To note

**Disclosing information to the Disclosure and Barring Service and Disclosure Scotland**

**Issue**

1. Our approach to redaction when making referrals to the Disclosure and Barring Service and Disclosure Scotland.

2. We are also making changes to our guidance on making referrals where we have information that a doctor poses a risk of harm to children and/or vulnerable adults; and have produced guidance on disclosing information under s.35B (2) of the Medical Act 1983, where we have information that a doctor poses a risk of harm to someone who is not a child and/or vulnerable adult.

**Recommendations**

3. The Strategy and Policy Board is asked to:
   
   a. Note the approach to redaction when making referrals to the Disclosure and Barring Service and Disclosure Scotland.
   
   b. Note the updated *Guidance on making referrals to the Disclosure and Barring Service* and updated *Guidance on making referrals to Disclosure Scotland*.
   
   c. Note the *Guidance on disclosure to the Disclosure and Barring Service and Disclosure Scotland under the Medical Act 1983 (Section 35B(2))*.
Disclosing information to the Disclosure and Barring Service and Disclosure Scotland

Issue

4 Since 2009 we have made referrals to the Disclosure and Barring Service (DBS). These referrals were initially made under a legal duty arising from the Safeguarding Vulnerable Groups Act 2006 (the SVGA 2006). Currently, referrals are made under a legal power arising from the SVGA 2006 (s.41(7)) as amended by the Protection of Freedoms Act 2012.

5 Similarly, we have made referrals to Disclosure Scotland (DS) since 2011 under a power contained in the Protection of Vulnerable Groups Act 2007 (s.8(2)).

Our approach to redaction

6 In view of the legal duty to refer information to the DBS contained in the SVGA 2006, traditionally we did not redact that information. We reviewed that position following an amendment to the legislation that removed the legal duty and replaced it with a power to refer information. We currently redact information referred under that power.

7 We have reviewed our process and taken legal advice as the redaction of bundles which are typically between 500-1000 pages is resource intensive, time consuming and can slow down disclosure. The legal advice indicated that we are not required to redact and that sending unredacted information is appropriate and proportionate.

8 As a result of the review and legal advice received we propose to revert to sending unredacted bundles to the DBS and the DS, except for certain types of particularly sensitive information such as that from the Family Courts or relating to Mental Health proceedings.

9 Information we refer is provided in accordance with statutory powers and it is unlikely that the DBS or DS would use the information in a way that would be detrimental to the interests of third party data subjects or providers of information. Changes were made to the GMC's online complaints form on 1 September 2014 which ensure we have explicit consent to refer information to the DBS or DS where complaints were received via the online form after that date.

Guidance for staff making referrals to the Disclosure and Barring Service

10 Guidance for staff making referrals to the Disclosure and Barring Service is at Annex A, and guidance for staff making referrals to Disclosure Scotland is at Annex B. The guidance sets out the conditions and categories of fitness to practise information which are likely to give rise to disclosure to the DBS and DS.

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11 The amendments to the guidance principally concern the ‘May Bar’ Test, and the type of cases which meet or are likely to meet the referral criteria as DBS has developed its thinking and clarified its position.

12 The changes include:

   a Guidance on referrals to the DBS and DS where there is a personal relationship between a doctor and patient.

   b Guidance on when we will refer cases where there is a failure by a registered doctor to make a safeguarding referral.

   c Clarification about when the referral criteria are met in cases relating to false statements about qualifications or experience. The proximity of harm to children and vulnerable adults as a result of the false statement e.g. whether the doctor commenced work in a post they lacked the knowledge or skills to carry out or whether the false statement was motivated by a desire to exploit or abuse children or vulnerable adults are aggravating factors.

   d Clarification about conduct that would not in and of itself meet the criteria but when part of a pattern of conduct could amount to callous disregard for procedures that could give rise to a referral.

13 We are agreeing updated case studies with the DBS that will accompany the guidance to assist staff assessing cases for this purpose.

Guidance on disclosure to the Disclosure and Barring Service and Disclosure Scotland under section 35B(2) of the Medical Act 1984

14 Occasionally we may hold information about a doctor’s behaviour in relation to someone who is not a vulnerable adult or child that we believe if repeated may present a risk of serious harm to vulnerable adults or children, and there is a likelihood of repetition. In that case, we may consider sharing information with the relevant barring authority under our Medical Act general power to disclose anything about a doctor’s fitness to practise where we consider it to be in the public interest.

15 There is clearly a significant public interest in sharing information with the DBS and DS. However, disclosure will only be appropriate under section 35B(2) where we are satisfied that a doctor’s fitness to practise is impaired and it is in the public interest to do so. This will usually be when there has been a finding of fact by a court or another regulator or the information has led to action on a doctor’s registration or a warning being issued.

16 Guidance for staff disclosing information to the DBS or DS under Section 35B(2) of the Act is at Annex C. The guidance sets out the categories of fitness to practise
information which are likely to give rise to disclosure in the public interest to relevant barring authorities under Section 35B(2). These include:

a 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.

b Indecent exposure involving someone other than a child or a vulnerable adult.

c Sexual harassment or inappropriate sexually motivated behaviour towards a person other than a child or vulnerable adult, e.g. a work colleague.

d Taking indecent photographs of someone other than a vulnerable adult or child without permission e.g. voyeurism.

e Stalking or harassment of someone other than a vulnerable adult or child, where this involves aggravating factors such as threatening or violent behaviour.
Supporting information

How this issue relates to the corporate strategy and business plan
17 The approach we have taken in relation to the referral of information to the DBS and DS is in line with strategic aim 3: to improve the level of engagement and efficiency in the handling of complaints and concerns about patient safety.

How the action will be evaluated
18 We will monitor these changes through our regular discussions with the DBS. The directorate also has systems and processes in place to monitor information security.

How the issues support the principles of better regulation
19 The proposed change in the process of sending non-redacted information supports efficiency and effectiveness; adopting a proportionate approach.

How the issues differ across the four UK countries
20 The DBS applies across England, Wales and Northern Ireland. DS is the equivalent scheme for Scotland.

What equality and diversity considerations relate to this issue
21 We do not currently hold data on the characteristics of complainants and third parties whose information may be referred to the DBS. In relation to the changes to the guidance, this reflects changes in DBS policy. The changes are likely to affect a very small number of cases.

If you have any questions about this paper please contact: Anna Rowland, Assistant Director of Policy, Business Transformation and Safeguarding, arowland@gmc-uk.org, 020 7189 5077.
Guidance on making referrals to the Disclosure & Barring Service

Introduction

1 This guidance provides an outline of the GMC’s procedure for referring information to the Disclosure & 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 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 Scottish Scheme. Therefore if any of the following apply, the referral should be made to DS:
   
a The doctor holds PVG Scheme membership, or
   
b The doctor’s GMC registered address is a Scottish registered address, or.
   
c The alleged conduct took place in Scotland.
   
d We are not aware that the same conduct has already been referred by an employer, employment body or employment agency although this will be rare.

4 Disclosure Scotland and the DBS have an agreement that facilitates their joint working in cases where jurisdiction is unclear.

Disclosure & Barring Service

5 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.
6 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

7 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 (i.e. pursuant to the doctor/patient relationship) or in everyday life, the conduct may result in a referral to the DBS.

Vulnerable adults

8 The term ‘vulnerable adult’ is defined in the Act 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

9 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.

10 In some circumstances a referral to the DBS can be made where the conduct occurs outside of these three jurisdictions (‘overseas’) if:

- The offence is equivalent to an autobar offence (i.e. the conduct amounts to an autobar offence under the laws of England, Wales or Northern Ireland).
- A person has engaged in an act or omission overseas that is equivalent to Relevant Conduct.
- The conduct occurring overseas, would, if committed in England, Wales or Northern Ireland, satisfy the Harm Test.

