

Guidance on making referrals to the Disclosure and Barring Service

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 which will be revised periodically. It 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, has been established in Scotland commencing from February 2011. A separate guidance document has been prepared for referrals to Disclosure Scotland (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'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 or employment agency although this will be rare.
- 4 If a doctor is barred under the England, Wales and Northern Ireland 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 Disclosure Scotland.
- 5 Disclosure Scotland and the DBS have an agreement that facilitates their joint working in cases where jurisdiction is unclear.

Disclosure & Barring Service

- 6 The Safeguarding Vulnerable Groups Act 2006 (the Act) was introduced as a result of the Bichard 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.

- 7** 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

- 8** 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 physically assaults a child, regardless of whether the conduct happens as part of a Regulated Activity (ie pursuant to the doctor/patient relationship) or in everyday life, the conduct may result in a referral to the DBS.

Vulnerable adults

- 9** The term 'vulnerable adult' is defined in the Act¹ as any person over the age of 18 to whom a Regulated Activity is provided (see paragraph 15 for the definition of a Regulated Activity).

Jurisdiction of the Scheme

- 10** 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.
- 11** 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 (ie 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
 - the issue occurring overseas, would, if it had occurred in England, Wales or Northern Ireland, satisfy the Harm Test.

¹ Section 60 of the Act

Application of the Scheme to the medical profession

- 12** The GMC has power under section 41 of the Act (as amended by the Protection of Freedoms Act 2012 (PFA)) to refer to the DBS information we hold, which suggests that a person poses a risk of harm to children or vulnerable adults.

Regulated Activity

- 13** 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.
- 14** Doctors involved in providing any form of health care to patients are conducting a Regulated Activity for the purposes of the Scheme.
- 15** 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.
- 16** The following are 'Regulated Activities' for the purpose of the SVGA Schedule 4, section 7(1) (as amended by s.66(2) PFA):
- a.** the provision to an adult of health care by, or under the direction or supervision of, a health care professional, including a doctor
 - 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 of a person who is in need of it by reason of age, illness or disability to do any of these things
 - c.** the provision by a social care worker of relevant social work to an adult who is a client or potential client
 - d.** 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

- e. 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
 - f. the transportation of adults who need it by reason of age, illness or disability.
- 17** 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 16(a), above.
- 18** The doctor does not have to engage the vulnerable adult in health care at the exact time of the act or omission. If a doctor is acting outside of his professional capacity as a doctor and instead he engages in any of the Regulated Activities described in paragraphs (b) to (f) above, then the person to whom he provides the Regulated Activity is a vulnerable adult.

Example

If a doctor conducts a social visit to the home of one of his/her 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 he/she is their treating doctor and therefore engages them in a Regulated Activity, ie health care.

- 19** 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 her previous history of sexual abuse.

The reasoning for this is that the doctor was not engaging the adult (in this case, his/her colleague) in a Regulated Activity at the time, ie 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

- 20 Before a referral to the DBS can be made, the Act requires a decision maker to "think" that **two conditions** are met.
- 21 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'¹ 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.
- 22 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.
- 23 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 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 and there are no other findings against the doctor, the decision maker need not consider the subsequent two parts of the first condition.

¹ 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 68-69 below.

The first condition

PART 1: AUTOBAR OFFENCES: Decision makers should refer the case to the DBS where we have evidence of an autobar offence having been committed (See paragraphs 28-41 below). If not, consider parts 2 & 3;

PART 2: RELEVANT CONDUCT: where the GMC 'thinks' that a doctor has engaged in Relevant Conduct and the trigger points are met, the decision maker should move on to consider the second condition (see paragraphs 52-67 below for guidance on what constitutes Relevant Conduct); **or**

PART 3: THE HARM TEST: where the GMC 'thinks' that a doctor poses a future risk of harm in relation to children or vulnerable adults and there is evidence to support the suggestion of risk, decisions makers should move on to consider the second condition (see paragraphs 68-84 below for

- 24** If referring for an autobar offence, the referral can be made as soon as we have evidence that the doctor has been cautioned in relation to, or convicted of, an autobar *or* connected offence (defined below at paragraph 30). However, the decision maker must also be satisfied that the first part of the second condition is met; which relates to whether the doctor is or has been, or might in future be, engaged in a regulated activity. For autobar offences, it is not necessary to proceed to consider the second part of the second condition (the "may bar" test).
- 25** If the GMC decision maker decides that the doctor 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 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 because of the matters that resulted in the first condition being met, the case can be referred to the DBS.

- 26 For the trigger points for autobar and Relevant Conduct cases see Fig1 (paragraph 69). For referral conditions see [Annex A](#).

The first condition

- 27 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

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

The current list of autobar offences is available

at: http://llrscb.proceduresonline.com/pdfs/app_1_dbs_factsheet.pdf

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

- 29 Before the autobar part of the first condition is met, decision makers will need to make sure that the doctor has been convicted of, or cautioned in relation to, an autobar or connected offence.
- 30 '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.
- 31 The vast majority of criminal conviction cases received by the GMC involve a doctor being convicted of an offence, rather than an offence connected to a criminal offence. However, decision makers should be alert to the possibility of a connected offence having been committed.
- 32 Some violent and sexual offences, if committed in Scotland, may only exist under Scottish law. Therefore when deciding which law applies, decision makers should look to see where the offence took place, rather than the doctor's place of work (this can

be done by reference to the location of the convicting court or the police force responsible for issuing the relevant caution or charge).

- 33** If a doctor commits an auto-bar or connected offence in England, Wales or Northern Ireland, the GMC will refer the doctor to the DBS. For the first condition to be met, there needs to be sufficient evidence that the doctor has been convicted of, or cautioned in relation to an auto-bar or connected offence and that the doctor is or has been, or might in future be, engaged in regulated activity.

Trigger point for referrals involving 'auto-bar' offences

- 34** The GMC may make a referral under the auto-bar part of the first condition when we receive one of the following:
- a Notice of police caution** – in relation to any of the auto-bar or connected offences
 - b Memorandum of criminal conviction** – indicating that the doctor has been convicted of any of the auto-bar or connected offences
 - c Overseas determination** – documentation of a determination indicating that the doctor has been convicted of or been cautioned in relation to a criminal offence in another jurisdiction which, if committed within the UK, would amount to an auto-bar or connected offence (see paragraphs 36-41 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, eg a letter from the police confirming details of the conviction.
- 35** It does not matter whether we received the document through a self-referral by a doctor, a referral from a trust, or as part of a doctor's application for restoration of his/her registration. 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.

Overseas offences

- 36** It is important that decision makers consider where the offence took place (and thus where the doctor was convicted or cautioned). The list of auto-bar offences covers offences in England, Wales, Scotland and Northern Ireland.
- 37** If we have information to suggest that a doctor 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 auto-bar offence. If so,

the GMC may refer the doctor to the DBS on the basis that they have committed an auto-bar offence.

- 38 If the conduct occurred in Scotland or the doctor's GMC registered address is in Scotland at the time of assessing the case, the Disclosure Scotland Scheme should be considered.
- 39 While we expect these cases to be few (we receive less than 10 overseas determinations cases per annum), on receipt of such a case the decision maker will need to consider whether the referral conditions are met.
- 40 In some cases, this decision will be clear-cut.

