Audit of the General Chiropractic Council's initial stages fitness to practise process

February 2015

professional standards authority

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We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

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1 The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence

2 CHRE.2010. *Right-touch regulation*. Available at http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation

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1. Overall assessment

Introduction

1.1 In July 2014 we audited all 75 of the cases that the General Chiropractic Council (GCC) had closed at the initial stages of its fitness to practise (FTP) process during the 12 month period from 1 June 2013 to 30 May 2014.

1.2 At the initial stages of the FTP process, the health and care professional regulators decide whether complaints should be referred for a hearing in front of an FTP panel or whether they should be closed.

1.3 We operate a risk based approach to carrying out audits and we audit each regulator at least once every three years. We carried out our last audit of the initial stages of the GCC's FTP process in August 2011.

1.4 Following publication of that audit report, in early 2012 the GCC reported to us that it had discovered 128 FTP complaints (or enquiries that might have become FTP complaints) which had not been properly dealt with. We commended the GCC's openness in this matter and we recorded in our Performance Review reports for 2011/12 and 2012/13 that the discovery of those unprocessed complaints demonstrated problems with the effectiveness of the initial stages of the GCC's fitness to practise processes. We also reported on the remedial action the GCC had taken in respect of the unprocessed complaints and in relation to its procedures for the initial stages of the fitness to practise process in our Performance Review reports for 2011/12, 2012/13 and 2013/14.[3]

1.5 The GCC has introduced several changes in order to improve the quality, consistency and timeliness of its case handling throughout the FTP process. We have commented in the relevant Performance Review reports on the evidence of the impact of those changes on the standard of the GCC's performance. Some of these changes are of particular relevance to the initial handling stage of the FTP process. For example, in late 2012 the GCC began using legal assessors (independent lawyers who provide legal advice to the Investigating Committee at meetings) to draft the Investigating Committee meeting minutes (and to draft the allegations for any case referred to an FTP panel hearing) (which appears to have resulted in improvements to both the quality of decisions and the timeliness of the process). Similarly, in February 2013, the GCC introduced a procedure manual for use by its casework staff. That manual was reviewed by an external regulatory lawyer in February 2014, as a result of which it was revised to include more detail about the steps to be taken once a complaint is received, the process to follow in order to prepare a case for consideration by the Investigating Committee, and relevant deadlines.

1.6 In this audit we looked for evidence that the GCC had complied with the casework framework as well as with its own internal processes and timeframes as set out in its current procedure manual. We also looked for evidence that the measures the GCC had taken following our previous audit had had a positive

[3] We refer to two of these linked unprocessed cases in paragraphs 2.22 and 2.94.

impact on the quality of the Investigating Committee's decisions and on improving the consistency and timeliness of the GCC's case handling.

1.7 Our overriding aim in conducting audits is to seek assurance that the health and care professional regulators we oversee are protecting patients, service users and the public and maintaining confidence in the reputation of the professions and the system of regulation. During our audit, we assessed whether the GCC had achieved these aims in the particular cases we reviewed. We considered whether any weaknesses in the handling of any of these cases might also suggest that the public might not be protected, or confidence not be maintained in the system of regulation, in future cases.

1.8 We summarise our findings and conclusions from this audit below. Our detailed findings are set out at pages 4 - 24 below. Our conclusions and recommendations are set out at pages 25 – 27.

Summary of findings

1.9 We concluded as a result of our audit that the GCC's operation of its initial stages FTP process has not created any risks to public safety, and that in the vast majority of the cases, the IC had made appropriate decisions to close cases without a referral for a hearing. However we also concluded that the extent of the weaknesses in the GCC's case handling that we identified in the audit (set out in detail below) means that its operation of the initial stages of its FTP process does not maintain public confidence in the regulatory process.

1.10 We identified widespread non-compliance with the GCC's own internal procedures, as well as failures to handle cases in accordance with the casework framework. The particular areas of failures/weaknesses identified include:

- Ineffective screening on receipt of 'complaints' and inconsistent completion and updating of risk assessments
- Customer service issues, including failing to respond to/acknowledge correspondence promptly, failing to provide clear information about the FTP process and failing to provide updates about progress and outcomes within reasonable timeframes
- Inadequate investigation of cases - failures to gather or validate relevant evidence or to do so promptly, sometimes as a result of inconsistent and ineffective use of case plans and case reviews
- Deficiencies in the evaluation of information by decision-makers and weaknesses in the reasoning provided for decisions, including failure to address all the relevant allegations and/or reaching decisions, on the basis of insufficient evidence
- Poor record keeping and various data protection breaches or potential breaches
- Ineffective systems for the sharing of relevant information between the Registration and FTP teams, leading to inappropriate action being taken in some cases.

1.11 Some of the errors/weaknesses we identified are basic in nature and a few have potentially serious implications. Most of the errors/weaknesses were observed in several of the cases, and some of them were present in the majority of the cases.

1.12 The extent of the issues identified in our audit suggests that the staff responsible for day to day case-handling were not effectively trained, supervised or monitored, which means not only that errors in individual cases were not avoided or rectified, but also that the GCC missed opportunities to learn lessons that might have improved its overall standard of casework.

1.13 We have set out our full assessment of the GCC's handling of the 75 cases closed at the initial stages of its FTP process that we audited, including the good practice we identified, in our detailed findings below. We have also made a number of recommendations in the conclusions and recommendations section of this report.

Method of auditing

1.14 In March 2010 we led a meeting with representatives from all the nine health and care professional regulators to agree a casework framework which describes the key elements common to the initial stages of an effective fitness to practise process that is focussed on protecting the public. A copy of the final casework framework agreed can be found at Annex 1 of this report.

1.15 When auditing a regulator, we assess their handling of cases against this casework framework. Our detailed findings are set out below under the headings referred to in the casework framework. We also take into account information gathered during previous audits, information we are provided with in our annual Performance Review of the regulators, concerns we receive about the performance of the regulator, and any other relevant information that is brought to our attention.

1.16 In this audit we reviewed 75 cases which had been closed by the GCC without being referred for a hearing in front of an FTP panel.

The GCC's FTP framework

1.17 The legislative framework governing the GCC's fitness to practise function[4] means that all allegations about a registrant's fitness to practise must be considered by GCC's Investigating Committee (IC).

1.18 The only allegations that the GCC can investigate are allegations of:

- Unacceptable professional conduct (UPC)
- Incompetence
- Criminal convictions
- Concerns about a physical or mental condition that has the potential to impact on a registrant's ability to treat patients.

1.19 The GCC's procedure manual states that an allegation can be either written or verbal and where it is not clear if someone is making an allegation (for example,

[4] The Chiropractors Act 1994 http://www.gcc-uk.org/UserFiles/Docs/The%20Chiropractors%20Act%201994.pdf

if the person says they are seeking advice) attempts should be made to clarify the situation. If there is still doubt about whether something is an allegation, the case should be referred to the IC.

The role of the IC

1.20 The IC is made up of chiropractic and non-chiropractic (or lay) members. Each meeting of the IC must involve at least three members of the IC – one of whom must be a chiropractor and one of whom must be a lay member. The IC is always chaired by a lay member. The IC also sits with a Legal Assessor. The role of the Legal Assessor is to advise the IC on points of law and procedure - the Legal Assessor is not involved in the IC's decision-making.

1.21 The IC considers whether or not it would be possible for an FTP panel to find the facts alleged proved at a hearing and if so, whether the facts proved would amount to UPC. If the IC decides that such a finding would be possible, it drafts formal allegations. If the IC decides that such a finding is not possible it closes the case. In either event, the IC's decision and the reasons for its decision are communicated in writing to the complainant and to the registrant.