Application of the Scheme to the medical profession

11 The GMC has power under the Safeguarding Vulnerable Groups Act 2006 (SGVGA) 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

12 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 and/or children.

13 Doctors involved in providing any form of health care to patients are conducting a Regulated Activity for the purposes of the Scheme.

14 Healthcare 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.

15 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; or

f  the transportation of adults who need it by reason of age, illness or disability.

16 In the majority of the GMC’s cases, a person will be a vulnerable adult because they are receiving a Regulated Activity as set out at paragraph 15(a), above.

17 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, i.e. health care.

**Example**

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, i.e. health care.

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

The fact that the person received a Regulated Activity from another provider is not relevant.

The only relevant question is whether the doctor provides a Regulated Activity to the person. If not, then the victim will not be a ‘vulnerable adult’.

18 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, i.e. health care.
The referral conditions

19 Before a referral to the DBS can be made, decision makers must be satisfied that two conditions are met (save for cases involving an autobar offence – see paragraphs 21 and 27-43 below).

20 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.

21 The one exception to considering the two conditions in succession is in relation to ‘autobar’ cases. Where the decision maker is satisfied that the doctor has committed an autobar offence it is not necessary to consider the second condition.

22 The first condition has three parts and as such can be met in three alternative ways. If the first part is not met, decision makers should move on to consider the second and third parts sequentially. If the first part is met, the decision maker need not consider the subsequent two parts.

<table>
<thead>
<tr>
<th>The first condition</th>
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<tbody>
<tr>
<td><strong>PART 1: AUTOBAR OFFENCES:</strong> Decision makers should refer the case to the DBS where we have evidence of an autobar offence having been committed (See paragraphs 27-43 below). If not, consider parts 2 &amp; 3;</td>
</tr>
<tr>
<td><strong>PART 2: RELEVANT CONDUCT:</strong> where the GMC ‘thinks’ that a doctor has engaged in Relevant Conduct and the trigger points are met, decision makers should move on to consider the second condition (see paragraphs 44-59 below for guidance on what constitutes Relevant Conduct); or</td>
</tr>
<tr>
<td><strong>PART 3: THE HARM TEST:</strong> 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 60-82 below for guidance on when the Harm Test is satisfied).</td>
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23 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).

24 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 the second condition (for a summary of the second condition, see the box below).
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.

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25 For the trigger points for autobar and Relevant Conduct cases see Fig.1 (paragraph 59). For referral conditions see Annex A.

**The first condition**

26 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**

27 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.


**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 caution in relation to the commission of autobar offence,
- attempting to commit,
- conspiring to commit,
- inciting another to commit,
e aiding or abetting in the commission of an autobar offence; or

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 autobar or connected offence in England, Wales or Northern Ireland, the GMC will refer the doctor to the DBS. Decision makers only need to be satisfied that there is sufficient evidence that the doctor has been convicted of, or cautioned in relation to an autobar or connected offence.

Trigger point for referrals involving ‘autobar’ offences

34 The GMC may make a referral under the autobar part of the first condition when we receive one of the following:

a Notice of police caution – in relation to any of the autobar or connected offence

b Memorandum of criminal conviction – indicating that the doctor has been convicted of any of the autobar 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 autobar or connected offence (see paragraphs 38-43 for further information about overseas offences)

d Any other authoritative document – in the absence of the above documents, any other document(s) that provides evidence of a conviction, e.g. a letter from the police confirming details of the conviction.

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.
36 In most cases, a conviction or caution for an autobar offence (or connected offence) will be obvious.

37 In some cases, the wording of the relevant offence contained within the police caution or the notice of criminal conviction may be slightly different to the wording of the relevant autobar offence. However, the caution notice or memorandum of conviction will usually contain reference to the legislation and section of the specific Act upon which the caution or conviction is based. Where it does not, the investigating officer with conduct of the case should be asked to obtain that information to establish that a referral for an autobar, or connected offence, is the correct approach.

Overseas offences

38 It is important that decision makers consider where the offence took place (and thus where the doctor was convicted or cautioned). The list of autobar offences covers offences in England, Wales, Scotland and Northern Ireland.

39 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 autobar offence. If so, the GMC may refer the doctor to the DBS on the basis that they have committed an autobar offence.

40 If the conduct occurred in Scotland, the doctor holds PVG Scheme membership, or the doctor’s GMC registered address is a Scottish registered address, the Disclosure Scotland Scheme should be considered.

41 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.

42 In some cases, this decision will be clear-cut.

For example

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

**Part 2: Relevant Conduct**

44 If the autobar criteria are not satisfied, the decision maker should apply the Relevant Conduct criteria to the case. These are where 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 exposures such a person to the risk of harm.

45 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.

46 ‘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)).

47 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.
48 If the sexual material does not involve children, consideration should be given to whether the doctors actions can be referred to the DBS under s35B (2) of the Medical Act 1983 (Decision makers should consult our separate Guidance on referrals to the DBS under s35B (2)).

49 With the exception of paragraph 45d above, the Relevant Conduct must have been directed towards a child or vulnerable adult.

50 Section 4(2) of the Act defines Relevant Conduct as endangering a child or vulnerable adult if the person:

- harms a vulnerable adult or child;
- causes a vulnerable adult or child to be harmed;
- places a vulnerable adult or child at risk of harm;
- attempts to harm a vulnerable adult or child, or
- incites another to harm a vulnerable adult or child.

51 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’.

52 The DBS guidance on referrals lists the following types of harm applicable to vulnerable adults and children:

- **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

- **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

- **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

- **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

53 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).

54 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 12-18 above for discussion on vulnerability).

55 In these cases, where a GMC registrant has harmed a person who is vulnerable 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 is charged with driving under the influence of alcohol or a controlled substance and, pursuant to personal arrangements, has a child (or children) or a vulnerable adult in his or her immediate care at the time, this will amount to Relevant Conduct.

The Relevant Conduct in this example will be putting a child or vulnerable adult in danger

If a doctor takes a group of elderly patients to the shopping centre in a hospice bus and is arrested as a result of careless or dangerous driving, the doctor is engaging in Relevant Conduct whilst providing a Regulated Activity.

i.e. 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
In the examples above the decision maker should proceed to consider the second condition.

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**

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 fitness to practise panel issues a warning, imposes conditions, suspends or erases a doctor or refuses an application for restoration

iii. a fitness to practise panel 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, and

iv. an assistant registrar of the Registration and Revalidation directorate refuses to register a doctor.

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 58(i) to (iv) 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.
Trigger points for considering referrals in Relevant Conduct cases (assuming the referral conditions are met):
Part 3: The Harm Test

60 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

61 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 the criteria for the ‘may bar’ test are met.

62 The Harm Test is prospective and involves an assessment of what a person may do in the future.

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

64 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

65 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

66 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.
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?

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.

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.

In both of 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 doctor’s state of mind indicates that he/she 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.

Evidence of such a risk 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

71 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 Relevant Conduct cases (see paragraph 72-82 below).

Exceptions to the application of the Harm Test in conduct cases

72 In certain circumstances, conduct cases may give rise to a referral to the DBS under the Harm Test rather than the Relevant Conduct criteria, where:

a Although there has not yet been a conviction, there is strong and compelling evidence that the person has committed a serious autobar offence and the GMC believes that there is a serious risk to children or vulnerable adults such that the DBS may bar the person; or

b There has been undue delay in the GMC’s fitness to practise process (i.e. in concluding the case) and the GMC believes the person poses a future risk to children or vulnerable adults such that the DBS may bar the person (see paragraph 92-133 below).

