General Medical Council

Part D – Carrying out a provisional enquiry

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Purpose

1 This guidance sets out the information that can be gathered through provisional enquiries. Although most types of evidence are relevant across the PE process, some are specific to the different streams and these nuances are explained below. For example, evidence of remediation is only gathered as part of a SCI and SCC provisional enquiry.

2 The guidance will primarily be used by staff in the Provisional Enquiry team and is intended to:

- support staff in identifying the evidence that is needed to decide whether the triage test* is met at the end of the PE process
- ensure that staff are aware of any evidential requirements that are specific to individual PE streams
- support staff in ensuring that evidence gathering is targeted and proportionate.

Key principles

3 The following principles apply to carrying out provisional enquiries.

a Provisional enquiries should be targeted and proportionate.

b The evidence needed will depend on the nature of the concerns about the doctor and should be assessed on an individual basis.

c In general, we aim to gather limited pieces of discrete and easily obtainable information so it should be feasible to obtain the evidence needed in a short timeframe. The exception to this is PIC PE where the enquiries may be more complex and take longer to complete.

d We should bear the nature of the triage test in mind when carrying out a PE. The decision maker is not applying the realistic prospect test (RPT) but trying to establish if a question is raised about the doctor's fitness to practise. This is a lower threshold and the amount of evidence needed will be less than in a full investigation.

* Do the concerns appear to raise a question as to whether the doctor's fitness to practise is impaired?

Evidential requirements of individual streams

4 When a provisional enquiry is received by the PE team, it should have been allocated to the appropriate stream by the Triage decision maker and this process is covered by part C of the guidance. The PE Investigation Manager will determine if the new concern should be accepted into the provisional enquiry process. If it isn't suitable, it should be returned to the Triage team either for re-streaming or for a triage decision to be made in the usual way.

5 The PE team should follow the approach outlined below when carrying out a provisional enquiry under the relevant stream. The doctor should be notified at the start of the process that we will be carrying out provisional enquiries.

Public interest concerns (PIC) provisional enquiries

6 Where a doctor has raised public interest concerns, we should not take the referral information at face value. The purpose of a PIC PE is to obtain independent evidence to corroborate allegations about a doctor who has raised patient safety concerns in the wider public interest. This will provide assurance that the referral was not made without due diligence carried out by the RO in relation to information provided to them locally or as an inappropriate alternative to resolving the concerns raised by the doctor locally or as an act of retaliation. The PIC PE process aims to prevent whistleblowers from undergoing an unnecessary and stressful investigation linked to their whistleblowing history but where the referrer's allegations cannot be substantiated by independent evidence.

Did the doctor raise public interest concerns?

7 The PE team should firstly confirm that there is a genuine whistleblowing context to the enquiry. This will require consideration of the specific concerns raised by the doctor and if they raise wider patient or public safety issues.

8 This table provides illustrative examples of issues that do, and do not, constitute a public interest concern. It is not however an exhaustive list.

Public interest concern?	
Yes **Is there a direct and adverse impact on patient or public safety?**	**No** **Does it only affect the doctor with no wider impact on patients or the public?**
Pressure on staffing including inadequate staffing levels, excessive working hours and insufficient breaks leading to substandard patient care. For example, a doctor being concerned that due to staff shortages they have been placed on the rota at a grade beyond their competence or experience. This has the potential to have a wider impact on patient safety.	A doctor being unhappy with how a trust have handled their health condition
Inadequate systems for the storage and transfer of patient records	The doctor is unhappy with the way a local investigation has been conducted or disagrees with its findings
Uncivil behaviour and breakdown in communications between colleagues which directly and adversely affect the quality of patient care provided	Dispute between two doctors (including partnership dispute) which doesn't impact on patient safety
Inadequate junior staffing levels overnight and during ward rounds and concerns about junior doctor induction are public interest concerns due to the implications for patient safety	Concerns about the quality of a training programme (this could however be the subject of a public interest disclosure to the GMC as a prescribed body)
In limited circumstances, concerns that appear to be of a civil or non-clinical nature (eg issues about landlord/tenancy issues or non-payment of monies owed for services rendered) but only where these have the potential to negatively impact upon patient or public safety	A dispute around locum fees or payments for extra duties – this is an employment issue

Badly maintained equipment and substandard hygiene practices in cleaning instruments/equipment which leads to a risk of harm to patients	Poor quality equipment where this does not directly have an adverse impact on patient care
Poor/inadequate working conditions leading to unsafe care for patients	Complaints about the quality of doctors' accommodation or canteen facilities

9 If the PE team is satisfied that the doctor raised public interest concerns prior to being referred, they should double check that these related to the organisation that has referred them to us. Alternatively, there may be a tangible link between the referrer and the organisation about which the doctor raised patient safety concerns. This would mean we need, where possible, to obtain independent evidence to verify them.

