General Medical Council

Professional standards

In effect: 9 May 2011

Making and using visual and audio recordings of patients

Summary

This guidance sets out what to consider if you are making or using visual and audio recordings of patients. It includes eight key principles of good practice. And explains when you will need specific patient consent and what to do if your patient doesn't have capacity. There is also a section on recording telephone calls. As well as recordings made for wider accessible public media, such as the TV or internet.

Confidentiality is another important factor. This is why we have included advice on what to consider when storing or disposing of recordings, and using a recording of a deceased patient

General Medical Council

Making and using visual and audio recordings of patients

Professional standards: More detailed guidance

This guidance came into effect 9 May 2011

This guidance was last updated on 18 December 2024.

You can find the latest version of all our professional standards at www.gmc-uk.org/guidance.

Contents

There may be many reasons why you need to make a visual or audio recording of a patient. If you do then this guidance is for you. It reminds you:

- to respect important ethical principles of consent and confidentiality
- that a recording made as part of a patient's care is part of their medical record and must be treated in the same way as any other medical record.

The guidance includes eight key principles to practice. And explains when you will need specific patient consent and what to do if your patient doesn't have capacity. There is also a section on recording telephone calls. As well as recordings made for wider accessible public media, such as the TV or internet.

Confidentiality is another important factor. This is why we have included advice on what to consider when storing or disposing of recordings, and using a recording of a deceased patient.

Making and using visual and audio recordings of patients

1. In our guidance *Decision making and consent*, we say:

8. The exchange of information between medical professionals and patients is central to good decision making. It's during this process that you can find out what's important to a patient, so you can identify the information they will need to make the decision.

9. The purpose of the dialogue is:

   a. to help the patient understand their role in the process, and their right to choose whether or not to have treatment or care

   b. to make sure the patient has the opportunity to consider relevant information that might influence their choice between the available options

   c. to try and reach a shared understanding of the expectations and limitations of the available options.

2. In our guidance *Confidentiality: good practice in handling patient information*. We say:

1. Trust is an essential part of the relationship between patients and medical professionals and confidentiality is central to this. Patients may avoid seeking medical help, or may under-report symptoms, if they think their personal information will be disclosed[2] without consent, or without the chance to have some control over the timing or amount of information shared.

2. Medical professionals are under both ethical and legal duties to protect patients' personal information from improper disclosure. But appropriate information sharing is an essential part of the provision of safe and effective care. Patients may be put at risk if those who are providing their care do not have access to relevant, accurate and up-to-date information about them.
3. There are also important uses of patient information for purposes other than direct care. Some of these are indirectly related to patient care in that they enable health services to function efficiently and safely. For example, large volumes of patient information are used for purposes such as medical research, service planning and financial audit. Other uses are not directly related to the provision of healthcare but serve wider public interests, such as disclosures for public protection reasons.
4. Healthcare is continuing to evolve and change. It is likely to be more challenging to make sure there is a legal and ethical basis for using patient information in a complex health and social care environment than in the context of a professional relationship with an individual patient ..

3. This guidance, which forms part of the professional standards, is intended to provide more detailed advice about how to comply with these principles when making or using visual and audio recordings of patients. The standards of good practice apply to doctors, physician associates and anaesthesia associates (collectively referred to as medical professionals and whom we address directly as 'you' throughout the guidance). As with all our professional standards, this guidance applies to all our registrants to the extent it is relevant to the individual's practice.

4. The professional standards describe good practice, and not every departure from them will be considered serious. You must use your professional judgement to apply the standards to your day-to-day practice. If you do this, act in good faith and in the interests of patients, you will be able to explain and justify your decisions and actions. We say more about professional judgement, and how the professional standards relate to our fitness to practise processes, appraisal and revalidation, at the beginning of *Good medical practice*.

About our Making and using recordings guidance

5. This guidance covers visual and audio recordings of patients made and used in any circumstances where medical professionals work in a professional capacity.[5]

This includes recordings made:

- on healthcare premises[2] within or outside the UK, and/or
- as part of the assessment, investigation or treatment of patients' condition or illness, and/or

- for purposes such as teaching, training or assessment of healthcare professionals and students, research, or other health-related uses which are not designed to benefit the patient directly, described as 'secondary purposes' in this guidance.

6. 'Recordings' in this guidance means originals or copies of audio recordings, photographs, and other visual images of patients that may be made using any recording device, including mobile phones. It does not cover copies of written records.