Strong and compelling evidence of an autobar offence

73 In paragraph 72a above, evidence can consist of material or information provided by the Police, a regulatory body, an employer or another investigatory body.

74 The fact that a doctor has been charged with a serious autobar offence (e.g. Rape), does not automatically amount to strong and compelling evidence. The circumstances of each case will need to be considered individually.
Decision makers should look at other evidence available at the time of making their decision to refer. For example, where a doctor has been charged with an autobar offence but the main witness refuses to give evidence, the fact that the prosecution fails does not mean a referral cannot be made. There are many reasons why a witness may refuse to give evidence in a criminal trial. Just because a witness does not give evidence does not mean the allegations are not true. Decision makers must look at the conduct alleged and whether the information available provides strong and compelling evidence to support it. The statements, documents and evidence prepared for both the criminal, and the GMC investigation could still amount to strong and compelling evidence.

Physical evidence, e.g. images seized from a doctors computer or forensic evidence is likely to satisfy the requirement for strong and compelling evidence.

Where a doctor has been charged with, but not convicted of an autobar offence before the criminal court for some other reason, e.g. the doctor absconds; the principle discussed at paragraph 75 above still applies.

In some cases, where a criminal trial is due to take place within a relatively short time period, it may be appropriate to await the outcome of the criminal case before making a referral to the DBS.

Undue delay

Where a GMC case has been open for more than 24 months and has not yet been completed, a referral to the DBS can be made. However, referrals should not automatically be made to the DBS.

A referral to the DBS should only be made where:

- there is evidence to suggest that the doctor poses a future risk of direct harm to children or vulnerable adults; and

- Both parts of the second condition are met.

Once the Harm Test is satisfied, decision makers must go on to consider the second condition.

At that stage, cases which do not meet the threshold for seriousness would not need to be referred to the DBS. This is discussed further in later parts of this document.

The second condition

Where the GMC decision maker is satisfied that there has been Relevant Conduct or that the Harm Test is met, the second condition must be applied.
The second condition has two parts.

**Part 1: The doctor has been, is, or might in the future, be engaged in a Regulated Activity**

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.

The vast majority of the GMC’s cases will satisfy the first part of the second condition.

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.

In relation to 85a 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.

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.

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 12-18 above for Regulated Activities).

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

92 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.

93 The ‘may bar’ test requires consideration of the doctor’s conduct in the round. Therefore the decision maker can rely on any previous act or omission by the doctor that was investigated and satisfied the referral criteria at the time. Where the 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.

Conduct involving clinical failures

94 The ‘may bar’ test will not be met where the conduct is purely clinical in nature because the action we have taken will remove the risk of any future harm from clinical incompetence e.g. placing conditions on the doctor’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.

95 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.

96 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 Fitness to Practise (FTP) Panel 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.

Conduct which undermines confidence in the profession

97 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

98 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.
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
- 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 e.g. an insensitive remark, rudeness or sarcasm towards a patient.
- Involves the making 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 **will** be met in cases which:

- Concern non-professional safeguarding issues for vulnerable groups (such as sexual or violent behaviour)
- Involves an abuse of a position of trust where harm to children or vulnerable adults results e.g. if a doctor defrauds an elderly patient
- Involves the making of a false report with intent to mislead or cover up a safeguarding matter e.g. where there is an investigation into an incident in the workplace involving Relevant Conduct (i.e. sexual harassment of a patient) and the doctor gives false or misleading information, the ‘may bar’ test will be met.

**Callous disregard for procedure**

**100** The may bar test will be met where the individual has demonstrated a ‘callous disregard’ for procedure.

**101** 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.

**102** In order for a callous disregard for procedure to raise wider safeguarding risks, it must be:
- **Serious; and**
- **Deliberate or reckless**

**103** 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.

**104** In cases where the conduct is a ‘one-off’ incident there must be a wholly exceptional disregard for procedure to meet the ‘seriousness’ threshold.

**Example**

A doctor boards a plane carrying blood contaminated with a life threatening disease. The blood is carried contrary to safety regulations and there is a serious risk that the blood could be spilt and infect passengers with the disease.

**105** The risk of harm to the passengers in the example above could be life threatening and would therefore meet the ‘seriousness’ threshold. If the doctor deliberately took the infected blood on the plane or if the doctor was reckless as to whether his fellow passengers may become infected from the blood, the second element would also be met.

**A callous disregard and clinical failings**

**106** Clinical failings, will not generally amount to a callous disregard for procedure as action taken by the GMC, on a doctor’s registration, will mitigate the future risk of harm to children or vulnerable adults and referrals under this ground should only be made in exceptional circumstances.

**107** What amounts to ‘exceptional circumstances’ can only be determined by looking at the circumstances of the individual case. If such a case arises, decision makers should discuss the case with their Head of Department before any referral is made.

**Failure to make a safeguarding referral**

**108** 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.
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 doctors 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.

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.

In some cases, the decision as to whether ‘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 110 above).

**False statements about qualifications or experience**

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

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.

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.

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:

1. **The seriousness of the harm or risk of harm** - e.g. could it have resulted in serious harm, injury or a fatality and how imminent was the harm - e.g. did the doctor commence work?

2. **The seriousness of the false statement** - e.g. 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.

3. **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 2nd 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 doctors actions could have resulted in a fatality.

**Personal relationships with patients**

116 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.

117 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.

118 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, e.g. accessing a patient’s contact details, the referral ground will be met. This is likely to be the case even if the conduct was a ‘one-off’ event. Similarly, if the incident is not an isolated one, this will increase the seriousness of the conduct.
Health of the doctor

119 A doctor's health 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.

120 Where the health 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.

121 Alcohol or drug dependency related convictions and intoxication within the workplace may raise safeguarding risks in relation to children and vulnerable adults.

122 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.

<table>
<thead>
<tr>
<th>Substance abuse outside the workplace would not meet the may bar test.</th>
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<tbody>
<tr>
<td>Such abuse indicates a general risk of harm rather than placing children and/or vulnerable adults at a direct risk of harm.</td>
</tr>
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</table>

123 Affective disorders in and of themselves would not satisfy the referral criteria, but behaviour caused by an affective disorder could do so.

124 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

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

126 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.

127 ‘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

• where the proposed referral is under paragraphs 123 to 128 (health of the doctor) and there are concerns about the effect a referral would have on the doctor’s health where there is an identified risk of suicide.

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

129 The GMC will only provide information that meets the referral criteria in this guidance or information which meets the criteria for disclosing information to the DBS under s.35B(2) of the Medical Act 1983 (see “Guidance on disclosure to the Disclosure & Barring Service and Disclosure Scotland under the Medical Act 1983 (Section 35B(2))”.

**General points**

130 This part of the guidance is intended to give general guidance on various points of the legislation and the operation of the Scheme, as well as the interaction between the Scottish Protection of Vulnerable Groups (PVG) Scheme and the Vetting and Barring Scheme in England, Wales and Northern Ireland.

**Cross border protocol**

131 The PVG Scheme operates in Scotland.

132 This Scheme is established under separate legislation and requires a separate process for making referrals to Disclosure Scotland, the body responsible for making barring decisions in Scotland. Separate guidance has been issued covering the GMC’s referral power in relation to this scheme.

133 If a doctor is barred under the England, Wales and Northern Ireland Scheme, he/she 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. The following principles should be applied:

*Relevant Conduct cases*

134 Decision makers should look at the place in which the ‘conduct’ took place

• If the conduct took place in England, Wales or Northern Ireland, refer to DBS.
• If the conduct took place in Scotland, refer the matter to Disclosure Scotland.

