General Medical Council

Part E – Deciding the outcome of a provisional enquiry (PE)

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Purpose

1 This guidance supports decision makers in the PE team to decide the outcome of provisional enquiries at the end of the triage process. It outlines the factors they should consider when deciding whether to:

a close the enquiry with no further action

b close the enquiry but, in addition, use the notify RO or notify Employers process

c promote the enquiry to a full investigation.

2 It supports a consistent and fair approach to decision making by guiding Assistant Registrars through the key considerations that are specific to the different PE streams. For example, by providing guidance on how to weigh evidence of remediation in SCI and SCC provisional enquiries. By key consideration, we mean things that are important to the decision maker's overall consideration of which PE outcome is appropriate. A flow chart summarising the decision making process can be found here.

Overarching principles

3 The following principles apply to all provisional enquiries.

a Decision makers must determine whether the concern appears to raise a question as to whether the doctor's fitness to practise is impaired.* This is known as the triage test.

b The decision should be based on the nature and seriousness of the allegations, the evidence obtained through our provisional enquiries and the risk of the conduct being repeated and placing patients at risk.

c Any decision on the outcome of a PE should be made in the context of our overarching objective to protect the public. This means decision makers should consider not only the protection of patients but our objectives to promote and

* Under one of the grounds set out in Section 35C(2) of the Medical Act 1983 which broadly summarised are misconduct; deficient professional performance; a criminal conviction or caution either in the UK or overseas; adverse physical or mental health; not having the necessary knowledge of English or a determination by a regulatory body in the United Kingdom or overseas to the effect that the doctor's fitness to practise is impaired.

maintain public confidence in the medical profession and proper professional standards and conduct for doctors.

d Even where we have obtained evidence of remediation, promotion to an investigation will be appropriate if a reasonable, well informed member of the public would consider the doctor's actions to be shockingly bad and therefore irremediable.

e Decisions at the end of the PE process should be transparent and address all the relevant factors. The decision maker should give clear reasons for deciding to close or promote an enquiry. The reasons do not need to be elaborate or lengthy but should aim to ensure the parties can understand in broad terms how we reached our decision. If inadequate reasons are given, there may be an inference that the decision maker had no good reasons or did not fully consider all the issues. This could give rise to a risk of legal challenge. Assistant Registrars (ARs) should bear in mind however that they are not making findings of fact or deciding if there is a realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree requiring action on their registration*.

Decision makers should refer to the relevant triage guidance on making and recording decisions. They may also find it helpful to refer to the Triage manual, the Triage manual for health enquiries and the Provisional Enquiry Decision makers guide.

Potential outcomes

4 There are three possible outcomes at the end of a provisional enquiry. This is with the exception of health PE where we do not use the notify RO or notify Employers process.

Close enquiry

5 This will be appropriate where the Assistant Registrar (AR) is satisfied that the enquiry does not raise a question as to whether the doctor's fitness to practise is impaired.

Promote to an investigation

6 The AR decides that a full investigation is required as, having considered all the information gathered through the provisional enquiry including evidence of

* Known as the realistic prospect test (RPT) which is applied by case examiners at rule 8 of the General Medical Council (Fitness to Practise) Rules 2004.

remediation, there is an outstanding question as to whether the doctor's fitness to practise is impaired.

Notify Responsible Officer (RO) or Notify Employers

Notify RO

7 At the conclusion of a provisional enquiry, the AR has the discretion to close the case and notify the doctor's RO of the concerns identified with the expectation the RO will arrange for them to be considered as part of the doctor's annual appraisal. An RO has responsibility for monitoring individual doctors' fitness to practise and for making recommendations for revalidation.

8 Decision makers should categorise an enquiry as Notify RO or Notify Employers (see below), if they conclude that the information provided does not meet our threshold for investigation, but that it should be shared and considered locally, at least in the first instance. The doctor will be informed and expected to consider the complaint as part of annual appraisal and revalidation.

9 As one of the main purposes of the notify RO/Employers process is to ensure concerns are reflected upon in the doctor's appraisal, allegations significantly more than 12 months old may be less suitable for this outcome.