Pathology slides

7. 'Recordings' in this guidance does not include pathology slides containing human tissue (as distinct from an image of such a slide). Photographs of microscope slides may be made without consent for the purpose of care or treatment of a patient, or for a secondary purpose, provided that images are anonymised or coded[3] before use for a secondary purpose, and always anonymised before they are published in the public domain. Where photographs of pathology slides are made for secondary purposes during a post-mortem examination, you should follow the advice in paragraph 51.

Principles

8. When making or using recordings you must respect patients' privacy and dignity, and their right to make or participate in decisions that affect them. This means that you must:

- give patients the information they want, or need, about the purpose of the recording
- make recordings only where you have appropriate consent or other valid authority for doing so
- ensure that patients are under no pressure to give their consent for the recording to be made
- where practicable, stop the recording if the patient asks you to, or if it is having an adverse effect on the consultation or treatment
- anonymise or code recordings before using or disclosing them for a secondary purpose, if this is practicable and will serve the purpose
- disclose or use recordings from which patients may be identifiable only with consent or other valid authority for doing so
- make appropriate secure arrangements for storing recordings
- be familiar with, and follow, the law[4] and local guidance and procedures that apply where you work.[5]

9. And you must not:

- make, or participate in making, recordings against a patient's wishes, or where a recording may cause the patient harm
- disclose or use recordings for purposes outside the scope of the original consent without obtaining further consent (except in the circumstances set out in paragraphs 10 and 15-17).

Recordings made as part of a patients care, including investigation or treatment of a condition

Recordings for which separate consent is not required

10. Consent to make the recordings listed below will be implicit in the consent given to the investigation or treatment, and does not need to be obtained separately.

- Images of internal organs or structures
- Images of pathology slides
- Laparoscopic and endoscopic images
- Recordings of organ functions
- Ultrasound images
- X-rays

11. When seeking consent to treatment or any other procedure[6] that involves making one of the recordings listed in paragraph 10, you should, where practicable, explain that such a recording will be made and could be used in anonymised form for secondary purposes, including in the public domain.

12. You may disclose or use any of the recordings listed in paragraph 10 for secondary purposes without seeking consent provided that, before use, the recordings are anonymised; for example, by the removal or coding of any identifying marks such as writing in the margins of an X-ray (see paragraph 17). Further advice on anonymising information is available from the Information Commissioner's Office.[7]

Recordings for which specific consent is required

Consent to make recordings as part of the patient's care

13. You must get the patient's consent to make a recording that forms part of the investigation or treatment of a condition, or contributes to the patient's care, except in the circumstances described in paragraph 10. You should explain to the patient why a recording would assist

their care, what form the recording will take, and that it will be stored securely.

14. Wherever practicable, you should explain any possible secondary uses of the recording in an anonymous or coded form when seeking consent to make the recording. You should record the key elements of the discussion in the patient's medical record.

Disclosure and use of recordings made as part of the patient's care

15. Recordings made as part of the patient's care form part of the medical record, and should be treated in the same way as written material in terms of security and decisions about disclosures. You must therefore follow the GMC's guidance in *Confidentiality: good practice in handling patient information.* You will usually need the patient's consent before disclosing recordings from which the patient can be identified (see paragraph 17). But disclosures may also be made where they are required by law, directed by the judge or other presiding officer of a court, or can be justified in the public interest.

16. Disclosures in the public interest may be justified where the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential. You must weigh the harms that are likely to arise from nondisclosure of information against the possible harm, both to the patient and to the overall trust between medical professionals and patients, arising from the release of information. You must make a separate assessment in each case, taking into account the proposed content of the recording, the way in which it will be used, the patient's rights to respect for their privacy and dignity, and whether making information publicly available is necessary to fulfil the objective. For further information about disclosures in the public interest see our guidance *Confidentiality: good practice in handling patient information*.[8]

17. You may disclose anonymised or coded recordings for use in research, teaching or training, or other healthcare-related purposes without consent. In deciding whether a recording is anonymised, you should bear in mind that apparently insignificant details may still be capable of identifying the patient. You should be particularly careful about the anonymity of such recordings before using or publishing them without consent in journals and other learning materials, whether they are printed or in an electronic format.

Adult patients who lack capacity - making recordings as part of care

18. If you judge that an adult patient lacks capacity[9] to decide about an investigation or procedure which involves a recording, you must get consent from someone who has legal authority to make the decision on the patient's behalf[10] before making the recording.