For example

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

- 41 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 auto-bar offences – making referrals in the absence of a conviction, caution or other trigger point

- 42 In general, we will only assess a case for referral to the DBS if one of the trigger points at paragraph 69 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 has committed a serious auto-bar offence despite there being, at the point of referral, no conviction or caution.
- 43 As, at the point of referral, there will be no conviction or caution yet issued, such referrals will be made under part 2 of the first condition which requires a decision maker to "think" that a doctor 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 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 autobar offence has been committed?

- 44** The Act gives the GMC a power to make a referral where a decision maker “thinks” that a doctor has engaged in Relevant Conduct. As explained at paragraph 21, 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.
- 45** If, having considered the evidence, the decision maker holds a reasonable belief a doctor has engaged in Relevant Conduct, which if proven would amount to a serious autobar offence, then a referral will be appropriate (subject to the second condition being satisfied – see below).
- 46** Even where we are considering referral prior to the issuing of 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 has been charged with a serious autobar 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 evidence at this point to enable us to form a reasonable belief i.e. “think” the doctor has engaged in Relevant Conduct. However, we should consider if a referral is appropriate in the following circumstances:
- if a doctor has been charged with a serious autobar offence and has absconded meaning the criminal proceedings are stalled without any conclusion
 - 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

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 committed the serious autobar offence and as such, engaged in relevant conduct

- 47** 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 has engaged in Relevant Conduct. If, however, we are only able to obtain limited evidence about the alleged criminal conduct, we should consider if the criteria are met for a referral under the harm test (see paragraph 84.)

- 48** 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 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 has engaged in Relevant Conduct.
- 49** In certain cases, physical evidence, such as images seized from a doctor’s computer or forensic evidence, is likely to be evidence which would enable a decision maker to form a reasonable belief that a doctor has engaged in Relevant Conduct.
- 50** 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

51 As the information is being considered for referral on the basis of part two of the first condition (i.e. “Relevant Conduct”), if the decision maker holds a reasonable belief that a doctor has engaged in Relevant Conduct 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 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 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

52 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 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.

- 53** Relevant Conduct can be any act or omission on the part of the doctor that:
- a** endangers a child or vulnerable adult or is likely to do so
 - b** has not, on this occasion caused actual harm, but if repeated against or in relation to a child or a 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.
- 54** '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 (SVGA Schedule 3, Part 1 ss4(3) and (4)).
- 55** Not all conduct involving illegal inappropriate sexual material, will involve an autobar offence. On occasion we receive employer referrals which indicate that a doctor has accessed inappropriate sexual material using employer resources. If this is the case, and a criminal case has not been progressed, GMC decision makers will need to consider whether the doctor's actions meet the Relevant Conduct criteria.
- 56** If the sexual material does not involve children or vulnerable adults, consideration should be given to whether the doctor's actions should be referred to the DBS under the harm test (please refer to paragraphs 85-86 below.)
- 57** With the exception of paragraph 53d above, the Relevant Conduct must have been 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.
- 58** The Act defines endangering a child¹ or vulnerable adult² if the person:

¹ Schedule 3, Part 1, para 4(2).

² Schedule 3, Part 1, para 10(2).

- 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.

- 59** When determining whether harm (or the risk of harm) has been caused it is important to remember that harm can be both physical (violent or sexual) or mental harm; it can be caused by action or inaction and must be more than just 'trivial or fleeting'.
- 60** The DBS guidance on referrals lists the following types of harm applicable to vulnerable adults and children:
- 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.

Risk of Harm relating directly to children and/or vulnerable adults

- 61** The definition of Relevant Conduct is not restricted to actions within Regulated Activity. It must simply involve a child, or a vulnerable adult (see Annex B, case study six for more details).
- 62** However, in some cases outside the doctor/patient relationship, the person who is harmed by the doctor might be a vulnerable adult because the doctor is providing them with some other Regulated Activity (see paragraphs 17-19 above for discussion on vulnerability).
- 63** In these cases, where a doctor 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. In these cases the GMC decision maker must go on to consider whether the second condition is met.

Examples

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.

ie he/she may have endangered his/her passengers and is also providing a Regulated Activity by transporting adults who need it by virtue of their age.

- 64** In the examples above the decision maker should proceed to consider the second condition.

Impairment on the grounds of health, performance or language and relevant conduct

- 65** If we have evidence that a doctor has treated children or vulnerable adults while their fitness to practise was impaired by reason of their health, performance or 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 or a case examiner decision to issue undertakings] will postdate the time when the doctor was working without restrictions from us. For example, if a doctor is diagnosed with an addiction to controlled substances and a tribunal subsequently finds their fitness to practise impaired by reason of 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.

- 66** The same principle will apply if a doctor has worked at a time when it was subsequently found their fitness to practise was impaired by poor performance or deficient knowledge of the English language.
- 67** A list of case studies is contained at [Annex B](#).

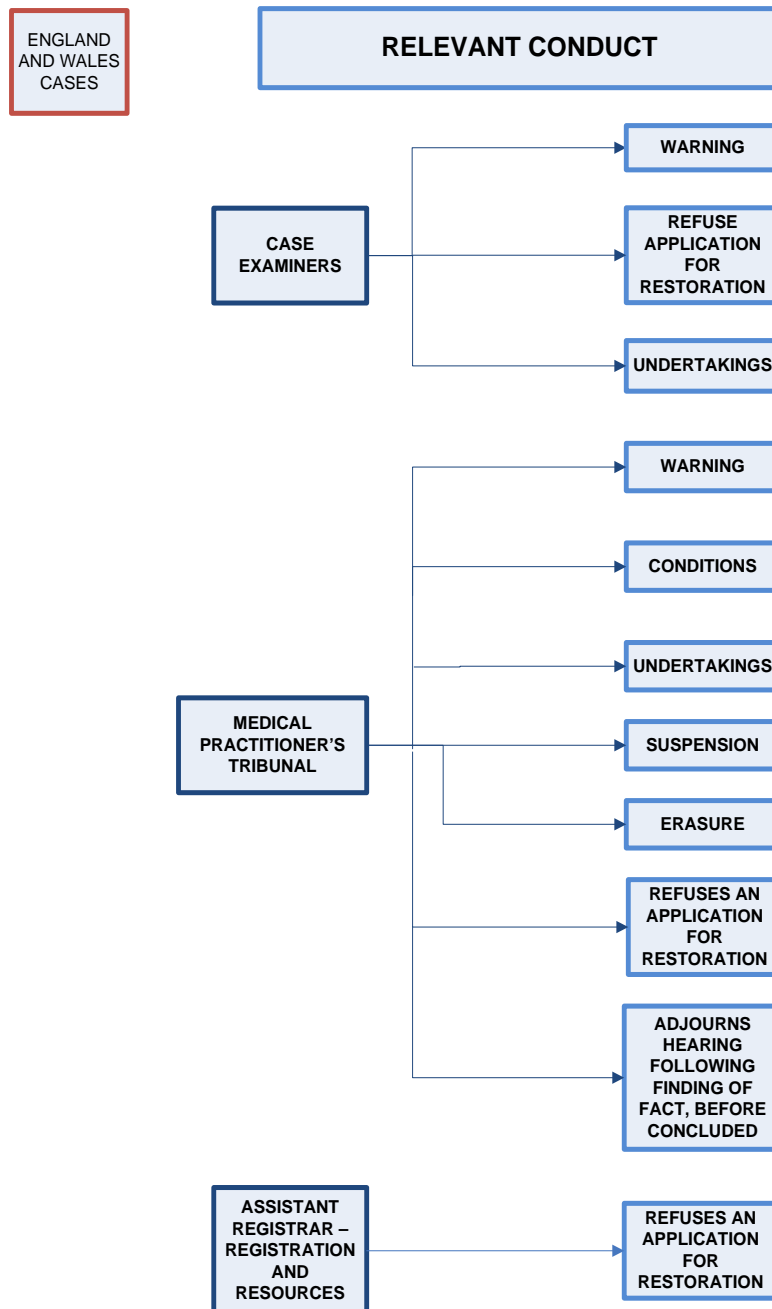
NOTE: Decision makers should note that Relevant Conduct applies not only to conduct which occurs in England, Wales or Northern Ireland, but also to conduct which occurs overseas. Therefore, if a doctor registered with the GMC has committed conduct that would amount to Relevant Conduct in a jurisdiction 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