Notify employers

10 If the doctor does not have a prescribed connection to a designated body (and therefore an RO), the AR can direct that we approach the doctor's employers to check that there are no other concerns. This notify employer process involves sharing the concerns with the doctor's employer(s) and asking for their assurance there are no fitness to practise issues for us to consider before we conclude the provisional enquiry and close the case.

Factors to consider when deciding the outcome of a PE

Triage threshold test

11 The same threshold applies to all provisional enquiries irrespective of the stream they fall under. PE is part of the triage process and the final threshold test to be considered by decision makers is:

Whether the allegation appears to raise a question as to whether the doctor's fitness to practise is impaired.

12 The triage test focuses on whether the issues are such that they require investigation by the GMC. Although this test applies universally, the factors to be considered by

decision makers will vary depending on the nature of the concerns and the information we have gathered through different provisional enquiry streams.

The circumstances of the Covid-19 pandemic

13 If the complaint or referral relates to the doctor's practice and/or conduct in a clinical setting during the Covid-19 pandemic and the circumstances which have arisen as a result of the pandemic could be key to clarifying whether a question is raised about the doctor's fitness to practise, the AR will need to assess how the circumstances of the pandemic impacted on the systems in which the doctor was working and on how they delivered care. This will involve carefully considering any information we have obtained about the specific circumstances in which the doctor was working at the time the concerns arose. For example, whether the doctor was working in a different role, specialty or environment to their usual working arrangements. Or if they were working without access to adequate equipment such as PPE.

14 The AR should apply the principles detailed 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* when deciding if the triage threshold test is met.

15 This includes taking into account the difficulties and pressures doctors were facing at the time of an incident during the Covid-19 pandemic, and considering whether the doctor took reasonable steps to:

- provide the best and safest care they could in line with the best evidence available at the time
- communicate effectively and work cooperatively with colleagues to keep people safe
- challenge and report poor practice or issues which negatively impacted on their practice, escalating their concerns rapidly
- demonstrate that they tried and exhausted other reasonable means to address any issues and concerns; and/or
- keep records of the decisions they make and the actions they take.

16 Where the concerns arose during the Covid-19 pandemic, the impact of the pandemic on the doctor's practice and ability to deliver safe care should generally be assessed simultaneously alongside the appropriate considerations for each PE stream as set out in parts C, D of the guidance and below. For example, in a PIC, SCI or SCC PE the circumstances of the pandemic should generally be considered alongside the seriousness of the concerns and the evidence of remediation provided by the doctor.

Public interest concerns (PIC) provisional enquiries

17 Decision makers should take the following key considerations into account before deciding the outcome of a PIC PE by answering the questions at the end of this section. If the concern(s) arose during the Covid-19 pandemic, the decision maker should also consider the circumstances in which the doctor was working.

Have the concerns been corroborated by independent evidence?

18 In some PIC PE cases, it may not initially be clear whether the concerns raised about a whistleblower are genuine or are a retaliation against the doctor for raising public interest concerns. A combination of the two may exist in some referrals.

19 When deciding the outcome, the AR should consider whether sufficient independent evidence has been obtained through our provisional enquiries to corroborate the concerns about the doctor's fitness to practise.

20 Some types of concern are easier to verify than others. Clinical issues, for example, can often be corroborated by obtaining the medical records and commissioning an independent expert view on the allegations.

21 It is harder to independently verify allegations of misconduct which rely on witness testimony particularly where one member of staff makes a serious allegation of misconduct against the whistleblower doctor and there were no other witnesses present.

22 Some types of concern may be more likely to be linked to a doctor's whistleblowing history. These include allegations of poor clinical practice identified by a detailed records review instigated after the doctor has raised public interest concerns. Or allegations of rudeness, bullying, poor teamworking or failure to work with colleagues which arose after the doctor acted as a whistleblower. Decision makers should treat concerns arising solely after the doctor raised patient safety issues with particular caution.