Establishing the timeline – did the doctor raise the public interest concerns prior to being aware of local or GMC action in relation to their fitness to practise?

10 It will be important to check the timeline of events carefully. We need to establish whether the doctor raised public interest concerns before becoming aware that the referring organisation had concerns about their fitness to practise.

11 In some cases, the referring organisation may have had genuine concerns about the doctor's fitness to practise which were being resolved locally. However there is a risk these concerns could have been unnecessarily escalated to the GMC due to the doctor subsequently acting as a whistleblower.

12 If the timeline remains unclear following the initial assessment by the Triage team, further information should be sought to clarify the chain of events leading to the doctor being referred to the GMC. This may best be achieved by asking the relevant Employer Liaison Adviser (ELA) to make enquiries with the Responsible Officer (RO) of the referring organisation. We should bear in mind however that independent evidence may be needed to clarify the timeline.

13 Although an enquiry may have been allocated to PIC PE, it should be restreamed or a triage decision made if our enquiries establish that the doctor raised public interest concerns since being dismissed, or becoming aware of a local disciplinary investigation or referral to the GMC, and there is no record of them having done so previously. In these circumstances, it is best practice to ask the employing organisation for their comments in relation to the concerns raised by the doctor and

to flag, as background information, any response they provide to subsequent decision makers in the doctor's case.

Is there evidence to support the concerns that is independent of any individual or organisation that may be involved in the whistleblowing history?

14 In carrying out a PIC PE, we need to:

a make bespoke enquiries to check the independence of evidence supporting the complaint or referral

b obtain objective and reliable evidence in relation to the concerns about the doctor where this has either not been provided by the referrer or it is not sufficient to assure ourselves there are genuine fitness to practise issues. By objective and reliable, we mean evidence which has arisen either from source material such as medical records or from an independent third party. The third party should have no connection with any individual or organisation that may be involved in the public interest concerns raised by the doctor.

Independent verification of concerns raised in a referral and the accompanying documentation

15 It is important not to accept the referral information without question or give it inappropriate weight given the complex factors at play where there has been a history of whistleblowing.

16 In the first instance, the PE team should identify whether further information is needed from the referrer to assess the independence of any third party evidence they included in support of their referral.

17 Care should be taken about the objectivity of internal investigations even where multiple departments are involved. The following action may be needed.

a If an independent review was commissioned by the referrer, checks should be made to establish:

- how the person undertaking it was selected
- if they have any links to the referring organisation
- if their review was based on independent source data or simply on information provided by the referrer or body involved in the doctor's whistleblowing history.

b If expert opinion is contained within the referral, care needs to be taken about:

- the independence of the expert and queries should be carried out to check the process for selection of the expert
- ascertaining whether the expert had access to independent source data to support their assessment of the evidence or if they relied solely on information provided by the referrer or body involved in the doctor's whistleblowing history.

c If a referral contains information about independent evidence (for example, evidence provided by the doctor or perhaps family members or colleagues), checks should be carried out to ensure we have the original unredacted evidence and are not relying on a summary of such evidence from the referring organisation or a body involved in the doctor's whistleblowing history.

18 As with information about the timeline, it may be appropriate to ask the relevant ELA to clarify the above or obtain any other information that is needed from the referrer.

Rapid reviews or investigations by Royal Colleges or other third party organisations

19 In PIC PE, the referrer may have submitted information from third parties to support their referral. Where a third party organisation is involved, care should be taken to check whether:

a there are any close links between the referring organisation and the third party. For example, there could be close links between doctors carrying out an independent investigation and senior doctors at the referring organisation.

b the third party review was based on independent source data and not information solely provided by the referrer or body involved in the doctor's whistleblowing history.

20 The PE team should consider carefully whether information that appears to be objective is truly independent. For example, further information may be needed to ensure that an external third party investigator or expert is independent.

Obtaining further evidence to independently corroborate the concerns

21 A PIC PE is used to obtain independent evidence to corroborate the allegation that the doctor's fitness to practise is impaired and provide assurance that the referral is based on genuine concerns.

22 The exact nature of the information to be gathered will be determined by an Assistant Registrar based on the nature and complexity of both the allegations and the doctor's whistleblowing history.

