>The GMC considers that the may bar test is likely to be met in cases where a doctor has threatened to withhold or withdraw a major course of treatment unless a patient commits to, for instance, following a specific religion. In such cases the doctor poses a risk directly in relation to children or vulnerable adults</p>	<p>Agree with GMC position.</p>	<p>This type should be handled on a case by case basis depending on the circumstances.</p>

	both within the professional context and in terms of broader safeguarding. As such, action taken by the GMC is unlikely to remove the risk of harm in relation to children or vulnerable adults and thus the may bar test is likely to be met and a referral to ISA made.		
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Case twenty one — physical assault

Broad case type	GMC position	ISA comments	Agreed guiding principles
Doctor physically assaults a person who is not a vulnerable adult (doctor is acting outside his capacity as a doctor i.e. watching a sports event on the weekend).	The GMC considers that in these cases there is no relevant conduct as the doctor has not engaged in conduct that has caused a direct risk of harm in relation to children or vulnerable adults. Rather, the doctor's behaviour reflects a general risk of harm. As such, the GMC would not refer these cases to the ISA.	Agree with GMC position assuming this scenario is dealing with the actions of a doctor operating outside his capacity as a doctor. For example in the pub or towards another member of staff rather than towards a person receiving health care or advice.	For relevant conduct to be established, there must be harm or risk of harm directly in relation to children or vulnerable adults rather than a general risk of harm to the population.

Case twenty two — physical assault of a patient

Broad case type	GMC position	ISA comments	Agreed guiding principles
Doctor physically assaults a patient	The GMC considers that in these cases the may bar test is likely to be met. The doctor's conduct indicates a direct risk of harm in	Agree with GMC position.	For relevant conduct to be established, there must be harm or risk of harm directly in

	<p>relation to children or vulnerable adults rather than a general risk.</p> <p>In such cases there are specific safeguarding concerns – that the doctor may repeat his conduct and cause harm to a child or vulnerable adult. Action taken by the GMC is not likely to remove the risk of harm to children or vulnerable adults, and as such, the GMC would be likely to refer such cases to the ISA.</p>		<p>relation to children or vulnerable adults rather than a general risk of harm to the population.</p> <p>In cases where a person has abused a position of trust to deliberately harm a vulnerable person, there is likely to be the potential for wider risk outside the regulated setting which cannot be removed by action taken by the regulator alone.</p>
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Guidance on making referrals to the ISA — Annex D

List of offences giving rise to automatic barring with and without representations

1. This list is taken from the University of Bristol website at <http://www.bris.ac.uk/secretary/legal/isa/offences.html>.
2. The list was suggested by ISA as an accurate description of the auto bar offences (as at 22 September 2009). Note ISA are currently reviewing the list and will advise of any alterations.

Children's Automatic Barring Offences – with no right to representations

- Rape [of a child]
- Sexual intercourse with a girl under the age of 13
- Assault by penetration
- Rape of a child under 13
- Assault of a child under 13 by penetration
- Sexual assault of a child under 13
- Causing or inciting a child under 13 to engage in sexual activity
- Sexual activity with a person with mental disorder impeding choice [where the victim is a child]
- Causing or inciting a person with a mental disorder impeding choice, to engage in sexual activity [where the victim is a child]
- Engaging in sexual activity in the presence of a person with a mental disorder impeding choice [where the victim is a child]
- Causing a person, with a mental disorder impeding choice, to watch a sexual act [where the victim is a child]
- Inducement, threat or deception to procure sexual activity with a person with a mental disorder [where the victim is a child]
- Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception [where the victim is a child]
- Engaging in sexual activity in the presence, procured by inducement, threat or deception, of a person with a mental disorder [where the victim is a child]
- Causing a person with a mental disorder to watch a sexual act by inducement, threat or deception [where the victim is a child];
- Care workers: sexual activity with a person with a mental disorder [where the victim is a child];

- Care workers: Causing or inciting sexual activity [where the victim is a child];
- Care workers: Sexual activity in the presence of a person with a mental disorder [where the victim is a child];
- Care workers: Causing a person with a mental disorder to watch a sexual act [where the victim is a child].