The Harm Test

135 If the case falls into the Harm Test category refer to the DBS as there is no equivalent of the Harm Test in the Scottish PVG Scheme.

Notifying the relevant doctor

136 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.

137 Where there are concerns about a doctors 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.

DBS requests for information

138 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.

139 In general, where the appropriate provision is cited and the identified person is on the List of Registered Medical Practitioners, 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

140 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 Anna Rowland and the Information Access Team, who will handle the request under the relevant legislation.

Annex A - Flow chart illustrating the two referral conditions

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

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

Is the first condition met?

FIRST PART
Do we have authoritative evidence to suggest that the doctor committed an autobar, or connected offence (including overseas offences)?

YES

NO

REFER THE CASE TO DBS

SECOND PART
1. Has the doctor engaged in Relevant Conduct?
2. Is the trigger point met?

YES

NO

THIRD PART
1. Is the Harm Test met?
i.e. is there a risk that the doctor may engage in behaviour which may cause harm or place children or vulnerable adults at risk of harm in the future?

YES

NO

DO NOT REFER THE CASE TO DBS

Is the second condition met?
(NB this need not be applied in autobar cases)

FIRST PART
1. Was the doctor engaged in a Regulated Activity at the time?
2. Is the doctor engaged in a Regulated Activity at present?
3. May the doctor engage in Regulated Activity in the future?

YES

NO

REFER THE CASE TO DBS

SECOND PART
May DBS bar the doctor because of the matters which caused the first condition to be met?

YES

NO

DO NOT REFER THE CASE TO DBS
Annex B

Guidance on making referrals to the DBS

Case Studies


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 titled ‘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.
<table>
<thead>
<tr>
<th>1. Attitude</th>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad case type</td>
<td>Doctor displays low-level rudeness towards patients, including sarcastic remarks.</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
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<table>
<thead>
<tr>
<th>2. Verbal bullying of colleagues</th>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad case type</td>
<td>Doctor verbally bullies work colleagues but not patients.</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
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</table>
### 3. Inappropriate prescribing because of incompetence

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor prescribes wrong medication to a patient as a result of incompetence (where there is no intention to cause harm).</td>
<td>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 harm to children and vulnerable adults. As such, the GMC would not refer this case to the DBS.</td>
<td>This case would not meet the referral criteria as it is a professional competency issue and the GMC/employer would remove any potential risk of harm through their own actions e.g. retraining, improved supervision.</td>
<td>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. 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.</td>
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<tr>
<td>For clarity, incompetence can include:</td>
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<td>- errors caused by poor training, stress;</td>
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<td>- one-off out of character errors; and</td>
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<td>- ignorance or confusion.</td>
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### 4. Inappropriate prescribing, intent, recklessness or repeat behaviour

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
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<tr>
<td>Doctor prescribes wrong medication to a patient as a result of intention to cause harm or such a callous disregard for procedure as to make the doctor a</td>
<td>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.</td>
<td>The case outlines where a doctor uses their position to harm a child or vulnerable adult. It would be difficult to make this distinction without admittance from the doctor or on the balance of probabilities</td>
<td>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</td>
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safeguarding risk. This may include where a pattern of harmful behaviour is demonstrated. As such, a referral to the DBS would be likely to be made in these cases. due to repeated behaviour. 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. may be where a pattern of harmful behaviour has emerged.

<table>
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<tr>
<th>5. Failure to diagnose correctly</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad case type</td>
<td>Doctor incorrectly diagnosed a patient due to incompetence (no intention to cause harm). For clarity, incompetence may include: - errors caused by poor training, stress; - one-off out of character errors; - ignorance or confusion.</td>
<td>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.</td>
<td>This case would not meet the referral criteria as it is a professional competency issue and the GMC/employer would remove any potential risk of harm through their own actions e.g. retraining, additional supervision.</td>
</tr>
<tr>
<td>Broad case type</td>
<td>GMC position</td>
<td>DBS comments</td>
<td>Agreed guiding principles</td>
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| Doctor provides a false report, for instance, as a response to an internal investigation into an incident conducted by the doctor's employer. | 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.  

The GMC also considers that the may bar test is not met in these cases. False reporting indicates a general risk of harm caused by general dishonesty, 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. | In most cases the GMC position would be correct. The only case where the duty to refer may be applicable would be if the false reporting was in relation to an incident where the GMC would otherwise think a referral to the DBS was appropriate. E.g. An employee is referred to the GMC due to relevant conduct. The doctor provides a false report in favour of the employee to attempt to mislead the GMC findings, potentially allowing someone who presents a risk to a child or vulnerable adult to continue in employment.  

The GMC’s determination would need to conclude that the false report was intentional and that the consequences of the GMC making an erroneous decision based on that evidence, would compromise the safety of children or vulnerable adults. | 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.  

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 conduct and the false report was intentional. These circumstances (although rare) demonstrate behaviour that, if repeated, is likely to result in harm directly in relation to children or vulnerable adults. |
7. False claims to experience on CV

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor lies on his/her CV to claim experience which he/she does not have in order to gain employment or promotion.</td>
<td>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. 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. 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.</td>
<td>The DBS does not want to be inundated with instances where a doctor has been less than honest on their CV. The lie must raise a serious safeguarding risk to children or vulnerable adults such that the DBS may consider barring the person. This would be relevant conduct as it is an action that MAY endanger children or vulnerable adults. The dishonesty is in relation to providing health care and under the definition of a vulnerable adult any adult who is receiving health care is a vulnerable adult. It is unlikely however to meet the second part of the second condition as the GMC (or the employer), on discovering the falsehood would take action against the doctor to remove the risk of harm to patients. However, in cases where a very serious safeguarding risk has</td>
<td>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. Lying on a CV is a professional matter, action taken by the regulator will usually remove the risk of harm to children or vulnerable adults.</td>
</tr>
</tbody>
</table>
occurred as a result of the doctor’s intentional falsification, the second part of the second condition may be satisfied as the GMC’s actions will prevent future risk in relation to that particular occupation and would not prevent the doctor, even if struck off the GMC register, from engaging in other forms of healthcare.

8. **Lying on CV to exploit vulnerable people including children**

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
</table>
| 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. | 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. 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. | Agree with GMC position | This type of case should be handled on a case by case basis depending on the circumstances.  
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.  
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 |
8. Failure to maintain adequate medical records

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
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</thead>
<tbody>
<tr>
<td>Doctor has poor record keeping skills, including for instance, a failure to properly record consultations.</td>
<td>In general, the risk of harm posed by the doctor will not be sufficiently serious to lead the GMC to believe that 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. 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 record keeping skills are unlikely to ever result in a referral to DBS.</td>
<td>Generally agree with GMC position. As noted 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 had specific information to indicate that the doctor was also responsible for medical records / medicines at a care home.</td>
<td>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. 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.</td>
</tr>
</tbody>
</table>
## 10. Lack of further investigation

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
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</thead>
<tbody>
<tr>
<td>Doctor fails to conduct follow-up investigations into a patient’s condition - due to incompetence.</td>
<td>The GMC considers that the may bar test is not met in these cases. Although the potential risk of future harm is serious, the matter is purely related to the doctor’s clinical competence and the future risk of harm is confined to the professional setting. In the absence of wider safeguarding risks, the action taken by the GMC will have removed any potential future risk of harm in relation to children and vulnerable adults. As such, the GMC would not refer these cases to the DBS.</td>
<td>Agree with GMC position.</td>
<td>Poor clinical skills are a professional matter. Action taken by the regulator can remove the risk of harm to children or vulnerable adults.</td>
</tr>
</tbody>
</table>

## 11. Driving under the influence of alcohol, possession of a banned substance

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor charged and convicted of, or cautioned in relation to driving under the influence of alcohol or possession of a banned substance.</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>
### 12. Driving under the influence of alcohol, possession of a banned substance with child (or children) in immediate custody

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>In these situations the GMC would need to consider the facts of each individual case.</td>
<td>Both examples would involve relevant conduct; it does not matter if it is the doctor’s own child. The definition of relevant conduct is not restricted to actions within regulated activity. The Act treats children as being vulnerable by virtue of their being under the age of 18. If there is harm or 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.</td>
<td>This type should be handled on a case by case basis depending on the circumstances. If there is harm or 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. 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 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.</td>
</tr>
</tbody>
</table>

**Example 1**

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 vulnerable groups including children.