23 This could include the following and staff should use the hyperlinks for further information about the different types of evidence which are sought across the PE process.

Evidence gathering

- medical records
- Datix or other reporting mechanisms such as formal clinical audits – this can be particularly useful to establish the timeline of patient safety concerns being raised and identify further sources of information about the incident/context/response of the referring organisation at the time.
- evidence from third party processes or investigations
- doctor comments

Evidence assessment

- medical case examiner advice
- independent medical expert opinion
- advice from a lay case examiner
- advice from the Legal team

PIC PE timeframe and escalation

24 Unlike other types of provisional enquiry, PIC PE does not have a set timeframe within which we aim to gather discrete pieces of evidence and make a decision on whether or not to open a full investigation. This type of PE is complex and gathering the information we need is likely to take some time. Nonetheless, Investigation Officers should keep timescales under review and escalate any excessive delays to determine the best way forward.

25 A PIC PE should be escalated for Assistant Director advice if it remains open after four months and we are experiencing delays or difficulties in obtaining the information needed. It should then be reviewed at regular intervals thereafter. Although the review points will be partly dictated by the circumstances of the PE, a review every 6-8 weeks is likely to be necessary so Assistant Directors can advise on appropriate next steps.

Assessing risk

26 It is important to assess any risk to public protection throughout the PIC PE process. Public protection includes protecting, promoting and maintaining the health, safety and wellbeing of the public, maintaining and promoting confidence in the medical profession and proper professional standards and conduct among doctors.

27 This may involve a careful balancing act as it is often unclear whether the referred doctor is:

a a doctor who has done the right thing by raising public interest concerns, as required by our standards and guidance, and is being unfairly targeted for doing so

b a doctor who has done the right thing by raising public interest concerns about an unsafe environment and there are unrelated and genuine concerns about the doctor's performance or conduct that raise risks to patients and public confidence, or;

c a doctor who is a risk to patients or to public confidence as a result of genuine concerns about their performance or conduct and they have raised public interest concerns in response to attempts to manage their performance or conduct.

It is often not possible to know which of these scenarios a referral relates to and it is not necessary to decide that it is one or the other until corroborating evidence clarifies this. It is very important that staff gathering information and decision makers keep all these possibilities under consideration throughout the PIC PE process and keep an open mind until reliable evidence is obtained.

Historical whistleblowing cases have revealed that whistleblowers who have done nothing other than raise concerns in the public interest in accordance with our guidance can be branded as troublemakers and that this can permeate throughout a whole organisation and even to other organisations who have links with it so that all the doctor's actions thereafter are viewed as misconduct. Care should be taken to keep an open mind even where there are multiple reports from different linked sources about a doctor. This must be balanced however with an open mind about the other possibilities including that a whistleblower might also pose a risk to the public or might have raised public interest concerns to deflect from their own failings.

28 Action should be taken to:

a close cases swiftly where we have established that the referral does not raise risks about the doctor's fitness to practise and provide feedback to the referrer

b manage serious interim risks and;

c address substantive risks that are supported by evidence.

29 Where the concerns about the doctor are serious and raise an immediate risk to patients or to public confidence in the profession, an Assistant Registrar should consider whether a referral to an Interim Orders Tribunal (IOT) is necessary. This can be done in the PIC PE process even where we are still seeking to independently corroborate the allegations and should not be delayed while further information is obtained. The rules require that any IOT referral prior to a rule 4 decision will need to be made by an Assistant Registrar* but advice can be sought from a case examiner if needed. We should not promote a case to an investigation solely to refer to an IOT if we are yet to obtain independent corroboration of the concerns raised. Even when it has been necessary to impose an IOT order to manage interim risks, a full investigation would further disadvantage a doctor in the longer term if it subsequently emerges that they have been subject to a retaliatory referral.

30 We can continue to progress the PIC PE by obtaining any information needed while awaiting the AR's decision or advice from a case examiner on referral to an IOT and/or while a case is being prepared for an IOT hearing.

Health provisional enquiries

31 Where there are concerns about a doctor's health and the triage team has decided the criteria are met for a Health PE, the enquiry will be carried out by the Health PE team based in the Communications Investigation team (CIT). The case plan will set out the information required which could include:

- the doctor's medical records
- information from treating clinicians
- copies of Occupational Health Reports
- information from the doctor's RO about any local management that is in place.

32 Operational guidance for carrying out a health provisional enquiry is here. It may also be necessary to gather some of the information set out below such as advice from a medical case examiner.