Children's Automatic Barring Offences – with right to make representations

- Murder;
- Kidnapping;
- False Imprisonment;
- Infanticide;
- Cruelty to children;
- Rape [of an adult];
- Administering drugs to obtain or facilitate intercourse;
- Sexual intercourse with a girl under the age of 16;
- Intercourse with, or procurement of, a person suffering from a state of arrested or incomplete development of mind (which includes severe impairment of intelligence and social functioning);
- Incest by a man;
- Incest by a woman;
- Buggery;
- Indecency between men;
- Indecent assault on a woman;
- Indecent assault on a man;
- Assault with intent to commit buggery;
- Abduction of a woman by force for sake of her property;
- Abduction of unmarried girl under 18;
- Abduction of unmarried girl under 16;
- Abduction of a person suffering from a state of arrested or incomplete development of mind (which includes severe impairment of intelligence and social functioning) from parent or guardian;
- Causing prostitution of women;

- Procurement of girl under 21;
- Detention of a woman in a brothel or other premises;
- Permitting girl, under 13, or between 13 and 16, to use premises for intercourse;
- Permitting a person suffering from a state of arrested or incomplete development of mind (which includes severe impairment of intelligence and social functioning) to use premises for intercourse;
- Causing or encouraging prostitution of, intercourse with or indecent assault on, girl under 16;
- Causing or encouraging prostitution of a person suffering from a state of arrested or incomplete development of mind (which includes severe impairment of intelligence and social functioning);
- Man living on earnings of prostitution;
- Woman exercising control over prostitute;
- Sexual intercourse with patients;
- Indecency with children under the age of 16;
- Procuring others to commit homosexual acts;
- Living on the earnings of male prostitution;
- Burglary [with intent to rape];
- Supply of drugs to children;
- Inciting a girl under the age of 16 to have incestuous sexual intercourse;
- Take, or permit to be taken, or to make any indecent photograph or pseudo-photograph of a child; distribution or possession of indecent photograph of a child;
- Making or possessing false or forged medical etc documents;
- Ill-treatment or wilful neglect of a patient with a mental disorder;
- Induce or knowingly assist a patient under guardianship or a person in 137 custody to absent themselves without leave; or knowingly harbours a patient who is absent without leave;
- Abduction of a child by parent;
- Abduction of a child by other persons;
- Possession of indecent photographs of children;
- Abuse of trust [being a person aged 18 years or over in a position of trust has sexual intercourse/ engage in sexual activity with a person under 18];

- Traffic in prostitution;
- Sexual assault;
- Causing a person to engage in sexual activity without consent;
- Sexual activity with a child;
- Causing or inciting a child to engage in sexual activity;
- Engaging in sexual activity in the presence of a child;
- Causing a child to watch a sexual act;
- Arranging or facilitating commission of a child sex offence;
- Meeting a child following sexual grooming;
- Abuse of position of trust: sexual activity with a child;
- Abuse of position of trust: causing or inciting a child to engage in sexual activity;
- Abuse of position of trust: sexual activity in the presence of a child;
- Abuse of position of trust: causing a child to watch a sexual act;
- Sexual activity with a child family member;
- Inciting a child family member to engage in sexual activity;
- Sexual activity with a person with a mental disorder impeding choice [where the victim is an adult];
- Causing or inciting a person, with a mental disorder impeding choice, to engage in sexual activity [where the victim is an adult];
- Engaging in sexual activity in the presence of a person with a mental disorder impeding choice [where the victim is an adult];
- Causing a person, with a mental disorder impeding choice, to watch a sexual act [where the victim is an adult];
- Inducement, threat or deception to procure sexual activity with a person with a mental disorder [where the victim is an adult];
- Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception [where the victim is an adult];
- Engaging in sexual activity in the presence, procured by inducement, threat or deception, of a person with a mental disorder [where the victim is an adult];
- Causing a person with a mental disorder to watch a sexual act by inducement, threat or deception [where the victim is an adult];

- Care workers: sexual activity with a person with a mental disorder [where the victim is an adult];
- Case workers: causing or inciting sexual activity [where the victim is an adult];
- Care workers: sexual activity in the presence of a person with a mental disorder [being a care worker involved in the care of a person who could reasonably be expected to have known had such a disorder intentionally engaged in an activity for the purpose of obtaining sexual gratification in the presence of/a place where you could be observed by that person knowing/believing that she/he was aware/intending that she/he should be aware that you were engaging in it];
- Care workers: causing a person with a mental disorder to watch a sexual act;
- Paying for sexual services of a child;
- Causing or inciting child prostitution or pornography;
- Controlling a child prostitute or a child involved in pornography;
- Arranging or facilitating child prostitution or pornography;
- Causing or inciting prostitution for gain;
- Trafficking into, within, or out of the UK for sexual exploitation;
- Administering a substance with intent intentionally [administered a substance to OR caused a substance to be taken by another person knowing he/she did not consent and with the intention of stupefying/overpowering hi/her so as to enable any person to engage in a sexual activity involving him/her];
- Committing an offence or trespassing with intent to commit a sexual offence;
- Exposure [intentionally exposed genitals intending someone would see them causing alarm/distress];
- Voyeurism [for the purpose of obtaining sexual gratification observed/operated equipment/recorded/installed equipment OR constructed/adapted a structure/part of a structure (to observe) – another person doing a private act knowing that the person did not consent to being observed];
- Trafficking people for exploitation;
- Causing or allowing the death of a child or vulnerable adult;
- Ill-treatment or wilful neglect.