- 68** 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
 - ii** a warning has been issued by the Investigation Committee
 - iii** a Medical Practitioners Tribunal issues a warning, imposes conditions, suspends or erases a doctor or refuses an application for restoration
 - iv** a Medical Practitioners Tribunal hearing has taken place but the case has not yet concluded, and there have been findings of fact which demonstrate that the doctor engaged in the Relevant Conduct, or
 - v** an assistant registrar of the Registration and Revalidation directorate refuses to register a doctor.
- 69** 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 determination has been made that the doctor engaged in Relevant Conduct (in accordance with the criteria set out at paragraph 68(i) to (v) 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.

Fig 1

Trigger points for considering referrals in Relevant Conduct cases (assuming the referral conditions are met):



Part 3: The Harm Test

70 The Harm Test should only be applied to cases which do not meet the autobar offence *or* Relevant Conduct criteria.

Referrals to the DBS involving The Harm Test

71 We should make a referral to the DBS in cases where the GMC “thinks” that a doctor *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.

72 The Harm Test is prospective and involves an assessment of what a person *may* do in the future. This assessment may be based on thoughts, beliefs or attitudes communicated by a doctor. However, a referral can also be made under the harm test (where the relevant conduct criteria are not met) based on an act or omission already committed by the doctor. In order for the harm test to be met, this act or omission must lead us to form a reasonable belief that the doctor may harm vulnerable groups or place them at risk of harm in the future.

73 At times it may be difficult to distinguish between the application of the Relevant Conduct provisions and the application of the Harm Test.

74 Decision makers should remember the following:

The Harm Test **ONLY** applies where

- the autobar or Relevant Conduct criteria are **not** satisfied; *and*
- there is an identifiable *future* risk of harm to children or vulnerable adults.

75 In applying the Harm Test decisions makers need to consider if there is an identifiable risk that a doctor **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

- 76** The important factor in 'Harm Test' cases is that the doctor has not yet engaged in Relevant Conduct but there is a risk that he or she *may* do so in the future either based on their past actions or specific thoughts, beliefs or attitudes they have expressed.
- 77** In making a decision about whether the Harm Test applies, GMC decision makers should consider:
- what is the person deemed to be at risk of doing in the future?
 - does the harm or risk of harm 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?
- 78** The Harm Test can be met where there has been no act or omission but a doctor has communicated something about their thoughts, beliefs or attitudes, which indicate that they pose a future risk of direct harm to children and/or vulnerable adults. This includes where a doctor 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 he/she is sexually attracted to children, but has not yet acted on his/her feelings, the Harm Test would be met.

Where a doctor tells his/her therapist that he/she has a desire to cause harm to elderly patients, but has not actually done so, the Harm Test would be met.

Where a doctor's health or language skills are not being safely managed/addressed as the doctor lacks insight, is non-compliant with treatment or has failed to remediate and while not currently working they may do so in the future.

79 In the examples above, GMC decision makers can assume the autobar provisions have not been met as the doctor has not been convicted of, or cautioned, in relation to an autobar, 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 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.

80 Evidence of the risks in the first two examples may come from a psychiatric report, from a Medical Case Examiner (CE) report or from other information gathered during the course of our investigation process.

Cases involving a 'general' risk of harm

81 The Harm Test will not usually apply in cases where the doctor's expression of his/her 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.

NOTE: The Harm Test does not apply to past conduct cases which satisfy the Relevant Conduct criteria. However, there are exceptions where the Harm Test can be applied to conduct cases (see paragraphs 82-84 below).

Application of the Harm Test in conduct cases

82 In certain circumstances, conduct cases may give rise to a referral to the DBS under the Harm Test rather than the Relevant Conduct criteria. This may occur where although we do not have reasonable grounds to believe that Relevant Conduct has occurred, the GMC has a reasonable belief that there is a serious risk to children or vulnerable adults such that the DBS may bar the person (i.e. the Harm Test is met).

When is it appropriate to consider a referral under the Harm Test

- 83** A conduct case cannot be referred as Relevant Conduct if we only have a suspicion (rather than a reasonable belief) that the conduct occurred. A referral to the DBS under the Harm Test may be appropriate where there has been no GMC finding (a 'trigger point') in respect of the conduct, but nevertheless the evidence still leads us to reasonably believe that the doctor may harm children and/or vulnerable adults or put them at risk of harm in the future). Where the evidence is such as to lead us to "think" Relevant Conduct has occurred, that will be the basis upon which a referral is made. Typically, this will be where a trigger point has been met. However, where the evidence is not sufficient to enable us to think that Relevant Conduct has occurred but is sufficient for us to consider that the doctor may harm children and/or vulnerable adults or put them at risk of harm in the future, a referral may still be made under the Harm Test.
- 84** Examples of conduct cases which could lead to a referral under the Harm Test may be where:
- We suspect that the doctor has committed a serious autobar offence (as listed at Annex C) but the evidence is not sufficiently strong to enable us to form a reasonable belief that Relevant Conduct has taken place. However, we "think" that (based on the evidence before us as to past conduct), the doctor may harm or place at risk of harm a child or vulnerable adult. While we will usually refer serious autobar cases under the Relevant Conduct criteria (as outlined at paragraphs 42 – 50 above), if the evidence we have obtained about the alleged criminal conduct is very limited, and so is not sufficient to enable us to "think" that Relevant Conduct has occurred, a referral could still be made if the Harm Test is satisfied.
 - We have concluded a case without specifically addressing or making a specific finding on an allegation which could fall within the definition of Relevant Conduct and raises a significant safeguarding concern. If the allegation has not been specifically addressed by or resulted in a finding by a GMC decision maker, and the evidence is not sufficient as to enable us to "think" the doctor engaged in Relevant Conduct, a referral could be made under the Harm Test. This could occur where the evidence is such as to make us "think" the doctor may cause future harm to a child or vulnerable adult. Broadly speaking, a serious allegation which gives rise to a significant safeguarding concern is one that a doctor's actions have harmed a child or vulnerable adult or placed them at risk of harm including abuse or neglect. There are different types of harm including physical, emotional, sexual and financial. Examples of serious allegations could include failing to make a safeguarding referral, a doctor abusing their professional position to exploit a patient for financial or other gain, inappropriate sexual remarks or behaviour and discrimination against patients on the basis of a protected characteristic. However, this is not an exhaustive list.