23 The more serious the allegation, the more careful decision makers need to be about ensuring that there is evidence to support a decision to close a PIC PE. For example, allegations relating to probity, sexual misconduct, abuse of trust and violent or abusive conduct in the workplace will require careful consideration of the totality of information obtained during the PE. Where these allegations are supported solely by statements from Trust staff (who may or may not have been involved in the doctor's whistleblowing history), we should have made serious efforts to try to obtain independent corroboration at PIC PE. If it has become challenging or protracted to obtain such evidence through provisional enquiries, or only partial evidence has been obtained, a full investigation may be indicated and should not be unreasonably delayed. This will allow for a more detailed assessment of evidence, including testing conflicts of evidence and obtaining witness statements where appropriate. Referral to

an IOT should also be kept under careful consideration by decision makers in these types of enquiry and, where needed, can be undertaken in the PE process.

The doctor's fitness to practise history

24 The AR should take the doctor's fitness to practise history, including any current open cases, into account when deciding the outcome of a PIC PE. If similar concerns to those raised in the referral have been previously raised with us, the first thing to check is whether those previous concerns could also have been linked to the doctor's whistleblowing history. If so, and we have been unable to independently corroborate the current concerns, this may weigh in favour of the PIC PE being closed. If the previous concerns are not related to the doctor's whistleblowing history, this will weigh in favour of the PIC PE being promoted with PIC investigation safeguards (see below) applied. This is because it suggests a pattern of concerns which indicate that the current referral is likely to have a legitimate basis.

25 The weight that should be given to previous cases will however vary depending on their individual circumstances, the extent to which they are similar to the new referral and whether or not they resulted in action being taken against the doctor. Decision makers should refer to our separate guidance on taking a doctor's fitness to practise history into account.

Receipt of new allegations

26 If new allegations have been made since the PIC PE was opened, ARs should consider whether these have any impact on whether it is to be closed or promoted to a full investigation. The first thing to check is whether the new allegations could be linked to the doctor's whistleblowing history. If so, and they could meet the threshold for investigation, this weighs in favour of joining the new allegations to the PIC PE and promoting or closing them as necessary.

27 If the new allegations have no connection to the doctor's whistleblowing history and are similar to those raised in the referral, this will (where they meet the threshold for investigation) weigh in favour of the PIC PE being promoted and the two matters being considered together.

28 If new allegations are not similar to the concerns being considered at PIC PE, there is unlikely to be an impact on the outcome of the provisional enquiry. For example, if we are already considering allegations about substandard clinical care and poor working relationships and the new enquiry relates to a conviction for driving with excess alcohol, it should not prevent us from concluding the PIC PE if we have been unable to corroborate the concerns raised by the referrer.

Questions to be answered by decision maker and possible outcomes

Does the information collected during the PIC PE suggest the doctor needs to undergo a GMC assessment of their health, language or performance as their fitness to practise may be impaired on these grounds?

29 If the answer is no ➡ proceed to question below.

If the answer is yes ➡ the enquiry should be promoted to a full investigation to enable an assessment to take place. The investigation should have PIC safeguards applied as described below.

Has independent evidence been obtained to corroborate the concerns raised in the complaint or referral? This could include medical records, third party investigation material or the opinion of an independent expert.

30 If the answer is no ➡ proceed to question below.

If the answer is yes and the evidence has clarified that the allegations are unfounded or not sufficiently serious to raise a question of impaired fitness to practise ➡ close the enquiry.

If the answer is yes and the evidence clarified that the allegations are well founded and raise a question of impaired fitness to practise ➡ promote to a full investigation and ensure that the PIC investigation safeguards are deployed.

31 Where only some of the concerns have been corroborated, the AR should consider if it is appropriate to close the allegations which are unsupported by independent evidence while promoting the others to a full investigation.

Based on the nature of the concerns and the outcome of our enquiries including, where applicable, the circumstances of the Covid-19 pandemic, do you consider that the referral raises a question as to whether the doctor's fitness to practise is impaired?

32 If the answer is yes ➡ promote to an investigation and ensure the PIC safeguards (see below) are applied.

If the answer is no ➡ close the enquiry.