**Example 2**

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.

A referral to the DBS is likely to be made in the second example, but not in the first.

Factors to consider in deciding whether the may bar test applies include:
child or vulnerable adult causing harm or posing a risk of harm

Depending on the circumstances, the DBS would be more likely to bar in the second instance (e.g. scout group), as the behaviour raises a greater safeguarding risk in relation to vulnerable groups including children.

- 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.

Where harm is caused by a genuine accident, in general the may bar test will not be met.

<table>
<thead>
<tr>
<th>13. Driving under the influence of alcohol with another adult in company</th>
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<tbody>
<tr>
<td><strong>Broad case type</strong></td>
</tr>
<tr>
<td>Doctor charged with driving under the influence of alcohol or possession of a banned substance and has an adult (or</td>
</tr>
</tbody>
</table>
adults) in the car at the time of arrest.

receives a 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.

**Example 2**

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.

A referral to the DBS is likely to be made in the second example, but not in the first.

the time she is receiving or being provided with a Regulated Activity.

However, both examples would involve relevant conduct as the definition of relevant conduct is not restricted to actions within regulated activity. It must simply involve a child, or an adult that is defined as vulnerable under the Act or conduct that may cause harm if repeated against a child or vulnerable adult.

If there is harm or 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.

However, where the drink driving incident relates to a purely private arrangement involving, for example, a relative of the doctor, the may bar test is unlikely to be met.

Depending on the circumstances, the DBS would be likely to bar in the second instance (e.g. hospice between the person and the child or vulnerable adult.

In cases where relevant conduct has occurred, whether DBS may bar the doctor will depend on the circumstances of the case.

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.

Factors to consider in deciding whether the may bar test applies include:

- 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
bus), as the behaviour raises a greater safeguarding risk in relation to vulnerable adults.

-  

Was the incident a ‘one off’ or had it happened before? etc.

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.

| 14. Substance abuse outside the workplace |
|-----------------------------------------|---------------------------------|-----------------|---------------|
| **Broad case type**                     | **GMC position**                | **DBS comments** | **Agreed guiding principles** |
| 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). | 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. | Agree with GMC position, this is not relevant conduct. | 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 11 above where the alcohol/substance misuse raises a risk of harm to children/vulnerable adults). If there is no evidence or information to believe there is a specific risk of harm to children or vulnerable adults then the DBS is unlikely to include the |
### 15. Alcohol or substance abuse in the workplace

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS Comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Working under the influence of drugs or alcohol</td>
<td>As long as there are no aggravating factors, the GMC considers that the action it takes will normally manage risk in these cases.</td>
<td><strong>Key issues to consider in deciding whether to make a referral:</strong></td>
<td>If the person is permitted by the GMC / GMC fitness to practice panel or committee to continue to practice 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.</td>
</tr>
<tr>
<td>• Alcohol or drug dependency</td>
<td></td>
<td>- Has a child or vulnerable adult actually been harmed?</td>
<td>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, GMC need to be satisfied that the behaviour if repeated outside their profession would not pose a risk of harm to vulnerable groups including children.</td>
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<tr>
<td>• Alcohol or drug convictions</td>
<td></td>
<td>- Has there been a reckless or callous disregard for the care of children or vulnerable adults?</td>
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<tr>
<td>• Drink driving convictions</td>
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<td>- Is this repeated behaviour / one off behaviour / one off relapse and have there been previous concerns / complaints / allegations?</td>
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<td>• Smelling of alcohol at work</td>
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<td>- Is the dependency causing other behavioural problems that may pose a risk of harm?</td>
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<td>- Has the person accepted responsibility for their condition?</td>
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<td>- Has the person accepted and receiving effective treatment / supervision / monitoring?</td>
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<tr>
<td>Question</td>
<td>Answer</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>If the person is subject to conditions / agreed undertakings / supervision / monitoring and / or treatment, do these actions mitigate any risk of harm to children or vulnerable adults within their professional practice?</td>
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<tr>
<td>If action by the GMC or a fitness to practice panel has mitigated the risk of harm within their professional practice, is there a risk of harm to a child or vulnerable adult outside their professional practice such that the DBS may consider including the person in a barred list?</td>
<td>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.</td>
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<tr>
<td>Are there any fitness to practice panel 'findings of fact' that may indicate that the DBS may consider including the person in a barred list?</td>
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<tr>
<td>Are there any other factors that may lead the DBS to consider including the person in a barred list?</td>
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<tr>
<td>Has the person been permitted to continue to work / been reinstated / permitted to continue to practice?</td>
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<tr>
<td>What risk of harm directly in relation to children or vulnerable adults does the person pose?</td>
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</table>
### 16. General fraud

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor defrauds his/her employer, or another person who does not fall under the definition of vulnerable adult.</td>
<td>The doctor’s behaviour reflects a general risk of harm. 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.</td>
<td>Agree with GMC position.</td>
<td>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.</td>
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</tbody>
</table>

### 17. Fraud of a patient

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC interpretation of the referral criteria</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor defrauds one of his/her patients.</td>
<td>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. The doctor has sought out a child or vulnerable adult for exploitation and this behaviour indicates a wider risk of such behaviour being repeated outside the professional setting. 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.</td>
<td>Agree with GMC position.</td>
<td>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.</td>
</tr>
<tr>
<td>Broad case type</td>
<td>GMC position</td>
<td>DBS comments</td>
<td>Agreed guiding principles</td>
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<tr>
<td>Doctor undertakes an intimate examination that is clearly not clinically indicated, or engages in sexually motivated behaviour towards a patient.</td>
<td>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. 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. 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. 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.</td>
<td>Agree with GMC position.</td>
<td>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. 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.</td>
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</table>
## 19. Affective disorders

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
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<tbody>
<tr>
<td>Doctor has an affective disorder (e.g. bipolar)</td>
<td>The GMC considers that an affective disorder in and of itself cannot meet the may bar test. 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.</td>
<td>Agree with GMC position. These types of cases must be viewed on a case by case basis.</td>
<td>Affective disorders in and of themselves cannot satisfy the referral criteria.</td>
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<td>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, in assessing the likelihood of a future risk of harm.</td>
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</table>

## 20. Withholding treatment

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor withholds treatment from a patient, e.g. because the treatment conflicts with the doctor’s personal views or beliefs.</td>
<td>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. The key consideration is the seriousness of the matter, which will indicate whether the matter is</td>
<td>Agree with GMC position.</td>
<td>This type should be handled on a case by case basis depending on the circumstances.</td>
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</tbody>
</table>
clinical or raises wider safeguarding concerns which cannot be removed by action taken by the GMC.

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.

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 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.

