

Guidance on making referrals to the Disclosure and Barring Service

Note - this Guidance (Annex B) contains case study examples that have been developed in respect of our regulation of doctors. As time progresses, we will develop more case studies in respect of our regulation of PAs and AAs.

Introduction

1. This guidance provides an outline of the GMC's procedure for referring information to the Disclosure and Barring Service (DBS).
2. It is a living document that relates to our regulation of doctors, Physician Associates (PAs) and Anaesthesia Associates (AAs). It will be revised periodically. Throughout the document, there are examples and case studies to help illustrate how the guidance works in practice. The document will also be reviewed in light of any bilateral agreement reached between the DBS and GMC.
3. A separate Scottish Protection of Vulnerable Groups (PVG) Scheme, overseen by Disclosure Scotland (DS), has been established in Scotland commencing from February 2011. A separate guidance document has been prepared for referrals to DS under the PVG Scheme. Therefore, if any of the following apply, the referral should be made to DS:
 - a. The alleged conduct took place in Scotland, or
 - b. The alleged conduct occurred outside the UK and the doctor, PA or AA's registered address is in Scotland at the time of assessing the case, AND
 - c. We are not aware that the same conduct has already been referred to DS by an employer, employment body, employment agency or the Scottish court (although this will be rare.)
4. If the relevant conduct took place outside the United Kingdom and the doctor, PA or AA's registered address is outside the United Kingdom at the time of making the assessment, we should assess whether a referral should be made to the DBS as the default position. This is the most appropriate option because the DBS deals with a higher number of referrals and covers a much wider geographical area than DS.
5. If a doctor, PA or AA is barred under the England, Wales and Northern Ireland Scheme ('the Scheme'), they will be automatically barred in Scotland, and vice versa. This means that, despite there being two separate schemes, GMC decision makers will not need to make dual referrals to the DBS and DS.
6. DBS and the DS have an agreement that facilitates their joint working in cases where jurisdiction is unclear.

Disclosure & Barring Service

7. The Safeguarding Vulnerable Groups Act 2006 (the Act) was introduced as a result of the Richard inquiry, following the deaths of Jessica Chapman and Holly Wells. The key focus of the legislation is to strengthen the way employers recruit people to work with children and vulnerable adults.
8. The DBS is a non-departmental public body established under the Act and is responsible for vetting all individuals who want to work or volunteer with vulnerable people. It is required to maintain two 'barred lists' – a 'children's list' and a 'vulnerable adults' list, and the DBS has the power to place individuals on these lists where it deems the individual poses a safeguarding risk. Anyone appearing on one (or both) of these lists cannot work with children and/or vulnerable adults.

Children

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

Vulnerable adults

10. The term 'vulnerable adult' is defined as any person over the age of 18 to whom a regulated activity is provided (see paragraph 14 for the definition of a regulated activity).

Jurisdiction of the Scheme

11. The DBS operates across England, Wales and Northern Ireland and the three referral categories (autobar offences, relevant conduct and the harm test) apply across England, Wales and Northern Ireland. This Guidance (from paragraph 22 below) provides detail setting out how the three referral categories work.
12. In some circumstances, a referral to the DBS can be made where the issue giving rise to the referral occurs outside of these three jurisdictions ('overseas'). This will be appropriate if:
 - the offence is equivalent to an autobar offence (i.e. the conduct amounts to an autobar offence under the laws of England, Wales or Northern Ireland)
 - a person has engaged in an act or omission overseas that is equivalent to relevant conduct

* This Guidance provides a definition of 'regulated activity' at paragraph 14.

-
- the issue occurring overseas, would, if it had occurred in England, Wales or Northern Ireland, satisfy the harm test.

Application of the Scheme to the professions we regulate.

13. The GMC has power under section 41 of the Act to refer to the DBS information we hold, which suggests that a person poses a risk of harm to children or vulnerable adults.

13A The information we hold will normally relate to registered doctors, PAs or AAs.

However, The Anaesthesia Associates and Physician Associates Order 2024 provides for a transition period until 13 December 2026 to register as a PA or AA. Until then, PA's and AAs are entitled to work as PAs or AAs without GMC registration. Should decision makers receive information about a PA or AA that suggests that the referral criteria to the DBS under this guidance may be met, but the PA or AA is not registered, legal advice should be sought on the application of the referral criteria, or any other basis for notification of the information to the DBS.

Regulated Activity

14. The provision of any form of health care by or under the direction or supervision of a health care professional is deemed to be a regulated activity. In this regard, all patients are covered by the Scheme as vulnerable adults or children.
15. Doctors, PAs and AAs involved in providing any form of health care to patients are conducting a regulated activity for the purposes of the Scheme.
16. Health care activities will be regulated activities regardless of how often they are provided. Health care is defined broadly in the legislation but it includes all forms of health care provided for individuals, whether relating to physical or mental health. It also includes palliative care and procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition. The DBS have clarified that any act of prescribing constitutes health care even if the prescription is issued to someone that is not a patient or being provided with medical care by the doctor. For example, a doctor prescribing controlled drugs for their flatmate to use recreationally or prescribing medication to people on the internet that they have not examined would be engaging in a regulated activity.
17. In some circumstances, the provision of health care can also include an activity which the doctor, PA or AA was only able to undertake by virtue of their professional role. For example, using NHS systems to inappropriately access the medical records of an individual who the doctor, PA or AA is not responsible for treating in a clinical capacity.
18. Decision makers may find this [guidance](#) helpful when considering if an adult was in receipt of a regulated activity from a doctor, PA or AA. It is not however an exhaustive list and the decision maker should apply their discretion to decide which category is applicable using the case studies at Annex B where necessary. In some cases, legal advice may be needed to clarify this issue. The following are regulated activities for the purpose of the Act:
 - a. the provision to an adult of health care by, or under the direction or supervision of, a health care professional*, including a doctor, PA or AA
 - b. the provision of relevant personal care to any adult in connection with eating or drinking, toileting, washing or bathing, dressing, oral care or the care of skin, hair or nails. This includes physically assisting and prompting a person who is in need of it by reason of age, illness or disability to do any of these things. A person will also undertake a regulated activity if they provide any form of training, instruction, advice or guidance relating to physical personal care which is given to an adult who is in need of it by reason of age, illness or disability
 - c. the provision of psychotherapy or counselling, but not life coaching, to an adult either

*A health care professional is a person who is regulated by any of the following professional regulators: General Medical Council, General Dental Council, General Optical Council, General Osteopathic Council, General Chiropractic Council, General Pharmaceutical Council, Pharmaceutical Society of Northern Ireland, Nursing and Midwifery Council and Health Professions Council.

in person or over the telephone. This psychotherapy or counselling must be related to health care the adult is receiving from, or under the direction or supervision of, a health care professional

- d. the provision by a social care worker of relevant social work to an adult who is a client or potential client
 - e. the provision of assistance in relation to general household matters to an adult who is in need of it by reason of age, illness or disability. The assistance must include either managing the person's cash, paying the person's bill or shopping for that person
 - f. the provision of certain forms of assistance in the conduct of an adult's own affairs, such as anything done by virtue of a power of attorney or independent mental health advocate
 - g. the transportation of adults who need to be conveyed somewhere by reason of age, illness or disability. For example, by a hospital porter, emergency care assistant or ambulance technician in the course of their employment
 - h. any activity which consists of or involves on a regular basis the day to day management or supervision of a person carrying out an activity mentioned on this list. For example, if a doctor is managing or supervising staff at a care home, they are engaged in a regulated activity even if they do not personally provide health care to the residents.
- 19.** In the majority of the GMC's cases involving patients, the patient will be a vulnerable adult because they are receiving a regulated activity as set out at paragraph 18(a) above.
- 20.** The doctor, PA or AA does not have to engage the vulnerable adult in health care at the exact time of the act or omission. If a doctor, PA or AA is acting outside of their professional capacity as a doctor, PA or AA and instead they engage in any of the regulated activities described in paragraphs (b) to (h) above, then the person to whom they provide the regulated activity is a vulnerable adult.

Example

If a doctor conducts a social visit to the home of one of their adult patients and sexually assaults the patient, although not providing them with health care on that occasion the patient will still be a vulnerable adult. This is because the doctor is their treating doctor and therefore engages them in a regulated activity, i.e. health care.

-
- 21.** An adult does not fall into the definition of a vulnerable adult simply because they are 'vulnerable' in the ordinary definition of the word.

Examples

If a doctor sexually assaults a colleague who has been sexually abused before, the colleague is not a vulnerable adult, regardless of whether the doctor knew or did not know about their previous history of sexual abuse.

The reasoning for this is that the doctor was not engaging the adult (in this case, their colleague) in a regulated activity at the time, i.e. health care.

If a doctor assaults a person at a football match and the person happens to have a social worker, the victim of the assault would not fall within the definition of a vulnerable adult even if the doctor knew that the person had a social worker.

The fact that the person received a regulated activity from another provider is not relevant.

The only relevant question is whether the doctor provides a regulated activity to the person. If not, then the victim will not be a 'vulnerable adult'.

The referral conditions

22. Before a referral to the DBS can be made, the Act requires a decision maker to “think” that **two conditions** are met.
23. The Act does not contain a definition of the word “think.” However, we interpret “think” as holding a reasonable belief. This will usually be satisfied by a ‘trigger point’* being met, but a referral may also be made where we hold information which otherwise gives us reason to believe that the two conditions are met.
24. The two conditions should be applied in succession – however, if the first condition is not met, there is no need to consider the second condition.
25. The first condition has three parts and as such can be met in three alternative ways. In multi factorial cases, the allegations/findings against the doctor, PA or AA may relate to distinct matters which are unrelated e.g. a conviction for assault and unrelated allegations of research misconduct. The decision maker needs to consider whether the two referral conditions are met in respect of each separate finding/allegation starting with the first condition. If the first part of the first condition is not met i.e. there is no auto-bar offence, decision makers should move on to consider the second and third parts sequentially for each broad finding. If, however the auto-bar criteria are met, the decision maker need not consider the subsequent two parts of the first condition.

The first condition

PART 1: AUTOBAR OFFENCES: Decision makers should refer the case to the DBS where we have evidence of an auto-bar offence having been committed (See paragraphs 30-45 below). If not, consider parts 2 & 3;

PART 2: RELEVANT CONDUCT: where the GMC ‘thinks’ that a doctor, PA or AA has engaged in relevant conduct and the trigger points are met, the decision maker should move on to consider the second condition (see paragraphs 56-82 below for guidance on what constitutes relevant conduct); or

PART 3: THE HARM TEST: where the GMC ‘thinks’ that a doctor, PA or AA poses a future risk of harm in relation to children or vulnerable adults and there is evidence to support the suggestion of risk, decision makers should move on to consider the second condition (see paragraphs 83-104 below for guidance on when the harm test is

* A ‘trigger point’ refers to a point in the GMC’s processes where a decision or determination has been made. Trigger points are explained further at paragraph 78-82 below.

-
26. If referring for an auto-bar offence, the referral can be made as soon as we have evidence that the doctor, PA or AA has been cautioned in relation to, or convicted of, an auto-bar **or** connected offence (defined below at paragraph 30-32). However, the decision maker must also be satisfied that the first part of the second condition is met; which relates to whether the doctor, PA or AA is or has been, or might in future be, engaged in a regulated activity. For auto-bar offences, it is not necessary to proceed to consider the second part of the second condition (the 'may bar' test).
27. If the GMC decision maker decides that the doctor, PA or AA has engaged in relevant conduct or satisfied the harm test, they must go on to consider both parts of the second condition

The second condition

FIRST PART: The decision maker must be satisfied that the doctor, PA or AA has been, is currently *or* may in the future be involved in a regulated activity with a child or vulnerable adult; ***and***

SECOND PART: The decision maker is satisfied that the DBS '***may bar***' the doctor, PA or AA because of the matters that resulted in the first condition being met.

If both parts of the second condition are met, the case can be referred to the DBS.

28. For the trigger points for auto-bar cases see paragraph 36 and relevant conduct cases see Fig1/paragraph 79 and Figure 2/paragraph 79B. A trigger point is not required for cases which meet the harm test. For referral conditions see [Annex A](#).

The first condition

29. The next part of the guidance deals with the three alternative parts of the first condition. Later parts of the guidance cover the second condition.

Part 1: Autobar offences

30. The Act prescribes a list of serious violent and/or sexual offences, which include offences against the person or property or some abuse of trust or authority. Other offences relate to fraud and forgery.

The DBS has advised that we should consult The Safeguarding Vulnerable Groups Act 2006 (Prescribed Criteria and Miscellaneous Provisions) Regulations 2009 (Statutory instrument 2009/37) for the most up to date list of autobar offences. A list of offences is also published as operational guidance for use by the Information Sharing Team.

NOTE: The list of autobar offences relates to offences committed in England, Wales, Scotland and Northern Ireland.

31. Before the autobar part of the first condition is met, decision makers will need to make sure that the doctor, PA or AA has been convicted of, or cautioned in relation to, an autobar or connected offence.
32. 'Connected Offences' include:
- a. **a caution** in relation to the commission of an autobar offence
 - b. **attempting** to commit an autobar offence
 - c. **conspiring** to commit an autobar offence
 - d. **inciting** another to commit an autobar offence
 - e. **aiding or abetting** in the commission of an autobar offence
 - f. **counselling or procuring** the commission of an autobar offence.
33. The Act applies to convictions prescribed on the list of autobar offences and connected offences as set out in paragraph 32 above. Decision makers should be alert to the possibility of a connected offence having been committed.
34. Not all conduct involving illegal inappropriate sexual material, will involve an autobar offence. On occasion, we receive employer referrals which indicate that a doctor, PA or AA has accessed inappropriate sexual material using employer resources. If this is the case, and a criminal case has not been progressed, GMC decision makers will need to consider whether the doctor's actions (or those of a PA or AA) meet the relevant conduct criteria.
35. If a doctor, PA or AA commits an autobar or connected offence in England, Wales or Northern Ireland, the GMC will refer the doctor, PA or AA to the DBS. For the first condition to be met, there needs to be sufficient evidence that the doctor, PA or AA has been convicted of, or cautioned in relation to, an autobar or connected offence and that the doctor, PA or AA is or has been, or might in future be, engaged in regulated activity.

Trigger point for referrals involving ‘autobar’ offences

36. The GMC may make a referral under the autobar part of the first condition when we receive one of the following:
- a. **Notice of police caution** – in relation to any of the autobar or connected offences
 - b. **Memorandum of criminal conviction** – indicating that the doctor, PA or AA has been convicted of any of the autobar or connected offences
 - c. **Overseas determination** – documentation of a determination indicating that the doctor, PA or AA has been convicted of or been cautioned in relation to a criminal offence in another jurisdiction which, if committed within the UK, would amount to an autobar or connected offence (see paragraphs 42-45 for further information about overseas offences)
 - d. **Any other authoritative document** – in the absence of the above documents, any other document(s) that provides evidence of a conviction, e.g. a letter from the police confirming details of the conviction.
37. It does not matter whether we received the document through a self-referral by a doctor, PA or AA, a referral from a trust, or as part of an application for the restoration of a doctor to the medical register, or the re-entry of a PA or AA to the register of PAs and AAs. As soon as we receive one of the documents above, a DBS referral will be made if the first part of the second condition is also met.

Offences in Scotland

38. It is important that decision makers consider where the offence took place (and thus where the doctor, PA or AA was convicted or cautioned). The list of autobar offences covers offences in England, Wales, Scotland, and Northern Ireland.
39. There is a requirement on the Scottish courts to make a referral to DS if an individual is convicted of the following:
- a. an offence which is categorised as a ‘relevant offence*.’ If someone is convicted of a ‘relevant offence’, DS will be notified by the Scottish court and will consider if that individual should be included on the children’s barred list.
 - b. an offence which would lead to automatic listing on the children’s and adults’ barred lists. This is the DS equivalent of autobar offences and a list of applicable offences is published as operational guidance.†

* Under Schedule 1 of the Protecting Vulnerable Groups Act (Scotland) 2007. A list of these offences is published as operational guidance.

† It is also set out in The Protection of Vulnerable Groups (Scotland) Act 2007 (Automatic Listing) (Specified Criteria) Order 2010.

-
40. Where we are informed that a doctor, PA or AA has been convicted of a relevant or an automatic listing offence, we do not need to assess these cases for referral to DS as they will already have been automatically notified of the conviction by the court.
 41. A referral should however be made to the DBS if the doctor, PA or AA has been convicted of an offence that only appears on the DBS list of relevant (autobar) offences* and does not fall under the lists set out in the PVG legislation. Legal advice should be sought if there is uncertainty over this.

Overseas offences

42. If we have information to suggest that a doctor, PA or AA has committed an offence in another overseas jurisdiction, decision makers will need to consider whether, if the conduct which underpins the criminal conviction or caution was carried out in England, Scotland, Wales or Northern Ireland, it would give rise to an autobar offence. If so, the GMC may refer the doctor, PA or AA to the DBS on the basis that they have committed an autobar offence.
43. While we expect these cases to be rare (we receive less than 10 overseas determinations cases per year), on receipt of such a case the decision maker will need to consider whether the referral conditions are met.
44. In some cases, this decision will be clear-cut.

For example,

A minor driving offence committed in New Zealand would not amount to an autobar offence because if the conduct took place in England, Wales, Scotland or Northern Ireland it would not constitute an autobar, or connected offence.

45. In other cases, more subjective judgement will be needed, for example, where the nature of the conviction or caution listed in the overseas determination is unclear or unknown.

Serious autobar offences – making referrals in the absence of a conviction, caution or other trigger point

46. In general, we will only assess a case for referral to the DBS if one of the trigger points at paragraph 79 or 79B has been reached. However, there will be some cases where, in light of the seriousness of the conduct, we make a referral because we have a reasonable belief that the doctor, PA or AA has committed a serious autobar offence despite there being, at the point of referral, no conviction or caution.
 47. As, at the point of referral, there will be no conviction or caution yet issued, such referrals
-

* As set out in [statutory instrument 2009/37](#) which is part of the Act

will be made under part 2 of the first condition which requires a decision maker to “think” that a doctor, PA or AA has engaged in relevant conduct rather than as an auto-bar offence under the first condition. A list of serious auto-bar offences is at Annex C. If we “think” that a doctor, PA or AA has committed an offence not on the list, and they pose an imminent risk of harm to children and/or vulnerable adults, we will also assess whether the case should be referred to the DBS. Referral in the absence of a trigger point is more likely where the offence that has allegedly been committed is one against a child or vulnerable adult.

