General Medical Council

Decisions on sharing information related to a Physician Associate or Anaesthesia Associate with the police

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Introduction

1. During the course of an investigation, we may obtain information that gives us reasonable grounds to believe that a criminal offence may have been committed but that the police are not aware of the matter. This guidance outlines the process to be followed where information obtained during an assessment of fitness to practise suggests that a PA or AA or another party involved in the case may have engaged in criminal conduct. Its purpose is to help staff identify information which may need to be shared with the police and to do so appropriately ensuring any disclosure is proportionate and lawful.

2. Our over-arching objective is the protection of the public which includes protecting, promoting and maintaining the health, safety and wellbeing of the public; promoting and maintaining public confidence in the professions, and promoting and maintaining proper professional standards and conduct.

3. Although we are not under a legal obligation to share information with the police, we have the power to do so under Schedule 3, paragraph 1(2) of The Anaesthesia Associates and Physician Associates Order 2024 (the Order) where the information relates to a PA or AA's fitness to practise and if we consider it to be in the public interest.

4. Where the information under consideration might also raise safeguarding concerns, staff should follow the process set out at paragraphs 36 to 39 below. Sharing information in relation to safeguarding concerns are decisions taken by the Designated Safeguarding Manager (DSM) who leads the Corporate Safeguarding Team.

Identifying information which may need to be shared with the police

5. It is important to emphasise that it is not our role to make a judgement on whether a criminal offence has been committed. It is for the police to decide whether to investigate possible criminal conduct, the Crown Prosecution Service, Procurator Fiscal or Public Prosecution Service to decide whether to prosecute criminal offences and the Courts to determine whether it has been proved beyond reasonable doubt that an individual is guilty of a criminal offence. Our task should be limited to passing information to the appropriate police force or public agency to enable them to assess whether a criminal investigation should take place. If there is insufficient evidence to charge someone with a criminal offence, the police may still act on the information for purposes such as safeguarding e.g. by making a disclosure under s113B(4) of the Police Act 1997 (as amended) following a request for an enhanced DBS check.

6. In most cases where a referral to the police is appropriate, it will be apparent to staff that criminal conduct may have taken place. Examples of scenarios where this may apply are given below:

a We have received information from a PA or AA's employer that they have submitted false expense claims for financial gain. This may also amount to criminal conduct, possibly theft or fraud by false representation, and the police should be notified of the information we hold. In some circumstances, it may also be appropriate to share the information with other statutory bodies such as the NHS Counter Fraud Authority.

b We are aware that a PA or AA with an interim measure of suspension has obtained employment and seen patients while representing to the new employer that they are a currently registered PA or AA. This is potentially criminal conduct under Article 19 of the Order.

c We have received information that a named individual (who is not a registrant) is offering to perform female genital mutilation (FGM) on members of the local community. Although the intelligence is about a third party, it should still be referred to the police for further investigation as potential criminal conduct. If, however, there is no direct link to a registered PA or AA and it is less clear whether the disclosure can be made under Schedule 3, paragraph 1(2) of the Order then the procedure at paragraphs 42 to 44 should be followed.

Information which does not need to be shared with the police

7. We should not share information with the police which does not meet our threshold for initial assessment. The following information is considered low-level and is not assessed by us and should not be referred to the police:

- any conduct amounting to a road traffic offence for which a Fixed Penalty Notice (FPN) could be issued
- conduct solely relating to speeding
- conduct that could amount to minor motoring offences where there are no aggravating circumstances, including traffic light offences, talking on a mobile phone while driving, not wearing a seatbelt and careless driving (which is distinct from dangerous driving)
- urinating in public

Legal basis for sharing information with the police

8. Our powers under Schedule 3, paragraph 1(2) of the Order allow us to disclose to any organisation information that relates to a particular PA or AA's fitness to practise provided we consider that it is in the public interest to do so. This is the legal basis on which we can refer potential criminal conduct to the police. It covers information which relates to the conduct of the PA or AA themselves but also information which relates to a third party (such as a patient or other individual involved in an initial assessment) where there is a direct link between the potential criminal conduct and an allegation relating to a PA or AA's fitness to practise.