<table>
<thead>
<tr>
<th>21. Physical assault</th>
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<tbody>
<tr>
<td><strong>Broad case type</strong></td>
<td><strong>GMC position</strong></td>
</tr>
<tr>
<td>Doctor physically assaults a person who is not a vulnerable adult (the doctor is acting)</td>
<td>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</td>
</tr>
</tbody>
</table>
outside his capacity as a doctor i.e. watching a sports event on the weekend).

relation to children or vulnerable adults. Rather, the doctor’s behaviour reflects a general risk of harm. As such, the GMC would not refer these cases to the DBS.

outside his capacity as a doctor. For example in the pub or towards another member of staff rather than towards a person receiving health care or advice. GMC should be aware that this does still constitute relevant conduct in that it is conduct which, if repeated against a child or vulnerable adult, would be likely to cause that child/vulnerable adult harm or put them at risk of harm. However, 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.

then the DBS is unlikely to include the person in a barred list and therefore a referral is not normally appropriate.

### 22. Physical assault a patient

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor physically assaults a patient</td>
<td>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. In such cases there are specific safeguarding concerns</td>
<td>Agree with GMC position.</td>
<td>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</td>
</tr>
</tbody>
</table>
- 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.

<table>
<thead>
<tr>
<th>Broad case type</th>
<th>GMC position</th>
<th>DBS comments</th>
<th>Agreed guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>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. 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. The likelihood of harm materialising in another setting is insufficiently direct and too speculative to give rise to a referral. 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.</td>
<td>Agree with GMC position.</td>
<td>Altering patient records is a professional matter and action taken by the regulator can remove the risk of harm to vulnerable groups including children.</td>
</tr>
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Referrals to Disclosure Scotland - General guidance for decision makers

Introduction

1. This document provides guidance on our power to refer information to Disclosure Scotland when certain referral grounds are met. It is a living document which may be revised periodically.

2. The guidance outlines the power the GMC has to refer an individual under the Protection of Vulnerable Groups (PVG) scheme, the legislative requirements and the practical steps needed.

3. The power to refer information to Disclosure Scotland covers cases where the doctor is a member of the PVG Scheme, or failing that, where the incident took place in Scotland (see paragraph 17 below).

4. A separate scheme has been established in England, Wales and Northern Ireland and this is known as the Vetting and Barring Scheme. Separate guidance covers referrals to the Disclosure & Barring Service (DBS).

The Protection of Vulnerable Groups Scheme

5. The Protection of Vulnerable Groups (Scotland) Act 2007 (PVG Act) and the PVG Scheme were established as a result of the Bichard inquiry, which was commissioned following the deaths of Jessica Chapman and Holly Wells. Similar to the DBS, the key focus of the PVG Scheme is to strengthen the way employers recruit people to work with children and protected adults.

6. The PVG Scheme is administered by Disclosure Scotland on behalf of Scottish Ministers. The scheme commenced on 28 February 2011 with the purpose of issuing disclosures to those seeking or doing ‘regulated work’, their employers and prospective employers, and to certain regulatory bodies. After scheme
membership commences, Disclosure Scotland actively monitors an individual’s criminal record to ensure there is no new information which might affect their ongoing suitability to work with vulnerable adults or children.

7 Disclosure Scotland also receives referrals from employers, regulatory bodies and other organisations specified in the PVG Act. Based on that information it will make decisions on whether to bar (prevent) individuals from working with children and/or protected adults.

8 Section 8 of the PVG Act enables the GMC to refer information to Scottish Ministers when certain referral grounds are met.

9 Section 19 of the PVG Act requires the GMC to provide Scottish Ministers with information when they request it from us.

10 The PVG Scheme is different from the DBS in a number of ways. The legislation which underpins the PVG Scheme gives us a power to refer a doctor to Scottish Ministers. The power to make referrals under s.8 does not extend to where we are aware that an employer, employment agency or employment business has already referred the individual to Scottish Ministers for the same conduct.

11 Unlike the DBS, the referral grounds in the PVG Scheme are based solely on past conduct. The PVG Scheme does not contain an equivalent to the prospective Harm Test applied by the Disclosure & Barring Service, and therefore there is no need for decision makers to consider cases and assess whether there is a risk of safeguarding concerns materialising in the future. To make a referral under the Act, the GMC must believe that a ground of referral specified in s.2 of the PVG legislation is met, summarised in a later section of this guidance.

12 The Scottish Government recommends that people doing regulated work in Scotland become members of the PVG Scheme, although it is not mandatory to do so. It is an offence to employ a barred individual to work with the group they are barred from, and it is intended that the employer checks this by getting a PVG disclosure. Barred individuals commit an offence if they seek or do regulated work with a group from which they are barred.

**Application of the PVG Scheme to the medical profession**

13 The GMC has a power under s.8 of the PVG Scheme to refer individuals to Scottish Ministers if in the exercise of our relevant functions we consider that a referral ground specified in s.2 of the Act is met. If the GMC is aware that an employer, employment agency or employment business has referred the same conduct, this power does not apply.
Similar to the DBS, regulated work in relation to children and protected adults under the PVG Scheme includes the provision of public and private healthcare services.

This means that all doctors who work with patients (children or adults) in independent or NHS healthcare services will be providing regulated work under the legislation as they are providing vulnerable groups with prescribed services. This means that we can use our power under s.8 to refer information to Disclosure Scotland about doctors when we consider that the grounds for referral are met.

**Which doctors does the PVG Scheme apply to?**

We have provided policy guidance later in this document to assist with the decision as to whether a referral is necessary or otherwise.

The following characteristics are relevant indicators as guidelines:

a. The doctor holds PVG Scheme membership; or

b. The doctor’s GMC registered address is a Scottish registered address; or

c. The alleged conduct took place in Scotland; or

d. We are not aware that the same conduct has already been referred by an employer, employment body or employment agency although this will be rare.

Disclosure Scotland and the DBS have an agreement that facilitates their joint working in cases where jurisdiction is unclear.

A prerequisite for making a referral to DS is that at least one of the referral grounds set out in s.2 of the PVG have been met. The doctor must:

i. Be doing regulated work;

ii. Have been doing regulated work; or

iii. Have been offered or supplied for regulated work.

If the prerequisite is satisfied, then the referral grounds set out in s.2 of the PVG Act are that the individual did one or more of the following:
21 We should use our power to refer when we consider that the case amounts to more than professional competence concerns that can be addressed by restricting or removing their right to work as a doctor in the UK.

22 The PVG legislation is about identifying those individuals with a real capacity to cause harm to vulnerable groups. We must therefore consider whether the doctor has done something (by way of act or omission) to raise safeguarding concerns. A doctor’s behaviour can raise safeguarding concerns if he or she:

i Through gross carelessness or negligence causes a patient to be harmed or exposed to a risk of such harm

ii Has developed inappropriate relationships with patients that could credibly give rise to harm or risk of harm.

iii Has engaged in inappropriate conduct with patients that call into question whether the risk of harm would extend beyond their role as a doctor and into any other area where they might be doing regulated work, for instance helping at a volunteer group with children or disabled adults.

iv Has demonstrated a sexual interest in children or otherwise sexually exploiting persons who are vulnerable.

v Has behaved in a violent way towards children or protected adults.

23 It is only necessary for one element of the referral grounds specified in s.2 of the PVG Act to be met for the referral to be appropriate. Of course there may be two or more depending on the case.
24 Harm is not defined in the PVG Act. However, referrals must be based on evidence to support a real concern that an individual may present a risk to protected adults or children in the future. This means that the harm the individual caused or placed people at risk of must amount to a significant risk of physical or psychological (or emotional) injury. Unlawful conduct such as theft, fraud, embezzlement or extortion can also be considered as harm. For example, someone who has stolen from an elderly and frail neighbour would meet the grounds for referral if the individual was doing regulated work with adults.