When will a decision maker “think” a serious auto-bar offence has been committed?

- 48.** The Act gives the GMC a power to make a referral where a decision maker “thinks” that a doctor, PA or AA has engaged in relevant conduct. As explained at paragraph 23, the Act does not contain a definition of “think.” However, we interpret the term “thinks” as holding a reasonable belief. This will usually be satisfied by a trigger point being met, but in the circumstances described above a referral may be made where we otherwise have reasonable grounds to believe that relevant conduct occurred. This requires some consideration of the evidence by the decision maker; including weighing up any competing evidence.
- 49.** If, having considered the evidence, the decision maker holds a reasonable belief a doctor, PA or AA has engaged in relevant conduct, which if proven would amount to a serious auto-bar offence, then a referral will be appropriate (subject to the second condition being satisfied – see below).
- 50.** Even where we are considering referral prior to a conviction or caution, in most circumstances, we will await the outcome of the criminal investigation. This is because the mere fact that a doctor, PA or AA has been charged with a serious auto-bar offence (e.g. rape) does not amount to evidence and is insufficient grounds in itself to “think” that relevant conduct has taken place. As the police are often reluctant to share evidence from a criminal investigation prior to its conclusion, we may be unable to obtain disclosure of sufficient information at this point to enable us to form a reasonable belief i.e. “think” the doctor, PA or AA has engaged in relevant conduct. However, we should consider if a referral is appropriate in the following circumstances:
 - if a doctor, PA or AA has been charged with a serious auto-bar offence and has absconded meaning the criminal proceedings are in abeyance
 - if there has been a lengthy delay in the criminal process [generally over 12 months although this will vary depending on the circumstances] leading to it becoming very protracted with no sign of resolution
 - if a key witness is unable or unwilling to give evidence at a court hearing leading to criminal proceedings being withdrawn against the doctor, PA or AA

In all of the above scenarios, we will still need to have obtained sufficient evidence from the police or other sources to enable us to “think” the doctor, PA or AA committed the serious auto-bar offence and, as such, engaged in relevant conduct.

- 51.** Evidence can consist of material or information provided by the police, a regulatory body, an employer or other investigatory body. The key factor is we have sufficient evidence to think a doctor, PA or AA has engaged in relevant conduct. If, however, the evidence we

have obtained about the alleged criminal conduct is not sufficient to enable us to “think” that the doctor, PA or AA has engaged in relevant conduct, we should consider if the criteria are met for a referral under the harm test (see paragraph 90 and 97-98).

52. Decision makers should take into account all of the circumstances of a case at the time of making their decision whether to refer. For example, where a doctor, PA or AA has been charged with a serious autobar offence, the fact that a prosecution fails because the main witness refuses to give evidence does not mean that a referral cannot be made. In this scenario, the statements, documents, and any other material prepared for both the criminal and GMC investigation could still lead a decision maker to hold a reasonable belief that a doctor, PA or AA has engaged in relevant conduct.
53. In certain cases, physical evidence, such as images seized from a doctor, PA or AA’s computer or forensic evidence, is likely to be evidence which would enable a decision maker to form a reasonable belief that a doctor, PA or AA has engaged in relevant conduct.
54. Each case will need to be considered individually having regard to all of the evidence and circumstances of the allegation as they are known to the GMC.

Consideration of the second condition

55. If the decision maker holds a reasonable belief that a doctor, PA or AA has engaged in relevant conduct or the harm test is met, then they will need to go on to consider both parts of the second condition:
 - i. First part: The decision maker must have a reasonable belief that the doctor, PA or AA has been, is currently or may in the future be involved in a regulated activity with a child or vulnerable adult; and
 - ii. Second part: The decision maker must have a reasonable belief that the DBS ‘may bar’ the doctor, PA or AA because of the matters that resulted in the first condition being met.

If both the first and second conditions are met, the case can be referred to the DBS.

Part 2: Relevant conduct

56. If the autobar criteria are not satisfied, the decision maker should apply the relevant conduct criteria to the case. These are where they “think” a doctor, PA or AA has;

Done something; or

Failed to do something ***and***

The act or omission results in actual harm to a child or vulnerable adult or exposes such a person to the risk of harm

and/or

There is no actual harm or risk of harm to a child or vulnerable adult but if repeated against a child or vulnerable adult, it would endanger them

-
- 57.** Relevant conduct can be any act or omission on the part of the doctor, PA or AA that:
- a.** endangers a child or vulnerable adult or is likely to do so
 - b.** has not on this occasion been directed at a child or vulnerable adult, but if repeated against or in relation to a child or vulnerable adult, would endanger that child or vulnerable adult or would be likely to do so*
 - c.** involves sexual material relating to children (including possession of such material)
 - d.** involves any sexually explicit images (however produced and whether real or imaginary) depicting violence against human beings (including possession of such material), if it appears to the DBS that the conduct is inappropriate, or
 - e.** is of a sexual nature involving a child or vulnerable adult if it appears to the DBS that the conduct is inappropriate.
- 58.** Sexual material relating to children[†] is defined[†] as indecent images of children or material (in whatever form) which portrays children involved in sexual activity and which is produced for the purposes of giving sexual gratification.
- 59.** If the sexual material does not involve children or vulnerable adults but there is concern that it poses a risk to vulnerable groups, consideration should be given to whether the doctor, PA or AA's actions should be referred to the DBS under the harm test (please refer to paragraphs 83-104 below.)
- 60.** With the exception of paragraph 57d above, the relevant conduct must have been capable of being directed towards a child or vulnerable adult. While practising with deficient language skills could constitute relevant conduct as it places a child or vulnerable adult at risk, attending an interview seeking medical employment while having deficient language skills does not directly place a vulnerable person at the risk of harm and therefore does not constitute relevant conduct.
- 61.** The Act states a person endangers a child[‡] or vulnerable adult[§] if the person:
- harms a vulnerable adult or child
 - causes a vulnerable adult or child to be harmed
 - places a vulnerable adult or child at risk of harm
 - attempts to harm a vulnerable adult or child, or
 - incites another to harm a vulnerable adult or child.

* We interpret 'against' as conduct 'directed at' a vulnerable group and 'in relation to' is interpreted as 'to concern or involve' a vulnerable group

[†] The Act Schedule 3, Part 1 ss4(3) and (4)

[‡] Schedule 3, Part 1, para 4(2).

[§] Schedule 3, Part 1, para 10(2).

-
- 62.** When determining whether harm (or the risk of harm) has been caused it is important to remember that harm can be both physical or mental; it can be caused by action or inaction and must be more than just 'trivial or fleeting'.
- 63.** The DBS guidance on referrals lists the following types of harm applicable to children and vulnerable adults:
- a.** emotional/psychological – such as threatening behaviour, bullying, intimidation, harassment, grooming, deliberate isolation and deprivation causing severe and persistent mental anguish or adverse effects on a child's emotional development
 - b.** physical – such as hitting, pushing, shaking, failure to arrange medical treatment or medication, under/over-prescribing and inappropriate restraint resulting in pain, injury or discomfort
 - c.** sexual – such as any inappropriate touching or coercion to participate in sexual acts, even without contact (including sexualised messages), and any form of sexual activity with a child under the age of consent
 - d.** neglect – such as failure to identify/meet basic physical, psychological or care needs, failure to protect from danger, ignoring a patient's or a resident's requests, poor hygiene or untreated weight loss likely to result in serious impairment of health or development
 - e.** verbal – such as demeaning, disrespectful, humiliating, racist/sexist, abusive comments causing distress
 - f.** financial – such as misuse of money, valuables or property, theft, exploitation and pressure regarding wills or inheritance

NOTE: What constitutes harm is subjective, and greatly dependent on the context of the act or omission which caused the harm or exposed the vulnerable person to harm.

Regulated activities outside healthcare

- 64.** The definition of relevant conduct is not restricted to actions within regulated activity. It must simply involve a child, or a vulnerable adult or be capable of being directed towards a child or vulnerable adult.
- 65.** However, in some cases outside the doctor, PA or AA/patient relationship, the person who is harmed by the doctor, PA or AA might be a vulnerable adult because the doctor, PA or AA is providing them with some other regulated activity (see paragraphs 19-21 above for discussion on vulnerability).
- 66.** In these cases, where a doctor, PA or AA registered with the GMC has harmed a child or vulnerable adult when providing them with a regulated activity other than health care, it is likely that relevant conduct will have occurred. The GMC decision maker must go on to consider whether the second condition is met in these cases.

Example

If a doctor takes a group of elderly patients to the shopping centre in a hospice bus and is arrested as a result of careless or dangerous driving, the doctor is engaging in relevant conduct whilst providing a regulated activity.

i.e. they may have endangered their passengers and are also providing a regulated activity by transporting adults who need it by virtue of their age.

Non-vulnerable groups and repetition of conduct towards vulnerable groups

67. Relevant conduct can also include acts or omissions by the doctor, PA or AA which didn't involve children or vulnerable adults but could cause them harm, or place them at risk of harm, if the same conduct were to be repeated and directed towards them (paragraph 57b).
68. Decision makers may need to consider findings against the doctor, PA or AA which relate to misconduct towards an organisation or someone who is not a child or vulnerable adult ('non-vulnerable group'). In order to decide whether the relevant conduct criteria are met, the decision maker will need to form an overall view on whether it is realistic for the doctor, PA or AA's conduct to be repeated against or in relation to a child or vulnerable adult and if this would cause or risk harm. In doing so, the decision maker should analyse the specific facts of a case and exercise their discretion when applying the referral conditions.
69. Where the conduct has been directed towards an organisation, it will often be too remote to suggest that it could be repeated against or in relation to a child or vulnerable adult, for example, if the doctor, PA or AA plagiarised a research paper or gave misleading evidence at a tribunal hearing. Where relevant conduct does not apply, the harm test should be considered.
70. A logical and proportionate approach should be taken when considering if the relevant conduct criteria are met. The starting point should be to take a broad view of the conduct and then decide if it could feasibly be repeated against or in relation to a child or vulnerable adult. Generally, there is no need to give weight to who the conduct was initially directed at, as it is sufficient at this stage to just identify the broad category of conduct and if it could be repeated towards a child or vulnerable adult. However, the link between the conduct and the potential for harm to be caused to vulnerable groups should not be too tenuous or unforeseeable.

Assault/threatening behaviour

A doctor assaults a colleague at work by grabbing the colleague's arm causing bruising because they are unhappy with their colleague's behaviour.

The conduct may be considered as assault. A doctor could repeat the broad conduct of assault against or in relation to a vulnerable group which could cause or risk harm. The fact that the initial conduct arose in the context of a work-related disagreement is not a significant factor at this stage.

Submission of false timesheet

A doctor submits a falsified timesheet to their employment agency, claiming money for a shift they did not complete.

The act of submitting a false timesheet cannot be feasibly repeated against vulnerable groups because there is no likely scenario that can be envisaged where a doctor would need to submit a timesheet whether false or not to a vulnerable group. To define the doctor's actions as relevant conduct here would be to define the conduct too broadly as dishonesty capable of being directed towards vulnerable groups.

71. Specific details about the location and context of the doctor, PA or AA's conduct are not relevant at this stage and should not prevent a conclusion that the same broad conduct could be repeated towards a child or vulnerable adult. The precise circumstances under which the conduct has arisen can be more appropriately addressed under the second part of the second condition (the may bar test).

Sexually motivated behaviour

A doctor converted a shower bottle to covertly record other gym users in the changing room at a gym. The doctor's actions were noticed by a gym user and a complaint was made.

The broad conduct to be considered is sexually motivated behaviour and voyeurism. The fact that the act took place in a gym should not prevent the possibility of repetition of the conduct i.e. covert recording, directly against or concerning a vulnerable group.

Assault/threatening behaviour

A doctor assaults their spouse in their private home and there is no child present. The doctor has not engaged their spouse in regulated activity and therefore they are not classed as a vulnerable adult.

However, if the doctor were to repeat the conduct of assault on a vulnerable adult, that adult could be endangered by being caused physical harm or placed at risk of harm. The fact that the conduct has occurred in the doctor's own home does not need to be considered at this stage.

- 72.** The following are examples of potential relevant conduct, as the doctor, PA or AA's behaviour, although not originally aimed towards a child or vulnerable adult, could be repeated and directed towards them. However, this is not an exhaustive list and discretion must be exercised when considering each case:
- Assault, threatening or abusive behaviour directed towards:
 - Family member
 - Work colleague
 - Member of the public
 - Dishonesty – if the same circumstances could feasibly be repeated and cause harm to vulnerable groups:
 - Amending patient medical records after death
 - Theft
 - Fraud
 - Sexually motivated or inappropriate behaviour directed towards:
 - Family member
 - Work colleague
 - Member of the public
- 73.** In summary, when applying paragraph 57b, the decision maker should consider the following:
- What has the doctor, PA or AA done or omitted to do?
 - Is it feasible to repeat the broad behaviour type towards a child or vulnerable adult?
 - If so, would harm be caused or risked?

Impairment for reasons connected to health, performance or language and relevant conduct

- 74.** If we have evidence that a doctor, PA or AA has treated children or vulnerable adults while their fitness to practise was impaired for reasons connected to their health, performance or lack of knowledge of the English language, this will amount to relevant conduct. This will involve looking back in time as the finding of impairment (either by a medical practitioners' tribunal, an associates' tribunal or a case examiners decision) will postdate the time when the doctor, PA or AA was working without restrictions from us. For example, if a doctor, PA or AA is diagnosed with an addiction to controlled substances and a tribunal subsequently finds their fitness to practise impaired for reasons connected to their health, we will consider their actions in working prior to the diagnosis to amount to relevant conduct. This is because by treating patients while impaired, they have engaged in an act which endangers a child or vulnerable adult or is likely to do so.
- 75.** The same principle will apply if a doctor, PA or AA has worked at a time when it was subsequently found their fitness to practise was impaired for reasons connected to their poor performance or deficient knowledge of the English language.

Failure to complete a Work Details Form (WDF)

- 76.** A finding that a doctor, PA or AA did not complete a work details form as part of the GMC investigation does not need to be addressed separately by the decision maker as it arises directly from our investigation. It is also in itself, very unlikely to meet the relevant conduct or harm test criteria as the doctor, PA or AA's actions in failing to return the form did not pose a direct risk of harm to vulnerable groups. There may however be rare circumstances when it is appropriate to reference it as supplementary evidence that the doctor, PA or AA has demonstrated a disregard for regulatory or other procedure.

Case studies

- 77.** A list of case studies for doctors is contained at [Annex B](#). Over time we will also develop a bank of case studies that are tailored to the practice of PAs and AAs

NOTE: Decision makers should note that relevant conduct applies not only to conduct which occurs in England, Wales or Northern Ireland, but also to conduct which occurs overseas. Therefore, if a doctor, PA or AA registered with the GMC has acted in a way that would amount to relevant conduct in a jurisdiction other than England, Wales or Northern Ireland, it may be treated in the same way as if it had occurred in one of the three jurisdictions covered by the Scheme.

Trigger points for referrals involving relevant conduct

Procedures involving doctors.

- 78.** Our position is that in order to establish that an act or omission has occurred or that an allegation has foundation:
- a. two case examiners must have either:

-
- i. decided that the allegation meets the realistic prospect test and agreed undertakings with the doctor or;
 - ii. decided that the doctor's actions were a significant departure from Good Medical Practice and issued a warning.

OR

- b. a medical practitioners tribunal must have found the allegation proved on the balance of probabilities.

When either of the above has occurred, this will be referred to as a 'finding' having been made.

79. A case which meets the relevant conduct criteria may be referred when:

- i. case examiners issue a warning, agree undertakings or decide to refuse an application for restoration to the medical register.
- ii. a warning has been issued by the Investigation Committee.
- iii. a medical practitioners' tribunal issues a warning, agrees undertakings, imposes conditions, suspends or erases a doctor or refuses an application for restoration to the medical register.
- iv. an assistant registrar in the Registration and Revalidation directorate refuses to restore a doctor to the medical register.

Procedures involving PAs and AAs

79A In relation to PAs and AAs, our position is that in order to establish that an act or omission has occurred or that an allegation has foundation:

- a) two case examiners must have either:
 - i. decided that the PA or AA's fitness to practise is impaired having found the allegation proved and a final measure has been imposed (conditions, suspension, or removal).
 - ii. decided that the PA or AA's actions were a significant departure from the professional standards expected and issued a warning.

OR

- b) an associates' tribunal must have found the allegation proved on the balance of probabilities.

When either of the above has occurred, this will be referred to as a 'finding' having been made.

79B A case which meets the relevant conduct criteria may be referred when:

- i. case examiners issue a warning, impose a final measure of conditions, suspension or removal (including at a review of final measures).
- ii. an associates' tribunal issues a warning, imposes a final measure of conditions, suspension or removal (including at a review of final measures).
- iii. an authorised decision maker of the Registration and Revalidation directorate

refuses a PA or AA's application for re-entry to the register of PAs and AAs.

- 80.** In multi-factorial cases, tribunals may find some allegations proved but determine these do not amount to either serious misconduct or impaired fitness to practise and do not impose a sanction (or final measure). Decision makers should still refer to these findings but where they do not raise safeguarding concerns, they do not need to make a formal assessment of whether the relevant conduct or harm test criteria are met. This is because, in the absence of any sanction (or final measure) or safeguarding concern, those specific findings do not meet a relevant conduct trigger point requiring assessment as set out in figures 1 or 2 below. Where there is a safeguarding concern, the decision maker must consider if the harm test is met.
- 81.** A referral should not be made until we have evidence to establish the allegation has foundation. Without such evidence or information, the DBS will close the case. In general, the DBS wish to receive referrals once a finding has been made that the doctor, PA or AA engaged in relevant conduct (in accordance with the criteria set out at paragraph 57(a) to (e) above). In such cases and where both parts of the second condition are met, we will immediately refer to the DBS, even where the determination is subject to appeal by the doctor, PA or AA.
- 82.** The decision maker should proceed to consider the harm test if there are any findings which do not meet the relevant conduct criteria.