9. Where there is no direct link between the potential criminal conduct and an allegation relating to a particular PA or AA's fitness to practise, or the position is not clear, we may still be able to disclose the information to the police under Schedule 3, paragraph 1(1) of the Order where the information relates to one of our functions (such as fitness to practise) notwithstanding how the information was received. Information about potentially criminal conduct of PA or AAs that are no longer registered with us, could fall into this category. As these matters are more finely balanced, we should follow the process set out in paragraphs 42 to 44 which includes seeking legal advice on our basis for disclosure.

Threshold test

10. The test to be applied by staff is whether there is sufficient information to form a reasonable belief that a criminal offence may have been committed by a PA or AA or third party directly involved in an assessment of fitness to practise. The following factors should be taken into account:

- There should be some evidence to support our belief and we should not make a referral based on information that amounts merely to an unsubstantiated or fanciful assertion.
- We should not take an allegation that a PA or AA or third party has committed a criminal offence at face value. If there is no supporting evidence, we should wait until we have some information that substantiates the allegation before making a disclosure to the police.
- Although some supporting evidence is required, we do not need to assess its weight and credibility before sharing the allegation with the police. Our role is to pass the information to the police and let them decide whether to pursue a criminal investigation.

11. In the first instance, staff should discuss their belief that a PA or AA or third party has engaged in criminal conduct with their manager and record a note of the discussion. The manager will advise on whether there are reasonable grounds to suspect that criminal conduct has occurred and whether we need to inform the alleged victim (if any) of our intention to share the information with the police. If the manager does not believe the threshold is met, no further action will be taken. The manager will also be able to advise whether the issue should be referred to the Corporate Safeguarding Team following the process set out in paragraphs 36 to 39.

Informing relevant parties of our intention to share information with the police

12. It is important to make a distinction between the victim (if applicable) and individual who is suspected of the potentially criminal conduct. The latter will most commonly be a PA or AA but could also be a third party linked to our initial assessment. The alleged suspect should not be advised of the referral to the police if there is a risk this will alert them about a possible criminal investigation and lead them to destroy evidence, interfere with witnesses or if to do so would increase the risk of harm to the alleged victim.

13. If, however, a PA or AA has self-referred potential criminal conduct then it may be appropriate to inform them that we intend sharing the information with the police. We should still consider however whether there is a risk that the PA or AA may destroy evidence or seek to influence witnesses and each case should be assessed individually based on its circumstances.

14. Where applicable, it will usually be appropriate to write to the alleged victim(s) of the criminal conduct to advise them of our intention to share information with the police before we do so. Prior to referral for a decision, the Investigation Officer will have established whether the alleged victim has made a complaint to the police themselves and will only refer for a decision on sharing if the alleged victim has not done so. Writing to the alleged victim promotes the transparency of the process and enables the person affected to understand why the GMC wishes to share information and the implications. The alleged victim will often (but not always) be the complainant in our initial assessment process. To avoid raising expectations that their information will be shared with the police, we should only write to the alleged victim if the matter has first been discussed with the relevant Head of Section and they have indicated disclosure is appropriate.

Our letter should include the following:

- details of the police force to whom we will make the disclosure
- confirmation of the information that will be disclosed and reassurance that it will be done in a secure manner
- the purpose of the disclosure and our power to make it – we are sharing the information with the police to enable them to consider if a criminal offence has been committed and we have authority to make disclosures in the public interest under Schedule 3, paragraph 1 of The Anaesthesia Associates and Physician Associates Order
- a request to the alleged victim to confirm:
    - whether they have any objections to the proposed disclosure and, if so, what these are
    - if they will be willing to assist with any potential criminal investigation (this information will be helpful to the police in making an initial assessment of the allegation)

- if they provide consent for us to pass their contact details to the police.

15. If it is a PA or AA who has been reported to the police, we should then contact the Data Protection or Disclosure Unit of the relevant force who will liaise with the officer leading the criminal investigation to provide regular updates on its progress. We will usually await the outcome of a police investigation before making a substantive decision on whether any action is required under our fitness to practise procedures.