19. Where no individual has legal authority to make the decision on a patient's behalf, or where treatment must be provided immediately, recordings may still be made where they form an integral part of an investigation or treatment that is provided in accordance with the relevant

legislation or common law.[11]

Adult patients who lack capacity - disclosure and use of recordings made as part of care

20. Where a recording has already been made as part of the patient's care, but may also be of value for a secondary purpose, you should anonymise or code the recording wherever that is practicable and will serve the purpose. If the recording cannot be anonymised or coded, you should seek the agreement of anyone with legal power to make decisions on behalf of the patient. If there is no person appointed, the law permits you to decide whether the recording can be used. Whoever takes the decision it should be made in the public interest, in accordance with the relevant legislation or common law (see paragraph 16).[12]

Children or young people - making recordings as part of care

21. Children or young people under 16 who have the capacity and understanding to give consent for a recording may do so, but you should encourage them to involve their parents in the decision making. Where a child or young person is not able to understand the nature, purpose and possible consequences of the recording, you must get consent from a person with parental responsibility to make the recording.[13] You should follow the advice in paragraphs 13 - 14 on seeking consent to make a recording, and in paragraphs 15 - 17 on disclosure and use of recordings made as part of care.

Recordings made for research teaching training and other healthcare related purposes

Existing collections used for teaching and training

22. Since 1997 our guidance has required doctors to get consent before making recordings that are not part of a patient's care. However, some doctors hold collections of recordings made over many years that they use solely for teaching purposes within a medical setting. Some pre-1997 recordings in these collections may continue to have a significant value for teaching. In these circumstances, you may continue to use anonymised recordings. You may also continue to use recordings where the patient is identifiable, as long as you have a record that consent was obtained for the recording to be made or used.

23. You must not use recordings for which there is no record of whether consent was obtained where:

- it is clear from the context that consent had not been given to the recording
- the patient is, or may be, identifiable.

Adults with capacity - making recordings for secondary purposes

24. You must get consent before making recordings for teaching, training, the assessment of healthcare professionals and students, research or other healthcare-related purposes. It is good practice to get the patient's written consent, but if this is not practicable, the patient's oral consent should be obtained. Written consent or a record of oral consent should be stored with the recording.

25. Recordings will vary from simple photographs to visual and audio recordings of consultations involving discussion of personal and emotional issues. The amount of information you should provide before seeking consent will vary according to the nature of the recording, what it will be used for, and the concerns of the individual patient. Before making the recording, you should explain:

- the purpose of the recording and how it will be used
- how long the recording will be kept and how it will be stored
- that patients may withhold consent, or withdraw consent during or immediately after the recording, and this will not affect the quality of care they receive or their relationship with those providing care.

26. You should give this information to patients in a way they can understand. You must answer any questions patients ask as honestly and as fully as you can. You should provide any additional support patients need to understand this information, to communicate their wishes or to make a decision. Further advice is available in *Decision making and consent*.[14]

27. In some cases, although no recording has been planned, a recording of an unexpected development during treatment or an investigation would make a valuable educational tool (an unplanned recording). Where the patient has capacity to consent, you should seek their agreement to make the recording. You should stop the recording if the patient asks you to do so. You must not make recordings for secondary purposes without consent or other legal authorisation.

Adults with conditions that may impair capacity

28. You must assess the patient's capacity to make a particular decision at the time it needs to be made. You must not assume that because a patient lacks capacity to make some decisions, they lack capacity to make any decisions at all, or will not be able to make the decision in the future. For example, some patients may not have capacity to weigh risks and benefits of significant treatments, but may be able to make decisions about whether to allow a recording of themselves to be made.

29. Before deciding whether patients have capacity to make a decision, you must take all practical and appropriate steps to enable them to make the decision for themselves; for example, by using simple language or visual aids, or by involving a carer or family member.

30. Further advice on maximising a patient's ability to make decisions and assessing capacity is set out in *Decision making and consent.*[15]

Adults who lack capacity - making recordings for secondary purposes

31. Where a patient lacks capacity to make a decision, you must act in accordance with the relevant legislation.[16] This means that in making any decision about or on behalf of the patient, including making recordings of them for secondary purposes (except in the circumstances in paragraph 33) you should be satisfied that making a recording:

- is necessary, and benefits the patient or is in their best interests
- that the purpose cannot be achieved in a way that is less restrictive of the patient's rights and choices.