A specific example of this scenario is a case which was concluded by way of undertakings following a performance assessment but the case examiners did not specifically address information that the doctor failed to carry out a safeguarding assessment on a 2 year old child with a head wound and history of unexplained injuries. In the absence of information about the view of the case examiners about the allegation to satisfy the Relevant Conduct criteria, this information could still be referred to the DBS under 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.

Referrals under the Harm Test where the allegation did not relate to a child or vulnerable adult

85 In certain circumstances, we may hold information about a doctor's behaviour in relation to someone who is not a vulnerable adult or child that we have a reason to believe, if repeated, may present a risk of harm to vulnerable adults or children, and we consider there is a likelihood of repetition. These cases may give rise to a referral under the Harm Test. For example, the Harm Test is likely to be met in the types of case listed below:

- A serious violent or serious sexual offence directed towards someone, other than a child or vulnerable adult and not in the presence of a child.
- Indecent exposure involving someone other than a vulnerable adult or child.
- Sexual harassment or inappropriate sexually motivated behaviour towards a person other than a vulnerable adult or child, e.g. a work colleague.
- Taking indecent photographs of someone other than a vulnerable adult or child without permission eg voyeurism.
- Stalking or harassment of someone other than a vulnerable adult or child, where this involves aggravating factors such as threatening or violent behaviour.

86 It is unlikely however that the Harm Test will be met in the following circumstances where the behaviour did not have a direct link to a child and/or vulnerable adult:

- a.** Soliciting offences which do not involve a vulnerable adult or child.
- b.** Drug offences which do not involve a vulnerable adult or child.
- c.** Stalking or harassment of someone other than a vulnerable adult or child and which does not have any aggravating factors such as threatening or violent behaviour.

The second condition

- 87** The second condition has two parts.
- 88** Where the GMC 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 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 has been, is, or might in the future, be engaged in a Regulated Activity

- 89** The first part of the second condition requires the GMC to consider whether the doctor:
- 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 GMC decision maker, and/or
 - c** **might in future** be engaged in a Regulated Activity.
- 90** The vast majority of the GMC's cases will satisfy the first part of the second condition.
- 91** A doctor is engaged in a Regulated Activity if he/she has contact with patients (children or adult) in any primary care or healthcare setting, regardless of whether the care is delivered through the NHS or other private arrangements.
- 92** In relation to 89a above, the GMC only need to be satisfied that the doctor was registered at the time that the Relevant Conduct occurred or the circumstances that give rise to the Harm Test criteria being met arose.
- 93** If a doctor was not engaged in a Regulated Activity at the time the incident took place, decision makers must consider whether the doctor is engaged in Regulated Activity at the time the second condition is being considered by the GMC.
- 94** Decision makers can assume that a doctor is engaged in Regulated Activity if the doctor's Siebel record indicates that he/she is currently employed as a doctor, or in more rare circumstances, where we hold information to suggest that the doctor is engaged in another type of Regulated Activity (refer to paragraphs 13-19 above for Regulated Activities).

- 95 If a doctor was **not** engaged in Regulated Activity at the time the incident took place, and is **not currently engaged** in Regulated Activity, decision makers should consider whether we hold information to suggest that the doctor **might engage** in such activities in the future (under the Harm Test).

Note: Doctors may engage in forms of Regulated Activity for which he/she does not need to be a registered doctor. For example where a doctor manages a care home (or plans to do so), we are **not required** to investigate to obtain this information.

Part 2: The 'May Bar' test

- 96 Part two of the second condition will only be met where the decision maker decides that the DBS 'may bar' the doctor because of his/her conduct in circumstances which give rise to the Relevant Conduct criteria or the Harm Test being met.
- 97 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 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 subject to the referral.

Clinical failures

- 98 The 'may bar' test will not 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 eg placing conditions on the doctor's registration or requiring him/her to retrain. In the absence of wider safeguarding issues for children or vulnerable adults, a referral to the DBS will not be appropriate.
- 99 The risk of harm must be serious enough that we "think" the DBS needs to be informed. It could be the case that although there is evidence of Relevant Conduct the information is not referred to the DBS as the risk of harm is low.
- 100 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 Practitioner's Tribunal who have considered evidence in a FTP case but it is for the DBS to assess the risk when making their decision on whether to 'bar' an individual.

Health and language concerns

- 101 The 'may bar test' will not be met where the concerns relate to health or language skills, and the GMC's actions manage the risk, for example, the doctor is subject to restrictions which fully address the health or language concerns and the restrictions are being complied with. If the doctor 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 protected adults.

Conduct which undermines confidence in the profession

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

Guiding principles on the 'may bar' test

103 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.

104 It is important to note that each case must be considered individually using the guiding principles.

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

- relate solely to professional competence
- relate to health or language skills and GMC action manages the risk
- is a result of risks taken within a private setting, *unless* it was established that the doctor intended to cause harm or the risk of harm to children and/or vulnerable groups
- involves a low risk of harm or causes minimal harm eg an insensitive remark, rudeness or sarcasm towards a patient
- involves 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 **will** 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 eg if a doctor defrauds an elderly patient
- involve the making of a false report with intent to mislead or cover up a safeguarding matter eg where there is an investigation into an incident in the workplace involving Relevant Conduct (ie sexual harassment of a patient) and the doctor gives false or misleading information.

Callous disregard for procedure

105 The 'may bar' test will be met where the individual has demonstrated a 'callous disregard' for procedure.

106 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 in a Regulated Activity in the future, may put children or vulnerable adults at risk of harm.

107 In order for a callous disregard for procedure to raise wider safeguarding risks, it must be:

Serious; and

Deliberate or reckless.

108 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.

109 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 admits children as volunteers in a clinical research trial without consent of their parents, contravening ethical guidelines and research protocols intended to protect participants. She also misrepresents 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. Her actions put the children involved in the research and vulnerable adults later in receipt of the drug at risk of serious harm

110 Concerns about clinical failings, health or English language skills will not generally amount to a callous disregard for procedure as action taken by the GMC, on a doctor's registration, will usually mitigate the future risk of harm to children or vulnerable adults and referrals under this ground should only be made in exceptional circumstances.

111 What amounts to 'extremely serious' in determining the threshold for callous disregard can only be established by looking at the circumstances of the individual case. If such a case arises, decision makers should discuss the case with the Assistant Director Policy, Business Transformation and Safeguarding before any referral is made. Relevant case studies are set out at Annex B.

Failure to make a safeguarding referral

112 The prevention of abuse of children and vulnerable adults at risk 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.

113 Doctors are often in a unique position to recognise where a safeguarding referral is necessary. Where a doctor fails to make a safeguarding referral in circumstances where a referral is indicated the doctor'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 is not simply a clinical failing, it has much wider consequences and the referral ground is likely to be met.

114 The 'may bar' criteria will also be satisfied where a doctor makes a false report relating to a safeguarding matter. For example, if a doctor engages in sexual harassment of a patient in the workplace and the doctor intentionally makes a false report to cover up the harassment, a referral to the DBS or DS will be necessary.

115 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 (as in the example at paragraph 114 above).