16. It will not always be practicable to inform the alleged victim(s) in advance of our disclosure. For example, if we have evidence of an immediate threat to specific individuals or the wider public or the alleged criminal conduct is so serious that we cannot delay sharing information with the police.

Legal considerations

17. In each case where we have a reasonable belief that criminal conduct may have occurred we must consider the relevant legal factors before sharing this information with the police. These include Article 8 of the Human Rights Act and data protection legislation to ensure that any disclosure we make is proportionate and lawful.

18. It may be necessary to obtain legal advice in particularly complex cases. Legal advice should also be sought if it is unclear whether our powers under Schedule 3, paragraph 1 of the Order apply. This will clarify whether there is a legal basis for disclosure under the Order or an alternative legal basis for disclosure.

Head of Section decision

19. For disclosures under Schedule 3, paragraph 1(2) of the Order, the Head of Section for the National Investigation team will make the final decision on whether the information should be shared with the police after weighing up all the relevant factors.

20. However, in cases where it is unclear whether we are able to rely upon Schedule 3, paragraph 1(2) of the Order, the decision will be escalated to the relevant Assistant Director. If there remains a question over whether there is an alternative legal basis for disclosure, the sharing of any information with the police will need to be authorised by the Director of Fitness to Practise. Please see paragraphs 42 to 44.

Sharing information with the police

21. We can share information with the police at any stage in our procedures if we have a reasonable belief that a PA or AA or third party has engaged in criminal conduct that the police are not already aware of and there is some evidence to support this belief. This

could be at the beginning of our initial assessment and referral does not need to be delayed until our procedures have concluded.

22. It is not necessary or appropriate to send large volumes of material to the police to review when making the initial disclosure. We should send the information by a secure method and redact any third-party data that is not relevant. The following information should be provided:

- The name of the PA or AA or third party
- A short summary of the information in our possession which gives rise to our concern that a criminal offence may have been committed. The information should be accurate, and we should take reasonable steps to verify it where appropriate. We should also provide any relevant context to the allegation e.g. confirm whether the PA or AA or third party denies the allegation. We should also take care that the information provided is not excessive or irrelevant to the police's consideration of whether a criminal offence has been committed.
- A brief description of any documentary evidence we hold that supports the allegation of criminal conduct (this is to give the police an idea of what information is available so they can request it if necessary)
- If the complainant has indicated that they do not want to co-operate with a criminal investigation, this should be noted in our initial disclosure, so the police are aware of their reluctance to be involved at the outset.

23. We can disclose any potentially criminal matters to the police and do not need to distinguish between different categories of offences according to their perceived seriousness. We should not however disclose trivial matters or those which do not meet our threshold for initial assessment as detailed in paragraph 7.

Clinical cases

24. The vast majority of allegations of substandard clinical care will not amount to criminal conduct. However, in rare circumstances, the care provided by a PA or AA to a patient who subsequently died may be so far below an acceptable standard that it could amount to an allegation of gross negligence manslaughter requiring referral to the police. When these cases arise, the police are usually engaged prior to our involvement. Where this is not the case, it is likely the matter will already have been referred to the Coroner because an inquest needs to take place to determine how the patient died and whether this was as a result of neglect. If the Coroner's view is that the actions of a PA or AA or other individual were so negligent that they caused or directly contributed to a patient's death, they will ask the police to investigate. The inquest proceedings will then be adjourned until such a time as the criminal investigation has concluded.

25. It will be extremely rare, but if you are dealing with concerns where the care is so far below the acceptable standard that it could amount to an allegation of gross negligence manslaughter prior to police involvement, it is more appropriate for the Coroner to refer the conduct to the police and we should take the following steps:

- Check whether the patient's death has already been referred to the Coroner
- If it has been referred, we should discuss with the Coroner's office whether a referral to the police has been considered and what the outcome was
- If the Coroner does not feel a referral to the police is necessary, this should be documented on file and further advice sought from the Legal team on whether we should make our own referral
- Where the Coroner has conducted or is conducting an inquest into the death of the patient, we should consider whether we wish to be added as an interested person in the Coroner's proceedings so that we can obtain timely disclosure of relevant information from the Coroner. However, in the first instance we should attempt to obtain this information via our standard routes, more information is available here.
- Advice should also be sought from the Legal team if the patient's death was not referred to the Coroner but we have a reasonable belief that the care provided was so far below an acceptable standard that criminal conduct may have occurred.