32. Where another person has legal authority to decide on the patient's behalf, they must apply the same principles before giving or refusing consent.

33. The law provides some exemptions from these principles to enable adults who lack capacity to be involved in research; and recordings may form part of such research. For further advice about involving adults who lack capacity in research see our guidance *Good practice in research*.[17]

Children or young people - making recordings for secondary purposes

34. Children or young people under 16 who have the capacity and understanding to give consent for a recording may do so, but you should encourage them to involve their parents in the decision making. If a child or young person lacks capacity to consent to a planned or unplanned recording being made, a person with parental responsibility may consent on their behalf. However, you should stop the recording if the child or young person objects verbally or through their actions, if they show distress in other ways about the recording, or if the person with parental responsibility asks you to stop. For further guidance see *0-18 years* and for guidance on involving children in research see *Good practice in research*.[18]

35. When a child or young person has developed the maturity to make decisions about recordings for themselves, you should use any opportunity that arises to offer them the option to withdraw or vary consent previously given by a person with parental responsibility, if:

- the child or young person is or may be identifiable from the recording
- it is reasonably practicable to act in accordance with the child or young person's wishes.

Recordings for use in widely accessible public media – television radio internet print

36. In general, the considerations set out in paragraph 16 and 22 - 23 also apply to recordings for use in widely accessible public media that are intended for a broad public audience; for example, to inform or educate the general public. There are, however, some issues set out below that are specific to recordings used in this context.

37. You must get the patient's consent, which should usually be in writing, to make a recording that will be used in widely accessible public media, whether or not you consider the patient will be identifiable from the recording, other than for the recordings listed in paragraph 10.

38. In some cases you may wish to publish in widely accessible public media a recording of a patient which was made as part of their care, although you did not get consent for this at the time the recording was made. Where this is the case, you must get the patient's consent if the patient is, or may be, identifiable (see paragraph 15). If the recording is anonymised, it is good practice to seek consent before publishing it. However, if it is not practicable to do so, you may publish the recording, bearing in mind that it may be difficult to ensure that all features of a recording that could identify the patient to any member of the public have been removed.

39. Before making any arrangements for individuals or organisations to record patients, their relatives or their visitors in a healthcare setting or context, you must get agreement from your employing or contracting body, and from the organisation in which the patients are being treated if this is different. Within the NHS, a contract with the filmmaker will normally be required. If in doubt, you should seek advice from your employing or contracting body; for example, from your department of medical illustration or a Caldicott Guardian[19] or equivalent.

40. If you are involved in recording patients for broadcast media, you should satisfy yourself that the patients' consent has been obtained in accordance with this guidance, even if you are not responsible for getting that consent or do not have control of the recording process. The Ofcom Broadcasting Code,[20] which covers all UK broadcasters, requires consent to be obtained in a way that is consistent with this guidance.

41. In addition, you should check that patients understand that, once they have agreed to the recording being made for broadcast, they may not be able to stop its subsequent use. If patients wish to restrict the use of material, they should be advised to get agreement in writing from the programme maker and the owners of the recording, before recording begins.

42. You should be particularly vigilant about recordings involving patients who may be vulnerable to intrusions in their privacy and dignity. If you believe that the recording is unduly intrusive or damaging to the patient's interests, you should raise the issue with the patient and the programme makers, even where the patient has consented to the recording. If you remain concerned, you should withdraw your co-operation.

Children or young people who lack capacity - recordings made for widely accessible public media

43. Where children or young people lack capacity to decide about a recording, you should follow the guidance in paragraph 34.

44. You must not participate in making or disclosing recordings of children or young people who lack capacity, where you believe that they may be harmed or distressed by making the recording or by its disclosure or use, even if a person with parental responsibility has given consent.

Adults who lack capacity - recordings for widely accessible public media

45. You must consider as separate issues making recordings of adults who lack capacity, and using or disclosing such recordings. When deciding whether to make a recording for use in widely accessible public media, you must follow the guidance in paragraphs 31 - 32.

46. Recordings of adult patients who lack capacity that have been made in accordance with the legal requirements set out in paragraph 31 may be disclosed for use in the public media, where this can be justified in the public interest. Where a person has legal authority to act on behalf of the patient, they will need to assess and decide whether disclosure is justified in the public interest. Where no person has legal authority to make this assessment, you must follow the guidance in paragraph 16.