Figure 1 - trigger points for considering referrals in relevant conduct cases in respect of doctors (assuming the referral conditions are met):

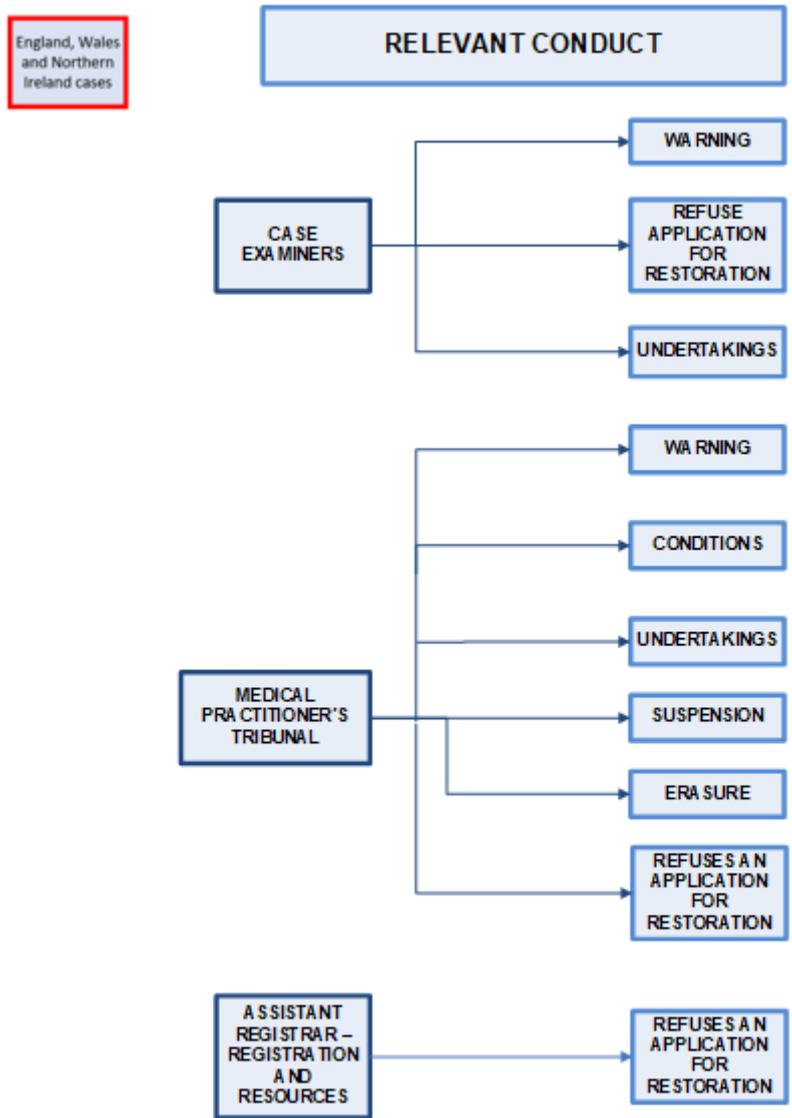
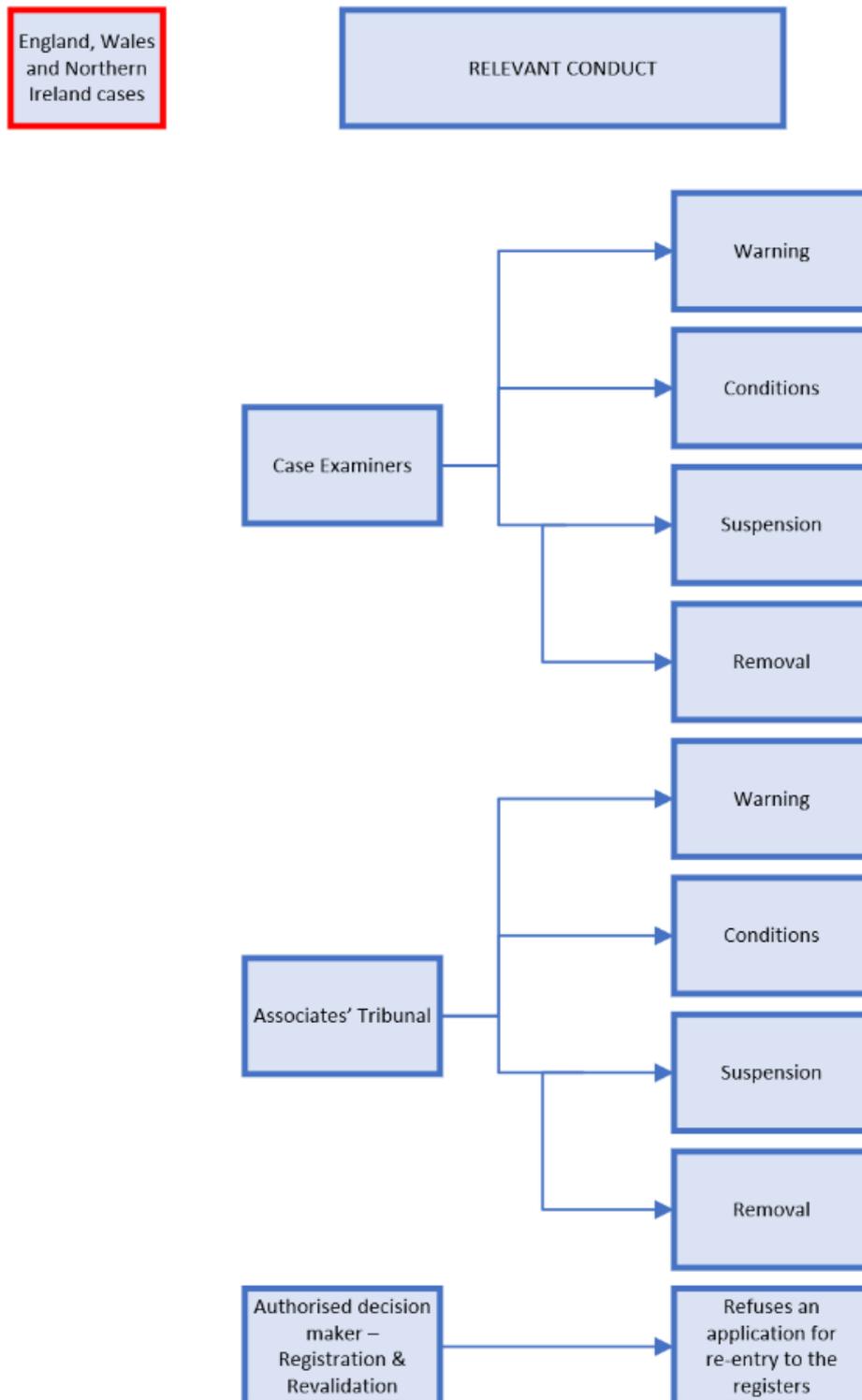


Figure 2 - trigger points for considering referrals in relevant conduct cases in respect of PAs and AAs (assuming the referral conditions are met):



Part 3: The harm test

83. The harm test will only need to be considered where the auto-bar or relevant conduct criteria are not satisfied in respect of some or all of the findings against the doctor, PA or AA.
84. There is no absolute requirement that there is a ‘trigger point’ in order for the harm test to be met.
85. The important factor in harm test cases is that the doctor, PA or AA has not yet engaged in relevant conduct but there is a risk that they may do so in the future either based on their past actions or specific thoughts, beliefs or attitudes they have expressed.
86. In applying the harm test decision makers need to consider if there is an identifiable risk that a doctor, PA or AA **MAY** do one or more of the following?
- i. harm a child or vulnerable adult
 - ii. cause a child or vulnerable adult to be harmed
 - iii. put a child or vulnerable adult at risk of harm
 - iv. attempt to harm a child or vulnerable adult
 - v. incite another to harm a child or vulnerable adult
87. In making a decision about whether the harm test applies, decision makers should consider:
- what is the doctor, PA or AA deemed to be at risk of doing in the future?
 - does the harm or risk of harm directly relate to a child or vulnerable adult?
 - how credible or compelling is the information that has been provided?
 - what is the likelihood of the behaviour occurring – is it more than trivial or fleeting?
 - what is the likely level of harm if the behaviour does occur?
88. We should make a referral to the DBS if we “think” that a doctor, PA or AA may engage in behaviour which may cause harm, or place children or vulnerable adults at risk of harm in the future **and** both parts of the second condition are met.

How can the harm test be met?

89. The harm test is prospective and involves an assessment of what a person **may** do in the future. It has two limbs and can be met if either one applies.
- Limb 1 – The doctor, PA or AA has done something (or failed to do something) which leads us to form a reasonable belief they **may** harm vulnerable groups in future.
 - Limb 2 - The doctor, PA or AA has expressed a thought, belief or attitude which indicates a future risk of direct harm to children and/or vulnerable adults.

Limb one – past conduct or omissions by the doctor, PA or AA

90. Where there is not enough evidence to conclude a doctor, PA or AA has engaged in relevant conduct, the decision maker should consider if this evidence is nonetheless sufficient to form a reasonable belief the doctor, PA or AA **may** harm vulnerable groups in future. At times, it may be difficult to distinguish between the application of the relevant conduct provisions and the application of the harm test.
91. Examples of common scenarios where decision makers will need to apply the harm test are set out below.

Scenario 1: Doctor, PA or AA's conduct did not relate to a child or vulnerable adult and could not feasibly be repeated and directed towards a vulnerable group

92. Decision makers will sometimes be asked to consider conduct by the doctor, PA or AA which did not relate to a child or vulnerable adult and could not feasibly be repeated and directed towards them. For example, the misconduct was directed towards an inanimate object or an employer or regulator. Potential findings requiring assessment could include a doctor, PA or AA submitting fraudulent expense claims, giving false evidence at a tribunal hearing or receiving a police caution for criminal damage.
93. It is unlikely that the harm test will be met in the majority of these cases. This is because, where the behaviour did not have a direct link to a child and/or vulnerable adult, there is unlikely to be any tangible evidence to suggest that the doctor, PA or AA may harm vulnerable groups in the future.

Scenario 2: Application of the harm test if there is insufficient evidence to support relevant conduct because there is no factual finding by a tribunal or case examiner

94. In rare circumstances, there may not be a formal finding in relation to an allegation which is of a safeguarding nature. In the absence of a finding, we may be unable to form a reasonable belief (as required by the relevant conduct criteria) that the doctor, PA or AA **has** endangered vulnerable groups if there is insufficient evidence to reach this conclusion.
95. We may however have enough information to form a reasonable belief that the doctor, PA or AA **may** harm children and/or vulnerable adults or put them at risk of harm in the future. In these circumstances, the harm test will be met as it is based on future risk rather than past conduct.
96. This scenario may arise when we have concluded a case without the case examiners or tribunal specifically addressing or making a finding on an allegation which raises a significant safeguarding concern. Most commonly this will occur where a doctor agrees

undertakings with the GMC in relation to their health or performance. Broadly speaking, a significant safeguarding concern arises where a doctor, PA or AA's actions have harmed a child or vulnerable adult or placed them at risk of harm including abuse or neglect. Examples include failing to make a safeguarding referral and a doctor, PA or AA abusing their professional position to exploit a patient for financial gain.

Example

A case was concluded by way of undertakings following a performance assessment. The case examiners did not make specific findings that the doctor failed to carry out a safeguarding assessment on a two-year-old child with a head wound and history of unexplained injuries. In the absence of a case examiner finding to satisfy the relevant conduct criteria, this information could still meet the harm test if we have a reasonable belief of future harm to a child or vulnerable adult due to the doctor's suspected past failures.

Scenario 3: Serious autobar

97. Consideration of the harm test may also be needed where we have information that suggests the doctor, PA or AA may have committed a serious autobar offence, but we do not have formal confirmation through a police caution or conviction.
98. While we will usually refer serious autobar cases under the relevant conduct criteria (as outlined at paragraphs 46-55 above), if the evidence we have obtained about the alleged criminal conduct is not sufficient to enable us to "think" that the doctor, PA or AA has endangered vulnerable groups, or that if the conduct were repeated against or in relation to a child or vulnerable adult, it would endanger that child or vulnerable adult or would be likely to do so, a referral could still be made if the harm test is satisfied. This requires only that the decision maker has a reasonable belief the doctor, PA or AA may harm vulnerable groups in future or place them at risk of harm.

Example

The doctor was investigated but not charged with an autobar offence but we nonetheless have enough information to form a reasonable belief they engaged in the criminal conduct and therefore may harm vulnerable groups. This evidence could arise through our own witness statements supported by documentary evidence such as text messages, e-mails etc.

Limb two – the doctor, PA or AA has communicated something about their thoughts, beliefs or attitudes, which indicate that they pose a future risk of direct harm to vulnerable groups

99. Where the harm test is not met on the basis of past conduct or omissions by the doctor, PA or AA, the decision maker should go on to consider the second limb. This will involve an assessment of whether the harm test is met through the doctor, PA or AA communicating something about their thoughts, beliefs or attitudes, which indicate that they pose a future risk of direct harm to children and/or vulnerable adults. This includes where a doctor, PA or AA is not currently practising but there is a risk they may in the future and they are not fit to do so safely.

Examples

If a doctor working in a paediatric ward of a hospital tells a colleague that they are sexually attracted to children, but have not yet acted on their feelings, the harm test would be met.

Where a doctor tells their therapist that they have a desire to cause harm to elderly patients, but have not actually done so, the harm test would be met.

100. In the examples above, decision makers can assume the auto-bar provisions have not been met as the doctor, PA or AA has not been convicted of, or cautioned, in relation to an auto-bar, or connected offence. The relevant conduct part of the first condition is not met as there has not been any past conduct (an act or omission). However, the information we hold indicates that the doctor, PA or AA poses a *future risk of harm* to children or vulnerable adults.

NOTE: Verbalising thoughts, beliefs or attitudes is not considered to be ‘an act’ by the doctor, PA or AA for the purposes of the relevant conduct criteria.

101. Evidence of the risks in the first two examples may come from a health assessment report or from other information gathered during the course of our investigation process.
102. The harm test will not usually apply in cases where the doctor, PA or AA’s expression of their thoughts, attitudes or beliefs indicates a general risk of harm rather than a specific risk in relation to children and/or vulnerable adults.

Example

A doctor commenting to a colleague that 'The management should be taken out and shot!' will not satisfy the harm test.

Although the comment may be unpleasant it does not indicate a safeguarding risk in relation to children or vulnerable adults.

- 103.** If neither of the two limbs under which the harm test can be met are satisfied, the decision maker should record this clearly in their decision giving brief reasons as appropriate.
- 104.** If the first referral condition is not met, there will be no requirement to consider the second one and no referral should be made to the DBS.

The second condition

- 105.** The second condition has two parts.
- 106.** Where the decision maker “thinks” that there has been relevant conduct or that the harm test is met, both parts one and two of the second condition must be applied. If the doctor, PA or AA has been convicted or cautioned in relation to an auto-bar offence, only part one of the second condition must be met.

Part 1: The doctor, PA or AA has been, is, or might in the future, be engaged in a regulated activity

- 107.** The first part of the second condition requires the GMC to consider whether the doctor, PA or AA:
- a.** has been engaged in a regulated activity at the time the relevant conduct occurred or the circumstances that gave rise to the harm test being satisfied arose, and/or
 - b.** is engaged in a regulated activity at the time the second condition is being considered by the decision maker, and/or
 - c.** might in future be engaged in a regulated activity.
- 108.** A doctor, PA or AA is engaged in a regulated activity (in this case the provision of healthcare) if they have contact with patients (children or adults) in any primary care or healthcare setting, regardless of whether the care is delivered through the NHS or other private arrangements.
- 109.** Most of the GMC’s cases will satisfy the first part of the second condition as the DBS has indicated it will be met solely by virtue of the fact the doctor, PA or AA is on our registers and might therefore engage in a regulated activity in future. For doctors, PAs and AAs who are erased or removed at the point a referral is being considered, the GMC will need to be satisfied that they were engaged in a regulated activity at the time that the relevant conduct occurred or the circumstances that give rise to the harm test being met arose. This requirement will usually be met if the doctor, PA or AA was registered at the relevant time.

Part 2: The may bar test

- 110.** Part two of the second condition will only be met where the decision maker decides that the DBS ‘may bar’ the doctor, PA or AA because of their conduct in circumstances which give rise to the relevant conduct criteria or the harm test being met.
- 111.** The may bar test requires consideration of the concerns in the round. Therefore, the decision maker can rely on any previous information about an act, omission or risk of harm posed by the doctor, PA or AA that was investigated and satisfied the referral criteria at the time. Where a fitness to practise (FTP) case was closed with no action, we will not rely on that information when assessing whether the may bar test criteria is met unless there is an identifiable pattern of similar behaviour in the past. In such cases, the information may be considered as part of the determination or CE decision subject to the referral.
- 112.** The decision maker should consider:
- the individual circumstances of the case and whether the doctor, PA or AA poses a future risk to children or vulnerable adults
- AND
- whether the sanction on the doctor’s registration or the measure imposed in respect of the PA or AA’s registration is or is not enough to mitigate the future risk from occurring.

Overall seriousness

- 113.** The risk of harm must be serious enough that we “think” the DBS needs to be informed as they may bar the doctor, PA or AA. It could be the case that although there is evidence that parts two and three of the first condition are met, the information is not referred to the DBS as there is not an unaddressed risk of harm to vulnerable groups.
- 114.** The GMC cannot form a conclusive view on the likelihood of the risk materialising in the future. The decision maker can be guided by any views expressed by a medical practitioners’ tribunal or associates’ tribunal, or the reasons given by case examiners for their decision, but it is for the DBS to assess the risk when making their decision on whether to bar an individual.

Guiding principles on the may bar test

- 115.** A set of guiding principles for considering the second part of the second condition are set out below, and a list of case studies are attached at Annex B.
- 116.** It is important to note that each case must be considered individually using the guiding principles. Decision makers are not strictly bound by these principles and can deviate from them but should give clear reasons for their decision to depart from them.