26. There may also be very rare cases where the patient did not die but the treatment provided was again so seriously below an acceptable standard that it may amount to potential criminal conduct, such as wounding with intent. These cases are likely to be particularly complex and advice should be sought from the Legal team on whether it is appropriate to make a disclosure to the police.

Inappropriate relationships with patients

27. Although an allegation that a PA or AA had an improper sexual relationship with a patient clearly represents a significant breach of GMC guidance, it would not usually amount to criminal conduct.

28. There may however be occasions when a PA or AA's inappropriate relationship with a patient could also constitute a criminal offence and a disclosure to the police should be considered. Section 38* of the Sexual Offences Act 2003 ('the 2003 Act') creates a specific

* There are other offences under sections 39 to 41 of the Sexual Offences Act 2003 which don't involve the care worker actually engaging in direct sexual activity with the person with a mental disorder. They are offences of causing/ inciting sexual activity with such a person (s39), engaging in sexual activity in the presence of such a person (s40), and causing such a person to watch sexual activity (s41)

offence committed by a care worker who engages in sexual activity with a person with a mental disorder who is receiving care in the setting they work in. Care workers will include PAs and AAs in addition to care home and agency workers, whether they are working in NHS or private hospitals or GP surgeries.

29. The 2003 Act uses the definition of a 'mental disorder' found in section 1 of the Mental Health Act 1983 which is "any disorder or disability of mind." This includes schizophrenia, depression, bipolar disorder, eating disorders and dementia. The definition only includes learning disability where it is associated with abnormally aggressive or seriously irresponsible behaviour. The 2003 Act also excludes dependence on alcohol or drugs as a qualifying disorder or disability of the mind.

30. You should therefore follow the guidance at paragraphs 8-23, if you believe that the following criteria are met:

- a PA or AA or other care worker has engaged in sexual activity with a patient who suffers from a mental disorder
- the PA or AA or other care worker knew, or could reasonably have been expected to know, that the patient had a mental disorder
- the PA or AA or other care worker had, or was likely to have, regular face to face contact with the patient as part of their caring role
- the PA or AA or other care worker was/is not married to the patient and was not in a sexual relationship with them immediately before the caring relationship began (these are exceptions under the Act)

The PA or AA does not need to have been in paid employment but could have been caring for the patient as part of a voluntary or informal role.

31. It is likely to be appropriate to seek legal advice in these cases before sharing the information with the police and to ascertain whether the complainant is willing to take part in a criminal investigation or if they have any objections to disclosure. We should take into account the impact disclosure will have on the alleged victim who may be vulnerable.

Enhanced Disclosure and Barring Service (DBS) checks

32. Even if an individual's actions do not amount to a criminal offence, the police are able in some circumstances to record information that suggests they pose a risk to children or vulnerable adults and caution needs to be exercised in allowing them to have unsupervised contact with these groups. The police may disclose this information on an individual's enhanced DBS check under s113B(4) of the Police Act 1997 even if no formal criminal action was taken against them.

33. If a PA or AA has formed an inappropriate relationship or otherwise behaved improperly with a child or vulnerable adult, we should therefore consider disclosing this information to the police even if we do not think it amounts to criminal conduct. In some

circumstances, the criteria for a referral to the DBS may also be met and advice should be sought from the Information Sharing Team.

Clinical examinations which may amount to sexual assault

34. In cases involving evidence that a patient has undergone an intimate examination, there may in some cases be a concern that the examination was sexually motivated (as opposed for example where such cases involve poor clinical skills, poor communication, or an inadequate approach to obtaining consent). Where we have a reasonable belief that the PA or AA's actions were sexually motivated, a referral to the police may be appropriate. A reasonable concern would usually arise from the case examiners concluding that the PA or AA's fitness to practise is impaired when considering the matter at the accepted outcomes stage of our processes. There may on occasion be cases where a reasonable belief arises prior to a case examiner decision, for example where the fact that an intimate examination took place is not in dispute and the context in which it has been undertaken (for example for a patient who presented with a sprained ankle) does not provide another arguable basis for the examination.