Deceased patients

Recordings made when the patient was alive

47. The duty of confidentiality continues after a patient has died. Guidance on disclosures after a patient's death is included in *Confidentiality: good practice in handling patient information*.[21] You should follow a patient's known wishes after their death. For example, if a recording was made with the patient's consent for a specific purpose, such as research or training, or for broadcast in a documentary, you may use the recording in accordance with the patient's consent where you have no reason to believe that consent was withdrawn before they died. You may use anonymous recordings made when the patient was alive (see paragraph 17).

48. However, if the recordings will be in the public domain or the patient is identifiable, you will need to consider whether the patient's family should be consulted; for example, if a recording includes information about a genetic condition, or other information about the patient's family. Where this is the case you should seek legal advice from your employing or contracting body, or from your medical defence organisation.[22]

Post-mortem examinations

49. Post-mortem examinations are governed by legislation in the UK.[23] You should ensure that you comply with the law and follow any relevant code of practice.

50. Recordings may form an integral part of a postmortem examination and separate consent is not needed for making recordings of organs, body parts, or pathology slides to assist in the determination of the cause of death. However, information for relatives about the post-mortem examination should include an explanation of why a recording may need to be made.

51. If you wish to make recordings of the body, organs or tissue during a post-mortem examination, for a secondary purpose such as teaching or research, you should seek consent at the same time as you seek consent to undertake the examination. If you have not foreseen this possibility, you may make recordings (including photographs of pathology slides) for secondary purposes without consent, provided that they do not include images that might identify the person.

52. You do not need consent to use recordings for secondary purposes provided that the recordings are anonymised before use; for guidance on recordings of deceased patients that may be published in the public domain, see paragraph 48.

53. For coroner's post-mortem examinations, you should check with the coroner or Procurator Fiscal before taking images of tissue during a post-mortem examination for purposes other than those authorised by the coroner or Procurator Fiscal.

Making recordings covertly

54. Covert recordings should be undertaken only where there is no other way of obtaining information which is necessary to investigate or prosecute a serious crime, or to protect someone from serious harm. This might arise in cases where there are grounds to suspect that a child is being harmed by a parent or carer. Before any covert recording can be carried out, authorisation must be sought from a relevant body in accordance with the law.[24] If you consider making covert recordings, you must discuss this with colleagues, your employing or contracting body, and relevant agencies, except where this would undermine the purpose of the recording, in which case you should seek independent advice. You must follow national or local guidance.[25] In most circumstances, covert recordings should be carried out by the police.

55. Covert recordings will fall within the scope of the *Regulation of Investigatory Powers Act 2000* or the *Regulation of Investigatory Powers (Scotland) Act 2000*, where it is used by a public body, such as an NHS body or those contracted to, or employed by, an NHS body. If circumstances arise where you might be involved in covert recordings you must ensure that you comply with the requirements of the relevant Act.

Recording telephone calls

56. Telephone calls from patients to healthcare organisations may be recorded for legitimate reasons, for example, for medico-legal purposes, staff training, and audit, provided you take all reasonable steps to inform callers that their call may be recorded. Given the sensitive nature of calls to medical advice lines or similar services, you should pay particular attention to ensuring that callers are aware that their call may be recorded. You must not make secret recordings of calls from patients.

Storing and disposing of recordings

57. Recordings made as part of the patient's care will form part of the medical record. They must be treated in the same way as other medical records, and you should be clear about the responsibility for the control and use of such recordings. If you make a recording for secondary purposes, you must satisfy yourself that there is agreement about the ownership, copyright, and intellectual property rights of the recording.

58. Anonymised recordings may belong to an employing or contracting body. You should make sure that you understand your contractual or other rights to hold and use recordings, particularly if you change your employer or contracting body. If in doubt, you should seek advice from a Caldicott Guardian or equivalent.

59. The UK health departments publish guidance on how long health records should be kept and how they should be disposed of. The guidance covers recordings made as part of a patient's care or as part of research. You should follow the guidance whether or not you work in the NHS.26

Endnotes

1. This does not include recordings of people in their workplace designed to illustrate or identify occupational hazards.

2. This guidance does not cover CCTV recordings of public areas in hospitals and surgeries, which are the subject of separate guidance from the Information Commissioner's Office.

3. Coded information – also known as pseudonymised information – is information from which individuals cannot be identified by the recipient, but which enables information about different patients to be distinguished, or information about the same patients to be linked over time; for example, to identify drug side effects. A 'key' might be retained by the person or service which coded the information so that it can be reconnected with the patient.