Protecting confidentiality

33 Care will need to be taken to protect confidential information about a doctor's health condition while obtaining evidence as part of a provisional enquiry. We should not disclose any information about the doctor's health to third parties including employers

* Under rule 6 of the General Medical Council (Fitness to Practise) Rules 2004

and, if there is a risk of doing so, we need the doctor's express consent to contact the third party.

34 Where evidence is required from a doctor's employer and we have the doctor's consent to contact them, they should be informed that we have opened a provisional enquiry and asked whether they have any relevant information to provide. Useful information may include (but is not limited to) the doctor's absence record, prescribing history, details of Occupational Health involvement, and any more general concerns the employer may have. We should not however provide the employer with any details of the PE or the nature of the concern we are considering unless we have the doctor's express consent to do so.

35 The doctor should be notified that we may need to seek further information about their health and asked to provide details of any health practitioners who may hold relevant information. If the doctor refuses to provide consent for us to obtain information about their health from a third party such as an occupational health report or a copy of their medical records, it is likely that it will be more appropriate for a full investigation to be opened. This will enable a decision to be made about whether to formally invite the doctor to a health assessment.

Single Clinical Incident (SCI) and Single Clinical Concern (SCC) provisional enquiries

36 The information gathering process for SCI and SCC provisional enquiries is broadly the same and more information on the common types of evidence that will be needed is in the section below titled "Evidence gathering in all provisional enquiries."

Evidence of insight and remediation

37 The key factor distinguishing SCI and SCC PE is that, although the threshold for a full investigation appears to be met, this will not be the case if we obtain cogent evidence that the doctor has remediated the concerns and it is highly unlikely they will be repeated. Where satisfactory evidence of remediation has been obtained, we can properly conclude that an SCI or SCC represents isolated misconduct on the part of the doctor and the chance of it being repeated is so small that their fitness to practise is not currently impaired. This is based on case law often described as the Cohen principles.*

38 The Cohen principles require decision makers to consider the following questions.

a Is the conduct which led to the allegation of impairment easily remediable?

* As established in the case of Cohen v GMC [2008] EWCH 581 (Admin)

b Has the conduct been remedied by the doctor?

c Is the conduct highly unlikely to be repeated?

39 The evidence of remediation required will vary depending on the specific nature of the concerns about the doctor's clinical care and the complexity of their interactions with the patient.

40 The doctor's RO or, in very rare circumstances, the RO responsible for the organisation where the clinical incident or concerns took place, should be asked to complete a form. This asks for details of any local investigation that took place together with the RO's view on the seriousness of the doctor's errors/actions and whether they have remediated the concerns.

41 If an RO has alluded to remediation information but has not provided details of this in their response, the PE team should follow up with the RO to request this and escalate to the ELA for advice and assistance if we receive no response.

42 In SCC provisional enquiries, further objective evidence of remediation may be needed particularly where the concerns were broad in nature and repeated over a longer period of time. Although it would depend on the nature of the concerns, this further evidence could include:

a successful completion of a formal re-training programme – eg retraining / return to work programme run by the deanery

b successful completion of an NCAS action plan (now known as practitioner performance advice)

c structured/detailed workplace assessments eg evidence of audit outcomes, record keeping review by independent expert, reflective practice, case based discussions, attendance at CPD courses, direct observation of procedural skills, multi-source feedback exercises, clinical evaluation exercises, testimonials from colleagues, engagement with supervision and mentoring

d objective evidence from local investigations eg performance data from local investigation

e objective evidence from training rotation eg Annual Review of Competence Progression (ARCP), specialist qualifications such as MRCP - Member of the Royal College of Physicians and MRCS - Member of the Royal College of Surgeons.

43 The Assistant Registrar (AR) should bear in mind that provisional enquiries are targeted and limited and it will likely only be feasible to obtain the above if it already exists and is readily available from the doctor or Responsible Officer.

44 We should not seek to rely solely on remediation evidence provided by the doctor and wherever possible should cross check it with other information provided by the RO together with objective evidence such as certificates confirming completion of training. The timing of remediation evidence may also be relevant with greater weight given to remediation activities completed before the doctor became aware of the GMC complaint or referral, for example in response to an initial local complaint.

Doctors in training

45 Where an SCI PE or an SCC PE relates to an alleged error or errors committed by a doctor in training, the AR should bear in mind that the doctor's RO is unlikely to be aware of the specific details of the alleged incident. The AR should therefore consider obtaining information directly from the organisation in which the incident took place.