Vulnerable Adults Barring Offences – with no right to make representations

- Sexual activity with a person with a mental disorder impeding choice [where the victim is child or adult];

- Causing or inciting a person, with a mental disorder impeding choice, to engage in sexual activity;
- Engaging in sexual activity in the presence of a person with a mental disorder impeding choice;
- Causing a person, with a mental disorder impeding choice, to watch a sexual act;
- Inducement, threat or deception to procure sexual activity with a person with a mental disorder;
- Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception;
- Engaging in sexual activity in the presence, procured by inducement, threat or deception, of a person with a mental disorder;
- Causing a person with a mental disorder to watch a sexual act by inducement, threat or deception;
- Care workers: sexual activity with a person with a mental disorder;
- Care workers: Causing or inciting sexual activity;
- Care workers: sexual activity in the presence of a person with a mental disorder;
- Care workers: causing a person with a mental disorder to watch a sexual act.

Vulnerable Adults Barring Offences – with right to make representations

- Murder;
- Kidnapping;
- False imprisonment;
- Infanticide;
- Cruelty to children;
- Rape [of a child];
- Procurement of a woman by threats;
- Procurement of a woman by false pretences;
- Administering drugs to obtain or facilitate intercourse;
- Sexual intercourse with a girl under the age of 13;
- Sexual intercourse with a girl under the age of 16;

- Intercourse with, or procurement of, a person suffering from a state of arrested or incomplete development of mind (which includes severe impairment of intelligence and social functioning);
- Incest by a man or a woman;
- Buggery;
- Indecent assault on a woman;
- Indecent assault on a man;
- Assault with intent to commit buggery;
- Abduction of unmarried girl under 18;
- Abduction of unmarried girl under 16;
- Abduction of a person suffering from a state of arrested or incomplete development of mind (which includes severe impairment of intelligence and social functioning) from parent or guardian;
- Causing prostitution of women;
- Procuration of girl under 21;
- Detention of a woman in a brothel or other premises;
- Permitting girl, under 13, or between 13 and 16, to use premises for intercourse;
- Permitting a person suffering from a state of arrested or incomplete development of mind (which includes severe impairment of intelligence and social functioning) to use premises for intercourse;
- Causing or encouraging prostitution of, intercourse with or indecent assault on, girl under 16;
- Man living on earnings of prostitution;
- Woman exercising control over prostitute;
- Sexual intercourse with patients;
- Indecency with children under the age of 16;
- Procuring others to commit homosexual acts;
- Living on the earnings of male prostitution;
- Burglary [with intent to rape];
- Supply of drugs to children;
- Inciting a girl under age of 16 to have incestuous sexual intercourse;

- Take, or permit to be taken, or to make any indecent photograph or pseudo-photograph of a child; distribution or possession of indecent photograph of a child;
- Making or possessing false or forged medical, etc documents [to falsely detain a patient through obtaining or possessing false medical documents];
- Ill-treatment or wilful neglect of a patient with a mental disorder;
- Induce or knowingly assist a patient under guardianship or a person in 137 custody to absent themselves without leave; or knowingly harbours a patient who is absent without leave [removing a person from a hospital or the specified place where they are living (or preventing their return) places the patient at serious risk of harm];
- Refuses to allow the inspection of any premises; or to allow the visiting, interviewing or examination of any person by a person authorised; or to produce for the inspection of any person so authorised any document or record the production of which is duly required by him; or otherwise obstructs any such person in the exercise of his functions [to prevent the Healthcare or the Mental Health Commission from carrying out their statutory functions in inspecting premises where patients have been detained];
- Abduction of a child by parent;
- Abduction of child by other persons;
- Possession of indecent photographs of children;
- Abuse of trust;
- Traffic in prostitution;
- Rape [of a child];
- Assault by penetration;
- Sexual assault;
- Causing a person to engage in sexual activity without consent;
- Rape of a child under 13;
- Assault of a child under 13 by penetration;
- Sexual assault of a child under 13;
- Causing or inciting a child under 13 to engage in sexual activity;
- Sexual activity with a child;
- Causing or inciting a child to engage in sexual activity;
- Engaging in sexual activity in the presence of a child;
- Causing a child to watch a sexual act;