PIC safeguards

33 Where a PIC PE is promoted to an investigation, the AR should ensure that PIC safeguards are applied to the case. These safeguards ensure that case owners and decision makers are aware of the PIC history and that, if further information is needed, the investigation plan focuses on ensuring (where possible) that this is

independent of the referrer or anybody involved in the doctor's whistleblowing history.

Closing a PIC PE – providing feedback via Outreach

34 When we close a PIC PE because the referral doesn't meet the investigation threshold or the concerns aren't corroborated by independent evidence, the AR in the PIC PE team should flag the outcome to the relevant ELA using the template e-mail provided. This will provide the ELA with details of the specific feedback that needs to be given to the Responsible Officer or other referrer on why the enquiry was closed. This feedback loop should be engaged if any allegations are closed even where others are promoted for a full investigation following the provisional enquiry.

35 The ELA will confirm by e-mail once the feedback has been given and this confirmation should be stored on the enquiry record.

Counter complaints about the Responsible Officer/Referrer

36 During the course of a PIC PE, we may receive a complaint about the RO or referrer from the doctor who has been referred to us. This may relate to how they have dealt with the referral in light of the history of the doctor raising patient safety concerns.

37 While doctors with a whistleblowing history are vulnerable to retaliatory referrals, ROs are also vulnerable to being complained about to the GMC in retaliation for legitimate actions they may take to manage concerns about doctors, and similar issues arise requiring that we seek to obtain independent corroborating evidence as soon as possible.

38 However, if there is evidence that an RO has carried out a retaliatory referral against a whistleblower, this is a serious matter, and needs to be carefully investigated. We should therefore consider the complaint against the RO/referrer in the context of the PIC PE particularly if it is closed with no further action as the allegations against the doctor are not corroborated. Lack of corroboration is not in itself evidence of a retaliatory referral but, depending on the nature of the concerns and the nature of the evidence we obtained, it may be. It is likely to be appropriate therefore to delay a final triage decision on the complaint against the RO/referrer until the PIC PE has concluded. All linked decisions ie complaints from each party about the other, should be processed on the same day to avoid new material coming in on one which may impact the other and to ensure the full context is considered at the conclusion of our enquiries and there is consistency in our decision reasoning.

Health provisional enquiries

39 The purpose of a health PE is to establish whether any issue of potential impairment arises as a result of the doctor's condition for example because it is not being adequately managed at a local level leading to an unaddressed risk to patients.

40 Once all the necessary information has been collected, the AR should reassess the enquiry in light of the new evidence obtained. This may include the doctor's medical records, information from treating clinicians and copies of Occupational Health reports.

41 The AR should review this evidence against our *Guidance for decision makers on assessing risk in cases involving health concerns*. This sets out in detail the factors which suggest a full investigation in relation to health concerns:

a may not be necessary

b may be required

c is likely to be required.

42 This will assist the AR to decide whether an investigation is necessary or whether the enquiry can be closed as there is no evidence to suggest the doctor's fitness to practise is impaired on health grounds. Further guidance on deciding the outcome of provisional enquiries involving health can also be found in the Triage manual for health enquiries.

Questions for decision maker and possible outcomes

Have we obtained sufficient information to conclude that there is no risk to patients as a result of the doctor's condition, for example because the doctor has insight into their condition, is complying with medical advice and any workplace risks are being adequately managed?

43 If the answer is yes ➡ proceed to next question.

If the answer is no ➡ it will usually be necessary to promote to an investigation to enable a GMC health assessment to be carried out.

Based on our enquiries and the evidence obtained, do you consider that the enquiry raises a question as to whether the doctor's fitness to practise is impaired?

44 If the answer is yes ➡ promote to an investigation and allocate to the Communications Investigation Team (CIT.)

If the answer is no ➡ close the enquiry.

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

45 The AR should consider the information obtained during our provisional enquiries to reach an overall view on whether a question is raised about the doctor's current fitness to practise. Key to this will be whether we have obtained reliable evidence of any identified failings on the doctor's part and, if so, that they have been successfully remediated leading to a low risk of repetition. If the concern(s) arose during the Covid-19 pandemic, the decision maker should also consider the circumstances in which the doctor was working.