False statements about qualifications or experience

116 For case studies relating to false claims on an application or CV as to experience, see Annex B.

117 Where a doctor 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 him/her securing employment as a result.

118 However, if the doctor is successful in obtaining employment 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 doctors CV or application form.

119 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*– eg could it have resulted in serious harm, injury or a fatality and how imminent was the harm ie did the doctor commence work?
- ii** *The seriousness of the false statement* – eg a non-surgical doctor asserting he is a qualified surgeon will present a very serious risk to patients. However, a doctor who says he achieved a higher score in an exam than he 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 lies on his 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 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 his/her 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 he/she lacked basic knowledge in anaesthetics.

As the doctor had attended work intent on carrying out a role he/she was 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

- 120** Paragraph 53 of [Good medical practice](#) states that a doctor must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.
- 121** Even if consensual, a personal relationship between a doctor 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 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 took appropriate steps to end the professional relationship.
- 122** Where there is evidence to suggest that a doctor has abused their position of trust in order to pursue a sexual relationship with a patient, eg 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

- 123** A doctor's health or lack of knowledge of English language will not usually be sufficient to meet the 'may bar' test unless there is other compelling information to indicate a specific risk of harm to vulnerable adults and children which cannot be mitigated solely by action taken by the GMC.
- 124** 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 to the DBS.
- 125** Alcohol or drug dependency related convictions and intoxication within the workplace may raise safeguarding risks in relation to children and vulnerable adults.
- 126** 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.

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.

127 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.

128 If an affective disorder causes a doctor to endanger a child or vulnerable adult (or cause risk of endangerment) or satisfy the Harm Test, then 'the may bar' criteria would need to be considered on the grounds of the risk posed by the doctor's behaviour.

General discretion

129 Even if the first and second conditions are met, the GMC retains discretion whether or not to make a referral to the DBS.

130 The GMC is not required to make a referral even where the conditions have been met. However, where the conditions have been satisfied, the GMC should have **good reasons** before deciding not to make a referral to the DBS.

131 'Good reasons' might include:

- being aware that another regulator or public body has already made a referral to the DBS in relation to that doctor and in relation to the same matter; or
- where it is a borderline case and the doctor is unlikely to present a real risk to children or vulnerable adults; or

132 If the criteria for making a referral are met then the decision maker can provide the DBS with any information relating to the doctor.

133 The GMC will only provide information that meets the referral criteria in this guidance.

General points

134 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

135 The decision maker should record their consideration of the first/second condition within their rationale for the decision.

136 Where the decision maker makes decisions outside of Siebel, the Safeguarding Referral Assistant (SRA) may input the decisions on behalf of the decision maker.

Relevant conduct cases where the doctor's registered address is outside the United Kingdom

137 If the relevant conduct took place outside the United Kingdom and the doctor'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.

Notifying the relevant doctor

138 Our policy is to notify each doctor when we refer to the DBS. This will generally be done through a standard information letter. We will notify the doctor's representative if they are on our records as acting for the doctor.

139 Where there are concerns about a doctor's health, which renders them vulnerable and there is a risk that the doctor may commit suicide, we should take reasonable steps to avoid unnecessary stress for the doctor concerned by following the separate guidance for dealing with the risk of suicide where we share information about doctors with the Disclosure and Barring Service or Disclosure Scotland.

DBS requests for information

140 On occasion, the DBS may exercise their power under s.42 of the SVG Act (or article 44 of the Northern Ireland Order) to request information about a doctor that they are considering placing on a barred list.

141 In general, where the appropriate provision is cited and the identified person is on the medical register, we will comply with the request.

NOTE: For requests made under s.42 of the Act (or article 44 of the Northern Ireland Order), we will advise the doctor of the disclosure unless we have already referred the matter to the DBS.

Follow-up questions from the DBS or doctors

142 In some cases, particularly those involving Relevant Conduct or the Harm Test, the doctor who has been referred to the DBS may contact the GMC requesting details of the information provided to the DBS. In such cases the disclosure request should be forwarded to the Assistant Director for Policy, Business Transformation and Safeguarding and the Information Access Team, who will handle the request under the relevant legislation.

Disclosures under section 35B(2) of the Medical Act 1983

143 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 under Section 35B(2) of the Medical Act 1983. This may be appropriate in exceptional circumstances where we have information about a doctor 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.

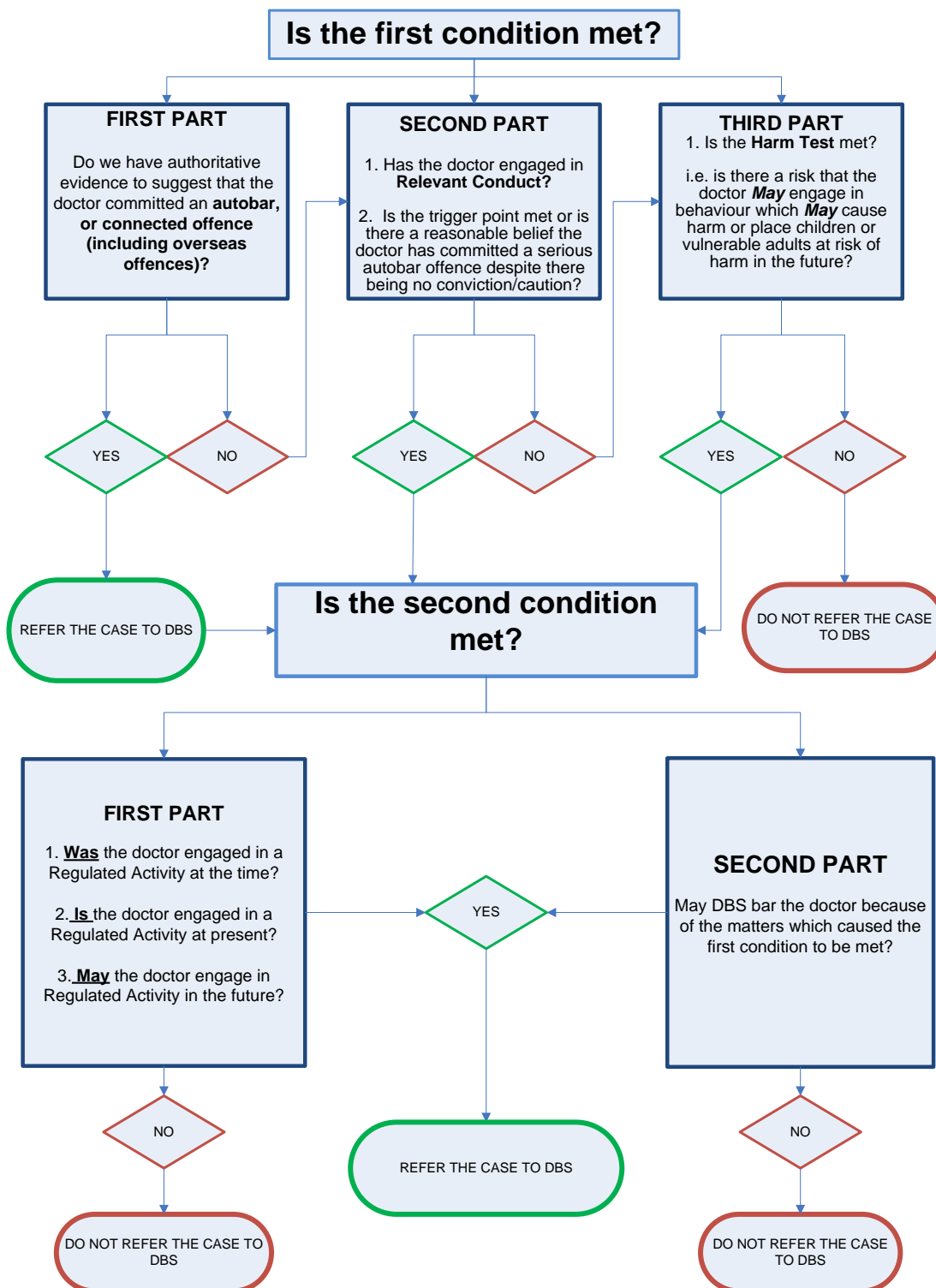
Annex A – Flow chart illustrating the two referral conditions