The 'may bar' test will generally **not** be met in cases which:

- relate solely to professional competence
- relate to health or language skills and GMC action manages the risk
- involve conduct at the lower end of the spectrum of seriousness that was not directed towards vulnerable groups and the likelihood of repetition towards a vulnerable group is low
- relate to low level dishonesty, including in a clinical setting, where there is no information to suggest a specific safeguarding concern or future risk of harm to vulnerable groups e.g. a doctor, PA or AA completing patient satisfaction questionnaires in order to satisfy the quota required, or working a single shift as a locum while on sick leave where there are no issues regarding competency.
- are a result of risks taken within a private setting, *unless* it was established that the doctor, PA or AA intended to cause harm or the risk of harm to children and/or vulnerable adults
- involve behaviour which is not of a sufficiently serious nature to form a reasonable belief that the DBS may bar the doctor, PA or AA. This may be due to there being a low risk of harm or minimal harm was caused e.g. an insensitive remark, rudeness or sarcasm towards a patient
- involve the making of a false report without intent to mislead or making a false report where it is not related to a safeguarding matter.

NOTE: For further examples of where the 'may bar' test is not met see [Annex B](#).

The 'may bar' test **is** likely to be met in cases which:

- concern non-professional safeguarding issues for vulnerable groups (such as sexual or violent behaviour)
- involve an abuse of a position of trust where harm to children or vulnerable adults results e.g. if a doctor, PA or AA defrauds an elderly patient
- involve the making of a false report with intent to mislead or cover up a safeguarding matter e.g. where there is an investigation into an incident in the workplace involving relevant conduct (i.e. sexual harassment of a patient) and the doctor, PA or AA gives false or misleading information.

Likelihood of repetition

Original conduct was not directed towards vulnerable group

- 117.** When considering whether the DBS may bar the doctor, PA or AA, the likelihood of repetition will be an important factor impacting on the potential future risk to vulnerable groups. This is particularly relevant when assessing the doctor, PA or AA's conduct towards a non-vulnerable person such as a colleague or member of the public. Decision makers

should have regard to all the circumstances when considering the likelihood that the doctor, PA or AA will repeat the same conduct towards a child or vulnerable adult and therefore pose a future risk of harm such that the may bar test is met.

118. The decision maker should consider:

- what the doctor, PA or AA is deemed to be at risk of doing in the future and will the GMC action mitigate this risk?
- if the conduct was a one off or does the doctor, PA or AA have a history of similar behaviour?
- what is the likelihood of the behaviour re-occurring and being directed towards a child or vulnerable adult – is it more than trivial or fleeting?
- what is the likely level of harm if the behaviour does re-occur and is directed towards vulnerable groups?

119. The decision maker should take into account any view given about the doctor, PA or AA's mindset by the case examiners or by the tribunal in its determination. For example, did they identify attitudinal concerns, evidence of premeditated behaviour, intent to cause harm, abuse of trust, dishonesty or disregard for the regulator? The level of insight and steps taken by the doctor, PA or AA towards remediating their behaviour will also be relevant to the risk of repetition and whether the DBS may bar the doctor, PA or AA.

120. Where the original act or omission was not directed towards a child or vulnerable adult, the may bar test will generally not be met if:

- a. the doctor, PA or AA's conduct was at the lower end of the spectrum of seriousness and;
- b. the likelihood of repetition is low and;
- c. there is no other evidence to suggest the doctor, PA or AA poses a specific risk to children or vulnerable adults.

Cases involving violence directed towards non-vulnerable groups

121. Where the doctor, PA or AA has been convicted of an offence involving violence or has otherwise been found to have engaged in violent conduct towards non-vulnerable groups, the decision maker should take the following factors into account when considering if the may bar test is met.

- a. The seriousness of the violence including whether it:
 - i. was sustained or repeated
 - ii. involved weapons
 - iii. resulted in significant injuries.
- b. Whether the violence was:
 - i. motivated by hostility towards someone's race, sexual orientation, disability, sex, gender, religion, age or the doctor, PA or AA's assumptions about the alleged victim's protected characteristics
 - ii. directed towards a vulnerable person (even though they were not in receipt of a regulated activity from the doctor, PA or AA). For example, someone with

learning disabilities or a serious mental health issue.

The presence of these two factors is likely to increase the overall seriousness and the likelihood the may bar test is met.

- c. Whether the doctor, PA or AA has a known history of violent or aggressive behaviour suggesting an increased risk it may be repeated and directed towards vulnerable groups.

- 122.** Having considered these factors, the decision maker should form a view on the future risk the doctor, PA or AA poses to vulnerable groups and whether this has been mitigated by the GMC's action. The may bar test is likely to be met where a doctor, PA or AA has engaged in serious violence resulting in significant harm, even where this has not resulted in a criminal conviction.

Conduct which undermines confidence in the profession

- 123.** The may bar test will generally not be met where action taken by the GMC is solely to maintain confidence in the profession unless the underlying concerns raise safeguarding issues.

Clinical failures

- 124.** The may bar test will also not usually be met where the concerns are purely clinical in nature because the action we have taken will remove the risk of any future harm from clinical incompetence e.g. placing conditions on the doctor, PA or AA's registration or requiring them to retrain. In the absence of wider safeguarding issues for children or vulnerable adults, a referral to the DBS will not be appropriate.

Callous disregard for procedure

- 125.** The may bar test may be met where the individual has demonstrated a 'callous disregard' for procedure.
- 126.** The DBS may bar these individuals as being unsuitable to work with children or vulnerable adults in the future because the callous disregard for procedure demonstrated, if repeated when working or taking part in a regulated activity in the future, may put children or vulnerable adults at risk of harm.
- 127.** Cases involving callous disregard generally arise from significant attitudinal failings which indicate a propensity for behaviour which could harm vulnerable groups rather than general incompetence. Clinical failings will not raise an issue of callous disregard if there is no evidence the doctor, PA or AA intended to cause harm or was reckless about behaviour likely to harm patients.
- 128.** Given the narrow nature of callous disregard (see below), it is not necessary for the decision maker to formally reference it in every case where the doctor, PA or AA was found to have provided substandard care such as failure to follow a treatment protocol, record relevant information in a patient's records or in respect of a doctor, prescribe a drug that was indicated for the patient's condition. Although there was a failure to follow correct

procedure, in the absence of clear recklessness or a deliberate intention to harm patients, this would not amount to callous disregard. In this type of case, the action taken by the GMC will usually manage the future risk of harm to children or vulnerable adults.

- 129.** Below are examples of the type of case where it would be appropriate to consider if the doctor, PA or AA has demonstrated a callous disregard for procedure:
- a. the doctor, PA or AA deliberately or recklessly worked outside the limits of their competence without the appropriate qualifications and/or experience
 - b. the doctor, PA or AA deliberately destroyed or otherwise inappropriately interfered with evidence for an investigation into harm caused to a patient or a fitness to practise issue
 - c. the doctor, PA or AA deliberately or recklessly failed to disclose, or provided a potential or current employer, with incomplete or misleading information about:
 - i. an ongoing disciplinary procedure or investigation into their fitness to practise
 - ii. their practice or registration being restricted due to fitness to practise concerns
 - iii. the circumstances of their dismissal.
 - d. there was a significant failure by the doctor, PA or AA to follow research protocols intended to safeguard participants in clinical trials or other types of research
 - e. the doctor, PA or AA deliberately or recklessly breached a suspension or conditions placed on their registration or local practice.
- 130.** Decision makers need only address callous disregard in their reasoning if it is relevant to the particular circumstances of the case.
- 131.** In order for a callous disregard for procedure to raise wider safeguarding risks, it must be:
serious; and
deliberate or reckless.
- 132.** For there to be a callous disregard for procedure the procedure must be relatively formal and clear to the individual to whom it applies. It can be evidenced through a pattern of behaviour and must be 'serious' overall in order to meet the threshold.

Example

A doctor admits children as volunteers in a clinical research trial without consent of their parents, contravening ethical guidelines and research protocols intended to protect participants. They also misrepresent the findings of the research to give false assurances about the safety of a new drug which as a result is given a licence for use in the UK. Their actions put the children involved in the research and vulnerable adults later in receipt of the drug at risk of serious harm.

- 133.** In cases where the conduct is a 'one-off' incident there must be an extremely serious disregard for procedure to meet the 'seriousness' threshold.

Example

A doctor carries out a locum shift while suspended from the medical register by the Interim Orders Tribunal after being charged with the sexual assault of a patient. The doctor was aware of the suspension and, in order to work, falsely informed their locum agency that the Interim Orders Tribunal hearing had not yet taken place.

- 134.** What amounts to ‘extremely serious’ in determining the threshold for callous disregard will generally be established by looking at the circumstances of the individual case. Relevant case studies are set out at Annex B.
- 135.** It will not however automatically follow that the may bar test will be met where we are satisfied that the doctor, PA or AA has shown a callous disregard for procedure. Although this will be a significant factor when considering whether the DBS may bar the doctor, PA or AA, it is not the sole consideration. We need to take a step back and consider, in all of the circumstances of the case, the factors which would weigh both in favour and against the may bar test being satisfied.

Failure to make a safeguarding referral

- 136.** The prevention of the abuse of children and vulnerable adults is a collective responsibility of all sections of society. However, those working with, or in contact with children or vulnerable adults hold a particular responsibility to ensure safe, effective services to protect those at risk. That responsibility extends to the prevention of, and early detection of abuse ensuring that appropriate protective measures can be put in place.
- 137.** Doctors, PAs or AAs are often in a unique position to recognise where a safeguarding referral is necessary. Where a doctor, PA or AA fails to make a safeguarding referral in circumstances where a referral is indicated the doctor, PA or AA’s failure may put a child or vulnerable adult at risk of harm or may have already caused harm. In these cases, the omission by the doctor, PA or AA is not simply a clinical failing, it has much wider consequences and the referral ground is likely to be met.
- 138.** The may bar test may be satisfied where a doctor, PA or AA makes a false report relating to a safeguarding matter. For example, if a doctor, PA or AA is, or is aware that a colleague is, routinely not completing paperwork relating to safeguarding assessments and intentionally makes a false report to cover this up, a referral to the DBS may be necessary.
- 139.** In some cases, the decision as to whether the may bar test is satisfied will not be so clear. Each case must be looked at individually to consider whether there are aggravating factors.

False statements about qualifications or experience

- 140.** For case studies relating to false claims on an application or CV as to experience, see Annex B.
- 141.** Where a doctor, PA or AA makes a false statement either in an application or CV any action taken by the GMC will usually remove the risk of harm to children or vulnerable adults. Therefore, the may bar test will not be met where the false statement(s) does not result in

them securing employment as a result.

- 142.** However, if the doctor, PA or AA is successful in obtaining employment and goes on to carry out clinical work despite not being suitably qualified and is incompetent to perform the role, the criteria for the may bar test will be met if there is a risk of serious harm to children or vulnerable adults as a result of the misleading statement(s) in the doctor, PA or AA's CV or application form.
- 143.** To determine whether there is a 'serious' safeguarding risk to a child or vulnerable adult, a decision maker should consider if any of the following apply:
- i. *The seriousness of the harm or risk of harm*– e.g. could it have resulted in serious harm, injury or a fatality and how imminent was the harm i.e. did the doctor, PA or AA commence work?
 - ii. *The seriousness of the false statement* – e.g. a non-surgical doctor asserting they are a qualified surgeon will present a very serious risk to patients. However, a doctor who says they achieved a higher score in an exam than they did but nevertheless passed the exam may not present such a risk.
 - iii. *Repetition* – was the statement an isolated or repeated incident? For example, the doctor, PA or AA lies on their CV but is detected by a prospective employer and does not gain employment as a result, but then goes on to make the same statement(s) again in a separate application and/or CV to another prospective employer?
 - iv. *Reprimand* – has the doctor, PA or AA previously been reprimanded for similar conduct in the past and gone on to repeat the false statement?
 - v. *Motive* – false statements made specifically for the purpose of obtaining access to children or vulnerable adults with a motive to exploit or abuse them is a serious aggravating factor.

Example

A Doctor in their second year of specialist training in anaesthetics fraudulently creates a false reference to support an application for a locum anaesthetist's role.

The doctor's application was successful. During the course of the doctor's work, it was noticed that they lacked basic knowledge in anaesthetics.

As the doctor had attended work intent on carrying out a role they were not qualified to perform, patient lives would be at risk. Had it not been for the intervention of others the doctor's actions could have resulted in a fatality.

Personal relationships with patients

- 144.** Paragraph 86 of [Good medical practice](#) states that a doctor, PA or AA must not act in a sexual way towards patients or use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.
- 145.** Even if consensual, a personal relationship between a doctor, PA or AA and patient while

there is an ongoing professional relationship is likely to meet the referral criteria. However, the individual case may have mitigating features which mean the doctor, PA or AA does not pose a risk of harm to an individual or to vulnerable groups, such as the circumstances under which the relationship arose or where the doctor, PA or AA took appropriate steps to end the professional relationship.

- 146.** Where there is evidence to suggest that a doctor, PA or AA has abused their position of trust in order to pursue a sexual relationship with a patient, e.g. accessing a patient's contact details, the referral ground will be met. This is likely to be the case even if the conduct was a 'one-off' event. Similarly, if the incident is not an isolated one, this will increase the seriousness of the conduct.

Health and language skills

- 147.** The may bar test will generally not be met where the concerns relate to health or language skills, unless there is other compelling information to indicate a specific risk of harm to children and vulnerable adults which cannot be mitigated solely by action taken by the GMC. The GMC's actions will manage the risk where, for example, the doctor, PA or AA is subject to restrictions which fully address the health or language concerns and the restrictions are being complied with. If the doctor, PA or AA is refusing to comply with the restrictions or has breached them, we will need to reconsider whether the may bar test might be met as our action is no longer mitigating the potential risk to children and/or vulnerable adults.
- 148.** Where the health or language concerns cause other behavioural problems that may pose a risk of harm, callous disregard for the care of, or actual serious harm to vulnerable adults or children, then it may be necessary to refer the doctor, PA or AA to the DBS.
- 149.** Alcohol or drug dependency related convictions and intoxication within the workplace may raise safeguarding risks in relation to children and vulnerable adults.

Substance abuse outside the workplace would not meet the may bar test.

Such abuse indicates a general risk of harm rather than placing children and/or vulnerable adults at a direct risk of harm.

- 150.** If a doctor holds a purely academic or research role this is unlikely to give rise to safeguarding concerns as there is no direct risk in relation to children and/or vulnerable adults.
- 151.** Affective disorders in and of themselves would not satisfy the referral criteria, but behaviour caused by or failure to manage an affective disorder could do so.
- 152.** If an affective disorder causes a doctor, PA or AA to endanger a child or vulnerable adult (or cause risk of endangerment) or satisfy the harm test, then the may bar criteria would need to be considered on the grounds of the risk posed by the doctor, PA or AA's behaviour.

Allegations and facts found proved where a sanction or final measure has not been imposed

- 153.** There will be rare circumstances where conduct is considered by case examiners or a tribunal makes factual findings in respect of some allegations, but it does not result in a sanction or a final measure being imposed on the doctor, PA or AA's registration. When considering if the may bar test is met, relevant weight should be given to the fact that a sanction or final measure was not imposed and the reasons given in the decision or determination regarding why a sanction or final measure was unnecessary. E.g. the matter was dealt with locally or the conduct was linked to health.
- 154.** However, that is just one factor to consider and decision makers should take into account all of the circumstances of a case when making their referral decision.

General discretion

- 155.** Although the decision maker should consider this guidance carefully, they retain discretion to deviate from it if this is appropriate based on the individual circumstances of a case. If they depart from the principles set out in the guidance, decision makers should provide full reasons setting out their rationale for departing from them.
- 156.** Even if the first and second conditions are met, the GMC retains discretion on whether or not to make a referral to the DBS. However, we should have **good reasons** before deciding not to do so. These might include being aware that another regulator or public body has already referred the doctor, PA or AA to the DBS in relation to the same matter.

General points

- 157.** This part of the guidance is intended to give general guidance on various points of the legislation and the operation of the Scheme.

Recording Decisions

- 158.** The decision maker should record their consideration of the first and, where applicable, the second condition within their rationale for the decision.

DBS requests for information

- 159.** On occasion, the DBS may exercise their power* to request specific information about a doctor, PA or AA that they are considering placing on a barred list.
- 160.** In general, where the appropriate provision is cited and the identified person is on our registers, and depending on the information requested, we will comply with the request.

* Under s.42 of the Act (or article 44 of the Northern Ireland Order)

Disclosures under section 35B (2) of the Medical Act 1983 or under Schedule 3, paragraph 1 of The Anaesthesia Associates and Physician Associates Order 2024 ‘the Order’

161. We have a general power* to disclose anything about a doctor’s fitness to practise to anyone where we consider it to be in the public interest. We also have a power under Schedule 3, paragraph 1(2) of the Order which 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. Such steps may be appropriate in exceptional circumstances where we have information about a doctor, PA or AA that suggests they pose a risk of harm to children and/or vulnerable adults but none of the referral limbs under the Act are satisfied.