Seriousness and enquiries that raise public confidence issues

46 The seriousness of the concerns may only become clear once further information is obtained as part of the PE process. In SCI and SCC PE, the view of the Medical CE or independent medical expert will be particularly important in determining the level of seriousness of a clinical incident or clinical concern.

47 There will be some enquiries where a full investigation may be required even though they relate to a single clinical incident or concern and the doctor has provided evidence about steps they have taken to remediate the concerns. This is because failure to investigate and, if appropriate, take action in these cases would undermine public confidence in the medical profession. It would also be inconsistent with our overarching objective to maintain and promote proper professional standards and conduct for doctors.

48 This principle* should be considered in all SCI and SCC provisional enquiries but is likely to be engaged in only a small number where the seriousness of the error(s), or disregard for patient safety, appears to be 'truly, exceptionally bad' and therefore not easily remediable.

49 In assessing whether an enquiry raises public confidence issues, the AR should consider whether a reasonable, fair-minded and informed member of the public would be likely to view the doctor's actions or failings as 'truly, exceptionally bad'. This could include a one off failing involving gross negligence or recklessness about a risk of serious harm.

50 When a documented discussion or other evidence from the SCI or SCC PE process clarifies the seriousness of the error(s) or disregard for patient safety are such that they could be considered to be 'truly, exceptionally bad' then the enquiry should be promoted to a full investigation.

* Based on case law established in CHRE v NMC and Grant [2011] EWHC 927 (Admin)

Enquiries that do not raise public confidence issues – evidence of serious failings and remediation

51 Most provisional enquiries involving clinical incidents or concerns will not raise public confidence issues and the main consideration for decision makers is whether there is evidence of any serious failings and, if so, whether they have been satisfactorily remediated by the doctor.

52 Once evidence of serious failings has been identified in relation to an SCI or SCC PE, the AR should consider these questions in order to establish whether the failings meet the investigation threshold.

a Is the conduct which led to the complaint or referral easily remediable?

b Has the conduct been remedied by the doctor?

c Is the conduct highly unlikely to be repeated?

These are known as the Cohen principles* and this approach allows us to take into account evidence of remediation during a PE involving clinical incidents or concerns.

53 Remediation is where a doctor addresses failings in relation to their knowledge, skills, conduct or behaviour. It can take a number of forms, including coaching, mentoring, training and rehabilitation (this list is not exhaustive), and where fully successful, will make impairment unlikely.

54 Having considered all the information gathered through provisional enquiries, the first question the AR should address is whether there is evidence of serious failings by the doctor. Once this has been established the AR should go onto consider firstly whether the doctor's conduct is easily remediable. By this we mean is it feasible for the doctor to remedy identified failings through further training, study or other methods such as supervised practice. The AR should weigh the extent of the clinical failings against the weight of the remediation evidence that is provided. For example, where an independent expert identifies broader failings, more cogent evidence of remediation (see examples below) would be required than in cases where the identified failings are narrower. Decision makers should not take the doctor's assurance at face value and wherever possible should cross check their personal statements against other remediation evidence such as the RO form and course certificates. The timing of remediation evidence may also be relevant with greater weight given in some circumstances to remediation activities completed before the doctor became aware of the GMC complaint or referral, for example in response to an initial local complaint.

* Derived from case law in Cohen v GMC [2008] EWCH 581 (Admin).

55 Our provisional enquiries may clarify that the misconduct has taken place over a prolonged period of time and reflects serious attitudinal or behavioural issues rather than issues of clinical competence. In these circumstances, evidence of remediation may be far less relevant and given considerably less weight by the decision maker.

56 Single clinical incidents (SCI PE) are generally likely to be easily remediable if they are an isolated event and there are no other concerns. However, the AR may need to exercise more caution in respect of SCC PE as the conduct may not clearly fall under the definition "easily remediable" in the following circumstances:

a any errors/failings identified took place over a significant period of time (the doctor/patient consultations were spread over more than six months)

b more than two or three failings in relation to the treatment provided have been identified. An SCC PE arising from four or five distinct failings eg failure to obtain consent, inadequate examination, failure to use safety equipment appropriately and irresponsible prescribing may be less easily remediable than an enquiry involving one or two identified failings.