Annex B – Guidance on making referrals to the DBS and list of case studies

Annex C – List of serious auto-bar offences

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

Guidance on making referrals to the DBS

Case Studies

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

Introduction

- a. 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.
- b. This document is supplementary to the DBS guidance document *DBS Guidance for Keepers of Registers on section 41 referrals*. This document includes a description of cases received by the GMC. The GMC has provided an assessment about whether the 'may bar' test within section 41(4)(b) is met in relation to each of these cases, and the DBS has given an opinion about the may bar test in each case and whether a referral should be made. The document does not deal in depth with referral trigger points or the first condition.
- c. The following case studies are intended as a general guide to help decision makers decide which cases raise safeguarding concerns and therefore may permit referral to the DBS. The examples are not prescriptive guidance for use in all cases, and decision makers should consider each case on its merits in deciding whether the referral criteria are met.
- 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.

Safeguarding Referrals to the Disclosure and Barring Service (DBS)

Case Examples

The following case studies are intended as a general guide to help the General Medical Council decide which cases raise safeguarding concerns and therefore should be referred to the DBS. The examples should not be construed as prescriptive guidance for use in all cases. GMC should consider the facts and evidence of each case carefully on its merits, in deciding whether the referral criteria are met. 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 (warning, undertakings, conditions, suspension or erasure). 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.

Under section 41 of the Safeguarding Vulnerable Groups Act 2006 and article 43 of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, a keeper of register may provide the DBS with any information he holds 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.

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 the local level or through GMC regulatory procedures. On its own, it is unlikely that this behaviour would be sufficiently serious for 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.	The doctor's behaviour indicates a general risk of harm, opposed to a risk specifically in relation to children or vulnerable adults. As such, the GMC would not refer this case to the DBS.	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.

3. Inappropriate prescribing because of incompetence		
Broad case type	GMC position	Guiding principles
Doctor prescribes wrong medication to a patient as a result of incompetence (where	The may bar test is not met as the matter is purely related to the doctor's clinical competence and the action taken by the GMC will remove the future risk of	Where a registrant has caused harm to a patient out of his or her professional incompetence, and there is no evidence of a wider risk of harm (i.e. outside the professional setting), the action taken by the

<p>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>harm to children and vulnerable adults. As such, the GMC would not refer this case to the DBS.</p>	<p>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>
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4. Inappropriate prescribing, intent, 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 held an intention to cause harm, or demonstrated a pattern of harmful behaviour indicating a callous disregard for procedure, and action taken by the GMC does not 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 extent to which doctor has demonstrated insight and remediation.</p>	<p>The may bar test is likely to be met in situations where the doctor has abused his or her position of trust to deliberately (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. Where a doctor continues this type of behaviour after the GMC and other bodies have exercised their powers to retrain etc., then the risk has not been removed and a referral is likely.</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 include:</p> <ul style="list-style-type: none"> - errors caused by poor training, stress; - one-off out of character errors; - ignorance or confusion. 	<p>The may bar test is not met as, although the potential future harm is serious, the matter is purely related to the doctor's clinical competence. In the absence of wider safeguarding risks, the action taken by the GMC has removed the future risk of harm to children and vulnerable adults. As such, the GMC would not refer this case to the DBS.</p>	<p>Where a registrant has caused harm to a patient out of his or her professional incompetence, and there is no evidence of a wider risk of harm (i.e. outside the professional setting), the action taken by the regulator or employer will remove the risk of harm and a referral to the DBS will not be required.</p>

6. False reporting and giving false evidence		
Broad case type	GMC position	Guiding principles
<p>Doctor provides a false report, for instance, as a response to an internal investigation into an incident conducted by the doctor's employer or a public inquiry into patient care failings.</p>	<p>The GMC considers that this case does not meet the first condition within section 41. Although there has been misconduct on the part of the doctor, it is difficult to see any direct harm in relation to children and vulnerable adults.</p> <p>The GMC also considers that the may bar test is not met in these cases. False reporting is likely to indicate a</p>	<p>False reporting without a deliberate aim to mislead would not trigger a referral to the DBS as the first and second conditions are not met. However, where there is a deliberate aim to mislead which would compromise the safety of children or vulnerable adults, the first and second conditions may be met.</p> <p>False reporting could give rise to a referral if the false report is in relation to a safeguarding matter, i.e. an incident involving relevant</p>

	<p>general risk of harm caused by general dishonesty, 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 GMC would not refer this case to the DBS.</p> <p>However, there are circumstances where deliberate dishonesty (for example when providing evidence to a local or formal inquiry into patient care) 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>conduct and the false report was intentional. These circumstances (although rare) demonstrate behaviour that, if repeated, is likely to result in direct harm to children or vulnerable adults.</p> <p>Factors to consider include the extent to which dishonesty could affect patient health outcomes and effective action/recommendations to better protect vulnerable adults and children in the future, and the extent to which the doctor has demonstrated insight and remediation.</p>
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7. False claims to experience on CV		
Broad case type	GMC position	Guiding principles
<p>Doctor lies on his/her CV to claim experience which he/she does not have in order to gain employment or promotion.</p>	<p>For clarity, the GMC considers that there is relevant conduct in such cases as the doctor's dishonesty has caused or potentially caused actual harm or placed patients at risk of harm.</p> <p>The may bar test is not likely to be met as the GMC's action is likely to have removed the risk of harm to</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 meet the may bar test. For the referral criteria to be satisfied, the lie must raise a serious safeguarding risk to children or vulnerable adults such that the DBS may consider barring the person.</p> <p>Lying on a CV is a professional matter and action taken by the regulator will usually remove the risk of harm to children or vulnerable</p>

	<p>children and vulnerable adults.</p> <p>The GMC considers that cases involving general dishonesty are not of the seriousness to meet the 'may bar' test, particularly if no actual harm has materialised. As such, the GMC would not be likely to make a referral to the DBS in such cases.</p>	<p>adults.</p>
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8. Lying on CV to exploit vulnerable people including children		
Broad case type	GMC position	Guiding principles
<p>Doctor lies on his/her CV to claim experience which he/she does not have in order to gain access to vulnerable people to take advantage of them.</p>	<p>In these cases the first condition will be met as the doctor will have either placed children or vulnerable adults at the risk of harm or caused actual harm.</p> <p>If the doctor has not yet raised other safeguarding concerns (by causing actual harm – for example financial or sexual exploitation of children or vulnerable adults, which would meet the first and second conditions) a referral will depend on whether it can be established that the doctor had the intention of harming children or vulnerable adults when lying on his or her CV. If this is established the GMC considers that the may bar test will be likely to be met.</p>	<p>This type of case should be handled on a case by case basis depending on the circumstances.</p> <p>In cases where the GMC is able to establish that a doctor has lied to deliberately exploit children and/or vulnerable adults, there will be a direct risk of harm in relation to these groups.</p> <p>If intention to exploit 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 risk of harm to children and vulnerable adults.</p>