2. Detailed findings

2.1 Overall, we found that the GCC's initial stages FTP process continues to protect the public. However, we found widespread weaknesses in the GCC's systems and processes in all the essential areas of initial stages casework set out in our casework framework (see Annex 1). We also found that the GCC had not operated its own casework handling processes consistently in accordance with its internal guidance and procedures. Our overall conclusions about the GCC's handling of its initial stages casework can be found at paragraphs 3.1–3.5.

2.2 In addition to the weaknesses and areas for improvement we identified during the audit, we also saw evidence of actions taken by GCC staff in individual cases that could be regarded as good practice if they were adopted routinely. For example:

- The use of password protection for affidavits sent by email in one case
- The inclusion within the decision letter sent to the registrant of an appendix listing all the documents which had been considered by the IC
- Identifying that a witness was potentially vulnerable and making arrangements to meet them at the train station to chaperone them to the GCC's offices
- Providing a complainant with a copy of the Authority's guidance on sexual boundaries between healthcare professionals and patients.

2.3 The weaknesses and areas for improvement that we identified during our audit are set out below, by reference to the principles set out in the casework framework (see Annex 1), as well as by reference to the GCC's internal casework guidance.

Receipt of initial information

2.4 During our audit we looked to see whether the GCC was adhering to guidance in the casework framework which includes: that there are no unnecessary tasks or hurdles for complainants/informants; that complaints/concerns are not screened out for unjustifiable procedural reasons; that clear information is provided; and that a timely response is given, including acknowledgements and seeking clarification where necessary.

2.5 We audited 61 cases where we identified weaknesses in the GCC's handling of this stage of the fitness to practise process.

Screening of complaints/concerns

2.6 The GCC's procedure manual appears to allow GCC staff to decide (after discussion with the FTP Lawyer and the Director of Resources and Regulation) that a particular matter does not amount to an allegation that needs to be considered by the IC. However, during this audit we saw several cases which had gone through the FTP process and been considered by the IC, although they essentially concerned requests for information from members of the public, rather than complaints about FTP matters. It was not clear to us why the GCC had decided that those enquiries should be treated as FTP allegations, or whether proper consideration had been given to that issue at the start of the case. We noted that in several of these cases the 'complainant' withdrew their 'complaint' or otherwise said they were unwilling to co-operate at an early stage of the process.

2.7 We also saw 10 cases which essentially concerned business disputes, of a type and level of seriousness which we considered would not generally be treated by other regulators as raising FTP issues, whether or not 'complaints' about them had been made. For example, in one case the GCC received a complaint from the owner of a property who stated that the registrant had failed to pay his rent. It was not clear to us why the GCC had treated that as an FTP matter and had opened an investigation into it.

2.8 In response to our audit feedback about the initial screening of complaints, the GCC has informed us that its Council has recently approved a change to its current approach which means that, in future, complaints about business disputes will be considered on a case by case basis and progressed to the IC only where there is a public protection issue. We welcome that development. However, we note that the GCC has not advised us that it intends to change its procedure in relation to the categorisation of requests for information as FTP matters.

Cases involving unnecessary tasks or hurdles for complainants

2.9 We identified three cases where the GCC had failed to ensure there were no unnecessary tasks or hurdles for complainants when initially making their complaint.

2.10 In one case it was clear from the complainant's initial emails that they had difficulty understanding written English. The GCC made no attempt to speak to

the complainant by telephone for over three weeks after the complaint was initially received.

2.11 In two other cases emails from the complainant were routed to the GCC caseworker's 'junk' email inbox and so were not read or actioned promptly. In response to our audit feedback, the GCC has informed us that this issue is rare and any instances would be considered and resolved by its outsourced IT team.

Failure to provide clear information

2.12 We identified 10 cases where the GCC failed to provide clear information about the fitness to practise process to the complainant at the outset of the case. In six of these cases the GCC failed to tailor its standard letters appropriately to ensure that clear information was provided.

2.13 In one of these cases the GCC did not explain to the complainant the consequences for the case of their remaining anonymous, or that their identity could be protected if the case went to a public hearing. We noted that the GCC did not explain how it would obtain the complainant's records without revealing the complainant's identity to the registrant.

Failure to provide a timely response or acknowledgements

2.14 We identified four cases where the GCC failed to respond to an initial complaint or provide an acknowledgment in a timely manner. We were particularly concerned about the GCC's delay in contacting the complainant in one of those cases (it took the GCC four weeks to do so) because the case concerned an allegation that the registrant had had an inappropriate relationship with two patients, and it might therefore have been necessary for the GCC to risk assess it promptly.

Failure to seek appropriate clarification

2.15 In 15 cases we found that the GCC failed to seek clarification from the complainant promptly.

2.16 In one of those cases the GCC had failed to make any independent enquiries of the patient to establish whether they had reported an alleged assault to the police.

2.17 In another two of those cases the GCC did not clarify if the patient's mother had legal power to make a complaint on the patient's behalf and nor did the GCC establish the date when the patient had lost capacity to make their own decisions.

2.18 In a further four cases the GCC did not take steps to clarify the details of the complaint at the outset, for example by taking a statement from the complainant. This led to delays in obtaining evidence, and in one of the four cases, to the IC closing the investigation into the allegation that the registrant had made disparaging remarks about patients and other chiropractors (because the GCC had not obtained sufficient details about what the complainant claimed the registrant had said). The other three cases were ultimately closed once the complainants withdrew their complaints.

Failure to follow internal processes

2.19 In this audit, in addition to the failures to comply with the casework framework identified above, we also saw evidence that the GCC had not complied with its own internal guidance and processes at the receipt of information stage of the FTP process, as set out below:

- In 23 cases we found that the GCC had not acknowledged the initial complaint within two days, as required by its procedure manual. In three of those cases, the initial complaint was not acknowledged until two weeks after it was received. In three of those cases the case was also not allocated to a caseworker within five days, as required by the procedure manual
- In 19 cases (15 of which were different cases to the 23 cases referred to above) we found no record of compliance with the procedure manual's requirement for the complaint to be considered by the GCC's FTP lawyer
- In one of the 19 cases referred to above there was also no record of compliance with the requirement in the procedure manual for the FTP lawyer to consider the case once the complainant said they wished to withdraw the complaint.

Risk assessment

2.20 Conducting risk assessments on receipt of new complaints and upon receipt of further information is necessary in order to enable the regulator to assess what action should be taken and to prioritise appropriately. In some circumstances the regulator may need to take immediate action to protect the public, such as applying for an interim order to be imposed to prevent the registrant from practising unrestricted while the investigation is on-going. The casework framework indicates that records should be kept of the reasons for risk assessment decisions.

Concerns about risk assessment decisions

2.21 In three cases that we audited we were not satisfied that the GCC's decisions not to apply for interim orders were appropriate. In the first case the GCC did not appear to have applied the correct legal test in considering whether or not to apply for an interim order. In the second case (which concerned an allegation of inappropriate touching by the registrant) inadequate reasons were provided for the decision not to apply for an interim order at that stage. In the third case (which concerned an allegation of assault on a baby) the GCC apparently concluded that no interim order application was required on the basis that the police were taking no action at that time.

Failure to conduct risk assessments

2.22 In six cases that we audited there was no record that the GCC had ever undertaken a risk assessment, either on receipt of the complaint, or later in the lifetime of the case. We did not conclude that the GCC should have taken any urgent interim action in any of these cases, but we were concerned by the absence of any evidence of risk assessment by the GCC. We were particularly concerned about the failure to assess risk in two linked cases where there was

information on the file that one of the two registrants involved was already the subject of a case going to a hearing which concerned similar allegations.