- Arranging or facilitating commission of a child sex offence;
- Meeting a child following sexual grooming;
- Abuse of position of trust: Sexual activity with a child;
- Abuse of position of trust: Sexual activity in the presence of a child;
- Abuse of position of trust: Causing a child to watch a sexual act;
- Sexual activity with a child family member;
- Inciting a child family member to engage in sexual activity;
- Paying for sexual services of a child;
- Rape [of a child];
- Assault by penetration;
- Sexual assault;
- Causing a person to engage in sexual activity without consent;
- Rape of a child under 13;
- Assault of a child under 13 by penetration;
- Sexual assault of a child under 13;
- Causing or inciting a child under 13 to engage in sexual activity;
- Sexual activity with a child;
- Causing or inciting a child to engage in sexual activity;
- Engaging in sexual activity in the presence of a child;
- Causing a child to watch a sexual act;
- Arranging or facilitating commission of a child sex offence;
- Meeting a child following sexual grooming;
- Abuse of position of trust: sexual activity with a child;
- Abuse of position of trust: causing or inciting a child to engage in sexual activity;
- Abuse of position of trust: sexual activity in the presence of a child;
- Abuse of position of trust: causing a child to watch a sexual act;
- Sexual activity with a child family member;
- Inciting a child family member to engage in sexual activity;

- Paying for sexual services of a child;
- Causing or inciting child prostitution or pornography;
- Controlling a child prostitute or a child involved in pornography;
- Arranging or facilitating child prostitution or pornography;
- Causing or inciting prostitution for gain;
- Trafficking into, within, or out of the UK for sexual exploitation;
- Administering a substance with intent intentionally;
- Committing an offence or trespassing with intent to commit a sexual offence;
- Exposure;
- Voyeurism;
- Trafficking people for exploitation;
- Causing or allowing the death of a child or vulnerable adult;
- Ill-treatment or wilful neglect.

Guidance on making referrals to the ISA — Annex E

Referral cover letter

GMC reference: *[insert case number]*

[Insert date]

[Add name and address]

To whom it may concern

Referral under the Safeguarding Vulnerable Groups Act 2006 and the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007

Section 41 of the Safeguarding Vulnerable Groups Act 2006 (the Act) and article 43 of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 (the Order) require the General Medical Council, as a Keeper of a Register, to refer prescribed information to the Independent Safeguarding Authority under legislated circumstances.

I enclose a referral form and bundle of prescribed information in relation to the following GMC registrant:

[Doctor's full name]

[Doctor's DOB]

[Doctor's GMC number]

[Doctor's last known address]

In accordance with the Safeguarding Vulnerable Groups Act 2006 (Regulated Activity, Miscellaneous and Transitional Provisions and Commencement No. 5) Order 2009 (SI 2009 No.2610 (C.114)), I request that ISA inform the GMC, following completion of its decision making process (noting whether the decision is subject to appeal), if the abovementioned doctor is placed on either the children's or adult's barred lists maintained under section 2 of the Act and article 6 of the Northern Ireland Order.

(including cases which are pending appeal), please advise the GMC of the outcome of your barring decision in each relevant case as and when a barring decision has been made and any appeal period has lapsed.

Under paragraph 21 of the abovementioned Transitional Provisions Order, we have a legitimate interest in being informed about whether ***[insert doctor's name here]*** has been barred from working with children and vulnerable adults by ISA as ***[insert doctor's name here]*** holds registration with the GMC ***[of if erased, has held registration in the past and may be eligible to do so in the future]***.

If there is any further documentation you require about this case, please advise me, in writing, and we will comply in accordance with our duty under section 42 of the abovementioned Act and article 44 of the Northern Ireland Order. We will also provide case updates periodically as appropriate.

Yours sincerely

[Member of staff to pp]

IM or Adjudication Manager full name

Position

Telephone number

Email address

Guidance on making referrals to the ISA — Annex F

Standard letter informing doctor of referral

[Insert date]

[Add name and address]

Dear *[insert doctor's name]*

Referral to the Independent Safeguarding Authority

Under the Safeguarding Vulnerable Groups Act 2006 (the Act) and the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 (the Order), the General Medical Council has both a legal obligation and a power to refer prescribed information to the Independent Safeguarding Authority (ISA).

I am writing to advise you that, in accordance with Act, the GMC has referred prescribed information it holds about you to ISA.

Section 41 of the Act and article 43 of the Order provide the specific circumstances in which the GMC must refer prescribed information to ISA. These are when two conditions are satisfied.