25 Similarly, inappropriate conduct must be of such a type that a reasonable person would consider that it was severe enough to justify consideration of whether or not the person is suitable to work with protected adults and children. Inappropriate conduct need not involve awareness of harm - a doctor who, for his own sexual gratification, covertly films other people who did not know he was doing so is nonetheless engaging in inappropriate conduct even though those he filmed may never know what he did.

26 The individual’s conduct need not be intentional in causing harm, if it is reckless or careless to such an extent that harm could result then that conduct is likely to be appropriate to refer.

27 It does not matter whether the conduct which harmed the person, or caused risk of harm took place as part of the doctor’s regulated work or in a setting outside that regulated work but there must be a direct link with children or protected adults. For example, someone who has taken inappropriate pictures of children on a beach would meet the grounds for referral if the individual was doing regulated work with children or vulnerable adults. The key point of this part of the referral ground is determining whether a doctor’s action or omission has harmed, or caused risk of harm, to a child or protected adult.

_Inappropriate conduct involving pornography_

28 The legislation provides that the referral grounds can be met if a doctor engages in inappropriate conduct involving pornography. In this part of the second referral ground there does not need to be a direct link to children or protected adults e.g. a doctor accessing pornography whilst at work and in the presence of colleagues could be said to be engaging in inappropriate conduct involving pornography. We must simply make a subjective judgement about whether a doctor has engaged in inappropriate conduct which involves pornography.

29 Decision makers should note that this referral ground (s.2 of the PVG Act) does not solely address convictions in relation to taking, possessing, distributing, showing or publishing indecent images of children. We may also consider that a doctor’s conduct is inappropriate conduct involving pornography in cases where the conduct does not lead to a criminal sanction (including where the
Crown case fails, or where the doctor’s conduct is inappropriate, but not illegal). For example, in the scenario at paragraph 28 above where a doctor accesses pornography at work and in the presence of colleagues, if the material he/she is viewing is mainstream adult pornography, the fact that no criminal offence has occurred is immaterial. A referral could still be made if the conduct is considered inappropriate. If, however, a doctor accesses mainstream adult pornography in a private setting, the conduct is unlikely to be regarded as inappropriate.

30 A referral to Disclosure Scotland may also be appropriate where a doctor’s conduct involves any extreme, sexually explicit images (however produced and whether real or imaginary) depicting violence against human beings (including possession of such material). Such conduct is likely to meet this part of the referral ground regardless of the setting. Similarly if a doctor allows or forces a child to view pornography, whatever the setting, he/she will be engaging in inappropriate conduct involving pornography and the referral ground will be met.

31 If a doctor is convicted of a criminal offence which involves pornography, it is likely that the Court Service will have made a referral in relation to the doctor (see paragraphs 42-46 below).

Inappropriate sexual conduct

32 This referral ground requires us to consider whether the doctor has engaged in inappropriate conduct of a sexual nature involving a child or protected adult.

33 There are a number of scenarios which could result in a doctor being engaged in ‘inappropriate conduct of a sexual nature’ involving children and/or protected adults. For example, if a doctor undertook an inappropriate examination of a patient that was not clinically indicated, or where a doctor enters an inappropriate relationship of a sexual nature with a patient.

34 Inappropriate conduct of a sexual nature might also include inappropriate touching; coercion to participate in sexually motivated behaviour (for example text messaging, phone calls, inappropriate sexual remarks) as well as any form of sexual activity that involves a child under the age of 18 or a protected adult.

35 Decision makers should note that this part of the referral ground may also be met where a doctor is convicted of, or cautioned in relation to a criminal offence, such as rape or sexual assault, or some other criminal offence of a sexual nature.

36 We should make a referral to Scottish Ministers when we know an individual has been convicted of an offence that we consider satisfies this ground of referral under the PVG Act. It is possible that even though a doctor is doing
regulated work in Scotland they not be PVG Scheme Members and therefore not subject to ongoing monitoring of their criminal records.

37 In all of these cases, before considering making a referral to Scottish Ministers the decision maker will also need to consider whether the referral trigger point has been met (see paragraphs 47–48 below). If a referral is made it is a requirement that we submit with it all of the Prescribed Information that we hold. This is set out in the PVG Prescribed Information Regulations, but the DS referral form provides a helpful guideline as to what to send.

Inappropriate medical treatment

38 The legislation gives us a power to make referrals to Scottish Ministers where a doctor has caused harm through providing inappropriate medical treatment. However, this ground is likely to be used only on an exceptional basis, as the Scottish Government has advised us that they only wish to receive referrals where the actual harm or risk of harm caused by a doctor’s act or omission is over and above harm caused by matters related purely to professional competence.

39 Accordingly, if a doctor caused harm to a patient through poor surgical skills, we would not need to consider making a referral to Scottish Ministers (even if a referral trigger point is met) as the matter relates to the doctor’s competence and thus can be managed through the GMC fitness to practise process.

40 From time to time we receive cases where there is evidence of some kind of intention to cause harm or recklessness as to the possibility of a child or protected adult being harmed. In these cases it is more likely that inappropriate medical treatment (for the purposes of the PVG Act) has been the ‘vehicle’ for causing harm or risk of harm to children and/or protected adults. In such cases, a referral to Scottish Ministers should be considered if the referral trigger point has been met.

How do we treat criminal offences under the PVG Scheme?

41 Unlike the Disclosure and Barring Scheme, under the PVG Scheme we cannot make a referral solely on the basis of a criminal conviction or police caution.

42 Where a court convicts an individual of a relevant offence (as set out in schedule 1 to the 2007 Act), the court must give Disclosure Scotland any prescribed information that it holds in relation to the convicted individual.

43 Section 11 requires that Disclosure Scotland must consider listing an individual in the children’s list where the individual has been referred by a court following a conviction for a relevant offence (relevant offences are applicable only to the children’s list and not the adults’ list). This duty to consider an individual for
listing is referred to as “automatic consideration for listing”. See section 12 of the PVG Act.

44 There is no schedule of relevant offences committed against protected adults which would lead to automatic consideration for listing on the adults list.

45 The courts also have a power to refer an individual for consideration for listing where that individual commits any offence other than a relevant offence (a “discretionary referral”). The court is required to be satisfied that it may be appropriate for the individual to be listed in the children’s list or in the adults’ list or both. Disclosure Scotland will consider this type court referral as they would any other referral if they are satisfied that it may be appropriate for the individual to be listed in the children’s list or adults’ list or both and that the individual does, has done or is likely to do regulated work with children or adults.

46 The Scottish Government has advised that we need only consider making a referral to Scottish Ministers if we consider that a referral ground is met and the referral trigger point has been reached, and we are not aware the court has already made a referral to Scottish Ministers. Decision makers should therefore make enquiries with the convicting court to confirm that a referral has been made before embarking on the DS referral process. Where we receive notice of a criminal conviction and no referral has been made by the court, we should assess the conduct that underpins the offence and decide if a referral ground is met under s.2 of the PVG Act.

Trigger point for considering referrals

47 We will consider a referral to Scottish Ministers where we have concluded our fitness to practise process and where the outcome is erasure. A temporary removal, such as suspension or temporary transfer, should not lead to a referral. For example, if a doctor made sexually inappropriate remarks to a patient and a fitness to practise panel decided to suspend the doctor because of his/her actions, we would not make a referral to Scottish Ministers.