Recording reasons for risk assessment decisions

2.23 We were pleased to note that risk assessments were carried out in the remaining 69 cases that we audited. However, in the vast majority of those cases (48) there was no record of the GCC's reasons for concluding that it was not necessary to apply for an interim order suspending the registrant from practising while the allegations were investigated. We note that, at the time those risk assessments were completed; the GCC's documentation did not require reasons for those decisions to be recorded (although our casework framework does include such a requirement). In response to our audit feedback the GCC has confirmed that it has now amended its documentation to require reasons to be given.

Failing to review risk assessments

2.24 We were also concerned to find that in 54 of the cases that we audited, the initial risk assessment was not reviewed by the GCC during the lifetime of the case. This included one case where the GCC failed to review the risk assessment despite receiving new allegations which were serious, of a sexual nature and had been reported to the police.

2.25 In response to our audit feedback the GCC has told us that it has revised its procedure manual to strengthen the process for reviewing risk assessments, following an audit it commissioned from an external solicitor in February 2014 which also highlighted this issue. While we are pleased to note that the GCC has revised its procedure manual around the requirement to review risk assessments, we note that the original manual also required staff to carry out risk assessment reviews, and that requirement was routinely breached. We will look for evidence in our next audit that the change to the manual has resulted in risk assessments being routinely reviewed.

Gathering information and evidence

2.26 Gathering relevant information and evidence at an early stage in the FTP process is essential to enabling a regulator to ensure that appropriate decisions can be reached and that any necessary action is taken promptly.

2.27 In this audit we found weaknesses in the GCC's gathering of information and evidence in the majority of the cases we audited (42 out of 75).This gives rise to a risk that cases may have been closed without adequate investigation.

Planning the investigation/prioritise time frames

2.28 In addition, we identified a large number of cases where the GCC had failed to follow the guidance in its own procedure manual:

- In eight cases we found that no case plan was ever created. In 18 cases we found that the case plan was not completed within five days of allocation of the case, as required in the procedure manual. In one of these cases (also referred to in paragraph 2.90 below) the case plan was not created until three months after the case was opened

- In 42 cases a case plan had been created but it was not updated during the lifetime of the case
- In eight cases a checklist had had not been created, as required by the procedure manual.

2.29 These failures to create case plans promptly (or at all) or to update them may have directly contributed to the failures to gather sufficient evidence which are highlighted below.

2.30 In six cases we identified unnecessary delays in the GCC requesting and providing relevant information to and from the complainant. In one case a complaint was received about alleged offensive material on the registrant's website. The GCC did not follow up on its initial letter to the complainant for two and a half weeks, nor did it access the registrant's website itself. By the time the GCC followed up on its letter to the complainant, the offending material had been removed from the website and the complainant wished to withdraw their complaint.

2.31 In nine cases that we audited the GCC failed to follow the steps set out in its case plan to gather information during the investigation and/or its case plan was inadequate. Examples are set out below:

- In one of those cases the case plan did not set out any investigative steps beyond writing to the complainant to obtain a witness statement and notifying the registrant of the complaint
- In another case the case plan did not identify the need to obtain either the dossier of evidence which the complainant had gathered from various patients or the patients' contact details. Further, the GCC appears to have been content to allow the complainant to continue compiling their own dossier of materials, even though it should have been clear from the correspondence that the complainant did not fully understand the GCC's role and that they could not conduct an impartial investigation into the matter
- In the same case, the complainant raised a new concern in a later email regarding treating a patient without consent. There was no indication that the GCC considered whether or not that should be investigated
- In a third case it was not clear from the file why the GCC Registrar had initiated the complaint. In addition, while it appears that the Registrar had suggested that a particular staff member should be contacted to provide witness evidence, that action was not taken, nor was any reason for that omission recorded
- In a fourth case the caseworker agreed to redact portions of the complainant's medical records that referred to a particular medical condition - however there is no record that any consideration was given to the potential relevance of that condition to the condition being treated by the registrant. As a result, neither the registrant nor the IC had access to the complete records.

Gathering sufficient information

2.32 In 17 cases we found that the GCC had failed to gather sufficient, proportionate and relevant information at the appropriate time.

2.33 We set out examples below:

- In one case we found no evidence that the GCC had considered obtaining corroborating evidence either from a colleague of the complainant (to whom the complainant claimed to have reported the incident shortly after it happened) or from the complainant's mother. Ultimately the IC closed the case, despite the fact that the registrant had no recollection of events so could not contradict the complainant's account[5]. Had the GCC sought evidence from the other potential witnesses, that might have formed a more robust basis for the IC's decision
- In a second case a complaint was received about statements made on a registrant's website. When the complainant decided to withdraw their complaint, the GCC did not (it appears) check for itself that the offending text on the website had been changed
- In another case although the complainant had included a link to the website they were complaining about in their original email to the GCC, the GCC did not use that link to access the website and instead asked the complainant to send copies of the relevant website pages.

Provision of expert advice

2.34 In one case a note on file recorded that the GCC had decided against obtaining an expert report partly on the basis of costs. We consider it would have been helpful to obtain an expert report in this case (as was noted in the initial case plan) given the complications caused by the complainant's prior medical conditions. However, we acknowledge that the case concerned a one-off incident of alleged harm to a patient during clinical treatment, which means that the IC's decision that the case was not serious enough to amount to unprofessional conduct was reasonable, and unlikely to have been altered by having access to an expert report.

2.35 In a second case the GCC did not consider obtaining an expert report at the outset of the investigation. We consider this should have been identified within the case plan as we consider the provision of expert advice was warranted due to the complex nature of the allegations.

Liaising with the parties

2.36 In seven cases we found that the GCC had failed to liaise with third parties to gather and validate information.

2.37 We were particularly concerned by one of those cases, which involved two patients who wished to remain anonymous. The GCC did not explain in adequate detail to the complainants (although this was a requirement within the GCC's procedure manual) that they would not have to meet the registrant and that they could remain anonymous in any public hearing. Both complainants subsequently

[5] We also refer to this case in paragraph 2.55.

decided to withdraw their complaints and not to provide witness evidence. A further concern was that although one of the complainants offered to provide the GCC with relevant text messages from the registrant, there was no record that the GCC followed up that offer.

2.38 In another of the cases referred to in paragraph 2.36 it was unclear whether the GCC was still investigating the aspect of the complaint that concerned the registrant denying the complainant access to the complainant's records once those records had in fact been returned to the complainant by the registrant. The GCC failed to clarify with the complainant that this part of the complaint was no longer 'live' once the records had been provided, and then did not make that clear to the registrant or the IC.

Reviewing the investigation

2.39 During this audit we became concerned that the purpose of the case reviews carried out by the GCC's staff did not appear to be clear to the staff and that reviews were not being carried out routinely or used consistently.

2.40 The GCC states that the purpose of case reviews is to highlight whether any further information is required; whether the risk profile of a case has changed and to confirm the completeness of the records received. The procedure manual[6] provides examples of situations when the case plan should be reviewed. We did not see evidence that that this had been complied with in the overwhelming majority of cases.

2.41 In one case we noted that the case review appeared merely to summarise the registrant's and complainant's comments on the case and the medical records. In another case the case review recorded an opinion that the medical records were consistent with the complainant's account - without noting that the records also revealed that the complainant's pain had been a longstanding problem (which was not consistent with the complainant's account).

2.42 In a third case we found no evidence that case reviews were completed at all – such reviews might have highlighted the need for further investigation, such as obtaining corroborating evidence.