57 If the AR's view is that the conduct is not easily remediable due to either its nature and/or its seriousness, eg there is a wide range of significant clinical failings, it will usually be appropriate to promote to an investigation.

58 If the conduct is remediable, the AR should consider if it has been successfully remediated by the doctor. The main evidence of remediation will usually be the form completed by the RO which sets out their view on the seriousness of any identified failings and the extent to which the doctor has remediated them.

59 In comparison with a SCI PE, the remediation evidence needed may be greater for a SCC PE if the conduct or failings were repeated over a significant period of time or several failings have been identified from the issues raised by the complainant/referrer.

60 In addition to the RO form, further evidence of remediation could include:

- certificates from completed training modules
- competency reports from supervising doctors
- professional development documentation
- evidence of participation in a College or Faculty run 'Continuing Professional Development' scheme or a personal development plan.

The above will not always be available and appropriate evidence of remediation will vary from case to case depending on the nature of the identified failings.

61 The AR should finally consider if the conduct is highly unlikely to be repeated. In SCI PE, where the conduct was an isolated, one-off event and the doctor has remediated, we can usually be satisfied the risk of repetition is very low and the doctor's current fitness to practise is not impaired.

62 However, this assessment may be more difficult in an SCC PE if any identified failings took place over a longer period and the interactions between the patient and doctor were complex. Decision makers should therefore consider the individual circumstances carefully when deciding if the evidence of remediation is sufficient to assure us that no question is raised about the doctor's current fitness to practise. In particularly complex enquiries, it may be necessary to seek advice from a medical or lay case examiner. Where there remains doubt over whether the threshold is met, the AR should promote the enquiry for a full investigation to allow further information to be gathered and the case examiners to assess whether the identified failings have been remediated.

63 The AR should also carefully consider any comments provided by the doctor which may provide an indication of their personal insight. This is relevant to the question of successful remediation and, in particular, whether the conduct is highly unlikely to be repeated. Expressions of apology can be considered as evidence of a doctor's insight and can be used, alongside other evidence, as part of any assessment of a doctor's remediation.

64 The AR may find it useful to consult the paragraphs on assessing insight in the *Guidance for decision makers on agreeing, varying and revoking undertakings*.

65 Evidence of remediation will be less cogent in the following circumstances.

- Where there is doubt about whether the identified failings are likely to be repeated as they took place over a significant period of time and the doctor knew, or ought to have known, the care they were providing was below an acceptable standard and/or contrary to accepted practice. If repetition is likely, a full investigation will be required.

- Where the remediation evidence appears superficial. For example, re-training is not targeted or is inadequate to address the areas identified as requiring remediation, such as a generic online CPD course.

- Where the doctor's fitness to practise history may raise concerns about the effectiveness of any remediation.

66 If the remediation evidence clearly shows that a failing has now been resolved and that therefore no question arises as to whether the doctor's fitness to practise is impaired, then the PE is likely to be suitable for closure.

67 Further information on remediation can be found in the following document: *Making decisions on cases at the end of the investigation stage: Guidance for the Investigation committee and case examiners.* Although this guidance is aimed at case examiners, the principles around the mitigating impact of remediation are the same.

New allegations

68 If new allegations have been made since the PE was opened, the AR should consider whether these have any impact on whether it is to be closed or promoted to a full investigation. Further guidance on how to deal with new information received during a PE can be found in the Provisional Enquiries manual.

69 If new allegations are not similar to the concerns being considered at SCI or SCC PE, there is unlikely to be an impact on the outcome of the provisional enquiry. For example, if we are considering allegations about substandard clinical care and the new enquiry relates to a conviction for fraud, it should not prevent us from closing the PE where it would otherwise be appropriate to do so.

Questions for decision maker and possible outcomes

Does the information collected during the PE suggest the doctor needs to undergo a GMC assessment of their health, language or performance as their fitness to practise may be impaired on these grounds?