[Annex A - Flow chart illustrating the two referral conditions](#)

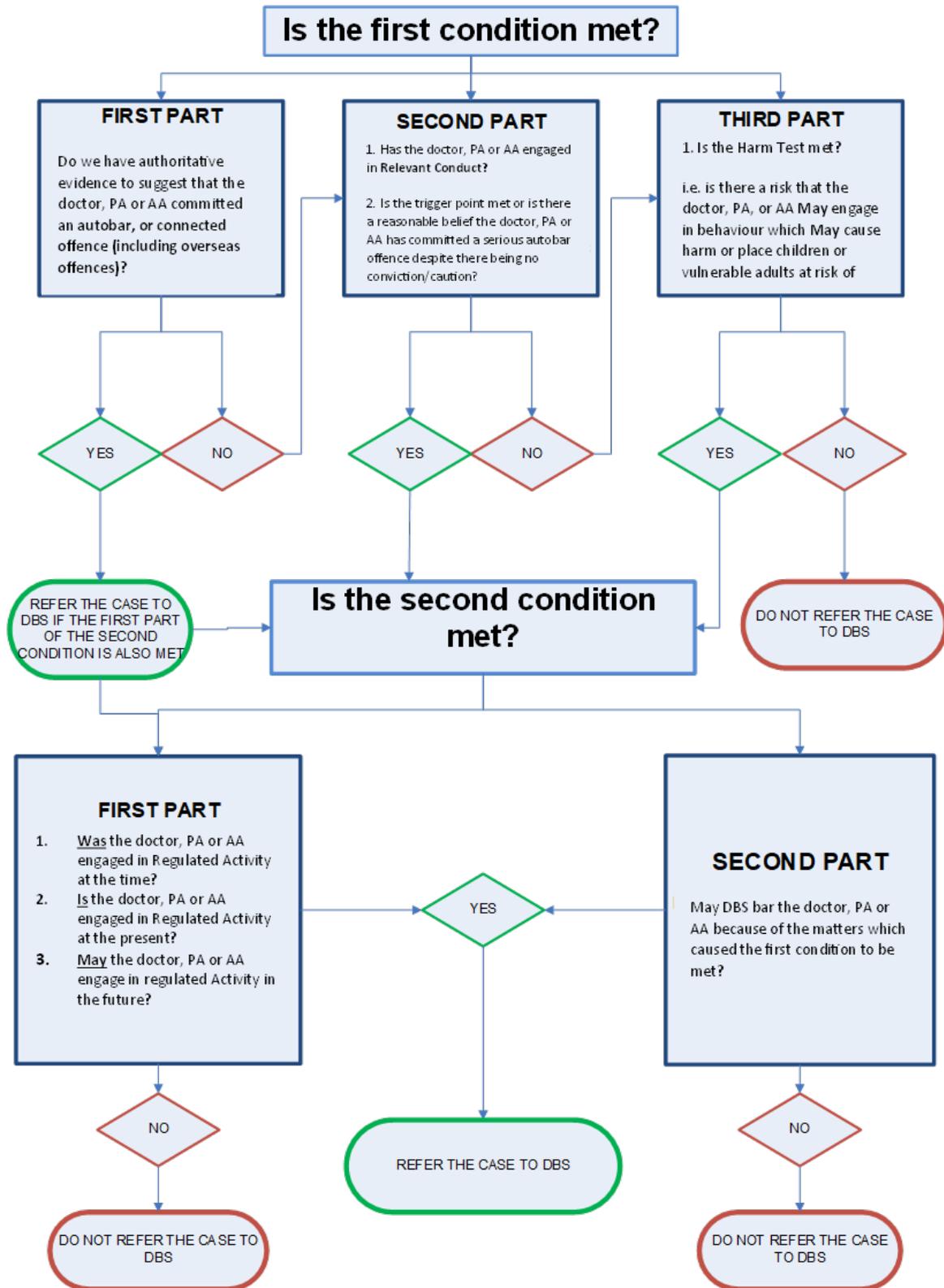
[Annex B - Guidance on making referrals to the DBS and list of case studies](#)

[Annex C - List of serious auto-bar offences](#)

* under Section 35B (2) of the Medical Act 1983

Annex A

Diagram showing the decision making process for assessing the legal power to refer information to the DBS in England and Wales cases:



Annex B

Note: Annex B contains case study examples that have been developed in respect of our regulation of doctors. As time progresses, we will develop more case studies in respect of our regulation of PAs and AAs.

Case Studies

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

Introduction

- a. A keeper of a register may provide the DBS with any information they hold in relation to a person if the first and second conditions are satisfied.
 - The first condition is that the keeper “thinks” that the person has been cautioned or convicted of a relevant offence, engaged in relevant conduct or that the harm test is satisfied.
 - The second condition is that the keeper “thinks” that the person is, or has been or might in future be, engaged in regulated activity and (except in relation to relevant offences) the DBS may consider it appropriate for the person to be included in a barred list.

In this context, we interpret “thinks” as having a reasonable belief.

- b. The purpose of this document is to provide guidance on the types of cases which would lead healthcare regulators to “think” that the DBS may bar an individual as a result of conduct or other circumstances that have given rise to the first condition at section 41(2) of the Safeguarding Vulnerable Groups Act (the Act) and article 43 of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, being met.
- c. The following case studies are intended as a general guide to help decision makers decide which cases raise safeguarding concerns and therefore may warrant referral to the DBS. The examples are not prescriptive guidance for use in all cases, and decision makers should consider each case on its individual facts and circumstances in deciding whether the referral criteria are met.
- d. In each of these broad case types, assume the GMC has concluded its fitness to practise process and, where appropriate, imposed restrictions on the doctor’s registration (including undertakings, conditions, suspension or erasure) or issued a warning.

References to vulnerable adults in the case examples should be construed as references to adults who are being provided with or receiving a regulated activity.

- e. .

Index	
No.	Case example
1	Attitude
2	Verbal bullying of colleagues
3	Inappropriate prescribing because of incompetence
4	Inappropriate prescribing, intention to harm, recklessness or repeat behaviour
5	Failure to diagnose correctly
6	False reporting and giving false evidence (Not to the GMC or other regulatory body)
7	False reporting and giving false evidence to the GMC or other regulatory body
8	False reporting – signing of cremation forms
9	False claims to experience on CV or job application
10	Lying on CV or job application to exploit vulnerable people including children
11	Dishonesty in appraisal
12	Failure to maintain adequate medical records (competence)
13	Altering patient records

14	Lack of further investigation
15	Driving under the influence of alcohol, possession of a banned substance
16	Driving under the influence of alcohol, possession of a banned substance with child (or children) in immediate custody
17	Driving under the influence of alcohol with another adult in company
18	Substance use outside the workplace
19	Alcohol or substance use in the workplace
20	General fraud
21	Fraud of a patient
22	Doctor engages in sexually motivated behaviour towards patients
23	Doctor has an inappropriate emotional relationship with a patient
24	Doctor engages in inappropriate behaviour towards colleagues
25	Affective disorders
26	Withholding treatment due to doctor's personal views or beliefs
27	Physical assault of someone who is not a vulnerable adult or child
28	Physical assault on a patient

29	Clinical research – doctor fails to comply with protocols placing participants at risk of harm
30	Clinical research – doctor deliberately misrepresents or inappropriately influences results
31	Doctor working while suspended
32	Doctor working while unlicensed for a short period due to an oversight
33	Doctor deliberately practising medicine without a licence
34	Doctor working while unregistered
35	Non-medically qualified person working while registered
36	Doctor deliberately misleads employer about a GMC fitness to practise investigation
37	Doctor breaches interim or substantive conditions or undertakings
38	Doctor knowingly practices medicine outside sphere of competence
39	Doctor fails to follow local procedures
40	Doctor's role as director of a care or residential home
41	Doctor works while impaired by a health condition
42	Doctor works while impaired by not having the necessary knowledge of English
43	Doctor works while impaired by deficient professional performance which includes professional competence

1. Attitude		
Broad case type	GMC position	Guiding principles
Doctor displays low-level rudeness towards patients, including sarcastic remarks.	The may bar test is not met as the matter does not raise any safeguarding concerns to lead the GMC to think the DBS 'may bar' the relevant doctor. Accordingly, the GMC would not refer this case to the DBS.	This behaviour would cause distress to a patient and should not be tolerated. However, this is a general misconduct issue that is best dealt with at a local level or through GMC regulatory procedures. On its own, it is unlikely that this behaviour would be sufficiently serious for the DBS to consider including the person in a barred list and accordingly a referral to DBS would not normally be required. However, if the behaviour persisted or escalated it may raise safeguarding concerns.

2. Verbal bullying of colleagues		
Broad case type	GMC position	Guiding principles
Doctor verbally bullies work colleagues but not patients.	<p>This may amount to relevant conduct as were the bullying to be repeated and directed towards children or vulnerable adults they could be caused or placed at risk of harm.</p> <p>When considering the may bar test, the decision maker should consider the specific circumstances of the conduct and the likelihood of the doctor repeating and directing it against</p>	If there is no evidence or information to believe there is a specific risk of harm to children or vulnerable adults then the criteria for a referral to the DBS will not be met.

	or in relation to a child or vulnerable adult. The may bar test is unlikely to be met where the doctor's behaviour indicates a general risk of harm, as opposed to a risk specifically in relation to children or vulnerable adults. As such, the GMC would not refer this case to the DBS.	
--	---	--

3. Inappropriate prescribing because of incompetence		
Broad case type	GMC position	Guiding principles
<p>Doctor prescribes wrong medication to a patient as a result of incompetence (where there is no intention to cause harm).</p> <p>For clarity, incompetence can include:</p> <ul style="list-style-type: none"> ● errors caused by poor training, stress; ● one-off out of character errors; and ● ignorance or confusion. 	<p>The may bar test is not met as the matter is purely related to the doctor's clinical competence and action taken by the GMC will remove the future risk of harm to children and vulnerable adults. As such, the GMC would not refer this case to the DBS.</p>	<p>Where a registrant has caused harm to a patient due to their professional incompetence, and there is no evidence of a wider risk of harm (i.e. outside the professional setting), the action taken by the regulator or employer will remove the risk of harm and a referral to the DBS will not be required.</p> <p>In cases where a registrant poses an ongoing risk of harm (i.e. outside the regulated setting) directly in relation to children or vulnerable adults despite action taken by the regulator, a referral should be made to the DBS.</p>

4. Inappropriate prescribing, intention to harm, recklessness or repeat behaviour		
Broad case type	GMC position	Agreed guiding principles
<p>Doctor prescribes wrong medication or in excess of recommended dose to a patient, or prescribing unlicensed medicine as a result of intention to cause harm or such a callous disregard for procedure as to make the doctor a safeguarding risk. This may include where a pattern of harmful behaviour is demonstrated.</p>	<p>If the GMC was able to establish that the doctor intended to cause harm, or demonstrated a pattern of harmful behaviour indicating a callous disregard for procedure, and action taken by the GMC does not remove the risk of harm to children and vulnerable adults, the may bar test is likely to be met. As such, a referral to the DBS would be likely to be made in these cases.</p> <p>Factors to consider include the extent to which the doctor has demonstrated insight and remediation and the likelihood that the harmful behaviour (intending to cause harm or a callous disregard for procedure) will be repeated.</p>	<p>The may bar test is likely to be met in situations where the doctor has abused their position of trust to deliberately (or recklessly) harm children or vulnerable adults. This may be a 'one off' occurrence or it may be where a pattern of harmful behaviour has emerged.</p> <p>A referral to the DBS may be appropriate if the doctor has demonstrated an intention to cause harm or a callous disregard for procedure. This harmful behaviour could be transferred to another regulated activity and our regulatory action may be considered insufficient to manage the future risk to vulnerable groups.</p>

5. Failure to diagnose correctly		
Broad case type	GMC position	Guiding principles
<p>Doctor incorrectly diagnosed a patient due to incompetence (no intention to cause harm). For clarity, incompetence may</p>	<p>The may bar test is not met as the concerns are purely related to the doctor's clinical competence and our action will remove the future risk of harm to children and vulnerable</p>	<p>Where a doctor has caused harm to a patient due to their professional incompetence, and there is no evidence of a wider risk of harm (i.e. outside the professional setting), the action taken by the GMC</p>

<p>include:</p> <ul style="list-style-type: none"> ● errors caused by poor training, stress; ● one-off out of character errors; ● ignorance or confusion. 	<p>adults. In the absence of wider safeguarding risks, the GMC would not refer this case to the DBS.</p>	<p>will remove the risk of harm and a referral to the DBS will not be required.</p>
--	--	---

6. False reporting and giving false evidence (Not to the GMC or other regulatory body)		
Broad case type	GMC position	Guiding principles
<p>Doctor provides a false report, for instance, as a response to an internal investigation into a serious patient safety incident or a Coroner’s inquest into a patient’s death.</p>	<p>The relevant conduct criteria are likely to be met in the majority of these cases. This is because providing false information about serious patient safety incidents will mean that appropriate lessons cannot be learned and the root causes will not be identified and addressed. This increases the risk the clinical failings will be repeated which places vulnerable groups at risk of harm.</p> <p>May bar test</p> <p>Whether or not the may bar test is met will depend on the individual circumstances of the case and whether the doctor deliberately made a false report to avoid personal scrutiny. Dishonesty of a calculated and premeditated</p>	<p>False reporting – non safeguarding issues</p> <p>With the exception of safeguarding investigations (see below), false reporting without a deliberate aim to mislead would not trigger a referral to the DBS as the second condition will not be met. However, where there is a deliberate and calculated aim to mislead which would compromise the safety of children or vulnerable adults, the may bar test is likely to be met on the grounds of the doctor demonstrating a callous disregard for procedure.</p> <p>When considering if the may bar test is met, factors to consider include the extent to which the doctor’s dishonesty could have affected patient health outcomes and effective action/recommendations</p>

	<p>nature would suggest a callous disregard for procedure and may indicate a specific and serious risk of future harm to children and vulnerable adults. In these cases, the may bar test is likely to be met and a referral is appropriate.</p> <p>Where the false reporting arose from a failure to gather and check the correct information, this is likely to indicate a general risk of harm caused by carelessness, as opposed to a specific risk of harm to vulnerable groups. In the absence of information to suggest that there are wider safeguarding risks, in these cases the action taken by the GMC will mitigate any future risk of harm in relation to children and vulnerable adults. As such, the may bar test is unlikely to be met and the GMC would not refer this case to the DBS.</p>	<p>to better protect vulnerable adults and children in the future. The extent to which the doctor has demonstrated insight and remediation and the likelihood of repetition will also be relevant factors.</p> <p>False reporting in relation to a safeguarding issue</p> <p>False reporting is likely to give rise to a referral if the false report is in relation to a safeguarding matter. For example, false or inaccurate information is given to a public inquiry into a child’s death or an investigation by a Safeguarding Board which impedes their ability to make recommendations to avoid future harm. These circumstances (although rare) would demonstrate behaviour that, if repeated, is likely to result in direct harm to children or vulnerable adults and raises a wider issue that the GMC sanction is unable to mitigate.</p>
--	---	---

7. False reporting and giving false evidence to the GMC or other regulatory body		
Broad case type	GMC position	Guiding principles
Doctor provides false information to GMC or another	Whether or not the relevant conduct criteria are met will depend on the nature and extent of the false information given by the doctor. Where	A doctor providing false information to the GMC e.g. the Interim Orders Tribunal or a Medical Practitioners Tribunal, without a deliberate aim to

<p>regulatory body</p>	<p>this significantly undermines the regulatory body’s ability to carry out its statutory functions and (in the case of the GMC) protect the public, this will amount to relevant conduct. For example, in cases involving serious misconduct, vulnerable groups will not be protected from the risk of the doctor repeating their behaviour if the Interim Orders Tribunal does not restrict the doctor’s registration on the basis of false information the doctor presents to it.</p> <p>May bar test – calculated and deliberate dishonesty</p> <p>Whether or not the may bar test is met will depend on the individual circumstances of the case and whether the doctor deliberately provided false information to avoid their registration being restricted. Dishonesty of a calculated and premeditated nature would suggest a callous disregard for procedure and may indicate a specific and serious risk of future harm to vulnerable adults and children. In these cases, the may bar test is met and a referral is appropriate.</p> <p>May bar test – false information provided due to carelessness</p> <p>Where the false reporting arose from carelessness rather than a deliberate attempt to</p>	<p>avoid action on registration would not usually trigger a referral to the DBS. However, where there is a calculated intention to mislead the regulatory body which would compromise the safety of children or vulnerable adults, the may bar test is likely to be met on the grounds of the doctor demonstrating a callous disregard for procedure.</p> <p>When considering if the may bar test is met, relevant factors to consider include:</p> <ul style="list-style-type: none"> ● the extent to which the doctor’s dishonesty could have placed vulnerable groups at risk of harm ● the likelihood of the dishonesty and disregard for regulatory procedures being repeated ● the extent to which the doctor has demonstrated insight and remediation.
------------------------	---	--

	<p>mislead, this is likely to indicate a general risk of harm as opposed to one specific to vulnerable groups. If no wider safeguarding risks have been identified, the action taken by the GMC will mitigate any future risk of harm in relation to children and vulnerable adults. As such, the may bar test will not be met and the GMC would not refer this case to the DBS.</p>	
--	--	--

8. False reporting – signing of cremation forms		
Broad case type	GMC position	Guiding principles
<p>Doctor provides false information on cremation form</p>	<p>Relevant conduct</p> <p>A doctor providing false or inaccurate information when completing a cremation form will not amount to relevant conduct. This is because their actions cannot harm a deceased person or place them at risk of harm.</p> <p>Harm test and may bar test – likely to be met where there is evidence of a callous disregard for procedure</p> <p>A single incidence of providing false information on a cremation form would also not lead to the harm test being met as there would be insufficient evidence that the doctor intended to</p>	<p>Providing false information on a cremation form will not meet the relevant conduct criteria but it is likely to meet the harm test.</p> <p>Where the doctor has persistently and systematically provided false information on cremation forms and the decision maker considers this amounts to a callous disregard for procedure, the may bar test is likely to be satisfied if there is a likelihood the doctor will repeat the callous disregard when providing healthcare or in another regulated activity. This would place children and vulnerable adults at risk of harm and a referral to the DBS should be made.</p>

	<p>harm vulnerable groups. The harm test may however be met if there is evidence to suggest the doctor has entered false information on cremation forms on multiple occasions which would suggest a callous disregard for the established procedure around signing an important statutory document designed to protect the public. This may enable us to form a reasonable belief the doctor may harm vulnerable groups in future, or place them at risk of harm, if they repeat and direct their actions towards children or vulnerable adults.</p> <p>Where the decision maker judges there to be evidence of callous disregard, the may bar test is likely to be met and a referral to the DBS should be made.</p>	
--	---	--