4. Relevant legislation includes, for example, the Data protection law, *Freedom of Information Act 2000* and the *Freedom of Information (Scotland) Act 2002*, and the mental capacity legislation in England, Wales and Scotland. If in doubt about your legal obligations, you should seek advice from your defence organisation.

5. You should seek advice from your employing or contracting body on how to access and comply with local policies and procedures; for example, from your local medical illustration department, or a Caldicott Guardian or equivalent.

6. See *Decision making and consent* for advice on making decisions about investigations and treatment, including sharing information with patients.

7. See the *Information Commissioner's Office* for organisations.

8. Paragraphs 63-70 of *Confidentiality: good practice in handling patient information*, provide advice on disclosing information in the public interest.

9. Further guidance on assessing capacity is set out in *Decision making and consent*.

10. Welfare attorneys and court-appointed guardians (Scotland); holders of lasting powers of attorney and court-appointed deputies (England and Wales).

11. Making decisions about treatment and care of patients who lack capacity is governed in England and Wales by the *Mental Capacity Act 2005* and in Scotland by the *Adults with Incapacity (Scotland) Act 2000*. In Northern Ireland, there is currently no relevant primary legislation, and decision making for patients without capacity is governed by the common law. At the time of publication, a legislative framework for new mental capacity and mental

health legislation is being developed. In Scotland ,under the Adults with Incapacity (Scotland) Act 2000, registered medical practitioners with lead responsibility for the patient's treatment and care are amongst those professionals who have authority to make these decisions, subject to issuing a certificate of incapacity (physician associates and aneasthesia associates are not).

12. Personal information can be disclosed if it will benefit or is in the best interests of the patient but this is unlikely to apply in the circumstances covered by this guidance. Paragraphs 13-17 of *Confidentiality: Disclosing information for education and training purposes* provides advice on disclosing personal information for education and training purposes about patients who lack capacity.

13. Further information about assessing capacity and consent issues for children or young people is set out in our guidance*0-18 years*.

14. Further guidance on sharing information is provided in paragraphs 11, 13b, 21, 27-29 of *Decision making and consent*.

15. Guidance on capacity issues is set out in *Decision making and consent,* paragraphs 76-86.

16. See endnote 11 for a summary of the law.

17. Paragraphs 34-36, 40 and 44-45 of *Good practice in research* may be relevant when involving adults who lack capacity in research.

18. Advice on involving children or young people in research is set out in paragraphs 36-40 of *0-18 years:*.

Guidance on particular considerations in relation to seeking and acting on consent for children or young people to participate in research is set out in paragraphs 34-36 of *Good practice in research*.

19. Caldicott Guardians are senior people in the NHS, local authority social care, and partner organisations, who are responsible for protecting the confidentiality of patient information, and for enabling appropriate information sharing.

20. The Ofcom Broadcasting Code.

21. Further information about disclosing information after a patient has died is set out in paragraphs 134-138 of *Confidentiality: good practice in handling patient information*.

22. The Information Commissioner's Office provides guidance on managing information about the deceased.

23. The *Human Tissue Act 2004* provides the framework for the regulation of human tissue in England, Wales and Northern Ireland. Scotland has its own Human Tissue (Scotland) Act 2006. The Human Tissue Authority publishes the Code of Practice 3 – Post mortem examinations (2009) and the Code of Practice 1 – Consent (2009).

24. The scheme for authorisations is set out in ss.28-30 of the *Regulation of Investigatory Powers Act 2000* and ss.5-8 of the *Regulation of Investigatory Powers (Scotland) Act 2000*.

25. *Safeguarding children in whom illness is fabricated or induced* (Department for Children, Schools and Families guidance revised March 2008).

Covert Surveillance: Code of Practice (Scottish Government, 2003).

Safeguarding Children in whom Illness is Fabricated or Induced (Welsh Assembly Government, 2008).

26. The NHS Code of Practice Records Management Code of Practice for Health and Social Care (Information Governance Alliance, 2016); Records Management: NHS Code of Practice (Scotland) (Scottish Government, 2012), Welsh Health Circular (2000) 71: For The Record (The National Assembly for Wales, 2000) and Good Management, Good Records (Department of Health, Social Services and Public Safety, 2011) all include advice on storing and disposing of recordings made as part of a patient's care or as part of research.

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