70 If the answer is no ➡ proceed to question below.

If the answer is yes ➡ the enquiry should be promoted to a full investigation to enable an assessment to take place.

Has the seriousness and nature of the concerns been clarified given the information we have collected through our provisional enquiries? If the concerns arose during the Covid-19 pandemic, this information will include the likely impact of the pandemic on the systems in which the doctor was working and on how they delivered care.

71 If the answer is no ➡ it is likely to be necessary to promote to a full investigation if this clarification can only be achieved through obtaining witness statements etc. However if there isn't enough information or evidence available to clarify the allegations and this position is unlikely to change, then the enquiry should be closed.

If the answer is yes ➡ proceed to next question.

Having reviewed the information gathered through our provisional enquiries including, if applicable, the impact of the pandemic on the doctor's actions and decisions, is there evidence of clinical failings on the part of the doctor and, if so, are the clinical failings sufficiently serious to raise a question of impaired fitness to practise should they not have been remediated by the doctor?

72 If the answer is yes ➡ proceed to next question.

If the answer is no ➡ close the enquiry and consider if the Notify RO/Notify Employers process is appropriate.

Have we obtained sufficient information to conclude that any identified failings are easily remediable, that the doctor has remediated them and they are highly unlikely to be repeated?

73 If the answer is yes ➡ proceed to next question.

If the answer is no ➡ promote to an investigation.

Based on our enquiries and the evidence of remediation provided, do you consider that the enquiry raises a question as to whether the doctor's fitness to practise is impaired?

74 If the answer is yes ➡ promote to an investigation.

If the answer is no ➡ close the enquiry and consider if the Notify RO/Notify Employers process is appropriate.

Further Information provisional enquiries

75 Further information provisional enquiries are used where the information we hold suggests that aspects of the complaint may be confused or based on a misperception or there may not be reliable evidence to support it. We therefore use the PE process to obtain one or two pieces of easily obtainable information to clarify the seriousness of the allegation and whether there is likely to be evidence to support it.

76 The evidence gathered during a Further Information PE may include local or third party investigation material which will help us determine whether a question is raised about the doctor's fitness to practise. We may also obtain case examiner advice on the seriousness of the concerns.

Further Information provisional enquiries can also be used when we receive an allegation that appears serious but the circumstances which have arisen as a result of the Covid-19 pandemic could be key to clarifying whether they are sufficiently serious to raise a question about the doctor's fitness to practise, and the concerns do not fall under another PE stream.

77 When considering the outcome of a Further Information PE, the AR must decide if the triage threshold test is met by answering the following questions.

Questions for decision maker and possible outcomes

Does the information collected during the PE suggest the doctor needs to undergo a GMC assessment of their health, language or performance as their fitness to practise may be impaired on these grounds?

78 If the answer is no ➡ proceed to question below.

If the answer is yes ➡ the enquiry should be promoted to a full investigation to enable an assessment to take place.

Has the seriousness and nature of the concerns been clarified given the information that we have collected through our provisional enquiries? If the concerns arose during the Covid-19 pandemic, this information will include the likely impact of the pandemic on the systems in which the doctor was working and on how they delivered care.

79 If the answer is no ➡ it is likely to be necessary to promote to a full investigation if this clarification can only be achieved through obtaining witness statements etc. However if there isn't enough information or evidence available to clarify the allegations and this position is unlikely to change, then the enquiry should be closed.

If the answer is yes ➡ proceed to next question.

Having reviewed the information gathered through our provisional enquiries including, if applicable, the impact of the pandemic on the doctor's actions and decisions, do you consider that the enquiry raises a question as to whether the doctor's fitness to practise is impaired?

80 If the answer is yes ➡ promote to an investigation.

If the answer is no ➡ close the enquiry and consider if the Notify RO/Notify Employers process is appropriate.

Voluntary erasure cases

81 As we usually only carry out a provisional enquiry in cases which suggest the information raises a question about the doctor's fitness to practise, voluntary erasure should not generally be granted until the outcome of the PE has been concluded.