9. False claims to experience on CV or job application		
Broad case type	GMC position	Guiding principles
<p>Doctor lies on their CV or job application to claim experience or qualifications which they do not have in order to gain employment or promotion.</p>	<p>Whether the relevant conduct criteria are met by a doctor providing misleading information on a CV will depend on what exactly the doctor was dishonest about and the circumstances. Each case should be considered on its own facts.</p> <p>If, however, a clear risk to vulnerable groups</p>	<p>Lying on a CV is a professional matter and action taken by the regulator will usually address the risk of harm to children or vulnerable adults.</p> <p>Cases involving a general risk of harm (including general dishonesty) rather than a specific risk in relation to children or vulnerable adults will not</p>

	<p>arose from the doctor’s dishonesty this will usually amount to relevant conduct. For example, if a doctor lied about having qualifications and/or suitable experience in order to work in a specific post when they were not qualified for that role. The doctor’s actions placed vulnerable groups at risk of harm even if actual harm did not materialise as the doctor was unsuccessful in gaining employment.</p> <p>May bar test</p> <p><i>Doctor was not successful in obtaining employment</i></p> <p>The may bar test is not likely to be met as the GMC’s action is likely to have addressed the risk of harm to children and vulnerable adults.</p> <p>The GMC considers that cases involving general dishonesty are not of the seriousness to meet the may bar test, particularly if no actual harm has materialised. This is even where the tribunal or case examiners have identified a risk of repetition or an attitudinal propensity towards dishonesty on the doctor’s part. As such, the GMC would not be likely to make a referral to the DBS in cases where a doctor has made false claims to experience or qualifications on a CV or job application and was unsuccessful in obtaining employment.</p>	<p>usually meet the may bar test. Where the tribunal or case examiners have identified a risk of repetition or an attitudinal propensity towards dishonesty on the doctor’s part, the decision maker should consider the overall seriousness of the doctor’s actions and whether they posed a specific safeguarding risk to vulnerable groups. Where this is not the case and the overall seriousness is beneath the level that the DBS would be likely to bar the doctor, no referral should be made as the may bar test will not be satisfied.</p> <p>For the referral criteria to be met, the dishonesty must raise a serious safeguarding risk to children or vulnerable adults such that the DBS may consider barring the person.</p>
--	---	--

	<p><i>Doctor was successful in obtaining and taking up employment</i></p> <p>The guidance states:</p> <p>“If the doctor is successful in obtaining employment and goes on to conduct medical work despite not being suitably qualified and is incompetent to perform the role, the criteria for the ‘may bar’ test may be met if there is a risk of serious harm to children or vulnerable adults as a result of the misleading statement(s) in the doctors CV or application form.</p> <p>To determine whether there is a ‘serious’ safeguarding risk to a child or vulnerable adult, a decision maker should consider if any of the following apply:</p> <ul style="list-style-type: none"> i. The seriousness of the harm or risk of harm– e.g. could it have resulted in serious harm, injury or a fatality and how imminent was the harm i.e. did the doctor commence work? ii. The seriousness of the false statement – e.g. a non-surgical doctor asserting they are a qualified surgeon will present a very serious risk to patients. However, a doctor who says they achieved a higher score in an exam than they did but nevertheless passed the exam may not 	
--	---	--

	<p>present such a risk.</p> <p>iii. Repetition – was the statement an isolated or repeated incident? For example, the doctor lies on their CV but is detected by a prospective employer and does not gain employment as a result, but then goes on to make the same statement(s) again in a separate application and/or CV to another prospective employer?</p> <p>iv. Reprimand – has the doctor previously been reprimanded for similar conduct in the past and gone on to repeat the false statement?</p> <p>v. Motive – false statements made specifically for the purpose of obtaining access to children or vulnerable adults with a motive to exploit or abuse them is a serious aggravating factor.”</p>	
--	---	--

10. Lying on CV or job application to exploit vulnerable people including children		
Broad case type	GMC position	Guiding principles
Doctor lies on their CV or job application to claim experience	As above, whether the relevant conduct criteria are met by a doctor providing misleading	In cases where the GMC is able to establish that a doctor has lied on a CV or job application to

<p>or qualifications which they do not have in order to gain access to vulnerable people to take advantage of them.</p>	<p>information on a CV or job application will depend on what exactly the doctor was dishonest about and the circumstances. Each case should be considered on its own facts.</p> <p>The relevant conduct criteria will usually be met in this scenario as the doctor acted dishonestly to enable them to gain access to children and/or vulnerable adults to take advantage of them. Were they to be successful, the doctor would also be practising in a post for which they were unqualified or did not hold the necessary skills. The doctor's actions therefore placed vulnerable groups at risk of harm and actual harm may have been caused should the doctor have been successful in obtaining employment.</p> <p>May bar test</p> <p>If there are no other safeguarding concerns about the doctor, a referral will depend on whether it can be established that they had the intention of harming children or vulnerable adults when lying on their CV or job application. If this is established the GMC considers that the may bar test will be likely to be met. This is because the doctor has demonstrated predatory behaviour which may be repeated in another regulated activity and the risk cannot be</p>	<p>deliberately exploit children and/or vulnerable adults, there will be a direct risk of harm in relation to these groups.</p> <p>If intention to exploit children and vulnerable adults can be established, it is likely that the may bar test will be met as the action taken by the GMC cannot remove the future risk of harm to children and vulnerable adults.</p> <p>If the doctor was successful in gaining employment, this will weigh heavily in favour of the may bar test being met. Decision makers should also refer to case study 34 below.</p>
---	---	--

	<p>mitigated by the GMC's action.</p> <p>If the doctor was successful in gaining and taking up employment, this will be an aggravating factor when considering if the may bar test is met. This is because the doctor will have actually worked in a role they were not qualified to undertake and have gained access to patients through doing so. This increases the safeguarding risk to vulnerable groups and the likelihood of the DBS barring the doctor.</p>	
--	---	--

11. Dishonesty in appraisal		
Broad case type	GMC position	Guiding principles
<p>Doctor does not declare an ongoing investigation by their locum agency/another employer during an appraisal by their designated body. This investigation had resulted in the doctor not being offered any locum assignments while the patient complaint is investigated.</p>	<p>Whether or not the relevant conduct criteria are met will depend on the individual circumstances of the case.</p> <p>In general terms, however, relevant conduct is likely to be established as the doctor's failure to declare the investigation/restrictions places patients at risk of future harm. This is because it prevents the doctor's appraiser from taking the complaint into account when deciding whether to recommend the doctor is revalidated. If a doctor is revalidated on the basis of inaccurate or incomplete information, this could have a</p>	<p>This type of case should be handled on a case by case basis depending on the circumstances.</p> <p>Where relevant conduct is established and the doctor has made a calculated attempt to undermine the revalidation process by deliberately withholding relevant information from their appraiser, this is likely to amount to callous disregard for procedure. The may bar test is likely to be met and a referral should be made to the DBS.</p>

	<p>direct impact on patient safety.</p> <p>The may bar test is likely to be met where the doctor has demonstrated that their actions amount to a callous disregard for procedure. This is because the doctor has deliberately withheld information from their appraiser in order to obtain a positive revalidation recommendation which could have serious consequences for patients.</p>	
--	---	--

12. Failure to maintain adequate medical records (competence)		
Broad case type	GMC position	Guiding principles
<p>Doctor has poor record keeping skills, including for instance, a failure to properly record consultations.</p> <p>(See case study 13 below about retrospectively amending medical records to conceal failings in clinical care)</p>	<p>In general, the risk of harm posed by the doctor will not be sufficiently serious to lead the GMC to believe that the DBS may bar the doctor from working with vulnerable groups. As such, the GMC would not be likely to refer the majority of these cases to the DBS.</p> <p>Although there is a potential future risk of harm, the risk is connected to the doctor’s professional status and so action taken by the GMC will mitigate the risk. However, if we hold specific information to suggest that the doctor plans to work in another form of regulated activity, such as managing a care home, the risk of harm may</p>	<p>Cases involving a general risk of harm (including poor record keeping skills) rather than a specific risk in relation to children or vulnerable adults will not meet the may bar test.</p> <p>Poor record keeping skills are a professional matter, and in most cases action taken by the regulator can remove the risk of harm to children or vulnerable adults. In these cases, the risk of harm is not sufficiently serious to lead the GMC to think that DBS may bar the doctor.</p> <p>However, there may be some circumstances where poor record keeping skills may impact on wider</p>

	<p>be extended to a setting outside the medical profession and thus the GMC's action may not have removed the risk of harm to children and vulnerable adults in a wider context. Again, the extent of the remaining risk will depend on the seriousness of the doctor's poor record keeping skills. Low-level concerns about record keeping skills are unlikely to ever result in a referral to the DBS.</p>	<p>regulated activity such that a child or vulnerable adult may be put at risk of harm. E.g. the GMC has specific information to indicate that the doctor is also responsible for medical records / medicines at a care home. Very rarely, a referral to the DBS may be appropriate in these circumstances if the concerns about a doctor's record keeping skills are very serious.</p>
--	--	---

13. Altering patient records		
Broad case type	GMC position	Guiding principles
<p>Doctor alters patient records to cover up a clinical error</p>	<p>The GMC considers that there is relevant conduct in such cases as the doctor's dishonesty could potentially cause harm or place patients at risk of harm.</p> <p>However, the may bar test is not likely to be met as the misconduct relates to the doctor's professional role and the GMC's action is likely to have removed the risk of harm to children and vulnerable adults.</p> <p>The likelihood of harm materialising in another setting is insufficiently direct and too speculative to give rise to a referral. Where the tribunal or case examiners have identified a risk</p>	<p>Altering patient records is a professional matter, and action taken by the regulator will usually remove the risk of harm to vulnerable groups including children.</p> <p>In some cases, the tribunal or case examiners will identify a risk of repetition or an attitudinal propensity towards dishonesty on the doctor's part. Where this applies, the decision maker should consider whether the doctor's actions raised a specific safeguarding risk to vulnerable groups and/or were sufficiently serious that the DBS may bar them. If these criteria are not met, a referral will not be indicated.</p>

	<p>of repetition or an attitudinal propensity towards dishonesty on the doctor's part, the decision maker should consider the overall seriousness of the doctor's actions. Where this is beneath the level that the DBS would be likely to bar the doctor and there is no specific safeguarding risk, no referral should be made as the may bar test will not be satisfied.</p> <p>Such cases may exceptionally give rise to a referral if the circumstances were extreme and suggested a callous disregard for procedure. For example, evidence of altering patient records on a large scale or persistently over a number of years.</p>	<p>The referral conditions may however be met in cases where the dishonesty was of an egregious nature and demonstrated a callous disregard for procedure. The risks arising from callous disregard cannot be mitigated by the GMC's regulatory action as the deliberately reckless behaviour may be repeated in another regulated activity. This would place children and/or vulnerable adults at risk of harm and a referral to the DBS is indicated.</p>
--	---	---

14. Lack of further investigation		
Broad case type	GMC position	Guiding principles
<p>Doctor fails to conduct follow-up investigations into a patient's condition due to incompetence.</p>	<p>The GMC considers that the may bar test is not met in these cases. Although the potential risk of future harm is serious, the matter is purely related to the doctor's clinical competence and the future risk of harm is confined to the professional setting. In the absence of wider safeguarding risks, the action taken by the GMC will have removed any potential future risk of</p>	<p>Poor clinical skills are a professional matter. Action taken by the regulator will usually remove the risk of harm to children or vulnerable adults.</p>

	harm in relation to children and vulnerable adults. As such, the GMC would not refer these cases to the DBS.	
--	--	--

15. Driving under the influence of alcohol, possession of a banned substance		
Broad case type	GMC position	Guiding principles
<p>Doctor charged and convicted of, or cautioned in relation to driving under the influence of alcohol or possession of a banned substance.</p>	<p>The GMC considers that there is no relevant conduct in such cases as the offence itself is too far removed from any potential risk to vulnerable adults or children.</p> <p>Unless it can be established from the information available that there is a likelihood the doctor would repeat their behaviour and drive children and vulnerable adults under the influence of alcohol or a banned substance, the doctor's behaviour indicates a general risk of harm as opposed to a risk specifically in relation to children or vulnerable adults. As such, the GMC would not refer these cases to the DBS.</p>	<p>If there is no information to suggest there is a specific risk of harm to children or vulnerable adults then the DBS is unlikely to include the person in a barred list and therefore a referral is not normally appropriate.</p> <p>Factors to take into account are:</p> <ul style="list-style-type: none"> ● The likelihood of the doctor driving children or vulnerable adults under the influence of alcohol or a banned substance ● Whether the doctor's role involves driving children or vulnerable adults in a professional capacity?

16. Driving under the influence of alcohol, possession of a banned substance with child (or children) in immediate custody		
Broad case type	GMC position	Guiding principles
<p>Doctor charged with driving under the influence of alcohol or possession of a banned substance and has a child (or children) in their immediate</p>	<p>In these situations, the GMC would need to consider the facts of each individual case. The fact that the doctor's behaviour relates to their own child, or that of a family member, rather than children who are not family members, such</p>	<p>This scenario should be handled on a case by case basis depending on the circumstances.</p> <p>If there is harm or a risk of harm to a child then relevant conduct has occurred irrespective of the setting or the relationship between the person and</p>

<p>care at the time of arrest.</p>	<p>as a scout group, does not mean that there is not a wider safeguarding risk. If the doctor had committed the offence after taking responsibility for a group of children such as cubs or scouts, this may be considered as an aggravating factor and increases the likelihood of a referral to the DBS.</p>	<p>the child.</p> <p>Factors to consider in deciding whether the may bar test is met include:</p> <ul style="list-style-type: none"> ● are there any aggravating and/or mitigating circumstances? ● what were the doctor’s intentions? ● was it a deliberate act? ● what was the doctor’s relationship with the person or people in the car? ● why was the person or people in the doctor’s car? ● was the incident a ‘one off’ or had it happened before? etc.
------------------------------------	--	---

17. Driving under the influence of alcohol with another adult in company		
Broad case type	GMC position	Guiding principles
<p>Doctor charged with driving under the influence of alcohol or possession of a banned substance and has an adult (or adults) in the car at the time of arrest.</p>	<p>Example 1 – the endangered adult is not vulnerable as they are not being provided with a regulated activity by the doctor</p> <p>The doctor has their aunt in the car when arrested. The doctor’s aunt is not considered a vulnerable adult when she is in the doctor’s car</p>	<p>If the doctor’s behaviour could feasibly be repeated towards a child or vulnerable adult and cause or risk them harm, then relevant conduct has occurred irrespective of the setting or the relationship between the doctor and the person in the car.</p>

	<p>as she is not receiving a regulated activity from the doctor. However, the relevant conduct criteria are likely to be met. This is because if the doctor were to repeat their reckless behaviour and it directly involved or concerned a vulnerable adult, they could be harmed or placed at risk of harm</p> <p><u>May Bar test</u></p> <p>The GMC considers however that the may bar test is not met. The specific circumstances surrounding the initial conduct should be taken into account and where the arrangements were private, do not involve and are unlikely if repeated to involve a vulnerable adult, this suggests that the doctor’s conduct indicates general risky behaviour rather than risky behaviour specific to vulnerable groups.</p> <p>Example 2 – the endangered adults are vulnerable as they are in receipt of a regulated activity from the doctor</p> <p>If the doctor is charged with drink driving while driving a number of elderly people to receive social care services in a hospice bus (a regulated activity in relation to adults), this will amount to relevant conduct. The may bar test is likely to be met as the doctor’s behaviour indicates a specific safeguarding risk in relation to</p>	<p>In cases where the first condition is met, whether the DBS may bar the doctor will depend on the circumstances of the case.</p> <p>In general, where the drink driving incident relates to a purely private arrangement involving an adult, the may bar test is unlikely to be met. It will usually be satisfied however if the doctor is found to be drink driving while undertaking a regulated activity such as transporting elderly care home residents to receive social care.</p> <p>Factors to consider in deciding whether the may bar test is satisfied include:</p> <ul style="list-style-type: none"> ● are there any aggravating or mitigating circumstances? ● What were the doctor’s intentions? ● Was it a deliberate act? ● What was the doctor’s relationship with the person? ● Why was the person in the doctor’s car? ● Was the incident a ‘one off’ or had it happened before? etc. <p>If there is no evidence or information to believe there is a specific risk of harm to children or vulnerable adults then the DBS is unlikely to include the person in a barred list and therefore a referral</p>
--	--	---

	vulnerable adults. A referral to the DBS is likely to be made in the second example, but not in the first.	is not normally appropriate.
--	---	------------------------------

18. Substance use outside the workplace		
Broad case type	GMC position	Guiding principles
Doctor has alcohol/substance use issues, but the doctor's performance has not been affected and the doctor is competent in their work (for clarity, no child or vulnerable adult has been harmed).	The GMC considers that there has been no relevant conduct in this case. The doctor's behaviour indicates a general risk of harm. There has been no act or omission that has caused harm or risk of harm directly in relation to a child or vulnerable adult. As such, the GMC would not refer such cases to the DBS.	Substance use outside the workplace indicates generally harmful behaviour rather than placing specific vulnerable groups including children at a direct risk of harm (but see comments at 19 below where the alcohol/substance use raises a risk of harm to children/vulnerable adults). If there is no evidence or information to believe there is a specific risk of harm to children or vulnerable adults then the DBS is unlikely to include the person in a barred list and therefore a referral is not normally appropriate.