2.43 In response to our audit feedback about the gathering of information and evidence the GCC has informed us that, following an audit it commissioned from an external solicitor in February 2014, it has amended its procedure manual to require two-weekly reviews of the cases each member of staff is dealing with. We will look for evidence of improvement in this area of GCC's case handling in our next audit.

[6] Section 18 (b) states: reviews of the case plan, by the case holder, then take place when:
- The witness statement has been agreed;
- Respondent observations are received;
- Complainant's comments are received;
- Respondent's further observations are received;
- Medical and other relevant records are received; and
- The case is referred to and from the IC.

Evaluation and giving reasons for decisions

2.44 Ensuring that detailed reasons are given for decisions which clearly demonstrate that all the relevant issues have been addressed, is essential to maintaining public confidence in the regulatory process. The provision of well-reasoned decisions also acts as a check to ensure that the decisions themselves are robust.

2.45 In our last audit we identified failures to provide all relevant information to the IC which might have impacted on the IC's decisions in linked cases. During this audit we looked for evidence that the GCC had improved on this area of weakness. Our findings indicate that the GCC needs to continue to improve in this area. We set out an example of one such concern in paragraph 2.52 below.

2.46 We are pleased to report that this audit did not identify any decisions to close cases that might pose a risk to patient safety. However we note that this largely reflects the fact that the majority of the cases we audited did not concern complaints that raised patient safety issues[7].

2.47 We identified a number of other concerns about the IC's evaluation and decision-making.

2.48 We identified six cases where we were concerned that the IC's closure decisions might have the effect of failing to maintain public confidence in the profession and/or in the regulatory process.[8]

Recording and giving sufficient reasons

2.49 We identified 29 cases where we found deficiencies in the GCC's evaluation of information and/or the provision of robust reasons for its decisions.

2.50 We identified 10 cases in which inadequate reasons for the IC's decisions were provided.

2.51 In one of these cases, the registrant admitted conducting an intimate examination of the complainant and making inappropriate comments immediately afterwards. In response to our audit feedback the GCC told us that the case was closed because, as the intimate examination could be clinically justified, there was no basis for attributing a sexual motivation to the registrant's inappropriate comments made afterwards. While we acknowledge that the registrant had demonstrated insight and remorse by admitting the allegation and by apologising for their behaviour, we consider the IC's decision provided inadequate reasons to explain why a referral to an FTP panel hearing (where the evidence could be tested and a full assessment made of the registrant's and complainant's respective credibility) was not made

2.52 Examples of the other cases in this section are set out below:

- A registrant involved in one case was the subject of two ongoing complaints raising similar allegations. We considered that the IC should have demonstrated it had taken account of that in the reasons for its decision to close the case. In response to our feedback, the IC has

[7] Please see paragraph 2.6 above in relation to enquiries/requests for information being treated as FTP complaints

[8] Please see paragraphs 2.94 - 2.99 for details of these cases

commented that it would need to be presented with a registrant's regulatory history in order to be able to take other allegations into account

- In a second case the IC concluded that there were aspects of the registrant's practice which could be criticised. However the IC's decision does not make it clear which aspects of the registrant's practice were open to criticism, nor how serious that was
- The IC eventually closed a third case, having accepted the registrant's assurances that he had upgraded his computer system. It was not clear whether the IC, when deciding it could close the case, took proper account of the span of the registrant's poor record-keeping practice which had been identified previously
- In a fourth case it was not clear from the IC's decision whether the reason the case was closed was because the complainant had only attended one appointment, and therefore the registrant had had no opportunity to review their initial findings. In response to our feedback the IC has commented that it did take into account that the case involved a single appointment when reaching the conclusion that the conduct did not amount to a serious failure to meet the required standard. We note that there was no record of this consideration in the IC's reasons
- In a fifth case it was not clear whether the IC had listened to an audio recording made by the complainant and if so, how it had taken that recording into account in reaching its decision
- In a sixth case we considered that the IC's reasons were too brief, particularly in relation to the IC's evaluation of the registrant's explanation of a particular clinical technique they had used. We also considered that the IC's decision would have been more robust if it had set out the nature of the registrant's communication failures
- In a seventh case the IC concluded 'the matters complained of by [the complainant], if proved, could not justify a finding of unacceptable professional conduct'. We considered that the basis for the IC's conclusion was unclear because the complaint related to potentially incorrect diagnosis and treatment
- In another case there was documentary evidence that supported the complainant's account that the registrant had asked a patient to pay in cash, in breach of the practice policy. It was not clear from the IC's decision how the IC had concluded that there was no case to answer, given that the evidence supported the complainant's claim of dishonest behaviour. In response to our audit feedback the IC has clarified how it concluded that dishonesty was not met in this case.

2.53 We look at one of the 29 cases mentioned in paragraph 2.49 above in more detail in paragraph 2.98 below, in the context of decisions that may fail to maintain public confidence in the profession and/or the regulatory process.

Addressing all allegations and identified issues

2.54 In three cases we found decision makers had failed to address all the relevant identified allegations and issues:

- In two cases the IC's decision did not refer to all the relevant issues. In the first case the GCC did not draw to the IC's attention additional allegations that had been made by the complainant when they commented on the registrant's observations (the complainant alleged that the registrant had commented on the complainant's clothing, had asked the complainant to remove their underwear, and had treated the complainant while the complainant was not wearing underwear). It is not clear from the IC's decision that the IC did in fact consider the complainant's allegations about the removal of the complainant's underwear. In response to our feedback the IC has assured us that it considered all aspects of the complaint. In the second case the IC's decision did not address aspects of the complaint concerning the explanation given for a refusal to treat, and complaint handling
- The IC's decision in the third case suggests that it was considered at the same time as another case, and that the complaints were the same. However, the information on the file suggests that the two complainants had raised different concerns.

2.55 In two cases that we audited we were concerned that the IC's decision to close the case without further action was unsound:

- In one case (which concerned an allegation that the registrant undid the complainant's underwear, without asking permission or explaining why) the IC commented that the complainant might have been mistaken about the treatment received, or there might have been a misunderstanding - even though the registrant had no recollection of the consultation and was only able to comment on their usual practice, and the complainant's account was therefore undisputed. The basis for the IC's decision was an assumption that the complainant's account was not credible, given the passage of time (seven years had passed). As noted in paragraph 2.33 above, the GCC had missed an opportunity to seek evidence that might have corroborated the complainant's account of conversations she had had shortly after the incident. In our view, given the circumstances of the case, the IC's approach (that the complainant's account was not credible based simply on the passage of time) did not provide a sound basis for its decision to close the case. We considered that the appropriate decision would have been either: to adjourn to seek further evidence; or to decide that the allegation itself was simply not serious enough to pass the legal test for referral for a hearing, regardless of whether or not it could be proved; or to refer the case for a hearing by an FTP panel
- In the second case the IC's decision did not address whether the treatment provided could have resulted in injury to the complainant. We noted that the IC did not have the benefit of an expert report to help with consideration of this issue. The IC decided that if it were proved that the registrant had known about the patient's pre-existing condition and had failed to act on that information, the registrant would have failed in their

duty of care. The IC stated that as that would have been an isolated lapse; it would be insufficient to require a referral for a hearing and it closed the case. We were concerned about the IC's approach that a one off incident of this type could not be serious enough to require a referral for a hearing. In response to our audit feedback the IC has stated that it reached its conclusion after hearing detailed legal advice on the meaning of UPC.

Considering the need for further evidence/information

2.56 In six cases that we audited it was not clear if the IC had enough evidence on which to base a sound decision to close the case. Examples are set out below.