9. Failure to maintain adequate medical records		
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 10 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 thus the action taken by the GMC will mitigate the risk. However, if we hold specific information to suggest that the doctor plans to work in another form of Regulated Activity, such as managing a care home, the risk of harm may be extended to a setting outside the medical profession and thus the GMC's action may not have removed the risk of harm to children and vulnerable adults in a wider context. Again, the extent of the remaining risk will depend on the seriousness of the doctor's poor record keeping skills. Low-level concerns about record keeping skills are unlikely to ever result in a referral to the DBS.</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 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>

10. Altering patient records		
Broad case type	GMC position	Agreed guiding principles
<p>Doctor fails to carry out appropriate follow up on a patient and when questions are asked about it he alters the patient record to cover up the fault</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 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.</p> <p>Such cases may exceptionally give rise to a referral if the circumstances were extreme such as evidence of altering patient records on a large scale or persistently over a number of years.</p>	<p>Altering patient records is a professional matter, and action taken by the regulator can remove the risk of harm to vulnerable groups including children.</p>

11. Lack of further investigation		
Broad case type	GMC position	Agreed 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</p>	<p>Poor clinical skills are a professional matter. Action taken by the regulator can remove the risk of harm to children or vulnerable adults.</p>

	wider safeguarding risks, the action taken by the GMC will have removed any potential future risk of harm in relation to children and vulnerable adults. As such, the GMC would not refer these cases to the DBS.	
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12. Driving under the influence of alcohol, possession of a banned substance

Broad case type	GMC position	Guiding principles
Doctor charged and convicted of, or cautioned in relation to driving under the influence of alcohol or possession of a banned substance.	The doctor's behaviour indicates a general risk of harm, opposed to a risk specifically in relation to children or vulnerable adults. As such, the GMC would not refer these cases to the DBS.	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.

13. 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
Doctor charged with driving under the influence of alcohol or possession of a banned substance and has a child (or children) in his or her immediate care at the time of arrest.	<p>In these situations the GMC would need to consider the facts of each individual case.</p> <p>Example 1</p> <p>If the doctor has his or her own child in the car when arrested for drink driving, we do not consider that the may bar test is met. This indicates general risky behaviour rather than risky behaviour specific to</p>	<p>This type 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 or vulnerable adult then relevant conduct has occurred irrespective of the setting or the relationship between the person and the child or vulnerable adult.</p> <p>In general where the drink driving incident relates to a purely private arrangement, the may bar test is unlikely to be met unless there was</p>

	<p>vulnerable groups including children.</p> <p>Example 2</p> <p>If the doctor is taking responsibility for other children, for instance, a scout group at the time of arrest, the may bar test is likely to be met as the doctor's behaviour indicates a specific safeguarding risk in relation to vulnerable groups including children.</p> <p>A referral to the DBS is likely to be made in the second example, but not in the first.</p>	<p>specific evidence or information to believe there is a likelihood of the behaviour being repeated against a child or vulnerable adult causing harm or posing a risk of harm.</p> <p>Factors to consider in deciding whether the may bar test applies include:</p> <ul style="list-style-type: none"> - are there any aggravating and 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>Where harm is caused by a genuine accident, in general, the may bar test will not be met.</p>
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14. 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</p>	<p>Example 1</p> <p>The doctor has his aunty in the car when arrested. The doctor's aunty is a vulnerable adult when she receives a</p>	<p>If there is harm or a risk of harm to a child or vulnerable adult then relevant conduct has occurred irrespective of the setting or the relationship between the person and the child or vulnerable adult.</p>

<p>adults) in the car at the time of arrest.</p>	<p>regulated activity in the care home she lives in. The doctor's aunty is not considered a vulnerable adult when she is in the doctor's car as she is not receiving a regulated activity at that time. The GMC considers that the may bar test is not met as the arrangements were private, do not involve a vulnerable adult and the doctor's conduct indicates general risky behaviour rather than risky behaviour specific to vulnerable groups.</p> <p>Example 2</p> <p>If the doctor is charged with drink driving while driving a number of elderly people to a place to receive social care services in a hospice bus (a regulated activity in relation to adults), the may bar test is likely to be met as the doctor's behaviour indicates a specific safeguarding risk in relation to vulnerable adults.</p> <p>A referral to the DBS is likely to be made in the second example, but not in the first.</p>	<p>In cases where relevant conduct has occurred, 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.</p> <p>Factors to consider in deciding whether the may bar test applies include:</p> <ul style="list-style-type: none"> - are there any aggravating and 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 is not normally appropriate.</p>
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15. Substance abuse outside the workplace		
Broad case type	GMC position	Guiding principles
<p>Doctor has alcohol/substance abuse issues, but the doctor's performance has not been affected and the doctor is competent in his/her work (for clarity, no child or vulnerable adult has been harmed).</p>	<p>The GMC considers that there has been no relevant conduct in this case. The doctor's behaviour indicates a general risk of harm. There has been no act or omission that has caused harm or risk of harm directly in relation to a child or vulnerable adult. As such, the GMC would not refer such cases to the DBS.</p>	<p>Substance abuse 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 13 above where the alcohol/substance misuse raises a risk of harm to children/vulnerable adults).</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>

16. Alcohol or substance abuse 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 • Alcohol or drug convictions • Drink driving convictions • Smelling of alcohol at work 	<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>

		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.
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17. General fraud		
Broad case type	GMC position	Guiding principles
Doctor defrauds his/her employer, or another person who does not fall under the definition of vulnerable adult.	<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>	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.

18. Fraud of a patient		
Broad case type	GMC interpretation of the referral criteria	Guiding principles
Doctor defrauds one of his/her patients.	<p>The GMC considers that in these cases the may bar test is likely to be met. The doctor's conduct indicates a direct risk of harm in relation to children or vulnerable adults rather than a general risk.</p> <p>The doctor has sought out a child or vulnerable adult for exploitation and this behaviour indicates a wider risk</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 such behaviour being repeated outside the professional setting.</p> <p>Action taken by the GMC cannot remove the risk of harm to children or vulnerable adults, and as such, the GMC would be likely to refer these cases to the DBS.</p>	
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19. 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 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 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>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>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, 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>	
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20. 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 cannot meet the may bar test.</p> <p>In certain circumstances, an affective disorder may cause a doctor to engage in relevant conduct, or satisfy the Harm Test. For instance, if a doctor's affective disorder triggered him/her to assault a patient, the GMC would be likely to consider that the may bar test is met and a referral would be likely to be made to the 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 regulator could consider the role of the disorder, among other factors, when assessing the likelihood of a future risk of harm.</p>