19. Alcohol or substance use in the workplace		
Broad case type	GMC position	Guiding principles

<ul style="list-style-type: none"> ● Working under the influence of drugs or alcohol ● Alcohol or drug dependency ● Convictions involving alcohol or drugs ● Smelling of alcohol at work ● Drinking or taking drugs before commencing a shift 	<p>As long as there are no aggravating factors, the GMC considers that the action it takes will normally manage risk in these cases.</p> <p>Aggravating factors would include a reckless disregard for procedures or a proven history of disregarding GMC restrictions.</p>	<p>If the person is permitted by the GMC / Medical Practitioners Tribunal to continue to practise as a registered medical professional then in the absence of any other sufficient, compelling information the DBS is unlikely to include the person in a barred list and therefore a referral is not normally appropriate.</p> <p>If the person has been erased from the register or is subject to suspension and if there is no risk of harm to children or vulnerable adults outside their professional practice, then the DBS is unlikely to include the person in a barred list and therefore a referral is not normally appropriate. For these cases, we need to be satisfied that the behaviour if repeated outside their profession would not pose a risk of harm to vulnerable groups including children.</p> <p>If the person has been convicted of a non-automatic barring drug offence or a drink driving offence and there is no specific evidence or information to believe there is a specific risk of harm to children or vulnerable adults then the DBS is unlikely to include the person in a barred list and therefore a referral is not normally appropriate.</p>
--	---	---

20. General fraud		
Broad case type	GMC position	Guiding principles
<p>Doctor defrauds their employer, or another person who does not fall under the definition of vulnerable adult.</p>	<p>The doctor's behaviour reflects a general risk of harm.</p> <p>For instance, there is a general risk that the doctor may defraud someone in the future, rather than a specific risk that the doctor may defraud a child or vulnerable adult in the future. As such, the GMC would not refer these cases to the DBS.</p>	<p>If there is no evidence or information to believe there is a specific risk of harm to children or vulnerable adults then the DBS is unlikely to include the person in a barred list and therefore a referral is not normally appropriate.</p>

21. Fraud of a patient		
Broad case type	GMC position	Guiding principles
<p>Doctor defrauds one of their patients.</p>	<p>The GMC considers that in these cases the may bar test is likely to be met. The doctor's conduct indicates a direct risk of harm in relation to vulnerable groups rather than a general risk.</p> <p>The doctor has sought out a vulnerable adult for exploitation and this behaviour indicates a wider risk of predatory behaviour being repeated outside the professional setting.</p> <p>Action taken by the GMC cannot remove the risk</p>	<p>In cases where a person has abused a position of trust to exploit a child or vulnerable adult, there is likely to be the potential for wider risk outside the regulated setting which cannot be removed by action taken by the regulator alone.</p>

	of harm to children or vulnerable adults, and as such, the GMC would be likely to refer these cases to the DBS.	
--	---	--

22. Doctor engages in sexually motivated behaviour towards patients		
Broad case type	GMC position	Guiding principles
<p>Doctor undertakes an intimate examination that is clearly not clinically indicated or engages in sexually motivated behaviour towards a patient.</p>	<p>The relevant conduct criteria will be met if a doctor engages in sexually motivated behaviour towards patients. This is because the patient (a vulnerable adult) will be placed at risk of sexual, emotional and psychological harm.</p> <p>May bar test likely to be met</p> <p>The GMC considers that in these types of cases the may bar test is likely to be met, although the facts of each individual case will need to be considered.</p> <p>In cases where a doctor undertakes, for instance, an intimate examination that is clearly not clinically indicated, the doctor's behaviour is likely to indicate a direct risk of harm in relation to children or vulnerable adults rather than a general risk of harm. This also applies to situations where the doctor undertakes an intimate examination that is clinically indicated</p>	<p>In cases where a person has abused a position of trust to exploit a child or vulnerable adult, there is likely to be the potential for wider risk outside the regulated setting which cannot be removed by action taken by the regulator alone.</p> <p>Cases involving poor clinical skills are a professional matter, action taken by the regulator can remove the risk of harm to vulnerable groups including children.</p>

	<p>but aspects of the doctor’s behaviour when conducting the examination are found to be sexually motivated. Action taken by the GMC in these cases cannot remove the potential future risk of harm to children and/or vulnerable adults (wider safeguarding concerns may remain despite GMC action). As such, the GMC would be likely to refer these cases to the DBS.</p> <p>May bar test unlikely to be met</p> <p>Where it is clear that the case is not sexually motivated, for example, where a doctor fails to use a chaperone when conducting an intimate examination because of a lack of understanding of good practice or the carrying out of an exam that is not clinically indicated has been found to be due to poor knowledge and skills with no sexual motivation, the GMC is not likely to consider that the may bar test is met. Any action taken by the GMC in such cases would remove any potential future risk of harm to children and vulnerable adults.</p>	
--	---	--

23. Doctor has an inappropriate emotional relationship with a patient		
Broad case type	GMC position	Guiding principles
Doctor engages in an	The relevant conduct criteria will be met if a	Where a doctor has breached professional

<p>inappropriate emotional relationship with a patient that breaches professional boundaries. For example, sending text or Facebook messages, meeting socially and sharing personal details and concerns with a patient.</p>	<p>doctor breaches a professional boundary through an inappropriate emotional relationship with a patient. This is because the patient (a vulnerable adult) will be placed at risk of emotional and psychological harm.</p> <p>May bar test</p> <p>Factors which may weigh in favour of the may bar test being met</p> <p>It will be important to consider the facts and circumstances of each individual case and, in particular, the overall seriousness of the doctor's actions. The presence of one or more of the following factors may weigh in favour of the may bar test being met:</p> <ul style="list-style-type: none"> ● The tribunal or case examiners found the doctor's behaviour to be sexually motivated ● The contact was unwanted and unsolicited by the patient. This indicates a propensity by the doctor to engage in predatory behaviour which may harm vulnerable groups or place them at risk of harm. ● The doctor inappropriately accessed the patient's records to obtain their contact details ● The patient was additionally vulnerable e.g. they have been diagnosed with a mental 	<p>boundaries by engaging in an inappropriate emotional relationship with a patient, the individual circumstances will determine whether the may bar test is met. Decision makers should consider whether any aggravating factors are present which suggest there is likely to be the potential for a wider risk to vulnerable groups that cannot be removed by our regulatory action alone. These include whether the patient was additionally vulnerable and if the doctor's behaviour was found to be sexually motivated. Where these factors are present, a referral to the DBS is likely to be indicated.</p> <p>Where the doctor's actions in breaching professional boundaries were not found to be sexually motivated and were at a low level of seriousness, the may bar test is unlikely to be met and referral to the DBS will not be indicated.</p>
--	---	---

	<p>health condition, have a learning disability or a serious illness</p> <ul style="list-style-type: none">● The doctor has continued to prescribe controlled drugs or drugs with the potential for addiction to the patient and there is no or inadequate medical records kept, no follow up or monitoring of the patient which causes or places them at risk of harm.● The doctor has a previous history of inappropriate behaviour towards patients or colleagues. This leads to a risk of repetition.● The doctor has not demonstrated insight or remorse into their inappropriate behaviour. <p>Factors which may weigh against the may bar test being met</p> <p>The presence of one or more of the following factors may weigh against the may bar test being met:</p> <ul style="list-style-type: none">● The contact between the doctor and patient was infrequent or at a low level. For example, having lunch together or exchanging occasional messages on social media.	
--	---	--

	<ul style="list-style-type: none"> ● The patient had only seen the doctor infrequently in a medical capacity ● The contact between the doctor and patient was fully consensual and the patient did not express any concerns about the doctor's behaviour. ● The tribunal or case examiners did not find the doctor's conduct to be sexually motivated ● The doctor does not have any previous history of inappropriate behaviour towards patients or colleagues. ● The doctor has demonstrated appropriate insight and remorse into their inappropriate behaviour. This leads to a low risk of repetition. 	
--	---	--

24. Doctor engages in inappropriate behaviour towards colleagues		
Broad case type	GMC position	Guiding principles
Doctor engages in inappropriate behaviour towards colleagues that breaches professional boundaries. For example, making remarks of a personal	If the inappropriate behaviour is directed towards colleagues, the relevant conduct criteria will be met where it is considered that if the doctor were to repeat that behaviour and direct it against or in relation to a child or	In cases where a doctor has engaged in inappropriate behaviour towards colleagues that was of a serious nature, there is likely to be the potential for a wider risk to vulnerable groups that cannot be removed by our regulatory action alone.

<p>nature, inappropriate touching or physical gestures.</p>	<p>vulnerable adult, harm could be caused or risked.</p> <p>May bar test</p> <p>Factors which may weigh in favour of the may bar test being met</p> <p>It will be important to consider the facts of each individual case. However, the presence of one or more of the following factors may weigh in favour of the may bar test being met:</p> <ul style="list-style-type: none"> ● The tribunal or case examiners found the doctor’s conduct to be sexually motivated. An assessment will need to be made however of the overall “seriousness” of the doctor’s actions and whether this is sufficient to support a reasonable belief the doctor may be barred. ● The misconduct was of a serious nature. For example, a one-off incident of significant gravity or there was a pattern of inappropriate behaviour over a period of time ● There was an imbalance of power between the doctor and the colleague and the conduct was serious overall ● The doctor has a previous history of inappropriate behaviour towards patients 	<p>As such, the GMC would be likely to refer these cases to the DBS.</p> <p>Where the inappropriate behaviour towards colleagues was of a less serious nature with no aggravating features, the may bar test is unlikely to be met and referral to the DBS will not be indicated.</p>
---	--	---

	<p>or colleagues. This leads to a risk of repetition.</p> <ul style="list-style-type: none"> ● The doctor has not demonstrated insight or remorse into their inappropriate behaviour ● The likelihood of repetition of inappropriate behaviour against a vulnerable adult or child after considering the specific circumstances of the conduct. <p>Factors which may weigh against the may bar test being met</p> <p>The presence of one or more of the following factors may weigh against the may bar test being met:</p> <ul style="list-style-type: none"> ● The tribunal or case examiners did not find the doctor's conduct to be sexually motivated ● It was a one-off incident at the lower end of the spectrum of seriousness ● There was no imbalance of power between the doctor and the colleague ● The doctor does not have any previous history of inappropriate behaviour towards patients or colleagues. This leads to a low risk of repetition. 	
--	---	--

	<ul style="list-style-type: none"> ● The doctor has demonstrated appropriate insight and remorse into their inappropriate behaviour ● The likelihood of repetition of the inappropriate behaviour against a vulnerable adult or child after considering the specific circumstances of the conduct. 	
--	--	--

25. Affective disorders		
Broad case type	GMC position	Guiding principles
<p>Doctor has an affective disorder (e.g. bipolar)</p>	<p>The GMC considers that an affective disorder in and of itself will not meet the may bar test.</p> <p>In certain circumstances, an affective disorder may cause a doctor to engage in relevant conduct, or satisfy the harm test. For instance, if a doctor's affective disorder triggered them to assault a patient, the GMC would be likely to consider that the may bar test is met and a referral may be made to the DBS.</p>	<p>Affective disorders in and of themselves cannot satisfy the referral criteria.</p> <p>If the affective disorder causes the individual to endanger a child or vulnerable adult (or cause risk of harm or satisfy the harm test), then the may bar criteria would need to be considered on the grounds of the behaviour. The decision maker should consider the role of the disorder and the extent to which it is being effectively managed by the doctor when assessing the likelihood of a future risk of harm and whether this is successfully mitigated through action taken by the GMC.</p>

26. Withholding treatment due to doctor's personal views or beliefs		
Broad case type	GMC position	Guiding principles
<p>Doctor withholds treatment from a patient, e.g. because the treatment conflicts with the doctor's personal views or beliefs.</p>	<p>The GMC considers that cases falling into this category would need to be assessed against the may bar test on an individual basis, particularly in light of the action taken by the GMC and our assessment of any residual risk.</p> <p>The key consideration is the seriousness of the matter, which will indicate whether the matter is clinical or raises wider safeguarding concerns which cannot be addressed by action taken by the GMC.</p> <p>The GMC considers that the may bar test is likely to be met in cases where a doctor has threatened to withhold or withdraw a major course of treatment unless a patient commits to, for instance, following a specific religion. In such cases the doctor poses a risk directly in relation to children and/or vulnerable adults both within the professional context and in terms of broader safeguarding. As such, action taken by the GMC is unlikely to remove the risk of harm in relation to children or vulnerable adults and thus the may bar test may be met and a referral to the DBS made.</p>	<p>This type should be handled on a case by case basis depending on the circumstances.</p>

27. Physical assault of someone who is not a vulnerable adult or child		
Broad case type	GMC position	Guiding principles
<p>Doctor physically assaults a person who is not a vulnerable adult (the doctor is acting outside his capacity as a doctor i.e. watching a sports event at the weekend).</p>	<p>The GMC considers that in these cases there is relevant conduct as were the doctor to repeat the broad conduct of assault against or in relation to a child or vulnerable adult this would cause or risk harm being caused to them.</p> <p>Circumstances where the may bar test is unlikely to be met</p> <p>The may bar test is unlikely to be satisfied where the violence was a one-off incident at the lower end of the spectrum of seriousness and there is no information to suggest it will be repeated and directed towards vulnerable groups.</p> <p>Circumstances where the may bar test may be met</p> <p>We consider that the may bar test may be met however where there was more than one incidence of violence or there was a single incidence which was serious in nature e.g. a sustained assault rather than a single punch or kick, as there is a risk the doctor may have anger or behavioural issues which could cause harm to</p>	<p>If there is no information to support a reasonable belief that a doctor poses a specific risk of harm to children or vulnerable adults then the DBS is unlikely to include the person in a barred list and therefore a referral is not normally appropriate.</p> <p>However, there may be a pattern or serious incidences of violence in a non-professional context which indicate a risk of future harm to vulnerable groups which cannot be mitigated by GMC action. A referral may be appropriate if a doctor's violent conduct suggests they have significant anger or behavioural issues which may become apparent when providing another regulated activity therefore placing vulnerable groups at risk of harm. These potential referrals will need to be assessed on an individual basis according to their circumstances.</p>

	<p>vulnerable groups in future if they were directed towards them.</p> <p>An additional factor in favour of the may bar test being met is the likelihood that the doctor would repeat such conduct against a vulnerable adult or child taking into account the specific circumstances in which the conduct arose.</p>	
--	---	--

28. Physical assault on a patient		
Broad case type	GMC position	Guiding principles
<p>Doctor physically assaults a patient</p>	<p>The GMC considers that in these cases the may bar test is likely to be met. The doctor's conduct indicates a direct risk of harm in relation to children or vulnerable adults rather than a general risk.</p> <p>In such cases there are specific safeguarding concerns that the doctor may repeat their conduct and cause harm to a child or vulnerable adult. Action taken by the GMC is not likely to remove the risk of harm to vulnerable groups, and as such, the GMC would be likely to refer these cases to the DBS.</p>	<p>In cases where a person has abused a position of trust to deliberately harm a child or vulnerable adult, there is likely to be the potential for wider risk outside the regulated setting which cannot be removed by action taken by the regulator alone.</p>

29. Clinical research – doctor fails to comply with protocols placing participants at risk of harm		
Broad case type	GMC position	Guiding principles
<p>Doctor fails to adhere to appropriate research protocols, placing those participating in clinical research (vulnerable adults and/or children) at risk of harm.</p>	<p>This may constitute a callous disregard for procedure. The protocols for clinical research trials are intended to ensure ethical treatment of participants and ensure participants are limited to those where there is an acceptable and informed level of risk. Failing to adhere to appropriate protocols may place vulnerable adults and children at risk of serious and avoidable harm which is disproportionate, inappropriate and unnecessary in the context of the clinical research.</p>	<p>This would amount to relevant conduct. In circumstances where the doctor’s failure to adhere to appropriate protocols was persistent and deliberate, the may bar test may be met on the grounds of callous disregard for procedure and a referral made to the DBS. However, there may be cases where the doctor’s failings were minor or due to a genuine oversight. The may bar test is unlikely to be met in these cases but careful consideration will need to be given to the individual circumstances of each potential referral.</p>

30. Clinical research – doctor deliberately misrepresents or inappropriately influences results		
Broad case type	GMC position	Guiding principles
<p>Doctor deliberately misrepresents or inappropriately influences the results of clinical research, placing vulnerable adults and children who may be in receipt of any treatment which is influenced by the research at</p>	<p>The doctor’s behaviour constitutes a callous disregard for procedure because of the potential serious and widespread impact of their actions on vulnerable adults and children in receipt of any drug which is licensed for use as a result of false data from clinical research.</p>	<p>This would amount to relevant conduct. The may bar test will be met in circumstances where a doctor has deliberately misrepresented or inappropriately influenced the results of clinical research.</p> <p>Although the doctor’s actions were directly related to their professional role, there is a risk they may</p>

risk of harm.		display a similar callous disregard for procedure in another regulated activity. Our regulatory action is insufficient to mitigate the risk of harm to children and vulnerable adults and a referral should be made to the DBS.
---------------	--	---

31. Doctor working while suspended		
Broad case type	GMC position	Guiding principles
Doctor practises medicine while suspended	<p>Where a doctor has practised medicine while suspended from the medical register this will constitute relevant conduct. Depending on the circumstances of the case, it may also amount to a callous disregard for procedure. Relevant factors are set out below.</p> <p>Where the doctor has worked while suspended due to an inadvertent oversight for example due to not fully understanding what work they are permitted to undertake while suspended, or in an emergency scenario in response to an immediate threat to life where no alternative medical help was available, this is unlikely to be serious enough to meet the may bar test.</p> <p>Where a doctor works while suspended on a single occasion or for a short period and there is no serious risk of harm or actual harm caused to</p>	This is relevant conduct. However, whether the may bar test is met will depend on the individual circumstances of the case which should be considered carefully by the decision maker.