46 When assessing remediation evidence relating to doctors in training, the AR should take into account any evidence of remediation provided by the doctor's educational and clinical supervisors.

47 If a trainee doctor has passed their Annual Review of Competence Progression (ARCP) in the time since an incident took place, an AR may also take this into account when weighing up evidence on remediation, but they should seek particular details relating to the incident in question.

48 Trainee doctors that are in permanent employment and a structured training environment are more likely to have effective structures in place to aid remediation.

Gathering information relating to the Covid-19 pandemic

49 Where there are concerns raised about a doctor's fitness to practise during the Covid-19 pandemic, we may need to obtain information on the circumstances which have arisen as a result of the pandemic and how they impacted on the systems in which a doctor was working and on how they delivered care. The purpose of obtaining contextual information is to ensure we take into account the difficult and demanding circumstances in which a doctor was working when making a decision whether or not to open a full investigation.

50 Further information about how to take the circumstances of the pandemic into consideration is set out in the guidance for decision makers *COVID-19: assessing the risk to public protection posed by a doctor as a result of concerns about their practice during the pandemic.*

Considering Covid-19 contextual factors across the individual PE streams

51 It is likely that most concerns raised about a doctor's clinical practice or misconduct during the pandemic will fit within the definition of an existing PE stream, particularly

PE – SCI, PE - SCC and PE - PIC. Concerns will be allocated to the relevant stream, as set out in part C of the guidance.

52 Contextual information related to the pandemic can then be obtained within these streams, alongside any information specific to the different streams, where this is required to reach a Rule 4 decision. The timing of gathering contextual information related to the pandemic may differ between within each PE stream. We have set out the nuances specific to each stream below.

PE - PIC

53 Obtaining the detail around the Covid-19 context should be completed in tandem with gathering the objective evidence in PIC enquiries to corroborate the concerns raised by the referring organisation. The contextual information will help to provide a complete picture for expert review and will enable the decision maker to determine whether a full investigation is necessary. The objective evidence required for PIC provisional enquiries is set out in the PIC PE section above.

PE - SCI and SCC

54 If, on the face of the allegations, the Investigation Manager considers that information on the circumstances in which the doctor was working may be enough to enable a decision to close the enquiry, then this information should be obtained first. This will prevent time spent on collecting information on insight and remediation where this is not necessary to make a triage decision. If it becomes clear after obtaining contextual information that this alone is not sufficient to make a triage decision, information on insight and remediation should then be obtained. The evidential requirements for SCI and SCC provisional enquiries are set out in the SCI/SCC PE section above.

55 However, the PE team should be mindful that some cases may require both contextual and clinical information to enable an informed decision. If the nature of the allegations and the circumstances known on receipt of the enquiry seem to indicate that contextual information alone may not be enough, then all evidence that has been identified as relevant, including evidence of remediation, should be requested together. Responses should be reviewed as and when received and the case owner should ensure that decisions are raised at the earliest stage possible.

PE - FI

56 If a concern does not fit within the definition of PIC, SCI or SCC, and has been identified as suitable for PE, the enquiry will be allocated to the FI PE stream as set out in part C of the guidance. Contextual information related to the circumstances in which the doctor was working during the pandemic can then be obtained.

PE - Health

57 Contextual information related to the impact of the pandemic on how a doctor has provided clinical care is not generally required in Health provisional enquiries. Although the pandemic may impact on the environment in which the doctor is working, as we only undertake a Health PE where the concerns relate solely to health and not clinical care or misconduct it will not be the determining factor of how their health condition may be impacting their ability to practise safely. Information gathering for Health provisional enquiries that have arisen during the pandemic should be conducted in the usual process as set out in the Health PE section above.

Evidence of context

58 Evidential requirements will be assessed on a case by case basis and the person completing the case plan will need to use their discretion in assessing the information that is needed relating to the circumstances in which the doctor was working. In doing so, they should keep in mind the key principles for PE and our overarching objective to protect the public and manage the overall risk posed by the doctor.

59 The information gathering process for provisional enquiries where consideration of the context of the pandemic is required is largely the same and the types of evidence that will be needed within each different stream is in the section below titled Evidence gathering in all provisional enquiries.

60 The key difference is that the PE team may need to obtain evidence to establish the context in which the doctor was working. This information may be obtained via the following:

- Doctor comments - when carrying out doctor disclosure, the doctor will be asked to comment on the circumstances in which they were working and to provide information they feel is relevant to the concerns being raised.
- Comments from the doctor's Responsible Officer - in SCI and SCC provisional enquiries where consideration of context is required, the doctor's RO should be asked to complete a form. This will ask the RO to provide contextual information relevant to the enquiry and, if necessary, specific details of the context, such as working arrangements at the time.