35. Where a referral to the police is indicated, this will usually relate to a complex case where we are likely to have obtained an expert report confirming that the examination was not conducted appropriately based on the patient's reported symptoms and the relevant clinical findings. The conclusions of the expert report, any witness statement provided by the patient and, where relevant, a copy of the case examiners' decision or associates tribunal's determination should be shared with the police to enable them to assess whether a criminal investigation is indicated.

Information that raises both safeguarding issues and concerns about potential criminal conduct

36. Occasionally there will be cases where the actions of a PA or AA or third party raise a serious safeguarding concern but may also amount to criminal conduct. For example:

- If a GMC expert identifies from a child's medical records that previous injuries they have suffered are not consistent with the explanation provided by their parents and are likely to have been non accidental. There is clearly a potential safeguarding risk of serious harm to the child that requires consideration by social services but if deliberate harm has been caused by the parents, this would also amount to criminal conduct.
- If a complainant with severe learning disabilities discloses that they have been physically assaulted by their carer.

37. Safeguarding concerns must be shared with the DSM as soon as possible. Staff should complete the safeguarding form and send it to the corporate safeguarding team via the GMC safeguarding reporting system in Siebel or via the safeguarding inbox. [View as Web Page: High level staff process map.vsdx]

38. Staff should provide as much information as possible, but still make a referral to the DSM even when there is limited information available. If a colleague is unable to access the online reporting system, then a referral can be sent to Safeguarding@gmc-uk.org

39. In situations where both criminal and safeguarding concerns arise, the DSM will make a decision on whether their threshold to share the information is met and how disclosure may be completed to the police and social services simultaneously to enable both agencies to take any necessary action without delay.

Further requests for information and monitoring any criminal investigation

40. We should co-operate with any reasonable requests from the police for further information that we hold about the conduct of a PA or AA or third party. However, in order to comply with the data protection legislation, we should ask them to make a formal request citing the exemption in Schedule 2, Part 1, paragraph 2(1) of the Data Protection Act 2018. This provision allows information to be disclosed where it is necessary for the purposes of the detection or prevention of crime and non-disclosure would be likely to prejudice this.

41. If a criminal investigation is opened involving a registered PA or AA, we should monitor it by seeking regular updates from the police investigating officer. We should also consider whether we need to put our processes on hold while we await the outcome of the judicial process. A referral to the Interim Measures Tribunal may also be indicated depending on the circumstances of the case and the seriousness of the alleged offence.

Sharing information if the application of Schedule 3, paragraph 1(2) is unclear, or the case is complex

42. In order to share information under Schedule 3, paragraph 1(2) of the Order, there must be a direct link between the events or allegation we are asking the police to consider and an individual PA or AA's fitness to practise. The Head of Section making the decision must be satisfied that disclosure is in the public interest and he/she should follow the step-by step approach set out in the supplementary guidance for decision makers.

43. Rarely, we may obtain information where there is no direct link between the potential criminal conduct and an allegation relating to a particular PA or AA's fitness to practise, or the position is not clear. We may still be able to disclose the information to the police

under Schedule 3, paragraph 1(1) of the Order where the information relates to one of our functions (such as fitness to practise) notwithstanding how the information was received. These cases are likely to be rare but as a matter of policy, we would only share information in these circumstances if we are satisfied that it is in the public interest. As these matters are more finely balanced, we should seek legal advice to clarify our basis and rationale for disclosure.

44. In these circumstances, the Head of Section should escalate the decision on whether to make a disclosure to their Assistant Director. The Assistant Director will need to balance the risk to an individual or the wider public of not disclosing the information against the impact on any individual named in the disclosure of it being shared with the police. In particularly complex cases where there is an unresolved question over the legal basis for sharing information, authorisation for the disclosure will also need to be given by the Director of Fitness to Practise.