	<p>children or vulnerable adults, or in an exceptional emergency situation to save life, this is unlikely to reach the threshold of seriousness to meet the may bar test.</p> <p>Where the following factors apply, GMC action is unlikely to be sufficient to manage the risk to vulnerable groups and the seriousness threshold to meet the may bar test is likely to be satisfied:</p> <ul style="list-style-type: none">● The doctor worked while suspended and put children or vulnerable adults at a specific risk of serious harm or caused serious harm to them.● The doctor deliberately and knowingly worked while suspended due to misconduct on a one-off occasion or a more sustained period, and the nature of the activity they undertook while suspended has given rise to further concerns of a similar nature e.g. there was an additional complaint that the doctor undertook an intimate examination without a chaperone.● The doctor has demonstrated a pattern of behaviour in deliberately misrepresenting the nature of restrictions on their registration in order to continue practising medicine, demonstrating a callous disregard for procedure.	
--	---	--

	<ul style="list-style-type: none"> ● The doctor has repeatedly sought work while suspended without disclosing the nature of their restrictions, particularly where this information is not shared at point of offer of employment. ● Doctor has been dishonest about status of registration with GMC when seeking employment in another sector. 	
--	---	--

32. Doctor working while unlicensed for a short period due to an oversight		
Broad case type	GMC position	Guiding principles
<p>Doctor practises medicine without a licence for a short period due to an oversight</p>	<p>Where a doctor works without a licence this will usually amount to relevant conduct. The purpose of holding a licence to practise is to demonstrate that a doctor has kept their knowledge and skills up to date. Even where there is no evidence of direct harm to patients, a doctor's actions in practising without a licence, places patients at risk of physical harm as they may not be competent or sufficiently up to date with their knowledge and skills. Patients are also placed at risk of financial harm as an unlicensed doctor will not have valid indemnity insurance.</p> <p>The may bar test will not however be satisfied where the doctor practises without a licence</p>	<p>A doctor working without a licence will usually amount to relevant conduct. However, where this was for a short period due to an oversight, the may bar test will not be met and no referral should be made.</p>

	<p>due to an oversight and this is for a short period of time. In the absence of evidence of a callous disregard for procedure, the GMC's regulatory action will be sufficient to manage the risk to patients and a referral to the DBS is not indicated.</p>	
--	---	--

33. Doctor deliberately practising medicine without a licence		
Broad case type	GMC position	Guiding principles
<p>Doctor deliberately practises medicine without a licence</p>	<p>Where a doctor works without a licence, this will usually amount to relevant conduct. The purpose of holding a licence to practise is to demonstrate that a doctor has kept their knowledge and skills up to date. A doctor's actions in deliberately practising without a licence or being reckless as to whether or not they hold a licence, places patients at risk of harm as they have not followed the process in place to provide assurance doctors are safe to practise. Patients are also placed at risk of financial harm as an unlicensed doctor will not have valid indemnity insurance.</p> <p>If a doctor has knowingly worked without a licence, particularly where this was for a substantial period of time, this is likely to</p>	<p>Where a doctor works without a licence, this will usually amount to relevant conduct.</p> <p>If the doctor has knowingly worked without a licence, particularly over a long period of time, this may amount to a callous disregard for procedure which (if repeated) could place vulnerable adults and children at direct risk of future harm. In these circumstances, the may bar test may be satisfied and a referral to the DBS indicated.</p>

	<p>indicate a callous disregard for regulatory procedure and the may bar test is likely to be met. This is more likely to be the case where there is a wider pattern of concerns about the doctor and there is a calculated intention on their part to avoid checks and review through the revalidation process. The may bar test is also more likely to be met if the doctor misled their employer as to their licensing status. Where the decision maker judges that there has been a callous disregard for procedure, GMC action is insufficient to manage the risk to vulnerable groups as the behaviour may be repeated in other regulated activities. This would place children and vulnerable adults at direct risk of harm</p>	
--	--	--

34. Doctor working while unregistered		
Broad case type	GMC position	Guiding principles
<p>Doctor working while unregistered</p>	<p>If a medically qualified person who is entitled to GMC registration and has held it in the past works while unregistered, similar principles will apply as where a doctor is working without a licence. A decision on whether to refer or share this information can be made on a case by case</p>	<p>If a qualified doctor who has previously held GMC registration works while unregistered, the same principles will apply as case studies 32 and 33. Each case should be considered on the basis of its individual circumstances to assess whether relevant conduct has occurred and whether the may bar test is met. Relevant factors will include</p>

	basis. Please see the above case studies.	whether the doctor's actions were due to an oversight or a deliberate and persistent disregard for procedure.
--	---	---

35. Non-medically qualified person working while registered		
Broad case type	GMC position	Guiding principles
Non-medically qualified person falsely pretending to be a doctor	<p>Where a non-medically qualified person has wilfully or falsely pretended to be a doctor or used the name of a doctor, this poses a direct risk of harm to children and vulnerable adults and will constitute relevant conduct. The may bar test would also be met as the GMC is unable to take any action to mitigate the risk to vulnerable groups.</p> <p>The GMC power to refer applies to all persons and we may hold this information in rare circumstances.</p>	A non-medically qualified person who deliberately and falsely pretends to be a doctor poses a risk to vulnerable groups and a referral should be made to the DBS. This information can be shared with the DBS in the absence of a GMC finding and such cases will need to be considered on their specific facts with legal advice obtained where necessary.

36. Doctor deliberately misleads employer about a GMC fitness to practise investigation		
Broad case type	GMC position	Guiding principles
Doctor deliberately misleads employer about a GMC fitness	The relevant conduct criteria will be met where there is evidence that children or vulnerable	The relevant conduct criteria will only be met where there is a clearly identifiable (rather than

<p>to practise investigation</p>	<p>adults have been harmed, or placed at risk of harm, by the doctor’s actions in deliberately misleading their employer about the nature of a GMC investigation or action on their registration. For example, the doctor has not informed their employer of a GMC condition not to undertake examinations of female patients without a chaperone. This places vulnerable adults at risk of harm as the employer does not enforce the condition and the doctor continues to examine patients unchaperoned.</p> <p>However, where the risk of harm is general and non-specific e.g. the doctor has not disclosed some allegations but their registration is unrestricted, the relevant conduct criteria will not be met. This is because it would be speculative to conclude that vulnerable groups were at direct risk of harm from a doctor whose registration is unrestricted due to the employer not being aware of every allegation being investigated. The matter will need to be considered on the individual facts to assess whether the failure to disclose posed a risk to patients that should be referred.</p> <p>Where the doctor deliberately misleads their employer and others about the nature of a GMC investigation or action on their registration AND a specific risk of harm to vulnerable groups has</p>	<p>general or speculative) risk of harm to children and/or vulnerable adults arising from the doctor’s dishonesty.</p> <p>Where such a risk is present, a referral to the DBS is likely to be appropriate as the risk of harm to vulnerable groups cannot be mitigated by the GMC’s action.</p>
----------------------------------	--	---

	<p>been identified, this behaviour is likely to indicate a callous disregard for procedure. The may bar test is likely to be met as the risks arising from this type of deliberate behaviour cannot be managed by action taken by us and the DBS may wish to consider barring.</p>	
--	--	--

37. Doctor breaches interim or substantive conditions or undertakings		
Broad case type	GMC position	Guiding principles
<p>Doctor breaches interim or substantive conditions or undertakings on registration</p>	<p>Where a doctor breaches interim or substantive conditions or undertakings on their registration this constitutes relevant conduct.</p> <p>Breach due to a deterioration in health</p> <p>In cases where the underlying cause of the breach is a deterioration in health (for example an occasional lapse in abstention from alcohol) GMC action is likely to be sufficient to manage the risk of future harm to vulnerable adults and children in other settings and the may bar test will not be met.</p> <p>Persistent breaches of interim or substantive restrictions</p> <p>Where the doctor has deliberately and persistently breached interim or substantive</p>	<p>A doctor breaching interim or substantive conditions or undertakings on their registration constitutes relevant conduct.</p> <p>A breach of undertakings due to a deterioration in the doctor's health is unlikely to meet the may bar test.</p> <p>Deliberate and persistent breaches of restrictions on registration which were imposed to address underlying fitness to practise issues are likely to constitute a callous disregard for procedure. The may bar test is likely to be met in these circumstances and a referral to the DBS indicated.</p> <p>A one-off failure to comply with interim or substantive conditions or undertakings will meet the may bar test if the doctor's actions give rise to</p>

	<p>restrictions which were imposed to address an underlying fitness to practise issue, this is likely to constitute a callous disregard for procedure. In these cases, GMC action is not likely to be sufficient to manage the risk of harm to vulnerable adults or children if the doctor undertook another regulated activity and a referral is likely to be indicated.</p> <p>One off breach of interim or substantive restrictions where the underlying concerns raise a safeguarding risk</p> <p>Where the doctor fails to comply with interim or substantive conditions or undertakings on a one-off basis and the underlying concerns relate to conduct which gives rise to a safeguarding risk (for example failing to provide a chaperone or undertaking intimate examinations when prohibited from doing so) this is likely to indicate a callous disregard for procedure which poses a risk of future harm to vulnerable adults and children which cannot be mitigated or managed by our action on registration and the may bar test is likely to be met.</p> <p>Aggravating factors may include failing to disclose restrictions on registration when accepting a job offer or misrepresenting the status of their registration with the GMC when</p>	<p>a safeguarding risk. For example, they undertake an intimate examination when prohibited from doing so. The may bar test is unlikely to be met if no safeguarding risk arises from a one-off breach.</p>
--	--	---

	seeking employment in another sector.	
--	---------------------------------------	--

38. Doctor knowingly practises medicine outside the limits of competence		
Broad case type	GMC position	Guiding principles
<p>Doctor knowingly practises medicine outside the limits of competence.</p>	<p>Where a doctor practises outside their limit of competence and is not aware of this, a referral will not be indicated as regulatory action is sufficient to mitigate the risk of future harm to vulnerable adults and children arising from clinical failings.</p> <p>However, where a doctor knowingly practises medicine outside their limit of competence, this may amount to a callous disregard for procedure.</p> <p>Factors to consider in determining whether a referral is appropriate include:</p> <ul style="list-style-type: none"> ● extent to which the doctor was aware they were not fit to carry out the procedure or provide treatment ● the doctor's motivation for practising outside their competence e.g. they did so deliberately for financial or reputational gain 	<p>A doctor's actions in knowingly practising medicine outside their limit of competence may amount to a callous disregard for procedure and the may bar test is likely to be met. The individual circumstances of each case should be evaluated to assess whether a referral to the DBS is appropriate.</p>

	<ul style="list-style-type: none"> ● potential or actual consequences of doing so ● extent of insight and remediation. 	
--	--	--

39. Doctor fails to follow local procedures		
Broad case type	GMC position	Guiding principles
<p>Doctor demonstrates a disregard for local procedures by failing to follow them</p>	<p>Unless it is of an extremely serious nature, a single failure to follow local procedures is unlikely to meet the may bar test. More persistent failures may however indicate a callous disregard for procedure. In these circumstances, the GMC action will not mitigate the future risk of harm to vulnerable groups as the callous disregard could be demonstrated in other regulated activities.</p> <p>Factors which indicate a referral is likely to be appropriate include:</p> <ul style="list-style-type: none"> ● Failure to attend a seriously unwell patient despite repeated requests in contravention of clear guidance or protocols. ● Persistently encouraging other staff to undertake duties outside their sphere of competence or engage in other serious breaches of local protocols. 	<p>Each case will need to be assessed on its individual circumstances and a referral is unlikely to be necessary if there was a single failure to follow local procedures. However, the may bar test is likely to be met if a doctor persistently and deliberately fails to follow local procedures or there is a one-off failure of an extremely serious nature. This would demonstrate a callous disregard for procedure which places vulnerable groups at risk of harm.</p>

	<ul style="list-style-type: none"> ● Persistent and serious failings in storage of controlled drugs in contravention of relevant guidance. ● Deliberate or reckless pattern of breach of local restrictions on employment that places vulnerable adults or children at risk of serious harm. 	
--	--	--

40. Doctor's role as director of a care or residential home		
Broad case type	GMC position	Guiding principles
<p>Doctor has not fulfilled their responsibilities as a director of a care or residential home leading to residents suffering harm</p>	<p>In some cases, a doctor's failings in their capacity as the director of a care or residential home will amount to relevant conduct. These failings could include not carrying out necessary DBS checks on staff or not taking action to address issues such as staff shortages where there is evidence these have led to residents being harmed, for example through falls due to lack of supervision etc. The relevant conduct criteria can be met even where the doctor is not directly providing healthcare to residents. This could be on the basis that:</p> <ul style="list-style-type: none"> ● they are responsible for the day to day supervision of staff who are providing 	<p>These cases should be considered on a case by case basis depending on their individual circumstances.</p> <p>Where the relevant conduct criteria are met and there have been significant safeguarding failures by the doctor which have resulted in children or vulnerable adults being harmed, the may bar test is likely to be met. A referral to the DBS will be indicated in these cases.</p>

	<p>regulated activities to residents such as the provision of personal care</p> <ul style="list-style-type: none"> ● by acting as a director of the care/residential home, the doctor may have responsibilities by virtue of their professional role as a medical practitioner or have a supervisory role. These responsibilities, including for safeguarding procedures, can be defined as the provision of healthcare. The residents of the home would therefore be classed as vulnerable adults in receipt of a regulated activity either directly from the doctor or via the person that the doctor is directly supervising in the provision of a regulated activity. <p>If it was considered that the person harmed is not a vulnerable adult because they are not one of the doctor's own patients, the relevant conduct criteria could still be met if the same failings would cause or risk harm were they to be repeated and directed towards a child or vulnerable adult.</p> <p>Whether or not the may bar test is met will depend on the individual circumstances of the case. Where the residents of the care/residential home have suffered significant harm as a result of safeguarding failures for</p>	
--	--	--

	<p>which the doctor was (at least partially) responsible, the may bar test is likely to be met. Safeguarding failures, such as not conducting DBS checks on staff working with vulnerable groups, could raise a wider risk that the GMC action is unable to mitigate as they may be repeated in another regulated setting.</p>	
--	--	--

41. Doctor works while impaired by a health condition		
Broad case type	GMC position	Guiding principles
<p>Doctor has treated patients while their fitness to practise is impaired by a health condition</p>	<p>If a doctor is diagnosed with a health condition and their fitness to practise is subsequently found to be impaired by a tribunal or CE decision to issue undertakings, we would consider their treating patients prior to the diagnosis (but at a time when their fitness to practise was impaired) to amount to relevant conduct.</p> <p>The may bar test would not be met however if the concerns solely relate to the doctor's health as our action is sufficient to manage any risk to vulnerable groups.</p>	<p>A doctor working at a time when their fitness to practise is impaired on health grounds is engaging in relevant conduct.</p> <p>The may bar test will not be met in cases which solely relate to health as our action is sufficient to manage the risk to vulnerable groups.</p>

42. Doctor works while impaired by not having the necessary knowledge of English		
Broad case type	GMC position	Guiding principles
<p>Doctor has treated patients while their fitness to practise is impaired by not having the necessary knowledge of English</p>	<p>If a tribunal finds that a doctor's fitness to practise is impaired by not having the necessary knowledge of the English language, we would consider their treating patients prior to the tribunal's finding (but at a time when their fitness to practise was impaired by poor language skills) to amount to relevant conduct.</p> <p>The may bar test would not be met however if the concerns solely relate to the doctor's language skills as our regulatory action would be sufficient to manage any risk to vulnerable groups.</p>	<p>A doctor working at a time when their fitness to practise is impaired on language grounds is engaging in relevant conduct.</p> <p>The may bar test will not be met in cases which solely relate to language skills as our action is sufficient to manage the risk to vulnerable groups.</p>

43. Doctor works while impaired by deficient professional performance which includes professional competence		
Broad case type	GMC position	Guiding principles
<p>Doctor has treated patients while their fitness to practise is impaired by deficient professional performance</p>	<p>If a tribunal finds that a doctor's fitness to practise is impaired by deficient professional performance, we would consider their treating patients prior to the tribunal's finding (but at a time when their fitness to practise was impaired by poor performance) to amount to relevant</p>	<p>A doctor working at a time when their fitness to practise is impaired on performance grounds is engaging in relevant conduct.</p> <p>The may bar test will not be met in cases which solely relate to performance as our action is</p>

	<p>conduct.</p> <p>The may bar test would not be met however if the concerns solely relate to the doctor's performance/professional competence as our regulatory action would be sufficient to manage any risk to vulnerable groups.</p>	<p>sufficient to manage the risk to vulnerable groups.</p>
--	--	--

Annex C

Serious autobar offences list

Act	Section	Offence
Common Law		Murder (and attempted murder)
Common Law		Rape
Common Law		Kidnapping
Common Law		Abduction with intent to rape
Common Law		Assault with intent to rape
Offences Against the Person Act 1861	21	Attempting to choke with intent to commit an indictable offence
Sexual Offences Act 1956	1	Rape of a man or woman
Sexual Offences Act 1956	5	Sexual intercourse with a girl under the age of thirteen
Sexual Offences Act 1956	14/15	Indecent assault on a man or woman (where victim under 13)
Indecency with Children Act 1960	1	Gross indecency with a child, (where victim is under 13)
Sexual Offences (Scotland) Act 1976	3	Sexual intercourse with a girl under 13
Sexual Offences (Northern Ireland) Order 1978	Article 3	Rape
Protection of Children Act 1978	1	Indecent photographs of children: take, permit or make, possess, distribute or publish an indecent photograph of a child
Civic Government (Scotland) Act 1982	52(&52A)	Indecent photographs of children: take, permit or make, possess, distribute or publish an indecent photograph of a child

Protection of Children (Northern Ireland) Order 1978	Article 3	Indecent photographs of children: take, permit or make, possess, distribute or publish an indecent photograph of a child
Sexual Offences Act 2003	1	Rape
Sexual Offences Act 2003	2	Assault by penetration
Sexual Offences Act 2003	5	Rape of a child under 13
Sexual Offences Act 2003	6	Assault of a child under 13 by penetration
Sexual Offences Act 2003	7	Sexual assault of a child under 13 (intentionally touched a girl/boy and the touching was sexual)
Sexual Offences Act 2003	8	Causing or inciting a child under 13 to engage in sexual activity
Sexual Offences Act 2003	30	Sexual activity with a person with a mental disorder impeding choice
Sexual Offences Act 2003	31	Causing or inciting a person with a mental disorder impeding choice, to engage in sexual activity
Sexual Offences Act 2003	34	Inducement, threat or deception to procure sexual activity with a person with a mental disorder
Sexual Offences Act 2003	35	Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception
Sexual Offences Act 2003	47	Paying for sexual services of a child, (where the victim is under 13)
Sexual Offences Act 2003	62	Committing an offence with intent to commit a sexual offence (where the primary offence is kidnapping or false imprisonment)
Sexual Offences Act 2003	72	Any of the above offences, when committed outside the UK
Sexual Offences Northern Ireland Order 2008		The corresponding offences to those set out above

Sexual Offences (Scotland) Act 2009		The corresponding offences to those set out above
Theft Act 1968 / Theft Act (NI) 1969	9	Burglary, with intent to rape
Theft Act 1968 / Theft Act (NI) 1969	9	The commission of any equivalent civilian offence under the Air Force Act; Armed Forces Act; Army Act or Naval Discipline Act.