61 Further clinical information may also be necessary to support the decision maker in deciding whether the allegations raise concerns about the doctor's fitness to practise. The case plan will set out the information required, which may include:

- Medical records
- Medical or lay case examiner advice

- Independent medical expert opinion - the PE team will provide the independent expert with contextual information that has been obtained. This will support the expert to factor in the circumstances in which the doctor was working in their assessment of the doctor's actions.

62 Operational guidance for gathering Covid-19 contextual information is here. It is also necessary to refer to the sections below to identify the evidence specific to the PE streams that needs to be obtained.

Evidence gathering in all provisional enquiries

63 The case plan will direct the evidence that should be sought during a provisional enquiry based on the nature of the concern, the complexity of the allegations and the specialist input required. The following types of information may be relevant to all types of PE and any nuances related to the individual streams are flagged below.

64 It may not always be possible to determine the information needed based on the initial complaint. Where this is the case, the decision should be deferred until the medical records have been gathered and the requirements are clearer.

65 Decision makers should bear in mind that it will usually be possible to re-stream a PE if it becomes appropriate to do so based on further information coming to light.

Medical records

66 Operational guidance on obtaining medical records is here.

PIC PE

67 Medical records should be sought where the referrer has raised concerns about the standard of clinical care provided by the doctor to specific patients. They will be necessary to obtain an objective medical opinion either from a medical CE or an independent expert as to whether the referrer's concerns raise a question about the doctor's fitness to practise.

SCI, SCC and Further Information (FI) provisional enquiries

68 We will need to request relevant medical records in the majority of SCI and SCC provisional enquiries. They may also be needed in Further Information (FI) PE cases where the matters are clinical but do not relate to an SCI/SCC. Given the relatively short timeframe within which enquiries will be carried out, it is likely that we will ask for only limited extracts from medical records and only from relevant sites.

69 It is particularly important to seek medical records in primary care cases as the RO is less likely to be familiar with a particular incident, due to their distance from the location of care provision.

70 Medical records are also likely to be of use in FI PE about clinical matters that do not relate to an SCI/SCC where the complaint or alleged chronology of events appears unclear or confused in places. They are also helpful to corroborate the patient's account of their treatment and enable us to obtain a medically qualified opinion on the standard of care given.

71 Where possible the person completing the case plan should specify the extent and type of medical records required. We should only request the specific information from the medical records that will help us to resolve the current concern and close the enquiry, eg information from a specific period of a CTG trace, or alternative types of medical records including those from a care home etc. The AR signing the medical records request* should review it carefully and be satisfied that obtaining the specified records will be of use to the enquiry.

72 The person completing the case plan and/or the AR signing the section 35A request should always consider the following.

- **a** Are the records likely to confirm whether or not the allegations raise concerns about the doctor's fitness to practise?
- **b** Is it likely this information could enable us to close the enquiry?

Exception

73 Medical records may not need to be sought where a healthcare provider, regulator, or Coroner has conducted a thorough, impartial review of the incident, and has shared a copy of a report relating to this review with the GMC.

74 In addition, it may not be necessary to seek medical records at the provisional enquiry stage where a doctor has admitted their error(s), has not challenged the alleged chronology of events, and this has been documented.

Datix or other reporting mechanisms such as formal clinical audits

75 This type of evidence is mainly relevant to PIC PE.

76 In some enquiries, we may be able to obtain independent data to assess the legitimacy of concerns about the doctor from Datix reports or formal clinical audits.

77 Datix reports can also be used to establish a timeline of when a doctor first raised patient safety concerns e.g. by flagging issues around staffing, equipment and unsafe clinical practices.

* under section 35A of the Medical Act 1983 (as amended)

Third party enquiries

78 There may be relatively quick enquiries that can be carried out in order to better understand the nature of a complaint or referral. The Thresholds guidance states:

"local enquiries may be more appropriate to establish whether the allegations arise out of a misunderstanding or whether there has been apparent misconduct by the doctor that we need to consider"

79 We can also seek information from third parties not directly involved with the doctor eg HM Coroner. However the person completing the case plan should bear in mind that PE is designed to be a swift and targeted process and if complex enquiries are required, a provisional enquiry may not be suitable and the matter would be more appropriately treated as a full investigation.