2.57 In the first case the IC did not have sight of the patient's GP records when reaching its decision. We accept the IC's explanation that it did not seek to obtain the records because it would have been inappropriate to do so, as the complainant had withdrawn the complaint. In the second case no information was gathered regarding the allegation that the registrant had practised without indemnity insurance, and that issue was not addressed in the IC's reasons.

2.58 In two further cases we considered that the IC should have adjourned so that the GCC could try to obtain the patient's medical records.

2.59 The IC's decision in the fifth case refers to a lack of direct patient evidence supporting the complaint. We were concerned that if the IC considered that the complaint was potentially serious enough to require a referral for a hearing if there was enough evidence to prove it, the appropriate decision would have been to direct the GCC to obtain evidence from the patients concerned, rather than to close the case.

2.60 In the same case we were concerned that the IC failed to correctly identify that it needed further information. The decision of the IC to close the case stated *'The Committee concluded that there was no case to answer either on the basis of the chiropractic records or on the basis of a patient complaint'.* We note the GP records (although requested) had not been received by the GCC or considered by the IC.

Customer care

2.61 Good customer service is essential to maintaining confidence in the regulator. In our last audit we identified that there were delays in communicating the outcome of IC meetings to the parties in all of the cases audited. As referred to in paragraph 1.4 above, the GCC told us that it had taken action following our previous audit in order to address this issue.

2.62 During this audit we identified various areas of weakness in the GCC's customer care, including in the provision of regular updates and acknowledgements to parties, complying with the GCC's own process and responding to queries raised by the parties.

Informing the parties of progress and outcomes

2.63 While we were pleased to see in this audit evidence that the GCC now generally notifies the parties of the IC's decisions far more promptly than was its previous

practice, we nevertheless identified general non-compliance with the internal timeframes the GCC has set itself:

- In 30 cases the parties were not informed of the IC decision within 24 hours. The IC considered one of these cases four times and the parties were not informed of the outcome of any of those four IC meetings within the set timeframe. Following the first IC meeting, the formal letter to both the registrant and complainant containing the IC's decision was not sent until over four weeks after the meeting had taken place. No apology or explanation was provided for the delay in providing the decision letters. In another three of these cases, the parties were never provided with the IC's decision in full
- In five of those 30 cases (and in 27 other cases) the parties were not provided with the IC's decision, in full, within seven days
- In eight cases either the registrant or the complainant or both were not informed of the date of the IC meeting at which their case would be considered
- In another eight cases the registrant was never informed that they were under investigation at all.

2.64 In six cases that we audited we found the GCC had failed to provide regular updates to the parties. In one of those cases there were significant delays in updating the parties – the complainant was not updated for a period of over two months at three different stages during the lifetime of the case. In a second case (and in a further 12 cases) the GCC had not acknowledged receipt of information or correspondence from the parties. We found that the GCC had failed to provide a response to queries and requests from the parties in one of those cases, as well as in a further 13 cases In one of those cases there was a seven month gap between the registrant's query and the GCC's next contact with them and no apology or explanation was offered for the delayed response.

2.65 In one of those cases and in a further seven cases we identified administrative failings had caused an unnecessary delay in the GCC's obtaining/provision of relevant information to the parties. In one of those cases the GCC failed to follow up a request for information for almost four weeks.

2.66 In one case we audited the GCC wrote to the registrant's representative to inform them of the IC meeting date at which the case would be considered. The GCC only updated that information three days before the rescheduled IC meeting date. No explanation or apology for the change of date was given.

2.67 In a further case there was no record that the GCC followed up on the complainant's willingness to make the complaint.

2.68 In another case the complainant was asked to contact the caseworker on a particular date to arrange for a witness statement to be prepared, but this was not followed up until the complainant contacted the caseworker over three weeks later, by which time the complainant was clearly frustrated that the GCC had not progressed the case.

2.69 In two cases that we audited there were issues related to the GCC's IT system which had a negative impact on the customer service provided to parties. In one

case the complainant emailed the GCC to request an extension of time but the GCC was not able to reply to that request until the deadline had passed because the complainant's email being routed to the caseworker's 'junk' email inbox. In another case a complainant raised a concern that the response they had received from an email sent to the GCC's general complaints email address was a failure notice saying 'invalid recipient'.

Explaining the regulatory process

2.70 We saw eight cases where the GCC had failed to explain to the complainant why an IC meeting had been adjourned or why the IC still needed to consider the case even though the complainant had withdrawn their complaint.

2.71 In one case, when notifying the complainant of the outcome the GCC told them that *'it would remain open to you to re-submit your complaint to the Investigating Committee in the future, should you so wish'.* We were concerned that the GCC did not explain the circumstances in which re-submitting a complaint that had already been considered might be appropriate (for example in the event of a repetition of the offending behaviour, or of new evidence coming to light) and that the letter might therefore raise false expectations about the regulatory process.

2.72 In another case, the GCC when responding to the complainant's email stating that they were unhappy with the IC's closure decision, advised that once the complainant had reviewed the full details of the IC's decision and drafted a letter to the Privy Council, the GCC would be happy to put that letter before the IC at its next meeting. In responding to our audit feedback, the GCC has not explained what purpose putting the complainant's letter to the IC could serve. Our concern is that the GCC's suggestion may have given the complainant false expectations that the IC might change its decision.

2.73 We considered that a letter sent by the GCC to a person who had contacted the GCC but who had said they did not intend to make a complaint was potentially confusing because the letter stated '*we will now begin to investigate …'* and it included standard consent forms for completion by a complainant. It appeared to us that the letter had not been appropriately tailored to the circumstances of the case. We noted that it was not clear from the file whether or not the GCC was treating the information provided as an FTP matter at this time. We considered that this letter should have explained the GCC's complaints process to the recipient.

2.74 We also identified administrative failings which meant the GCC failed to follow its own internal processes in 15 cases. In one of those cases a letter to the complainant was sent to the wrong house number and was returned to the GCC marked 'not called for'. While the letter was then sent by email to the complainant, we noted that no action was taken in order to establish why the error had occurred, even though it could have resulted in confidential data being disclosed in appropriately. In another of those cases we found no record of compliance with the procedure manual's requirement to confirm that the GCC had permission to share the complainant's details with the registrant.

Record keeping

2.75 We consider that the maintenance of a single comprehensive record of all actions and information on a case is essential for effective case handling and good quality decision making. Poor record keeping can lead to inappropriate decision making and poor customer service.

2.76 In this audit we found the GCC had demonstrated a poor standard of record keeping across the case files. We saw failures to record actions taken, failures to record reasons for decisions, as well as failures to share relevant information between the GCC's Registration and FTP teams, which meant that in some cases inappropriate registration action was taken.

2.77 Following our last audit we recommended the GCC reviewed its policy of not recording FTP history on the relevant case files and its policy on alerting the IC to a registrant's previous FTP history.

2.78 During this audit we identified four cases where we considered that there was a failure to record FTP history or to do so accurately. In a further case there was no record that the registrant's previous FTP/prosecutions history had been taken into account by the Registrar when granting re-registration.

2.79 Following this audit we asked the GCC to clarify whether it routinely informs the IC whether or not the registrant in each case has any FTP history. We also asked the GCC to explain what it treats as being FTP history for these purposes. We were particularly interested to check whether the GCC only informs the IC that there is FTP history in circumstances where the registrant concerned has been the subject of a referral to an FTP panel hearing that has resulted in a finding of unprofessional conduct, or whether the IC is also informed if a previous complaint has resulted in a less serious outcome. The GCC has not provided any response to our query.

Links between the Registration and FTP processes

2.80 49 of the cases we audited contained no evidence to show that the Registrations team had been informed by the FTP team that the registrants were under investigation.