48 Because Scottish Ministers will rely on findings of fact made by the GMC in deciding whether or not to place a doctor on a barring list, we should refer all cases that result in erasure and which meet the referral grounds where we are unaware the same conduct has not already been referred by an employer, employment agency or employment business. This is a referral under s.8 of the PVG Act.

Updates

49 Where we refer cases to Scottish Ministers following erasure there will generally be no need to provide Scottish Ministers with updates on the relevant case
unless the doctor later applies for restoration and we refuse the application for restoration.

**Scottish Ministers’ requests for information**

50 On occasion, Scottish Ministers may exercise their power under s.19 of the PVG Act to request that we provide them with information about a doctor that they are considering placing on a barred list. We must provide the requested information if we have it.

51 Scottish Ministers’ power to request information under s.19 is broad. The provision allows them to request any information that they think might be relevant to their decision about whether to place an individual on a barred list. We are legally required to provide the information requested by Scottish Ministers under s.19 of the PVG Act if we hold it. We are not required to provide information we do not hold. However before we comply with such a request, we must be certain that the request is being made under s.19 (1)(b) of the Act. If Scottish Ministers’ letter does not quote s.19, or quotes a provision other than s.19, we should respond to Scottish Ministers letter asking them to clarify under which provision they are making the request.

52 Where we provide information to Scottish Ministers pursuant to a request made under s.19 of the Act, we will advise the doctor that we have provided the information (unless we have already referred the matter to Scottish Ministers). See paragraphs 57 and 58 below for information on notifying the doctor concerned.

**Prescribed information**

53 Prescribed information refers to information that we must provide if we make a referral under s.8 of the PVG Act. **Schedule 2** of the Regulations specifies what the GMC must provide.

54 If Scottish Ministers make a request for information under s.19 of the PVG Act it will be for specific information and it is not ‘prescribed information’ in the terms of the regulations.

**Cross border protocol**

55 A scheme which is similar to the PVG Scheme has been commenced in England, Wales and Northern Ireland. This Scheme is established under separate legislation and will require a separate process for making referrals to DBS), the body responsible for making barring decisions in England, Wales and Northern Ireland. Separate guidance has been issued covering the GMC’s referral duty in relation to this scheme.
If a doctor is barred under the Scottish PVG Scheme, he/she will be barred for the same group(s) in England, Wales and Northern Ireland, and vice versa. This means that, despite there being two separate schemes to cover all four jurisdictions, GMC decision makers will not need to make dual referrals to DBS and Disclosure Scotland. In deciding which body to refer to, decision makers should consider the following choices, in order:

a  If a doctor holds PVG Scheme membership, refer the matter to Disclosure Scotland; or

b  If the doctor does not hold PVG Scheme membership, decision makers should look at the doctor’s registered address. If it is in Scotland, refer the matter to Disclosure Scotland. If it is in England, Wales or Northern Ireland, refer the matter to the DBS; or

c  Look at where the conduct took place. If the alleged conduct took place in Scotland, refer to Disclosure Scotland. If the alleged conduct happened in England, Wales or Northern Ireland, refer to the DBS.

Notifying the relevant doctor

Where we refer a doctor to Disclosure Scotland our policy is to notify the doctor that a referral has been made. We will also write to the doctor to inform him/her that we have provided information about him/her following a request by Scottish Ministers. 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.

Where there are concerns about a doctors 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.
Annex A

Referrals to Disclosure Scotland: general guidance for decision makers

Does the PVG Scheme Apply?
1. Is the doctor a PVG member? Or
2. Did the conduct occur in Scotland? Or
3. Is the doctor's registered address in Scotland?

YES

Do any of the following apply to the doctor?
1. He/she is currently engaged in Regulated Work
2. He/she has been engaged in Regulated Work in the past
3. He/she has been offered Regulated Work
4. He/she has supplied Regulated Work

YES

Has the doctor, whether or not in the course of his/her Regulated Work done any of the following?
1. Caused Actual Harm to a child or protected about:
2. Exposed a child or protected adult to the Risk of Harm;
3. Engaged in Inappropriate Conduct involving Pornography;
4. Engaged in Inappropriate Conduct of a Sexual Nature involving child or protected adult;
5. Given Inappropriate Medical Treatment to a child or protected adult

YES

Do both of the following apply?
- The case against the doctor has been concluded?
- The doctor has been erased from the LRMP?

YES

Has another organisation referred the case to Disclosure Scotland?

YES

ONLY refer the minutes from the FTP panel hearing

NO

Refer all prescribed information that we hold in relation to the case

FTP process has been concluded but not resulted in Erasure

FTP process has not been concluded

DO NOT REFER

Keep the referral under review
Guidance on disclosure to the Disclosure & Barring Service and Disclosure Scotland under the Medical Act 1983 (Section 35B(2))

Introduction

1 This guidance provides an outline of the GMC’s procedure for referring information to the Disclosure & 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.

The legislative background

3 The GMC has statutory powers to refer doctors who may pose a risk to vulnerable adults or children to the Disclosure & Barring Service (DBS) in England, Wales and Northern Ireland (Safeguarding Vulnerable Groups Act 2006) and to Disclosure Scotland (DS) under the Protecting Vulnerable Groups Act as amended. The DBS or Disclosure Scotland considers the information it receives to decide whether it is appropriate to bar the person from working or volunteering with vulnerable adults and children.

4 A referral can only be made where we hold information about a doctor which meets specific criteria as set out in our guidance for decision makers published on our website. In particular, a referral is usually only appropriate if we hold information that a doctor has committed relevant conduct directly involving a vulnerable adult or child.

5 However, 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 believe if repeated may present a risk of serious harm to vulnerable adults or children, and we believe there is a likelihood of repetition. In that case, we may consider sharing information with the relevant barring authority under our general...
power to disclose anything about a doctor’s fitness to practise to anyone where we consider to be in the public interest under Section 35B(2) of the Medical Act 1983.

What type of information do we routinely disclose to the Disclosure & Barring Service and Disclosure Scotland?

6 There are a number of categories of fitness to practise information which are likely to give rise to disclosure in the public interest to relevant barring authorities under Section 35B(2). Disclosure will usually only be appropriate where there has been a finding of fact by a court or another regulator or the information has led to action on a doctor’s registration or a warning being issued and no referral has been made to the DBS or Disclosure Scotland. These are as follows:

a 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.

b Indecent exposure involving someone other than a vulnerable adult or child.

c Sexual harassment or inappropriate sexually motivated behaviour towards a person other than a vulnerable adult or child, e.g. a work colleague.

d Taking indecent photographs of someone other than a vulnerable adult or child without permission e.g. voyeurism.

e Stalking or harassment of someone other than a vulnerable adult or child, where this involves aggravating factors such as threatening or violent behaviour.

What type of information do we not routinely disclose to the Disclosure & Barring Service and Disclosure Scotland?

7 There are a number of categories of information which is unlikely to be in the public interest to disclose to the barring authorities under Section 35B(2). This is because we do not believe the relevant authorities may wish to consider barring on receipt of this information. These are as follows:

i Soliciting offences which do not involve a vulnerable adult or child.

ii Drug offences where this does not involve a vulnerable adult or child.

iii 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.
How will we apply our discretion?

8 This guidance is indicative only and not intended to be prescriptive or exhaustive and we will continue to apply our discretion in exercising our power under Section 35B(2) to share fitness to practise information with the barring authorities where we consider it to be in the public interest to do so.

More information

9 For more information about our policy on disclosing fitness to practise information please contact Assistant Director for Policy and Planning, Anna Rowland on 020 7189 5167.

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