80 If, as a result of making third-party enquiries, it is clear that an organisation with which a doctor does not have a prescribed connection holds relevant information (e.g. information relating to their own internal investigation), we should seek to obtain this information.

PIC PE

81 We should obtain information about any third party processes which are entirely separate from investigations carried out by the referring organisation. These could include a Coroner's inquest into a patient's death or care, an Employment Tribunal or an NCAS assessment.

82 If the concerns raised by the referrer are also contained in, or based on, these third party processes then this will serve as independent corroboration and provide reassurance that the referrer's concerns about the doctor's fitness to practise are objective and well founded.

Inspections by healthcare regulators

83 It may also be relevant to consider inspection reports by the Care Quality Commission (CQC) in England, the Healthcare Inspectorate in Wales, the Care Inspectorate in Scotland or the Regulation and Quality Improvement Authority in Northern Ireland. This will particularly be the case where the referring organisation has been placed in special measures or required to take action to remediate identified patient safety concerns. Reviewing inspection reports will assist the decision maker in considering if the public interest concerns raised by the doctor were legitimate and shared by others.

84 They may also help to determine whether factors such as poor teamworking and inadequate communication or leadership in the workplace resulted in the doctor being hindered in providing an acceptable standard of care.

Formal investigations by public bodies (e.g. other regulators, Health and Safety Executive, National Fraud Office)

85 We may receive a complaint or referral that concerns the outcome of a formal process. We should obtain a copy of the report if we believe that it will help resolve the issue and the report has been produced by a credible body.

86 Given the targeted nature of the provisional enquiry process, consideration should be given to whether or not the third party investigation is complete and, therefore, whether the report is likely to be available within the timescales for a PE.

Medical case examiner advice

87 After obtaining medical records, or relevant third party information, the PE team will usually need to seek either medical case examiner advice, or the opinion of an external expert through a documented discussion. Where possible, the AR should indicate which is likely to be appropriate to the enquiry.

88 Operational guidance on obtaining medical CE advice during a provisional enquiry is here.

PIC PE

89 The medical CE can also advise on the likely value of any evidence provided in support of the referral and the weight that should be given to it, together with the scope of any third party investigation and the appropriateness of the methodology used to assess the doctor's practice. This will help the decision maker assess whether the conclusions reached are reliable and based on a sufficient sample of the doctor's work to give fair and objective findings about whether their fitness to practise is impaired.

SCI and SCC provisional enquiries

90 The AR may feel it is appropriate to initially seek the opinion of a medical case examiner on whether or not an expert opinion is required. This will be useful where the AR has insufficient specialist knowledge to determine whether an external expert opinion will be useful, or what kind of specialist input is needed.

91 To help determine whether there is a (clinical) FTP issue that warrants investigation, a medical CE can be asked to advise on general medical issues and whether the doctor's actions raise a question about their fitness to practise.

92 At this stage, the medical CE is not being asked to advise whether the realistic prospect test is met but whether the standard of care 'appears' to raise a question of impaired fitness to practise. If this is the case, we should usually proceed to obtain

the view of an independent expert through a documented discussion together with evidence about the doctor's insight and remediation.

93 The Medical CE or independent expert (see below) are also able to advise on the seriousness of the incident in question. This will help the AR to assess at the outcome of the PE whether the matter is egregious (shockingly bad) and the enquiry should be promoted directly for a full investigation.

Independent medical expert opinion

SCI and SCC provisional enquiries

94 An independent expert opinion should be considered if we need to clarify the seriousness of the doctor's alleged failing(s) eg to determine whether the incident or complication was within a normal error range or not. Although a medical case examiner can give general advice, they are not able to provide specialist expertise.

95 The independent expert will provide a view (via a documented discussion) on whether the complaint contains any information that suggests the doctor's care fell below the standard expected of a doctor practising at that level. In answering this question, the expert will consider if there were any significant breaches of *Good Medical Practice* or our other published guidance.

96 We may consider seeking case examiner advice on whether, in light of the steps taken to remediate, a question is raised regarding the doctor's current fitness to practise. On occasion if the concerns involve specialist matters we may wish to seek advice from the expert to help our understanding of the remediation. However, we should bear in mind it is not the expert's role to comment on the quality of the doctor's remediation or express a view on whether the doctor is fit to practise.

97 Where a documented discussion or other independent evidence from the PE process identifies very grave concerns about the seriousness of the doctor's error(s), or a reckless disregard for patient safety, such that they could be considered to be "truly, exceptionally bad" then the enquiry should be promoted to an investigation without delay. Referral to an IOT may also need to be considered as a priority.

