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When Regulated Persons Are Suspected of Committing Crimes

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From a public policy perspective, there is little consensus on how regulators of professions and law enforcement agencies should coordinate their efforts when a registrant is suspected of committing a crime. Despite some media articles in the past (e.g., related to lawyers and physicians), few regulators even have a published policy on the topic. The policies that do exist tend to be brief and do not address the coordination of efforts.

The hesitancy to develop a comprehensive policy is understandable. There are several policy challenges including the following:

1. How serious should the apparent criminal conduct be before a regulator notifies law enforcement? Some conduct, while technically criminal in nature, is unlikely to result in charges.
2. How certain should the regulator be that the conduct is criminal in nature before reporting it to law enforcement? Regulators are not experts in criminal law.
3. Should a report be made by a regulator without the consent of the possible "victim" of the crime? In *To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act*, the Task Force warned against the reporting of sexual abuse cases to law enforcement without the consent of the patient who may have consciously chosen not to go to the police.
4. What are the unintended consequences of such reports? For example, will people be less willing to come forward to regulators with incompetence or misconduct concerns for fear of being conscripted into a criminal investigation?
5. When should the notification be made? Will law enforcement involvement result in reduced access to witnesses and documents for the regulator if the regulator's investigation is not substantially

completed by the time the notification is made?
6. If notification is made early, should regulators continue to investigate concerns in parallel with any law enforcement investigation or proceedings?
7. Would coordination between regulators and law enforcement create impediments to either process? For example, would any evidence gathered by regulators be rendered inadmissible in the related criminal proceedings because the safeguards contained in criminal law were not followed (e.g., relating to restrictions on using evidence obtained through an authorized regulatory search and seizure)? Or would there be any concern about an abuse of process by the regulator in any such coordination?
8. What impact does the confidentiality provisions applicable to the regulator have on its ability to disclose information to law enforcement authorities?
9. Should there be a corresponding obligation on law enforcement to report matters relating to registrants to regulators? If so, in what circumstances?

In England a comprehensive memorandum of understanding (MOU) on the topic was recently updated. The updated MOU follows the 2018 report of Professor Sir Norman Williams on *Gross negligence manslaughter in healthcare*. That report states:

> The review was set up to consider the wider patient safety impact resulting from concerns among healthcare professionals that simple errors could result in prosecution for gross negligence manslaughter, even if they occur in the context of broader organisation and system failings. In particular, there was concern that this fear had had a negative impact on healthcare professionals being open and transparent should they be involved in an untoward event, as well as on their reflective practice, both of which are vital to learning and improving patient care.

The MOU itself addresses the following topics:

Who is agreeing? The MOU is between UK's health and social care regulators, health organizations, such as the National Health Service, and law enforcement.

What triggers the duties under the MOU? The MOU applies "in the course of healthcare delivery where suspected criminal activity on the part of an individual is believed to have 'led to or significantly contributed to' the death or serious life-changing harm (whether of a physical or psychological nature) of a patient or service user." This is a lower threshold than the "reasonable grounds to believe" test. However, the "harm" requirement is intended to result in the use of the MOU only in more serious types of criminal conduct.

What is the goal of the MOU? The goal is described as aiming to:

- "facilitate efficient and effective co-ordination of appropriate approaches, patient safety learning responses and investigations, while taking steps to avoid prejudicing regulatory or criminal investigations or criminal proceedings
- ensure relevant information and 'confidential information' is quickly, lawfully and efficiently shared between the relevant signatories where necessary to progress learning responses, investigations and proceedings
- ensure evidence is quickly identified, secured and handled in accordance with best practice

- allow steps to be taken quickly to manage ongoing risk and as far as possible protect the public and service users"

What happens when the MOU is triggered? The party who believes the MOU has been triggered will convene a meeting of the parties' representatives, called the incident coordination group (ICG). Other agencies (e.g., coroner) can be invited in appropriate cases. In some circumstances it may be inappropriate for some parties to attend the meeting(s). For example, if the police are already involved in an investigation, it may not be suitable for them to share information with the group. Similarly, it may not be appropriate for the provider of the service to be involved if their own conduct is in issue.

At their meetings the ICG will canvass the following:

- sharing of information amongst the parties consistent with the applicable confidentiality provisions,
- coordinating parallel investigations and proceedings (including amongst regulators),
- ensuring that the suspected individual's rights are respected,
- securing, preserving and sharing (where appropriate) evidence,
- organizing the liaison with the patient and their family and representatives,
- harmonizing public messaging,
- facilitating future learning and patient-safety plans, and
- recording the discussions and action items.

What about the original concerns about organizational and system failings? The ICG is intended to be a vehicle for identifying and considering the contributions of the broader context to the conduct. The ICG's mandate includes facilitating and coordinating learnings that the individual parties can then develop in parallel to the criminal investigation. Also, the MOU specifies that any expert witnesses to be used in criminal proceedings act under the authority of law enforcement and are to be instructed to be impartial and neutral. Such experts are to be told to consider any systemic contributions to the conduct.

While the MOU is largely an aspirational and process-orientated document, it should facilitate a thoughtful approach to suspected criminal conduct coming to the attention of regulators.

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