2.81 In response to our audit feedback about this, the GCC has provided us with evidence to show that in the majority of these cases the Registrations team was informed about the FTP investigation and that the Registrations database was updated appropriately – that is, that the only issue is about failing to record those actions on the files. While the casework framework does not require records to be kept of such actions, we consider it good practice to keep a record on the case file of internal correspondence about changes that are required to the Registrations database.

2.82 In one of the cases referred to in paragraph 2.78 above, the GCC received a complaint that a former registrant was practising whilst unregistered. Whilst we note the GCC carried out Google searches which revealed websites advertising the former registrant's services as a chiropractor, and the GCC sent warning letters to the former registrant; the GCC did not instruct an enquiry agent to investigate until 14 months after the GCC had received the complaint. In fact, the former registrant had re-registered one week before the enquiry agent was

instructed. We were concerned by the fact that the FTP team were not aware that the individual had re-registered – which indicated a failure in communication between the Registrations and FTP teams.

2.83 In another case, the GCC has provided us with evidence from its database which shows that the registration status of an individual was not changed to show they were under investigation.

2.84 We identified nine cases during this audit where we found that the GCC had failed to accurately record the current FTP status of the registrant on the case file. In one of these cases there was a separate case under way concerning the registrant's alleged dishonesty, but the two cases were not linked. In another case the registration status of the registrant was changed to 'under investigation' eight days after the investigation was opened - however this was not recorded in the case file, as is required by the GCC's procedures. In the same case an email from the Registration Officer asked the FTP caseworker whether the registrant had any other FTP history – which caused us a degree of concern because it suggests that the Registration Officer felt unable to rely upon the Registrations database.

Comprehensive, clear and coherent case records

2.85 During this audit we identified widespread misfiling of documents and found several files where all the relevant information had not been filed in a single accessible place. We also saw evidence of some documents not being dated, of documents being omitted from the bundles of papers for the IC (and therefore having to be provided separately) and of poor file maintenance, with many case files not kept in chronological or any other logical order.

2.86 We also found that generally there were inadequate records of actions that are required by the GCC's procedure manual. For example:

- In 42 of the cases we audited there were no documented records of the case reviews that are required to take place between paralegals and FTP lawyers, or of any action points arising from those case reviews
- In four cases there was no record of the IC Chair's agreement to grant a request for an extension of time (although the extensions were granted)
- In 13 cases there were no records to demonstrate completion of case preparation requirements set out in the procedure manual.

2.87 The GCC has informed us that it has revised its filing systems to ensure consistency and that more rigorous monitoring of cases will take place in future. We will expect to see improvement in the overall standard of the GCC's record keeping in our next audit.

Timeliness and monitoring of progress

2.88 The timely progression of cases is one of the essential elements of a good FTP process. It is essential to manage workflow evenly, because delays in one part of the process that cause backlogs can stress the system unless relieved quickly.

2.89 In this audit we saw a number of cases where the GCC had not taken action in a timely manner, including 23 cases where actions that were required in order to

comply with the procedure manual had not been taken or documented promptly. This led to a concern that case progression was not being actively monitored by the GCC so that any delays could be identified and rectified promptly.

2.90 We set out various examples below.

- We found six cases where the GCC did not request relevant medical records promptly. In one of those cases, the complainant's records were not requested until 22 months after the complaint had been received, even though the IC had instructed the GCC to obtain the records six months earlier. In a further case the GCC did not follow up its requests for records systematically - the final set of records did not arrive until over three months after the requests were initially made
- In a seventh case there were long gaps between warning letters being sent to the registrant and any further action being taken by the GCC when the registrant failed to respond, including one gap of almost seven months. There was also a period of almost six months of no active case management
- In two other cases there were unnecessary delays of between three and seven weeks in finalising witness evidence
- In one of the cases referred to in the first bullet point above (which took two years to conclude) the GCC also did not disclose the registrant's observations to the complainant until over two months after they had been received despite two documented reminders to do so
- In a tenth case the checklist and case plan were not completed until over three months after the case had been opened (as referred to in paragraph 2.28 above). There was also a delay of one month in disclosing the registrant's observations to the complainant
- In the eleventh case there was a delay of six weeks in chasing the complainant to confirm they wished to proceed with the complaint
- In a twelfth case there was a delay in considering whether information amounted to an allegation. The case was not formally opened until almost two weeks after the complaint was first received and this only occurred after the case was reviewed by an FTP lawyer
- We audited four cases which had to wait for periods of between one and four months for the IC to consider them, due to the volume of cases waiting for consideration by the IC.

2.91 We were concerned about significant delays in the progression of one case that we audited. No action was taken by the GCC until almost 13 months after the complaint was initially received - the GCC did not classify the complaint as an allegation until over one year after it had been received, and the IC first considered the case four months after that. There was also a delay in notifying the registrant about the complaint – this was not done until almost six months after the IC first instructed the GCC to do so.

2.92 We audited two linked cases where there was an unexplained period of five months' inactivity by the GCC during the investigation. The GCC has not been able to provide us with an explanation in its response to our audit feedback.

Public protection

2.93 Each stage of the regulatory process should be focused on protecting the public. Protection of the public includes not only directly protecting them from harm, but also declaring and upholding professional standards, and maintaining public confidence in the profession and the regulatory system.

2.94 In relation to two linked cases[9] we were concerned by the lack of any risk assessment, the failure to identify and gather evidence and the failure of the IC to adjourn in order to seek the consent of the patient for the release of their records. These two cases were amongst the 128 that the GCC discovered in early 2012 had not been processed correctly on initial receipt (see paragraph 1.4 above). These two cases concerned allegations that registrants had provided inappropriate treatment, applied psychological pressure and asked inappropriate questions about a vulnerable patient's personal history. The IC closed the cases (the complainant had withdrawn their complaints) which we considered was premature, as no real investigation had been conducted at that time and indeed the GCC had not had any direct contact with the patient nor established that the patient was unfit to be contacted. In response to our audit feedback the GCC has commented that there was little prospect of pursuing the cases by the time they were processed, as no usable evidence was available and it did not consider that there were any serious public protection issues involved. We do not understand how the GCC reached this conclusion given that it did not carry out any investigation. We consider that the allegations were serious enough to mean that the GCC should have attempted to obtain evidence before the cases were closed.

2.95 In another case the GCC had not followed its own code of practice for criminal investigations and prosecutions, in that no consideration had been given to prosecuting an individual who was practising while unregistered with the GCC. The GCC referred the matter to the police, but by the time that referral was made (there was a seven week delay) by the FTP team, the GCC's Registrations team had allowed the individual to re-register, apparently without informing the FTP team and without considering the relevance of the allegations that the individual had been practising while unregistered. This case demonstrates the potentially serious impact of an inadequate system for sharing information between the Registrations and FTP teams. [10]

2.96 In the same case, there was no evidence to show that the Registrations team had been made aware of the allegations that the individual concerned had been practising while unregistered. The Registrations team therefore re-registered that individual, without considering the allegation that they had been practising illegally. The matter of the registrant's previous illegal practice was then considered by the IC. The IC's reason for closing the case was that the registrant '*was not on the register at the relevant time his behaviour could not be such as to*

[9] See also paragraph 2.22 for details of these cases
[10] See also paragraph 2.82 for further details

amount to unacceptable professional conduct, because section 20 of the Act applies only to registered chiropractors'. While we considered that reasoning to be unsound (because at the date of the IC meeting the registrant was a registered chiropractor) and we identified concerns about the IC's failure to explore the case fully, our primary concern was that the Registrations Team had incorrectly re-registered the individual. In relation to the FTP team's case file, we noted that there was no record of the registrant's previous registration status or their previous FTP history, and in fact a box had been ticked to indicate that the registrant had no previous FTP history. The information provided to the IC about the registrant was therefore incorrect. This raises an additional concern that the issue highlighted in our previous audit, of relevant information about the registrant's FTP history not being shared with the IC has not been effectively addressed. A further concern we identified was that the FTP team did not become aware that this individual had re-registered for over two months - which indicates that there is another gap in the GCC's processes for sharing information between the FTP and Registrations teams.