Lay case examiner (CE) and In House Legal Team (IHLT) advice

98 The view of a lay CE or the IHLT may also be sought where there is a lack of clarity relating to non-clinical aspects of an enquiry. At this stage, the CE or legal adviser is not being asked to advise whether the RPT is met but whether the complaint raises a question of impaired fitness to practise in relation to the doctor that should be investigated.

PIC PE

99 Where there are conflicts or clear inconsistencies in evidence and/or the whistleblowing history is very complex, it may be helpful to obtain case examiner or legal advice on the weight that can be given to individual pieces of information provided about the doctor.

Doctor comments

100 Doctors don't have to comment on allegations during a provisional enquiry. However, there may be circumstances where the concerns can only be resolved by an explanation from the doctor and/or provision of evidence of insight and remediation.

PIC PE

101 It may be useful to ask the doctor to clarify the timeline of their raising public interest concerns and whether this was prior to the referral being made to the GMC. If the doctor makes comments as part of PIC PE and raises concerns about other doctors, the Investigation Officer should be mindful that we may also need to consider their fitness to practise.

102 If there is any suggestion from the doctor that their revalidation has been deferred unfairly, this should be referred to Registration and Revalidation. It should not be dealt with in Fitness to Practise and should not be mentioned in the Triage decision. Registration and Revalidation have their own processes for dealing with doctors who have raised public interest concerns and the revalidation process.

Health PE

103 We will need to seek the doctor's consent to access their medical records or obtain other information about their health as this information is confidential. For example from their treating doctors or Occupational Health department.

SCI and SCC provisional enquiries

104 A doctor's comments will be particularly helpful where evidence of remediation is needed to enable us to conclude that there is no issue of impaired fitness to practise. We encourage doctors to provide evidence of additional training or remediation which they feel is relevant to the specific concerns being raised and helps to demonstrate the steps they have taken to address any potential concerns about their practice. We also ask for any local response the doctor or their employer has made to a complaint.

Responsible officers and designated bodies (except the remediation evidence required in SCI and SCC PE which is covered above)

105 In provisional enquiries, we only routinely write to a doctor's RO or the incident location RO if we believe they have helpful information to assist our decision making.

This is with the exception of SCI and SCC PE where we will always contact the RO to ask for their view on the seriousness of the incident/concerns and details of any local remediation carried out by the doctor.

PIC PE

106 Please refer to the PIC section above for details of enquiries we may need to make to verify the independence of information provided in support of a referral.

Health

107 Concerns about a doctor's health must remain confidential. When asking for information, we should confirm that confidential fitness to practise concerns have been raised, without providing any details or enclosing a copy of the concerns.

Further Information PE

108 In some Further Information PE (where the criteria for SCI or SCC PE are not met) we may need to request further information from the doctor's Responsible Officer or ask them to provide an indication of expected timescales relating to any current local investigations. If a doctor's deviation from local guidelines/protocols (where these are in place) forms part of the concerns raised about them, copies of these guidelines should be requested from the RO.

109 In general, however, unless the information can be provided imminently, we should proceed without awaiting the outcome of a local investigation.

Where a doctor has no RO/designated body

110 Where the doctor has no RO or designated body, or the incident occurred at a previous workplace, staff may approach the organisation in question for further information.

111 Where an institution is not a designated body, the PE team should first approach the relevant ELA for advice on employer disclosure. It may then be appropriate to write to the Chief Executive or Medical Director for further details.

Employer information

112 There is no requirement under the rules or Medical Act for the GMC to notify a doctor's employer of a provisional enquiry. However we do have a power to disclose

information relating to a doctor's fitness to practise if we consider it to be in the public interest to do so*.

113 When approaching employers or third parties for information, we do not generally 'disclose' the existence or nature of the PE. In some circumstances, the AR may need to consider whether or not a disclosure is nonetheless required in order to request information from a doctor's employer if our request is very specific and/or they question our basis for doing so. If we do so, we should take care not to disclose any confidential information when making our request. Where we hold confidential information, take care not to disclose it inadvertently by sharing information that enables the recipient to guess the nature of the confidential information.

Use of personal information

114 Staff should have regard to the overarching guidance *Guiding Principles on using personal information when considering concerns*.

115 If we propose to share sensitive information, that relates to the complainant or a third party, with external individuals or organisations as part of provisional enquiries we will need to notify the individual how their personal information will be used in our fitness to practise process and give them an opportunity to let us know if they have any concerns or specific requests about that use.

* Under section 35B(2) of the Medical Act