21. 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 removed by action taken by the GMC.</p> <p>The may bar test is not likely to be met where a doctor withholds treatment because it conflicts with the doctor's personal opinion or interests (i.e. doctor prescribes one kind of drug from a range of appropriate drugs because he has a financial or other interest in doing so). In these cases, the GMC would not be likely to make a referral to the DBS.</p> <p>The GMC considers that the may bar test is likely to be met in cases where a doctor has threatened to withhold or withdraw a major course of treatment unless a patient commits to, for instance, following a specific religion. In such cases the doctor poses a risk directly in relation to children or vulnerable adults both within the professional context and in terms of broader safeguarding. As such, action taken by the</p>	<p>This type should be handled on a case by case basis depending on the circumstances.</p>

	GMC is unlikely to remove the risk of harm in relation to children or vulnerable adults and thus the may bar test is likely to be met and a referral to DBS made.	
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22. Physical assault of someone who is not a vulnerable adult or child

Broad case type	GMC position	Guiding principles
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 on the weekend).	<p>The GMC considers that in these cases there is no relevant conduct as the doctor has not engaged in conduct that has caused a direct risk of harm in relation to children or vulnerable adults.</p> <p>The harm test may be met however if 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 vulnerable groups in future if they were directed towards them.</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> <p>However, there may be serious incidences of violence in a non-professional context which indicate a risk of future harm to vulnerable groups such that the harm test would be met. In rare circumstances, 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 a 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>

23. Physical assault a patient

Broad case type	GMC position	Guiding principles
Doctor physically assaults a patient	The GMC considers that in these cases the may bar test is likely to be met. The doctor's conduct indicates a direct risk of harm in relation to children or	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

	<p>vulnerable adults rather than a general risk.</p> <p>In such cases there are specific safeguarding concerns – that the doctor may repeat his conduct and cause harm to a child or vulnerable adult. Action taken by the GMC is not likely to remove the risk of harm to children or vulnerable adults, and as such, the GMC would be likely to refer such cases to the DBS.</p>	<p>action taken by the regulator alone.</p>
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24. 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 substantive and deliberate, the may bar test is likely to be met 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>

25. 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 risk of harm.</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 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.</p>

26. Doctor working while suspended		
Broad case type	GMC position	Guiding principles
<p>Doctor practises medicine while suspended</p>	<p>Where a doctor has practised medicine while suspended from the medical register this will constitute relevant conduct. This may constitute a callous disregard for procedure, depending on the circumstances of the case. Relevant factors are set out below:</p> <p>Where the doctor has worked while suspended due to an inadvertent oversight for example due to doctor 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</p>	<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>

	<p>where no alternative medical help was available this is unlikely to constitute a threshold of seriousness 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 vulnerable adults or children, 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 doctor has worked while suspended for a short period due to a deterioration in health the action taken by the GMC will usually be sufficient to manage the risk to vulnerable adults and children.</p> <p>Where the following factors apply, GMC action is unlikely to be sufficient to manage the risk to vulnerable adults and children 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 vulnerable adults or children at a specific risk of serious harm or caused serious harm to them.• The doctor deliberately and knowingly worked while suspended due to conduct issues on a one-off occasion or a more sustained period, and the nature of the activity he undertook	
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	<p>while suspended has given rise to further concerns.</p> <ul style="list-style-type: none"> • 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. • The doctor has repeatedly sought work while suspended without disclosing nature of 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. 	
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27. Doctor working while unlicensed		
Broad case type	GMC position	Guiding principles
<p>Doctor practises medicine without a licence</p>	<p>Where a doctor works without a licence due to an oversight for a short period this is unlikely to be relevant conduct because it doesn't present a specific risk of harm unless there are additional factors.</p> <p>However where a doctor has knowingly worked without a licence for a substantive period of time this may indicate a callous disregard for procedures which</p>	<p>A doctor working without a licence due to an oversight would not amount to relevant conduct as it would not present a risk of harm to vulnerable groups.</p> <p>However, where the doctor has knowingly and persistently worked without a licence, this may amount to a callous disregard for procedure which (if repeated) could place vulnerable adults and children at risk of future harm. In these circumstances, the may bar test may be satisfied</p>

	above case study number 27.	
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29. 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 to practise investigation	Where the doctor deliberately and persistently misleads their employer and others about the nature of a GMC investigation into their fitness to practise or action on their registration, this behaviour is likely to indicate a callous disregard for procedure. This behaviour cannot be mitigated or managed by action on registration and the DBS may wish to consider barring.	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.

30. Doctor breaches interim or substantive conditions or undertakings		
Broad case type	GMC position	Guiding principles
Doctor breaches interim or substantive conditions or undertakings on registration	Where a doctor breaches interim or substantive conditions or undertakings on their registration this constitutes relevant conduct. 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	A doctor breaching interim or substantive conditions or undertakings on their registration constitutes relevant conduct. A breach of undertakings due to a deterioration in the doctor's health is unlikely to meet the may bar test. Deliberate and persistent breaches of restrictions on registration which were imposed to address underlying performance issues are likely to

	<p>vulnerable adults and children in other settings and the may bar test will not be met.</p> <p>Where the doctor has deliberately and persistently breached interim or substantive restrictions which were imposed to address an underlying performance issue, this is likely to constitute a callous or reckless 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>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 or reckless disregard for procedure which poses a risk of future harm to vulnerable adults and children which cannot be mitigated or managed by the professional regulator's action on registration and the may bar will be met.</p> <p>Aggravating factors may include failing to disclose restrictions on registration when accepting a job offer or misrepresenting status of registration with GMC when seeking employment in another sector.</p>	<p>constitute a callous or reckless 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 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>
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31. Doctor knowingly practises medicine outside sphere of competence		
Broad case type	GMC position	Guiding principles
<p>Doctor knowingly practises medicine outside sphere of competence.</p>	<p>Where a doctor practises outside their sphere 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. However where a doctor knowingly practises medicine outside their sphere of competence, this may amount to a reckless or 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 doctor was aware they were not fit to carry out procedure or provide treatment. • potential or actual consequences of doing so. • Extent of insight and remediation. 	<p>A doctor's actions in knowingly practising medicine outside their sphere of competence may amount to a reckless or callous disregard for procedure. The individual circumstances of each case should be evaluated to assess whether a referral to the DBS is appropriate.</p>

32. 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>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. • 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. 	<p>Each case will need to be assessed on its individual circumstances. However, the may bar test is likely to be met if a doctor demonstrates a callous disregard for local procedures which places vulnerable groups at risk of harm.</p>

33. 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>	<ul style="list-style-type: none"> • 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, 	<p>A doctor working at a time when their fitness to practise is impaired on health grounds is relevant conduct.</p> <p>The "may bar" test will not be met in cases which solely relate to health</p>

	<p>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> <ul style="list-style-type: none"> 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>as our action is sufficient to manage the risk to vulnerable groups.</p>
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34. 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>	<ul style="list-style-type: none"> If a tribunal finds that a doctor’s fitness to practise is impaired by not having the necessary knowledge of English, 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. 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>A doctor working at a time when their fitness to practise is impaired on language grounds is 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>

35. 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>	<ul style="list-style-type: none"> • 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 conduct. • 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>A doctor working at a time when their fitness to practise is impaired on performance grounds is relevant conduct.</p> <p>The "may bar" test will not be met in cases which solely relate to performance as our action is 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.