2.97 In a fourth case, there was an eight day delay in asking the Registrations team to update the registrant's registration status to show that an interim suspension order had been put in place. The information about that interim suspension did not appear on the GCC's website until nine days after the order was imposed. This case also highlighted to us the inadequacy of the GCC's current legislative framework which only permits interim suspension orders to be imposed for a maximum of two months. In the majority of cases, a two month suspension period is likely to be far too brief to allow the regulator to investigate the case fully and, if appropriate, adjudicate on it at a panel hearing. We note that the other regulators that we oversee generally have legal powers to impose interim orders for up to eighteen months (subject to reviews). We are aware that the limitations of the GCC's current legislative framework have already been brought to the Department of Health's attention by the GCC, and we look forward to its being brought into alignment with the frameworks of the other regulators that we oversee.

2.98 In a fifth case, GCC staff effectively undermined the decision that had been reached by the IC. The IC had closed the case, on the basis that the plaque which was the subject matter of the complaint had been removed from the registrant's practice. When the registrant then contacted the GCC for clarification about the IC's decision, GCC staff told the registrant that they could reinstate the plaque.

2.99 We identified a concern in a sixth case - the letter sent to the complainant containing the IC's decision only referred to one aspect of the complainant's concerns. The complaint related to text on the registrant's website encouraging the use of chiropractic and making various statements about conventional medical treatment, including a statement that giving fever-reducing medication to a child can prolong the length of an illness. The letter sent to the complainant simply stated *'The Committee did not consider that the content of this article raised any professional conduct issues and it directed that the case be closed'* without explaining the basis for the IC's decision (for example without explaining whether the IC had concluded that there was adequate scientific evidence to support the text on the website).

Data protection

2.100 Ensuring that sufficient protection is given to sensitive and personal data is not only a legal requirement, but it is essential to maintaining public confidence in a regulator's FTP procedures. Complainants (and other parties involved in the FTP process) need to be assured that their personal information, particularly where it relates to health, will only be disclosed by the regulator where necessary.

2.101 In the Authority's Performance Review of the GCC in 2013/2014 [11] we reported two examples of data protection breaches by the GCC, one of which had been reported to the Information Commissioner's Office (ICO).

2.102 During this audit we looked for evidence that the GCC had maintained the security of data protection in its handling of FTP cases. In this audit we identified 13 cases where there had been a data protection breach or where there was the potential for a data protection breach to occur. In addition we were concerned that in some cases the GCC had not taken appropriate action either to remedy the situation or to notify relevant individuals about what had happened. We set out the details of these cases below:

- In the first case the GCC sent a bundle of documents to the complainant which contained names and addresses of some individuals who had provided testimonials in support of the registrant at an interim orders hearing. The complainant then emailed the GCC stating that they planned to contact those witnesses. The GCC's unauthorised disclosure of the witnesses' personal data was only identified when the Chair of the IC was considering a procedural request from the complainant. We noted that once the breach had been identified, the GCC informed the witnesses about what had happened and asked the complainant to return the papers and to confirm that they would not contact the witnesses. However there is no evidence that the matter was escalated within the GCC as a matter which required internal investigation (for example to the relevant line manager or to the Chief Executive/Registrar) nor that any consideration was given to whether it should be reported to the Information Commissioners Office (ICO)
- In the second case the GCC disclosed sensitive personal information about the complainant's health to the registrant, contrary to Counsel's advice. The GCC also failed to tell the complainant the full extent of the disclosure that had been made to the registrant. We do not accept the GCC's position that it was entitled to rely upon the fact that the complainant had signed its standard consent form which sets out that the individual provides consent for disclosure of all their medical records, because it was clear to us that the complainant had expressly limited the extent of the records that it was permissible to disclose. We also note that the extent of the disclosure made by the GCC exceeded that set out in its own legal advice
- In the third case the caseworker sent a letter to an address which was not the registered address for the registrant because they were aware that

[11] Performance Review Report 2013/14 http://www.professionalstandards.org.uk/library/document-detail?id=d716599e-2ce2-6f4b-9ceb-ff0000b2236b

the registrant had recently moved house to the city in question, and there was only one registrant registered as living in that city. The address the letter was sent to was actually the registered address of another registrant, who had a completely different name to that of the registrant. We were concerned that there was no evidence on the file that the GCC had retrieved the letter or ensured its destruction, nor that the GCC had notified the correct registrant about what had happened, nor that the matter had been escalated internally to a relevant manager or the Chief Executive/Registrar, nor that any consideration had been given to whether the matter should be reported to the ICO

- In the fourth case the registrant became aware of the identity of the registrant who was the subject of another linked case as a result of the GCC providing that information in a letter. As a result, the registrant discussed the cases with the other registrant, including discussing the remedial actions they had taken. There was no evidence that the GCC had escalated this data breach to a manager or the Chief Executive/Registrar, or that the registrant whose data had been shared had been notified about what had happened, or that the GCC had considered whether the matter should be reported to the ICO
- In a fifth case medical information about the complainant which was not relevant to the case was provided to the other parties**.** There was evidence that the GCC staff member involved had raised this issue with their manager, but there was no record to show that it had been escalated any further within the GCC, or that the complainant had been notified about what had happened, or that the information had been retrieved/destroyed or that any consideration had been given to whether the matter should be reported to the ICO. In response to our audit feedback about this case the GCC has told us that it did not consider the breach serious enough to require notification to the ICO
- In the same case, a telephone attendance note recorded a conversation between a caseworker and a registrant about the fact the registrant had spoken to other registrants who were also the subject of complaints. The note also recorded a discussion between the caseworker and the registrant about the actions another registrant had taken. The information about the other registrants came from a letter that the GCC had sent to the registrant in error. We were concerned this was a confidentiality breach
- In a sixth case the complainant only gave consent for medical records from a specific time period and relating to their musculoskeletal health to be obtained. The GCC assured the complainant that the request for records would be limited to the particular time period, but in fact the records that the GCC obtained and disclosed to the registrants spanned a wider time period, and also disclosed information about other elements of the complainant's health. We note that the GCC took steps to retrieve the records, and also considered obtaining legal advice (although there is no record such advice was actually obtained, or if obtained, that it was followed). There was a second data breach in this case, when the GCC

disclosed two registrants' names when writing to a third registrant. We noted that the GCC identified the need to ensure that its letter had been securely disposed of and that an apology was provided to both registrants, but those actions were not in fact completed. The only action recorded was an apology provided to one of the registrants. We note that the GCC reported this case to the ICO and the ICO apparently took no action. The GCC has not confirmed whether both data breaches in the case were reported to the ICO

- In another case the appendix to the letter sent to the registrant notifying them of the IC's decision included a reference to the complainant's name although the complainant had requested they remain anonymous. There was no evidence that this matter was escalated to the relevant line manager or the Chief Executive/Registrar or that any consideration was given to whether it should be reported to the ICO. There is also no evidence that the GCC notified the complainant about what had happened
- Two cases that we audited raised concerns about the security of emails containing case-related information that are sent to or from the GCC without password protection or encryption. In the one case, emails from IC members were sent from their Yahoo or Gmail email addresses. In the other case, the text of a draft affidavit was pasted into an email because the recipient could not open it as an attachment
- In three linked cases the GCC actioned the complainant's request for their contact details to be removed from the complaint, but then failed to remove those details from other case papers. It is not clear whether the complainant was ever made aware of this
- In the final case that raised concerns about data protection breaches, it appeared that the GCC had previously sent a letter enclosing the complainant's hospital records to the registrant's previous address. The explanation that the GCC provided was that this was due to human error. We note that the GCC apologised to the complainant and that it appears that the letter was sent by special delivery and was returned unopened.