The first condition is that the GMC thinks that a person:

1. Has committed an autobar offence, prescribed by regulations;
2. Has engaged in relevant conduct after 12 October 2009, as defined by Schedule 3 to the Act and Schedule 1 to the Order; or
3. Satisfies the Harm Test, defined by section 41(3) of the Act and article 43(3) of the Order.

The second condition is that the GMC thinks that:

1. The person to which the referral relates is engaged, or may engage in regulated or controlled activity, as defined by Schedule 4 to the Act and article 9 of the Order; and

2. ISA may consider it appropriate for the person to be included in a barred list because they have engaged in relevant conduct or satisfy the Harm Test.

Section 41(5) of the Act and article 43(5) of the Order confer powers on the GMC to refer prescribed information about a person where we think the person has engaged in relevant conduct prior to 12 October 2009. Section 42 of the Act and article 44 of the Order place the GMC under a duty to refer prescribed information about a person to ISA where ISA makes a request for such information to assist it in making a barring decision.

Prescribed information is defined within the Safeguarding Vulnerable Groups Act 2006 (Prescribed Information) Regulations 2008 and the Safeguarding Vulnerable Groups (Prescribed Information) Regulations (Northern Ireland) 2009.

If you wish to discuss this matter further, including the reasons for the referral being made, I can be contacted on the telephone number below. Alternatively, ISA may contact you in due course about your case, but if you wish to speak to them in the interim you can do so by telephoning 0300 123 1111. You can also access information about ISA by accessing their website at www.isa-gov.org.uk.

Yours sincerely

Contact name
Position
Telephone number
Email address

Guidance on making referrals to the ISA — Annex G

Letter notifying doctor of referral where the doctor is known to have health concerns

[Insert date]

[Add name and address]

Dear Dr *[insert doctor's name]*

Referral to the Independent Safeguarding Authority

We are writing in relation to the Independent Safeguarding Authority (ISA). ISA is a statutory agency which was established under the Safeguarding Vulnerable Groups Act 2006 (the Act). The role of ISA is to determine whether individuals pose a risk to vulnerable people, and therefore should be stopped from working with these groups.

The General Medical Council (GMC) has both a legal obligation and a power to refer information to ISA in situations described under the Act, including when we become aware that a person has been convicted of, or cautioned in relation to an offence listed within the Act.

On X date 20XX you were cautioned/convicted for/of XYZ offence. This offence is one of the offences listed within the Act, and as such, the GMC is required to refer a range of information it holds about you to ISA that relates to your conviction/caution *[delete that which doesn't apply]*, including details of any action that we have taken on your registration.

Following this referral, ISA will use the information that it collects in relation to your case to determine your ongoing suitability to work with vulnerable people. If ISA decide to progress your case through its process, you will be given an opportunity to make representations as to why you should not be prevented from working with vulnerable people.

ISA will also forward you the information it will consider in making any final decisions about your suitability to work with vulnerable groups.

We appreciate that this letter may cause you concern, and the Act contains some complex terminology. If you wish to discuss this matter with us please contact me on the number below. ISA will contact you in due course, but if you wish to speak to them about your case you can do so by calling 0300 123 1111.

You can also obtain information about ISA by accessing their website at www.isa-gov.org.uk. In particular, the ISA website includes two documents which explain the legal obligation on the GMC to refer information to ISA, and the ISA Decision Making Process. These two documents are available by using the following specific web-links, or you can access the ISA website and enter the document title within the website's search facility:

- **ISA guidance on referrals:** <http://www.isa-gov.org.uk/default.aspx?page=379>;
and
- **ISA Decision Making Process guidance:** <http://www.isa-gov.org.uk/default.aspx?page=382>

Yours sincerely

Full name
Position
Telephone number
Email address

Guidance on making referrals to the ISA — Annex H

Letter advising doctor of referral to ISA where we are unsure of the doctor's last known registered address

GMC reference:

Date

Doctor's name and address

Dear Dr XXXX

Referral to the Independent Safeguarding Authority

I am writing in relation to the Independent Safeguarding Authority (ISA). ISA is a statutory agency established under the Safeguarding Vulnerable Groups Act 2006 (the Act). The General Medical Council (GMC) has a legal obligation to refer information to ISA in situations described within the Act.

We have referred information which we hold about you to ISA. ISA will contact you in due course, but if you wish to speak to them about your case you can do so by calling 0300 123 1111.

Alternatively, if you wish to discuss this matter with the GMC, I can be contacted using the details provided below.

Yours sincerely

Contact Name
Assistant Registrar
Contact Telephone Number
Email address