2.103 In response to our feedback about these cases, the GCC has informed us that it has re-trained the relevant staff members on data protection and freedom of information in relation to FTP matters as of September 2014.

2.104 Given the number of data protection issues we identified during the audit, as set out above, we will look for evidence that the GCC's handling of data protection issues in practice has improved to an adequate standard across all of its caseload in our next Performance Review.

3. Conclusions and recommendations

3.1 Our overall conclusion from the audit is that the GCC's operation of its initial stages FTP process has not created any risks to public safety, and that in the

majority of the cases, the IC made appropriate decisions to close cases without a referral for a hearing.

3.2 However, public protection in the context of a regulator's FTP process means more than just directly protecting the public from harm – it means declaring and upholding professional standards, and maintaining public confidence in the profession and the regulatory system.

3.3 The extent of the deficiencies we found in this audit (as set out in detail above) which related to failures across every aspect of the casework framework, as well as widespread failures to comply with the GCC's own procedures, raises concern about the extent to which the public can have confidence in the GCC's operation of its initial stages FTP process.

3.4 In summary, the particular areas of failures/weaknesses identified in our audit include:

- Ineffective screening on receipt of 'complaints' and inconsistent completion and updating of risk assessments
- Customer service issues, including failing to respond to/acknowledge correspondence promptly, failing to provide clear information about the FTP process and failing to provide updates about progress and outcomes within reasonable timeframes
- Inadequate investigation of cases through failures to gather or validate relevant evidence or to do so promptly - sometimes as a result of inconsistent and ineffective use of case plans and case reviews
- Deficiencies in the evaluation of information by decision-makers and weaknesses in the reasoning provided for decisions, including failures to address all the relevant allegations and/or reaching decisions on the basis of insufficient evidence
- Poor record keeping and various data protection breaches or potential breaches
- Ineffective systems for the sharing of relevant information between the Registration and FTP teams, leading to inappropriate action being taken in some cases
- Widespread non-compliance with internal guidance and procedures.

3.5 We have also concluded that the steps taken by the GCC, in particular the processes it introduced in its procedure manual in February had not at the time of the audit resulted in consistent improvement in the quality of its casework.

3.6 We make a number of specific recommendations for the GCC below.

Recommendations

3.7 We welcome the fact that, in response to our audit feedback, the GCC has informed us that it has already taken some further steps to improve its FTP processes – in particular, by introducing changes to staff procedures relating to updating case plans during the lifetime of a case; instituting regular discussions between paralegals and FTP lawyers to review cases; and introducing a new checklist to improve the quality and provision of reasons around risk

assessments. We consider it essential that the GCC reviews those measures in the light of our audit report, in order to evaluate whether they are sufficient to address all of the weaknesses highlighted by our audit, as well as to ensure that it has effective mechanisms in place to monitor their effectiveness in improving the quality and consistency of its case-handling.

3.8 We would also encourage the GCC, as part of its consideration of our audit findings, to consider which of the processes and timeframes set out in its procedure manual should be prioritised and if they are (or can be made) achievable, taking into account the resources it has available. In addition we recommend that the GCC reviews how it screens complaints, with a view to changing its approach in order to focus its limited resources on progressing only those 'complaints' which amount to genuine FTP concerns.

3.9 The number of cases where we found one or more of the failures/weaknesses above gives rise to a separate concern about the effectiveness of any monitoring or quality assurance arrangements that the GCC had in place during the relevant period. We therefore recommend that the GCC reviews its arrangements for training, supervision and quality assurance of casework.

3.10 We also recommend that the GCC ensures that confidential, sensitive information is protected, that data breaches are identified, consistently classified and reported and appropriate actions taken.

3.11 In our view, the GCC will need to consider how it can provide its stakeholders with the appropriate degree of assurance that the actions it had already taken to improve its case-handling prior to our audit, the actions it had planned to take but had not yet completed before we completed our audit, and any additional measures the GCC decides to take once it has reviewed our audit findings, are sufficient to ensure that the necessary improvements in the quality and consistency of its case-handling are achieved within a reasonable timeframe and are effective to improve the quality and consistency of its case handling. We will look for evidence of improvement in the areas of weakness identified during this audit in our next audit. We will also encourage the GCC to share with us any evidence of the impact of its improvement measures in our annual Performance Review.

1. Annex 1: Fitness to practise casework framework

1.1 The purpose of this document is to provide the Authority with a standard framework as an aid in reviewing the quality of regulators' casework and related processes. The framework will be adapted and reviewed on an on-going basis.

Stage specific principles

Stage	Essential elements
Receipt of information	• There are no unnecessary tasks or hurdles for complainants/informants • Complaints/concerns are not screened out for unjustifiable procedural reasons • Provide clear information • Give a timely response, including acknowledgements • Seek clarification where necessary.
Risk assessment	*Documents/tools* • Guidance for caseworkers/decision makers • Clear indication of the nature of decisions that can be made by caseworkers and managers, including clear guidance and criteria describing categories of cases that can be closed by caseworkers, if this applies • Tools available for identifying interim orders/risk. *Actions* • Make appropriate and timely referral to Interim Orders Committee or equivalent • Make appropriate prioritisation • Consider any other previous information on registrant as far as powers permit • Record decisions and reasons for actions or for no action • Clear record of who decided to take action/no action.

Stage	Essential elements
Gathering information/ evidence	*Documents/tools* • Guidance for caseworkers/decision makers • Tools for investigation planning. *Actions* • Plan investigation/prioritise time frames • Gather sufficient, proportionate information to judge public interest • Give staff and decision makers access to appropriate expert advice where necessary • Liaise with parties (registrant/complainant/key witnesses/employers/other stakeholders) to gather/share/validate information as appropriate.
Evaluation/decision	*Documents/tools* • Guidance for decision makers, appropriately applied. *Actions* • Apply appropriate test to information, including when evaluating third party decisions and reports • Consider need for further information/advice. • Record and give sufficient reasons • Address all allegations and identified issues • Use clear plain English • Communicate decision to parties and other stakeholders as appropriate • Take any appropriate follow-up action (e.g. warnings/advice/link to registration record).

Overarching principles

Stage	Essential elements
Protecting the public	• Every stage should be focused on protecting the public and maintaining confidence in the profession and system of regulation.
Customer care	• Explain what the regulator can do and how, and what it means for each person • Create realistic expectations. • Treat all parties with courtesy and respect • Assist complainants who have language, literacy and health difficulties. • Inform parties of progress at appropriate stages.
Risk assessment	• Systems, timeframes and guidance exist to ensure ongoing risk assessment during life of case • Take appropriate action in response to risk.
Guidance	• Comprehensive and appropriate guidance and tools exist for caseworkers and decision makers, to cover the whole process • Evidence of use by decision makers resulting in appropriate judgements.
Record keeping	• All information on a case is accessible in a single place. • There is a comprehensive, clear and coherent case record • There are links to the registration process to prevent inappropriate registration action • Previous history on registrant is easily accessible.
Timeliness and monitoring of progress	• Timely completion of casework at all stages • Systems for, and evidence of, active case management, including systems to track case progress and to address any delays or backlogs.

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